



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

April 22, 2026

Michael Townsend  
61 Diamond Avenue NE  
Grand Rapids, MI 49503

RE: License #: AS410418699  
Investigation #: 2026A0579024  
Michael's Refuge

Dear Michael Townsend:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

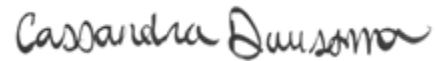
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in cursive script that reads "Cassandra Duursma".

Cassandra Duursma, Licensing Consultant  
Bureau of Community and Health Systems  
350 Ottawa, N.W., Unit 13  
Grand Rapids, MI 49503  
(269) 615-5050

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF COMMUNITY AND HEALTH SYSTEMS  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS410418699
<b>Investigation #:</b>	2026A0579024
<b>Complaint Receipt Date:</b>	03/02/2026
<b>Investigation Initiation Date:</b>	03/04/2026
<b>Report Due Date:</b>	05/01/2026
<b>Licensee Name:</b>	Michael Townsend
<b>Licensee Address:</b>	61 Diamond Avenue NE, Grand Rapids, MI 49503
<b>Licensee Telephone #:</b>	(616) 516-6621
<b>Administrator:</b>	Michael Townsend
<b>Licensee Designee:</b>	Michael Townsend
<b>Name of Facility:</b>	Michael's Refuge
<b>Facility Address:</b>	722 Eastern Avenue SE, Grand Rapids, MI 49507
<b>Facility Telephone #:</b>	(616) 481-2423
<b>Original Issuance Date:</b>	03/03/2025
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/03/2025
<b>Expiration Date:</b>	09/02/2027
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED/ MENTALLY ILL/ DEVELOPMENTALLY DISABLED/ AGED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Funds were inappropriately taken from Resident A.	Yes
Michael Townsend and Mark Townsend intimidate residents and their supports.	No
Paperwork was not completed to establish the monthly fee for services in the home.	No
Residents are left without supervision or adequate staffing.	No
Transportation was not provided to Resident A's doctors' appointments so they were missed or canceled.	No
Resident B does not receive adequate care.	No
Residents do not receive adequate meals.	No
Residents are given incorrect medications.	No
There are cameras throughout the home without the consent of residents or their guardians.	Yes
Additional Findings	Yes

## III. METHODOLOGY

03/02/2026	Special Investigation Intake 2026A0579024
03/04/2026	APS Referral Denied
03/04/2026	Special Investigation Initiated - Letter Stephen Conrad, APS
03/04/2026	Contact - Telephone call made Resident A
03/05/2026	Contact- Document Received Stephen Conrad, APS
03/05/2026	Contact- Telephone Call Made Guardian A
03/05/2026	Contact- Document Sent Shawna Maciel, AFC Licensee
03/06/2026	Contact- Telephone Call Received Shawna Maciel, AFC Licensee, Jose Maciel, AFC Licensee
03/09/2026	Contact- Face to Face

	Resident B, Resident C, Resident D, Mark Townsend (Direct Care Worker), Marie Carmen (Direct Care Worker), and Natasha Grew (Direct Care Worker)
03/10/2026	Contact- Document Received Michael Townsend, Licensee Designee
03/30/2026	Contact- Document Received Stephen Conrad, APS
04/15/2026	Contact- Telephone Call Made Relative A2
04/15/2026	Contact- Telephone Call Made Michael Townsend, Licensee Designee
04/21/2026	Exit Conference Michael Townsend, Licensee Designee

**ALLEGATION: Funds were inappropriately taken from Resident A.**

**INVESTIGATION:** On 3/2/26, I received this referral which alleged License Designee, Michael Townsend, took Resident A to her bank and withdrew \$4,200 to cover the expenses of Resident A living in the home. Mr. Townsend also took Resident A to the store and used her EBT card to purchase food for his own family.

On 3/4/26, I confirmed these allegations were reported to Adult Protective Services (APS) and denied for investigation.

On 3/4/26, I contacted APS caseworker Stephen Conrad who was reported to be involved with case management for Resident A. He reported although Resident A has moved to a new placement, he is aware of the allegation and that it was reported to him that direct care worker (DCW) "Moe" was the individual involved with the allegation. He reported Resident A could be interviewed via telephone; however, she is often not truthful when interviewed.

On 3/4/26, I attempted a telephone interview with Resident A. It was reported the phone number was not in service.

On 3/5/26, Mr. Conrad reported he spoke with Guardian A and she requested to speak with me regarding her concerns regarding the home.

On 3/5/26, I completed a telephone interview with Guardian A who reported she is "extremely concerned" about what occurred while Resident A briefly resided at this home. She stated she was unaware that Licensee Designee, Michael Townsend,

and DCW Mark Townsend were different people. She stated Resident A reported it was "Moe" who was involved in the allegation and Guardian A believed she was interacting with "Moe" but now she is not certain whether it was Michael Townsend or Mark Townsend involved with the allegation.

Guardian A stated Michael Townsend or Mark Townsend were persistent and harassing Resident A, her relatives, and Guardian A about being paid for Resident A's placement and services in the home. She stated there was a delay because she was recently appointed guardian of Resident A and there are rules and processes for how she could access and utilize funds. She stated once Resident A became guarded, Resident A stopped having access to her own funds and she made this clear to Michael Townsend or Mark Townsend.

Guardian A stated Michael Townsend or Mark Townsend found a debit card that was in Resident A's possession, drove her to the bank, and forced her to withdraw \$4,200 for payment for her placement in the home. Guardian A reported she repeatedly told Michael Townsend he would be paid once the financial arrangements were legally made, so she is certain he was aware that Resident A, her family, Guardian A, and he, could not withdraw funds from Resident A's accounts until these arrangements were made legally. She stated she is certain Michael Townsend knew taking these funds was illegal and he did not tell Guardian A he did this. Resident A told her, and she then confronted him about it.

Guardian A stated Resident A also reported that Michael Townsend or Mark Townsend took her to the grocery store and forced her to use her EBT funds to purchase groceries that they did not bring to the AFC home but instead used for themselves and their families. She stated this home is not operated by a non-profit so they are not allowed to have residents who have EBT funds. She stated the funds should have ended when she moved into this home and even if there was extra on the card, it should have been for Resident A's personal use, not for the home and not for Michael Townsend, Mark Townsend, or their families. She stated the licensees at Resident A's new placement may have additional information to provide regarding this allegation.

On 3/5/26, I contacted licensees Shawna Maciel and Jose Maciel via email to introduce myself and requested return contact should they have any concerns regarding Resident A.

