GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 18, 2026

Leone Swanberg
5329 McCords
Alto, MI 49302

RE: License #: AM410008670
Investigation #: 2026A0583032
Swanberg AFC - Springwood

Dear Ms. Swanberg:

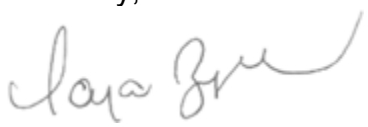
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM410008670
Investigation #:	2026A0583032
Complaint Receipt Date:	04/14/2026
Investigation Initiation Date:	04/15/2026
Report Due Date:	05/14/2026
Licensee Name:	Leone Swanberg
Licensee Address:	5329 McCords Alto, MI 49302
Licensee Telephone #:	(616) 893-6613
Administrator:	Benjamin Visel
Licensee Designee:	N/A
Name of Facility:	Swanberg AFC – Springwood
Facility Address:	1158 Springwood Drive SE Kentwood, MI 49508-6055
Facility Telephone #:	(616) 532-0356
Original Issuance Date:	08/01/1979
License Status:	REGULAR
Effective Date:	10/15/2024
Expiration Date:	10/14/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A gets into other residents' beds.	No
Resident A does not receive adequate personal care.	No
Resident A does not receive her medications at the proper times.	No
Resident A does not receive her medication as prescribed.	Yes
Resident A suffered a stroke and staff failed to obtain timely medical care.	No

III. METHODOLOGY

04/14/2026	Special Investigation Intake 2026A0583032
04/15/2026	Special Investigation Initiated - On Site
04/17/2026	Contact - Document Received Intake 210297 received
05/01/2026	APS Referral
05/15/2026	Exit Conference Benjamin Visel

ALLEGATION: Resident A gets into other residents' beds.

INVESTIGATION: On 04/14/2026 complaint allegations from an anonymous complainant were received via the online complaint form and assigned for my investigation on 04/15/2026. The complaint alleged, "there are concerns that the resident is getting into different beds".

On 04/15/2026 I completed an unannounced onsite investigation at the facility and privately interviewed staff Sarah Husman, Resident A, Resident B, and Resident C.

Ms. Busman stated that she is a new staff member and works independently. She confirmed that Resident A is diagnosed with significant cognitive impairment and often follows other residents around to engage them in activities such as playing cards. She stated Resident A has been observed in other residents' bedrooms looking for social interaction, but never in other residents' beds.

Resident A was observed as clean and appropriately clothed. Because of her cognitive impartments, she answered questions with minimal one-word answers. She confirmed she follows other residents through the facility and has wandered into other residents' bedrooms looking for social interaction. She stated that she sat on the top of other residents' beds but has never gotten under their linens. She stated she leaves other residents' bedrooms when requested.

Resident B confirmed that she is Resident A's roommate. She stated Resident A has never sat on her bed, and she has not observed her entering other residents' bedrooms.

Resident C stated that Resident A follows other residents through the facility looking for social interaction. She stated Resident A has been observed sitting on top of other residents' beds but has never gotten under their linens. She stated Resident A leaves residents' bedrooms promptly when requested by residents or staff.

On 05/01/2026 I completed an Adult Protective Services complaint via the online portal.

On 05/06/2026 I received a voicemail message from Network 180 Recipient Rights staff Michael Kiuk. He confirmed Network 180 is investigating multiple complaints at the facility. He stated he is assigned to investigate allegations of improper care while Melissa Gekeler is assigned to investigate allegations of medication errors.

On 05/07/2026 I reviewed an email message from Mr. Visel. The email contained Resident A's Assessment Plan, signed 01/12/2026, which indicates Resident A controls aggressive and sexual behaviors and understands verbal communication.