On 3/6/26, Ms. Maciel contacted me via email and telephone and reported she would like to discuss concerns regarding Resident A's placement at Michael's Refuge. I placed a return phone call to her. Ms. Maciel stated Resident A reported allegations involving "Moe" which she believes is Michael Townsend. She stated she was not aware that Michael Townsend and Mark Townsend are two different people but her understanding is that Moe refers to Michael Townsend. Ms. Maciel stated Resident A and Guardian A both told her that Michael Townsend took Resident A to the bank and forced her to withdraw \$4,200 for her AFC payment. Ms. Maciel stated

Michael Townsend also called to warn Ms. Maciel that Guardian A would not pay her and reported he had to take Resident A to the bank to withdraw funds to receive payment. She stated therefore, he confirmed taking the funds with her. She stated when he said this, she advised this was not appropriate since Resident A is guarded, that she has worked with Guardian A in the past, and informed him Guardian A would ensure that payment was received, even if it had to be backpay.

Ms. Maciel reported Resident A also reported to her that Michael Townsend forced Resident A to use her EBT card to purchase groceries which were not utilized in the home and that Michael Townsend took them to his personal home. Ms. Maciel stated although Resident A can utilize a telephone, she does not believe Resident A is capable of completing a telephone interview and is not a reliable historian. She also stated that Resident A's mental health has been negatively impacted by her telephone use, which is why her personal number is no longer in service.

On 3/9/26, I completed an unannounced on-site investigation at Michael's Refuge. Interviews were completed with Mark Townsend, Resident B, Resident C, Resident D, and DCW Marie Carmen. Resident E was present and spoken to but was not interviewed. Licensing Consultant Natasha Grew was also present. Mark Townsend confirmed he goes by the name Moe and that allegations related to "Moe" likely are referring to him as Michael Townsend does not regularly work in this home.

Mark Townsend reported Guardian A did not provide payment for Resident A's placement at this home. He stated Guardian A advised she was completing paperwork but reported in the meantime, Relative A2 had access to Resident A's funds. He stated it was Guardian A who suggested contacting Relative A2 about payment. He stated Relative A2 suggested and gave permission to use Resident A's debit card and take Resident A to the bank to withdraw the funds from Resident A's account. He denied that Resident A was forced to withdraw the money against her will or that he or Michael Townsend harassed anyone about the payments. He reported Guardian A knew they would be contacting Relative A2 because it was her suggestion since she could not access the funds. He stated Resident A left this home, at her own request, so a refund was issued to Guardian A.

Mr. Mark Townsend provided an invoice that noted \$193.55 was owed for December 2025, \$2000 for January 2026, and \$2000 for February 2026 totaling \$4193.55. It was reported a prorated refund of \$344.85 was owed to Guardian A due to Resident A discharging on 2/24/26.

Mr. Townsend stated Resident A did not have an EBT card while living at this home. He stated on one occasion, Resident A went grocery shopping with him and another resident who was using the last of the funds on her EBT card for her own food items, but Resident A did not have her own EBT card. He expressed understanding that residents cannot receive food assistance while living in this AFC home. He denied ever using a resident's EBT funds for himself or his family. He stated due to Resident A's diagnosis of dementia; she often gets details confused but she did not

have an EBT card brought to this home.

Mark Townsend requested consultation regarding how he should have handled this situation. It was discussed and known that prior to Resident A's placement in the home, Mark Townsend and Michael Townsend had dealt with a different guardian who was not responsive and a lack of payment from another resident. He reported being frustrated with a lack of cooperation from guardians and discussed that they cannot operate without monthly payments. I advised that it is not appropriate for Michael Townsend or Mark Townsend to involve themselves with obtaining funds from resident bank accounts. I advised payments should come from the resident's designated payee/guardian. I advised if payments were not obtained, then legal action should be taken to obtain payment.

On 3/30/26, Mr. Conrad reported he received Resident A's bank statements and confirmed there was a \$4255 check cashed on 2/18/26. He reported it appeared Resident A wrote the check despite her having a guardian. He stated the allegation was being referred to law enforcement for criminal investigation.

On 4/15/26, I completed a telephone interview with Relative A2 who stated Relative A1 was previously Resident A's Power of Attorney (POA) for medical decisions, with him as the secondary POA, and he was the only POA for Resident A's finances. He stated Resident A had a mental health crisis induced by a conflict with Relative A1 and ended up requiring treatment at Pine Rest. He stated he temporarily took over as primary medical POA but he could not take full responsibility on his own at this time and Pine Rest would not allow Resident A to discharge without a guardian. He stated this is when the court became involved and Guardian A was appointed. He stated Guardian A then was able to discharge Resident A to Michael's Refuge.

Relative A2 stated Resident A's discharge from Pine Rest to Michael's Refuge put him "between a rock and a hard spot" because since he had temporarily acted as Resident A's medical POA and had been her financial POA, everyone was coming to him regarding payments, medical appointments, and other matters he was no longer legally privy to when Guardian A was appointed. He stated he struggled to get in contact with Guardian A to address these matters.

Relative A2 stated Mark Townsend kept reporting to him that they were not getting paid for Resident A's placement and care even though he advised he was no longer involved with Resident A's finances. He stated he attempted to address this with Guardian A, but Guardian A advised him that he was responsible for paying the bill until the financial arrangements with Guardian A were made. He stated he contacted Resident A's bank and they advised him that since Resident A was placed in a guardianship, he no longer had legal access to the account. He stated he also no longer had proof of POA because the previous POA noted Relative A1's involvement and it was torn up and thrown away.

Relative A2 stated he was aware that Resident A's name was on a joint account and

advised Mark Townsend that she had a debit card in her possession. He stated he did not have knowledge of Michael Townsend taking Resident A to the bank. He stated he did not give permission for Resident A to be taken to the bank because he knew he could not legally be involved with Resident A's money. He stated he advised Mark Townsend that Resident A still had a debit card in her possession though. He stated he later learned that Resident A was taken to the bank and withdrew the funds for her AFC payment when Resident A called him and said, "(Guardian A) is not going to be happy with me, I got the money" for Michael Townsend. He again confirmed that Guardian A told him that he was responsible for arranging the AFC payment and reported he felt "put in the middle" of the situation that he legally could not be involved in.

On 4/15/26, I attempted a telephone interview with Michael Townsend. It was unsuccessful. Mr. Townsend later responded via email, attempting to schedule a time for a telephone interview.

On 4/21/26, I completed a telephone interview with Mr. Michael Townsend. He stated after two months of Resident A residing at the home, he had still not received payment for her living there because Guardian A was unable to arrange it. He stated Guardian A advised him to contact Relative A2 so he did. He stated Relative A2 advised that Resident A had a debit card in her possession and he called the bank to increase the amount that Resident A could withdraw. He stated he took Resident A to the bank but did not go into the bank with her. He stated he does not know the exact amount Resident A withdrew and reported it was the amount that Mark Townsend told him Resident A owes and it was given to him via cashier's check that Resident A obtained from her bank. He denied that he forced Resident A to obtain the funds without her consent and Relative A2 and Guardian A's knowledge. He stated he does not believe any residents have EBT cards and believes that Resident A may have been shopping with Ms. Carmen when Ms. Carmen used her EBT card. He acknowledged that since the home is not a nonprofit, he is aware residents cannot continue to receive EBT benefits while living in the home.

<b>APPLICABLE RULE</b>	
<b>R 400.637</b>	<b>Handling of resident funds and valuables.</b>
	<b>(11) A licensee, staff, volunteers, members of the household, and their family members cannot accept, take, or borrow money, resident funds, or valuables from a resident, even with the consent of the resident.</b>
<b>ANALYSIS:</b>	Mark Townsend confirmed that Michael Townsend took Resident A to the bank to obtain payment for AFC services, despite knowing Resident A had a guardian. Guardian A, Ms. Maciel, and Relative A2 confirmed this as well.  Mr. Conrad confirmed \$4255 was withdrawn from Resident A's

	<p>account via check she wrote, although it was known she had a guardian at that time. Furthermore, the account statement provided by Mark Townsend showed a balance of \$4193.55 was owed so additional funds were withdrawn at that time.</p> <p>Michael Townsend reported he transported Resident A to the bank to obtain her owed funds that were subsequently given to him via cashier's check. He reported Relative A2 assisted with obtaining the payment by increasing the debit card amount and informing him of the card. He reported Guardian A advised him to contact Relative A2 when she could not arrange payment.</p> <p>Based on the interviews completed and documentation observed, there is sufficient evidence that resident funds were inappropriately taken by Michael Townsend.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION: Michael Townsend and Mark Townsend intimidate residents and their supports.**

INVESTIGATION: On 3/5/26, Guardian A stated she has concern regarding Michael Townsend and Mark Townsend's interactions with residents. She stated Resident A reported Michael Townsend and/or Mark Townsend forced her to withdraw funds from the bank even though she knew that was not appropriate and she did not want to. She stated Resident A reported she also did not want to use her EBT funds for Michael Townsend or Mark Townsend's personal use, but they forced her to.

Guardian A stated Michael Townsend's persistent calls and requests for Resident A's family and Guardian A to take Resident A's funds for payment, even though they knew it was illegal, were inappropriate and felt like harassment. She stated it was reported Mark Townsend "scolded" residents for opening the door when Ms. Maciel arrived at the home. She stated Resident A also discussed Mark Townsend giving her forceful and unwanted hugs on occasion.

On 3/6/26, Ms. Maciel stated she was concerned by what she witnessed when she arrived at the home to obtain Resident A's medications. She stated a resident opened the door and Mark Townsend raised his voice and scolded the resident stating, "You don't open the door for anyone, not even the police." She stated she felt that was "extremely inappropriate".

On 3/9/26, Mark Townsend denied that he or Michael Townsend harass, intimidate, or make residents uncomfortable. He denied raising his voice toward any residents or touching residents in an unwanted or inappropriate way. He stated due to safety

concerns in this neighborhood he requests residents not open the door but he has not yelled at residents for opening the door.

Resident B, C and D denied concerns regarding Mark Townsend or Michael Townsend's behaviors or interactions with them. Resident B expressed DCWs can be frustrated with her because of the amount of assistance she needs but denied that they ever speak inappropriately toward her or raise their voices. She could not elaborate on how she knew DCWs were frustrated with her. She reported that she gets frustrated with DCWs and with herself due to the limited use of her legs.

On 4/15/26, Relative A2 reported he did feel intimidated by Mark Townsend and is concerned that Resident A was intimidated by them to withdraw money from her bank account even though she knew she was not supposed to. He stated Mark Townsend was persistent in calling and texting him saying, "Where's my money? I need my money," even though they knew he no longer had legal access to Resident A's funds. He stated he also learned they contacted Resident A's estranged husband to get payment which he did not feel was appropriate.

On 4/20/26, Michael Townsend stated he spoke to Guardian A and Relative A2 on multiple occasions, but he did not harass them. He stated he believes he contacted Relative A2 two or three times. He denied reaching out to any other relatives of Resident A. He stated to his knowledge, Mark Townsend reached out to Relative A2 one time but there were "gaps in between" so it was not repeatedly. He reported Resident A went into her bank to obtain funds independently and he brought her there following the guidance of Relative A2 so she was not forced to obtain the funds.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.</b>
<b>ANALYSIS:</b>	<p>Guardian A, Relative A2, and Ms. Maciel expressed concern regarding how Mark Townsend speaks to residents.</p> <p>Relative A was reported to not be a reliable historian and was not interviewed regarding the allegations.</p> <p>Resident B, C and D denied concerns regarding their treatment by Mark Townsend and Michael Townsend. Mark Townsend and Michael Townsend denied that they intimidate or harass residents.</p> <p>Based on the interviews completed there is insufficient evidence that residents are not treated with dignity and respect.</p>

<b>CONCLUSION:</b>	VIOLATION NOT ESTABLISHED
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**ALLEGATION: Paperwork was not completed to establish the monthly fee for services in the home.**

**INVESTIGATION:** On 3/5/26, Guardian A stated no paperwork was done with her to set a fee for AFC services. She stated while Michael Townsend withdrew \$4,200, she is not certain that Resident A would be paying that much for services. She stated it is possible that amount is correct, but no amount was ever agreed upon and she did not complete any documentation to establish this amount.

On 3/9/26, Mark Townsend reported Guardian A completed the necessary admission paperwork to admit Resident A into the home. He denied that paperwork was not completed and that a fee was not established.

I observed Resident A's Resident Care Agreement. It was documented that Resident A's monthly fee for services was \$2000. Guardian A's signature was on the second page with a date of 1/6/26.

On 3/10/26, Michael Townsend provided an email to Guardian A dated 12/30/25 discussing that Resident A's Resident Care Agreement was attached for her completion.

<b>APPLICABLE RULE</b>	
<b>R 400.685</b>	<b>Resident admission; resident assessment plan; resident care agreement; health care appraisal.</b>
	<b>(6) A licensee shall complete a written resident care agreement at the time of a resident's admission that includes all of the following:</b>  <b>(b) The services to be provided and the fee for those services.</b>
<b>ANALYSIS:</b>	Guardian A denied completing paperwork to establish a fee for services.  Mark Townsend reported Guardian A completed the necessary paperwork required to admit Resident A into the home.  Michael Townsend provided an email submitting Resident A's Resident Care Agreement to Guardian A.  I observed Resident A's Resident Care Agreement with Guardian A's signature dated 1/6/26 that noted Resident A

	would pay \$2000 monthly for services in the home.  Based on the interviews completed and documentation reviewed, there is insufficient evidence that a resident care agreement noting the fee for services was not completed.
<b>CONCLUSION:</b>	VIOLATION NOT ESTABLISHED

**ALLEGATION: Residents are left without supervision or adequate staffing.**

**INVESTIGATION:** On 3/4/26, I reviewed the referral which alleged residents are often left without supervision.

On 3/5/26, Guardian A stated Resident A regularly reported residents being left alone without supervision in the home. She stated she did not know specific dates but recalled on one occasion, Mark Townsend left residents unattended. She stated she recalls that incident because it was reported they did not have sufficient staff to take Resident A to a doctor’s appointment and it was canceled but Mark Townsend later left to take someone to the airport during his shift.

On 3/6/26, Ms. Maciel stated she does not have knowledge of residents being left in the home without supervision but based on what she saw, she has concerns about there being an appropriate level of supervision in the home. She stated when she arrived to return Resident A’s medication, the DCW who was alone in the home could not speak English to interact with her or the residents. She stated based on her knowledge of Resident A’s needs and her observation of this DCW, the DCW could not have met Resident A’s needs because she cannot communicate with her. She stated she is also aware that there are two immobile residents, including one living on the second floor of the home. She stated she does not believe that one DCW could safely transfer and evacuate residents if there was a fire so she does not believe that having one DCW in the home is sufficient.

Mr. Maciel was also present on the telephone and reported that he and Resident A have discussed that she was regularly left alone with other residents in the home.

On 3/9/26, Mark Townsend denied that residents are ever left alone in the home. He stated Ms. Carmen has her own room upstairs and typically does not leave the home aside from occasionally going to the store. He stated it is coordinated so that another DCW is in the home when Ms. Carmen leaves. He stated that if he is listed on the staff schedule and must transport a resident, he ensures that Ms. Carmen is available in the home.

Mark Townsend denied there was ever a time when Resident A was not taken to her doctor’s appointment but he then transported someone to the airport. It was

confirmed that Michael Townsend does not regularly work shifts in this home so he does not believe the allegation related to Michael Townsend.

Mark Townsend stated Ms. Carmen speaks multiple languages but does have a limited use of English. He stated she speaks enough English to be able to meet resident needs. He gave the example that Resident F was recently injured eloping from the home and she knew to call him and Michael Townsend to respond and they confirmed a bystander had called 911. He denied concern that Ms. Carmen does not speak sufficient English to meet resident needs and ensure their safety. Mark Townsend stated there is only one person who needs assistance with transferring. He stated one DCW using a Hoyer lift is needed to transfer Resident B. He stated the other residents ambulate independently. He denied that anyone with mobility impairments has resided on the second floor. He reported that Resident E is the only resident living on the second floor of the home and she ambulates independently.

I observed Resident E and Ms. Carmen to be the occupants of the second floor of the home while I was present.

I observed Resident B, C, D and Resident E in the home. Resident B was observed to not have use of her legs and to require one DCW and a Hoyer lift for transferring. Resident E walked with a slight limp but ambulated independently. Resident C and D were observed ambulating independently. I had previous engagement with Resident F and observed him to ambulate independently as well.

Resident B, C and D denied concerns regarding adequate staffing in the home. Resident B reported DCWs could respond to her timelier but she understands she has significant needs and DCWs also must assist other residents in the home. Resident B, C and D denied being left alone in the home. They reported Ms. Carmen has limited use of English but they are able to communicate with her, although it takes some effort for her to understand them at times.

I observed a schedule in the home. It was a one-page posted document listing which individual worked from 8:00 a.m. to 3:00 p.m. and then 3:00 p.m. to 8:00 p.m. each day. 8:00 p.m. to 8:00 a.m. each day was not documented. Mark Townsend reported evenings were covered by Ms. Carmen who is the live-in staff for this home. Mark Townsend denied documenting who actually worked, for example should one DCW have to take a resident to an appointment. He denied maintaining an accurate schedule for historical purposes noting who worked on which days.

I reviewed the fire drill records for the home which noted fire drills were done in April, May, June, July, and August of 2025. No additional fire drills were documented so they could not be used to review appropriate evacuation times.

I attempted to interview Ms. Carmen. An interview could not be completed due to Ms. Carmen not being able to understand or respond due to her limited use of English. I inquired what she would do in an emergency and she could not respond

appropriately and did not appear to understand me. I inquired if she knew how to call 911 and she did not appear to understand me and could not respond appropriately.

On 4/15/26, Relative A2 stated his primary concern about Resident A’s placement in the home was a lack of staffing. He stated he believes residents are left alone without staff present. He stated after Resident A moved into the home, some of her prescriptions continued to come to her personal home. He stated he spoke to Mark Townsend about which medications were needed at the home and agreed to deliver them the next day. He stated when he arrived at the home, Resident A answered the door. He stated there was no DCW present and he did not know who to give Resident A’s medications to. He stated he ended up leaving the medications with Resident A, which he felt very uncomfortable about. He stated Mark Townsend was also “never at the home.” He stated every time he discussed something with Mark Townsend; he was driving in his car. He stated he could tell Mark Townsend was in a car and Mark Townsend would say, “Hold on let me pull over and write that down” while they were speaking.

On 4/21/26, Michael Townsend reported Ms. Carmen is always present in the home and may leave briefly during the day to go shopping. He stated if Ms. Carmen leaves the home, they ensure another DCW is present. He denied that residents are ever left alone. He reported he is also present in the evenings, typically from 10:00 p.m. to 6:30 a.m. approximately five days per week. He stated he is occasionally at the home as early as 6:00 p.m. or 8:00 p.m.

<b>APPLICABLE RULE</b>	
<b>R 400.633</b>	<b>Staffing requirements.</b>
	<p><b>(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following:</b></p> <p><b>(b) 12 residents for small group and family homes.</b></p>
<b>ANALYSIS:</b>	<p>Resident B, C and D denied concerns regarding inadequate staffing and denied being left alone. Mark Townsend and Michael Townsend denied that residents were left alone in the home.</p> <p>Guardian A, Relative A2, Ms. Maciel, and Mr. Maciel expressed concern about residents being left alone and/or a lack of DCWs appropriate to meet resident needs. The documentation in the home was not sufficient to determine the staffing ratio and evacuation times.</p>

	Based on the interviews completed and documentation reviewed, there is insufficient evidence to support that there is not one direct care worker to six residents in the home.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: Transportation was not provided to Resident A’s doctors’ appointments so they were missed or canceled.**

**INVESTIGATION:** On 3/5/26, Guardian A stated on one occasion, even though it was agreed transportation would be provided for Resident A’s medical appointments, Mark Townsend refused to transport Resident A to the appointment leading it to be canceled. She stated it was reported to her at this home that there were challenges with scheduling doctors’ appointments, which is not an issue at Resident A’s new placement, so it is believed they were not scheduling appointments so they did not have to transport Resident A because they were not willing to transport her.

On 3/6/26, Ms. Maciel expressed concern that Michael reported he could not schedule Resident A’s appointments with her physician or at Pine Rest. She stated she had no issue scheduling the appointments so she does not believe there were actual challenges, instead Michael Townsend did not want to or could not transport Resident A, so the appointments were not scheduled or attended.

On 3/9/26, Mark Townsend reported they did not cancel Resident A’s appointments and her missing appointments were not due to transportation issues. He stated Resident A was brought to a follow-up appointment and she could not be seen because Guardian A had not completed the necessary documentation. He stated Guardian A then did not cooperate with rescheduling medical appointments or connecting Resident A to a primary care doctor and physical therapy as needed. He stated Resident A’s health care appraisal was completed by Pine Rest at discharge but she did need follow-up appointments that Guardian A did not cooperate with. I reviewed an acceptable discharge summary that meets the requirements of a health care appraisal for Resident A from Pine Rest.

I reviewed Resident A’s Resident Care Agreement which noted transportation will be provided to and from scheduled appointments with a staff escort.

On 3/10/26, Michael Townsend provided emails between himself and Guardian A on 12/31/25 and 2/23/26 requesting her assistance with connecting Resident A to a primary doctor and physical therapy services, as well as informing Guardian A that a follow-up appointment was cancelled because she did not complete Resident A’s necessary paperwork.

On 4/15/26, Relative A2 stated he is aware that some of Resident A’s medical

appointments were missed due to Resident A's doctors continuing to contact him. He stated it was not a transportation issue that caused the missed appointments, rather it was reported to him that Guardian A had not completed the necessary paperwork to allow Resident A to be seen or did not call to reschedule the appointments as needed. He stated this was reported to him by the individuals calling on behalf of the doctor's offices.

<b>APPLICABLE RULE</b>	
<b>R 400.697</b>	<b>Resident transportation.</b>
	<b>(1) A licensee shall ensure the availability of transportation services as provided for in a resident care agreement. A licensee shall provide or arrange transportation for residents in a certified facility.</b>
<b>ANALYSIS:</b>	<p>Guardian A and Ms. Maciel reported they believe Resident A's appointments were missed due to Mr. Mark Townsend or Mr. Michael Townsend being unwilling or unable to transport Resident A.</p> <p>Relative A2 and Mark Townsend reported Resident A's appointments were missed due to Guardian A not completing necessary paperwork or rescheduling appointments.</p> <p>Based on the interviews completed, there is insufficient evidence that transportation was not provided to Resident A.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: Resident B does not receive adequate care.**

**INVESTIGATION:** On 3/4/26, I reviewed the referral which alleged "other residents" were neglected by DCWs.

On 3/5/26, Guardian A stated Resident A expressed concern that Resident B, her former roommate, is bedbound and DCWs would not toilet her so she was left in briefs soiled in urine and feces all day. She stated based on her interactions with Michael Townsend and/or Mark Townsend; she does not believe Resident B could be receiving adequate care in this home.

On 3/6/26, Ms. Maciel stated Resident A expressed concern to her that there are two residents in the home who are immobile, including Resident B, who do not receive adequate care.

On 3/9/26. Mark Townsend reported Resident B is the only resident who requires

the assistance of one DCW and a Hoyer lift to ambulate independently. He reported all other residents of the home ambulate independently. He stated Resident B typically calls out for assistance with toileting and she is regularly checked and positioned by DCWs, approximately every two hours. He denied that Resident B does not receive adequate care.

Resident B called for Mark Townsend's assistance while I was present. I requested to observe his interaction with her. He agreed. Ms. Grew and I followed him into Resident B's bedroom. I asked Resident B if she would allow permission for me and Ms. Grew to observe Mark Townsend as he provided care for her, which at this time involved toileting her. She agreed that Ms. Grew and I could remain in the room. I observed Mark Townsend change Resident B's brief, thoroughly clean her peri-area, and then transfer Resident B to her commode using her Hoyer lift. As I was observing Mark Townsend toileting Resident B, I observed a small sore on Resident B's lower back. I inquired if Resident B had any bed sores and she advised she did not think that she did and denied being in any pain. Mr. Townsend reported he believes the injury is a sore or cut from Resident B's commode since the seat is hard plastic and she is unable to hold her weight up. He reported Resident B's visiting physician comes to the home in two days and he will have the mark observed at that time and discuss treatment options. He denied the mark was from neglect or a lack of toileting as it is above where her briefs sit.

Resident B stated DCWs could respond timelier when she calls for them, "and sometimes it feels like it takes forever" however she understands there are other residents who require assistance too and DCWs always respond to her eventually. She stated she is "washed up" every day and always toileted as thoroughly as I observed her being toileted today. She stated she sees a doctor at this home so her medical needs are met. She denied any concern regarding her care in the home.

I reviewed a "Morning Shift Log" documenting Resident B's activities of daily living (ADL) which was from the week of 2/22/26 which including repositioning every two hours and "commode care". All activities were checked on 2/23/26 and 2/26/26-2/29/26. Half of the activities were checked on 2/24/26 and no activities were checked on 2/25/26.

I reviewed Resident B's assessment plan dated 9/5/25. The first page was blank. The second page noted Resident B needs assistance with toileting but did not specify what type of assistance was needed.

On 4/21/26, Michael Townsend reported Resident B is positioned and toileted every two hours. He reported the wound on her back was observed by a physician as scheduled and has since healed. Consultation was provided regarding completing her ADL log in a thorough manner so her care is adequately documented.

<b>APPLICABLE RULE</b>	
<b>R 400.671</b>	<b>Resident care.</b>

	<b>(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.</b>
<b>ANALYSIS:</b>	<p>Mark Townsend was observed while toileting and transferring Resident B and did so appropriately. Mr. Townsend denied that Resident B has not received adequate care. Resident B denied that she does not receive adequate care. Michael Townsend denied that Resident B does not receive adequate care.</p> <p>A log of activities of daily living for Resident B was partially maintained in the home documenting the care provided to her. Significant sores or redness indicating neglect were not observed as Resident B was toileted. Resident B's assessment plan was partially completed. The second page noted Resident B needs assistance with toileting but did not specify how.</p> <p>Based on the interviews completed, observations made, and documentation reviewed, there is insufficient evidence that Resident B does not receive care as specified in her assessment plan.</p>
<b>CONCLUSION:</b>	VIOLATION NOT ESTABLISHED

**ALLEGATION: Residents do not receive adequate meals.**

**INVESTIGATION:** On 3/4/26, I reviewed the referral which alleged residents were given cereal with no milk for their breakfast meal and boiled potatoes with ketchup for dinner. In the two months Resident A lived in the home, she lost 20 pounds.

On 3/5/26, Guardian A confirmed the allegation as reported and stated she does not believe there is a menu in the home.

On 3/6/26, Ms. Maciel stated Resident A told her she was given cereal with no milk for breakfast and boiled potatoes with ketchup for dinner at Michael's Refuge.

On 3/9/36, Mark Townsend reported there is a menu in the home and it accurately reflects the three nutritionally balanced meals residents are served each day. He denied that residents receive dry cereal or boiled potatoes for a meal.

Resident B, C, and D denied concerns regarding the food in the home and reported they receive three nutritionally balanced meals each day. They denied ever being

served dry cereal or boiled potatoes as a meal. Resident D reported she has diabetes and it is well maintained in this home. Resident B reported she has gained weight while living in this home, which she does not like.

I observed the full kitchen on the second floor of the home to have a full pantry. I observed the basement in the home to have a full refrigerator, a freezer, and a large shelving unit with numerous canned and boxed items. The food in the home appeared sufficient in quantity and nutritionally balanced.

I reviewed resident weight logs. Resident B’s weight log was blank. Resident A, Resident D, and Resident E did not have a weight log maintained. Resident C’s weight log started in April 2025 stopped in August 2025 and noted a five-pound weight gain. Resident F’s weight log started in July 2025 and ended in August 2025 and noted a three-pound weight loss.

On 4/21/26, Michael Townsend stated Resident A was “a very picky eater” and would not eat everything that was served to her. He reported adequate meals were provided to Resident A and all residents in the home.

<b>APPLICABLE RULE</b>	
<b>R 400.663</b>	<b>Nutrition; adoption by reference.</b>
	<b>(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.</b>
<b>ANALYSIS:</b>	Resident B, C, and D reported receiving three nutritionally balanced meals each day and denied the allegation. Mark Townsend and Michael Townsend denied the allegation as well.  I observed a menu that appeared nutritionally balanced and the home has a sufficient supply of nutritionally balanced food.  Based on the interviews completed and observations made, there is insufficient evidence to support the allegation that residents do not receive a minimum of three nutritious meals daily.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: Residents are given incorrect medications.**

**INVESTIGATION:** On 3/4/26, I reviewed the referral which alleged when Resident A moved to her new placement, another resident’s medication was included with hers.

On 3/5/26, Guardian A stated Resident A reported she was regularly given the

wrong medications while living in the home. She stated when Resident A was discharged from the home, Michael Townsend included two medication bottles for another resident in her medications.

On 3/6/26, Ms. Maciel stated that when she accepted Resident A's medications into her home, the medications included two of another resident's medications and were missing Resident A's medications. She stated she had to go to Michael's Refuge to return the incorrect medication and obtain Resident A's medication.

On 3/9/26, Mark Townsend stated he was in a rush to put together Resident A's medications since she was discharged a few days earlier than planned. He stated Resident A's medications were delivered at the same time as Resident E's and Resident E has numerous pill bottles. He stated medications are sorted in resident specific boxes in the medication cart but he had not had a chance to put Resident A and Resident E's medications in their correct boxes. He stated he accidentally placed two of Resident E's medications in Resident A's bag at the time of discharge and left two of Resident A's medications at the home. He stated medications are typically organized to prevent error but, in this instance, due to the delivery date and Resident A's discharge date, he made a mistake. He denied that the medications had been passed incorrectly.

I observed the medication cart and found medications were sorted in plastic boxes for each resident. They appeared organized.

Resident B stated she believes she gets most of her medication correctly. She denied receiving medication that is not prescribed to her. She stated she believes she does not always get her stool softener as prescribed.

Resident C and D denied concerns regarding not receiving their correct medications or receiving medication that is not prescribed to them. Resident D stated she has diabetes, receives her medication correctly, and her diabetes is well managed in this home.

I observed Resident B's medication administration record (MAR) since she expressed concern about her medications. I observed that only one of Resident B's medications was initialed as being passed on 3/5/26.

On 4/21/26, Michael Townsend stated if he arrives after dinner, he passes medication to the residents. He stated he ensures that the resident's medications match what is on their MAR and follows the "rights" of medication passing. He reported that Mark Townsend is typically present in the home when medications are delivered and ensure medications are sorted into the correct clear bin for each resident. He denied that residents are given incorrect medication or do not receive their medications as prescribed.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.</b>
<b>ANALYSIS:</b>	<p>Guardian A, Ms. Maciel, and Mr. Mark Townsend reported Mark Townsend put two of Resident E's medications in with Resident A's medications when she discharged from the home and left two of Resident A's medications at the home. Mark Townsend reported this was done in error.</p> <p>Resident B, C, and D denied receiving medication that is not prescribed to them. Mark Townsend and Michael Townsend denied that residents receive medications that are not prescribed to them.</p> <p>Based on the interviews completed there is insufficient evidence that prescription medication is used by a person other than the resident for whom the medication is prescribed.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:** There are cameras throughout the home without the consent of residents or their guardians.

**INVESTIGATION:** On 3/6/26, Ms. Maciel stated she has concern that "there are cameras all over the place" and that this is not authorized by residents or their guardians. She stated she observed cameras in the foyer of the home but that was as far as she entered the home. She stated Resident A reported there are cameras "everywhere but resident bedrooms."

On 3/9/26, Mark Townsend reported there are cameras placed in common areas on the main floor of the home. He stated they were placed so he and Michael Townsend can check in when they are not in the home. He stated they are not utilized for supervising residents or in place of staff just for his and Michael Townsend's use. He stated he was not aware that the use of cameras had to be specified in the resident care agreement and he would modify those to note the use of cameras in the home.

I observed a camera in the foyer and next to the kitchenette on the main level of the home.

On 4/21/26, Michael Townsend stated there is a camera in foyer and kitchenette hallway of the home. He denied that the cameras are used to supervise residents

and reported only he and Mark Townsend utilize them to check on the home when they are not present. He denied being aware that approval of the use of cameras had to be noted on the Resident Care Agreement and agreed to update the agreement to reflect the use of cameras in the home.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights, licensee responsibilities.</b>
	<b>(3) A licensee and staff shall respect and safeguard all of the following resident rights to:</b> <b>(p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.</b>
<b>ANALYSIS:</b>	Ms. Maciel expressed concern about cameras in the home.  I observed two cameras on the main level of the home in common areas.  Mark Townsend reported there are cameras for his and Michael Townsend's use to check in when they are not at the home. He reported he was not aware that the use of cameras had to be noted in the resident's care agreement. Michael Townsend confirmed what Mark Townsend reported.  Based on the interviews completed and observations made, there is sufficient evidence that residents are not treated with recognition of need for privacy due to the use of cameras which was not noted in the resident care agreements.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDINGS**

**INVESTIGATION:** On 3/9/26, I requested to review the Resident Register to confirm who resides and has resided in the home.

I observed the Resident Register had not been updated since August 2025. It did not include Resident E or Resident A's admission and discharge dates.

<b>APPLICABLE RULE</b>	
<b>R 400.615</b>	<b>Resident Register.</b>
	<b>A licensee shall maintain a chronological register of all residents admitted that includes the following information for each resident:</b> <b>(a) Resident full name.</b> <b>(b) Resident date of birth.</b>

	<p><b>(c) Date of admission.</b>  <b>(d) Date of discharge and location, if known, where the resident moved.</b></p>
<b>ANALYSIS:</b>	<p>The Resident Register has not been updated since August 2025 and did not include Resident E or A's time in the home.</p> <p>Based on the documentation reviewed, there is insufficient evidence that a chronological register of residents with all the information required by the rule is maintained in the home.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 3/9/26, while reviewing the staff schedule, it was determined that a record was not kept of who worked from 8:00 p.m. to 8:00 a.m. The date of the schedule was also not listed, rather it was a one-page document listing days of the week without specific dates. The titles for the staff on duty were also not listed.

Mark Townsend acknowledged that changes to the schedule were not documented anywhere or if a DCW took a resident on an outing, that the DCW in the home was documented. He confirmed a schedule with the date worked is not maintained.

<b>APPLICABLE RULE</b>	
<b>R 400.639</b>	<b>Staff records.</b>
	<p><b>(3) A licensee shall maintain for 90 days a daily work schedule and assignments that includes all of the following:</b></p> <p><b>(a) Names of staff on duty.</b>  <b>(b) Job titles.</b>  <b>(c) Hours or shifts worked.</b>  <b>(d) Date of schedule.</b>  <b>(e) Scheduling changes when made.</b></p>
<b>ANALYSIS:</b>	<p>An accurate and complete schedule listing the names and titles of the staff on duty, the hours they worked, the date of the schedule, and changes to the schedule I not maintained for 90 days. Therefore, the violation is established.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 3/9/26, while reviewing Resident A's Resident Care Agreement dated 1/6/26, I observed there were several incomplete areas including the section of the form regarding holding Resident A's funds and valuables.

<b>APPLICABLE RULE</b>	
<b>R 400.685</b>	<b>Resident admission; resident assessment plan; resident care agreement; health care appraisal.</b>
	<b>(6) A licensee shall complete a written resident care agreement at the time of a resident's admission that includes all of the following:</b>  <b>(h) A resident's funds and valuables policy is established.</b>
<b>ANALYSIS:</b>	The section of Resident A's Resident Care Agreement form dated 1/6/26 regarding safekeeping of funds and valuables was incomplete. Therefore, the violation is established.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 3/9/26, while reviewing Resident A's Resident Care Agreement dated 1/6/26, I observed that Michael Townsend had not signed the form.

<b>APPLICABLE RULE</b>	
<b>R 400.685</b>	<b>Resident admission; resident assessment plan; resident care agreement; health care appraisal.</b>
	<b>(8) A resident care agreement must be signed by all applicable parties. A copy of the signed resident care agreement along with copies of the policies listed in subrule (6) of this rule must be provided to the resident or the resident's designated representative and maintained in the resident's record.</b>
<b>ANALYSIS:</b>	Michael Townsend's signature was missing from Resident A's Resident Care Agreement form dated 1/6/26. Therefore, a violation is established.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 3/9/26, while reviewing Resident B's assessment plan it was observed that the first page of the document was blank.

<b>APPLICABLE RULE</b>	
<b>R 400.685</b>	<b>Resident admission; resident assessment plan; resident care agreement; health care appraisal.</b>

	<p><b>(2) A licensee shall not accept or care for a resident until a written assessment has been completed. A written assessment plan must include all of the following:</b></p> <p><b>(a) The amount of personal care, supervision, and protection required by the resident that is available at the facility.</b></p> <p><b>(b) The services, skills, and physical accommodations required by the resident that are available at the facility.</b></p> <p><b>(c) The resident is compatible with other residents, assigned roommate, and members of the household.</b></p>
<b>ANALYSIS:</b>	Resident B's assessment plan included a blank front page, therefore it was incomplete. Due to this, a violation is established.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 3/9/26, while reviewing Resident B's assessment plan to confirm her care needs, it was observed that Michael Townsend had not signed the document indicating he was involved with the completion of the assessment plan.

<b>APPLICABLE RULE</b>	
<b>R 400.685</b>	<b>Resident admission; resident assessment plan; resident care agreement; health care appraisal.</b>
	<b>(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.</b>
<b>ANALYSIS:</b>	Resident B's assessment plan did not include Michael Townsend's signature indicating he was involved in the completion of the assessment plan.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 3/9/26, while observing the full kitchen upstairs, a countertop convection oven, as well as a pan and a pot on the stove were observed to contain

cooked food, including hot dogs, that were cold and appeared to be sitting for some time.

<b>APPLICABLE RULE</b>	
<b>R 400.665</b>	<b>Food service.</b>
	<b>(4) Food must be stored at temperatures that will protect against spoilage. Cold foods must be stored at 40 degrees Fahrenheit or below and hot foods stored at 140 degrees Fahrenheit or above until served to residents, except during periods that are necessary for preparation.</b>
<b>ANALYSIS:</b>	Cooked food was observed unheated in a countertop convection oven and a pan and pot on the stove in the full kitchen in the home. They appeared to have been there some time. Therefore, sufficient evidence is found to support that food is not stored at temperatures to protect against spoilage.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 3/9/26, while observing the food in the refrigerators and freezers in the home, I observed they did not have necessary thermometers to ensure they were maintained at the correct temperatures.

<b>APPLICABLE RULE</b>	
<b>R 400.665</b>	<b>Food service.</b>
	<b>(5) Refrigerators and freezers must be equipped with thermometers.</b>
<b>ANALYSIS:</b>	I did not observe thermometers in all the refrigerators and freezers in the home. Therefore, the violation is established.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 3/9/26, I observed that resident medications were removed from their pharmacy supplied containers and kept in a plastic pill container with the resident's initial on them on top of the desk near the medication cart prior to medication passing.

I observed Mark Townsend take a pill container to a resident for medication passing. He reported he was not aware that pill containers could not be utilized in AFC homes.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.</b>
<b>ANALYSIS:</b>	<p>I observed pill containers with resident initials pre-set with medications on the desk next to medication cart. Mark Townsend stated he was not aware that pill containers could not be utilized in AFC homes.</p> <p>Based on the observation made and interview completed there is sufficient evidence that prescription medications are not kept in their pharmacy container and in locked cabinet prior to medication passing.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 3/9/26, while reviewing Resident B's MAR it was observed that only one of her medications was initialed as passed on 3/5/26, several others were not initialed and left blank.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<p><b>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:</b></p> <p><b>(b) Complete an individual medication log that contains all of the following:</b></p> <p><b>(v) Initials of the individual who administered the medication at the time given.</b></p>
<b>ANALYSIS:</b>	I observed only one of Resident A's medications was initialed as passed on 3/5/26, the others were left blank.

	Based on the observation made there is sufficient evidence that Resident B's MAR lacked the initials of the individual who administered the medication at the time given.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 3/9/26, Mark Townsend reported that Ms. Carmen lives in this home and is the primary staff overnight, as needed, and works regular day shifts. He reported that Ms. Carmen recently responded to Resident F falling outside of the home by calling him and Michael Townsend. He stated he confirmed a bystander had called 911. He reported that Ms. Carmen was trained in the home.

I attempted to interview Ms. Carmen. Ms. Carmen spoke limited English and only responded to basic conversational interactions. I asked her how she would respond to an emergency. She could not respond and did not appear to understand me. I asked her what she would do if there was a fire in the home. She could not respond and did not appear to understand me. I asked her if she knew how to call 911. She could not respond and did not appear to understand me. The interview ended with Ms. Carmen being unable to answer most of my questions.

<b>APPLICABLE RULE</b>	
<b>R 400.629</b>	<b>Direct care staff; qualifications and training.</b>
	<b>(4) Direct care staff shall possess all of the following qualifications before working independently: (b) Be capable of appropriately handling emergency situations.</b>
<b>ANALYSIS:</b>	I attempted to interview Ms. Carmen regarding emergency situations that could occur in the home. She could not respond due to her limited use of English. She appeared able to respond in English to only basic conversational topics.  Based on the interview completed, there is sufficient evidence that Ms. Carmen is not capable of appropriately handling emergency situations due to her limited use of English.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 3/9/26, while reviewing fire drill records to ensure appropriate staffing levels, I observed that a fire drill had not been documented since August 2025.

Resident B reported she has not participated a fire drill since she moved into this

home in August 2025.

<b>APPLICABLE RULE</b>	
<b>R 400.619</b>	<b>Emergency preparedness plan.</b>
	<b>(8) A licensee shall practice the emergency preparedness plan, including the fire safety plan, at least once a quarter per calendar year during each shift, 7 a.m. to 3 p.m., 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. A record of the practices must be maintained for 2 years.</b>
<b>ANALYSIS:</b>	<p>I observed that a fire drill had not been documented since August 2025.</p> <p>Resident B reported she has not done a fire drill since she moved into this home.</p> <p>Based on the interview completed and documentation reviewed, there is insufficient evidence that emergency preparedness plans are practiced as specified in the rule.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 3/9/26, I requested the e-score evacuation assessments for the current residents in the home to confirm appropriate evacuation times since this home has special certification.

Mr. Mark Townsend reported he did not know what e-scores were or that they had to be done.

On 4/21/26, Michael Townsend stated he did not know what e-scores were and was not aware they needed to be done due to this home having specialized certification.

<b>APPLICABLE RULE</b>	
<b>R 400.619</b>	<b>Emergency preparedness plan.</b>
	<b>(4) Evacuation assessments must be conducted within 30 days after the admission of each new resident and at least annually after the admission of the last new resident. A licensee shall forward a copy of each completed assessment to the responsible agency and retain a copy in the facility for 2 years. A facility that is assessed as having an evacuation difficulty index of "impractical" using appendix f of the 2021 edition of NFPA 101, Life Safety Code, which is adopted by reference in subdivision (b) of this subrule, shall have a period of 6 months after the</b>

	<p><b>date of the finding to do either of the following:</b></p> <p><b>(a) Improve the score to at least the "slow" category.</b></p>
<b>ANALYSIS:</b>	<p>I requested e-scores to confirm appropriate resident evacuation times. Mark Townsend and Michael Townsend stated they did not know what e-scores were or that they needed to be completed.</p> <p>Based on the interview completed and documentation reviewed, there is sufficient evidence that evacuation assessments are not completed as required by the rules.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 3/9/26, while investigating allegations that Resident A lost 20 pounds while living in the home, I reviewed resident weight logs. Resident B's weight log was blank. Resident A, D and E did not have a weight log maintained. Resident C's weight log started in April 2025 and stopped in August 2025 and noted a five-pound weight gain. Resident F's weight log started in July 2025 and ended in August 2025 and noted a three-pound weight loss.

<b>APPLICABLE RULE</b>	
<b>R 400.691</b>	<b>Resident records.</b>
	<p><b>(1) A licensee shall complete and maintain a separate record for each resident that includes all of the following:</b></p> <p><b>(g) Admission and monthly weight record.</b></p>
<b>ANALYSIS:</b>	<p>Resident A, D and E did not have a weight log maintained in the home. Resident B's weight log was blank. Resident C and F's weight log had not been updated since August 2025.</p> <p>Based on the documentation reviewed, there is sufficient evidence that a monthly weight record is not being maintained.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:** On 3/9/26, while observing the second floor of the home, I observed that a door that was previously open during the inspection for the addendum to allow resident bedrooms upstairs and provided floor separation, was closed. A deadbolt lock was observed on the door.

<b>APPLICABLE RULE</b>	
<b>R 400.725</b>	<b>Means of egress.</b>
	<b>(3) Doors that form a part of a required means of egress must be equipped with positive latching, non-locking-against-egress hardware and have a width to allow for residents requiring wheelchairs or other devices to easily navigate through doorways.</b>
<b>ANALYSIS:</b>	There is a locking-against-egress deadbolt lock on the door that provides floor separation on the second floor of the home. Therefore, the violation is established.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 4/21/26, I discussed possible outcomes of the investigation with Michael Townsend. Training resources were discussed. Consultation was provided regarding the violations established. He did not dispute my recommendations. He requested the outcome of the investigation be shared with him via email.

#### **IV. RECOMMENDATION**

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license be modified to a provisional license.

*Cassandra Duursma*

04/21/2026

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Cassandra Duursma  
Licensing Consultant

Date

Approved By:

*Jerry Hendrick*

04/22/2026

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Jerry Hendrick  
Area Manager

Date