On 05/15/2026 I completed an exit conference via telephone with administrator Benjamin Visel. He agreed with the special investigation finding.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(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.
ANALYSIS:	Staff Sarah Husman stated Resident A often follows other residents to engage them in activities such as playing cards. She stated Resident A has been observed in other residents' bedrooms looking for social interaction, but never in other residents' beds. Resident A confirmed that she follows other residents around the facility and has entered other residents' bedrooms looking for social interaction. She stated she sat on the top of other residents' beds but has never gotten under their linens. Resident B stated Resident A has never sat on her bed and she

	has not observed her entering other residents' bedrooms. Resident C stated Resident A follows other residents around the facility looking for social interaction. She stated Resident A has been observed sitting on top of other residents' beds but has never gotten under their linens. Resident A's Assessment Plan indicates Resident A controls aggressive and sexual behaviors and understands verbal communication. Based upon my investigation, which includes interviews and a review of pertinent documentation, a preponderance of evidence does not support that a violation of the applicable rule occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A does not receive adequate personal care.

INVESTIGATION: On 04/15/2026 I observed that the complaint alleged Resident A had "a full brief on occasion raising concerns of neglect" and "bedding smelled of urine and resident is often not showered/cleaned".

While onsite on 04/15/2026 Ms. Husman stated that she works independently and provides all Resident A's personal care. She stated she provides adequate personal care in accordance with Resident A's Assessment Plan. She stated Resident A is incontinent at night and requires the use of an adult brief. She stated Resident A often drinks large volumes of liquids before bed causing her to leak though the adult brief and require laundering of her bedding.

Resident A was observed as clean and with no personal hygiene odors. She stated that Ms. Husman assists her daily with bathing and grooming

Resident B stated that Ms. Husman changes Resident A's bed linens almost daily and assists her with bathing and grooming. She stated she did not observe their shared bedroom to have odors of urine. She stated Resident A is appears clean and appropriately dressed daily. She stated she is happy with the level of care provided at the facility.

Resident C stated that she observes Resident A to display adequate hygiene. She has never observed Resident A disheveled or displaying urine odors. She stated she is happy with the level of care provided at the facility.

While onsite I observed Resident A's bedroom appeared clean and free of foul odors.

On 05/04/2026 I interviewed Relative 1 via telephone. She confirmed she is Resident A's legal guardian. She stated on 04/08/2026 she transported Resident A directly to a physician's appointment and observed Resident A displayed "foul body odor" indicative of a lack of showering and grooming. She stated she assisted Resident A into a bathroom and observed Resident A's brief was soiled with urine and feces. She stated she also observed "dried" feces on Resident A's buttocks.

On 05/05/2026 I interviewed Network 180 Behavior Specialist Kim Novak via telephone. She stated on 04/08/2026 she spoke to Ms. Human in person. She stated Ms. Husman informed her Resident A was experiencing an increase in incontinence since her most recent strokes and required a higher level of personal care than Ms. Husman could provide. Ms. Novak stated Ms. Husman said she was "not a CNA" and it was not her role to assist Resident A with wiping and showering.

On 05/06/2026 I interviewed Ms. Husman via telephone. She stated she is familiar with Resident A's Assessment Plan and provided bathing and grooming assistance. She stated on 04/08/2026, Resident A was properly showered and groomed prior to her medical appointment. She stated she is not a "CNA" and it is not her role to provide physical hands-on care such as physically cleaning residents in the shower or wiping after toileting.

On 05/06/2026 I interviewed administrator Ben Visel via telephone. He stated Resident A required staff assistance with showering and grooming in the form of verbal prompts. He stated Resident A did not require hands-on personal care. He stated he observed Resident A "almost daily" from 03/23/-04/03/2026 and she appeared adequately groomed. He confirmed he did not observe Resident A on 04/08/2026.

On 05/07/2026 I received and reviewed an email message from Mr. Visel. The email contained Resident A's Assessment Plan, signed 01/12/2026. The Assessment Plan indicates staff must assist Resident A with toileting in the form of "verbal prompts before leaving, bedtime, etc". The document stated staff assist Resident A with bathing in the form of "prompts and cuing needed for thoroughness".

On 05/07/2026 I interviewed Ms. Husman via telephone. She stated she verbally prompts Resident A to shower and change her adult brief. She stated she did not provide hands-on care which is in accordance with Resident A's Assessment Plan.

On 05/15/2026 I completed an exit conference via telephone with administrator Benjamin Visel. He agreed with the special investigation finding.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(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.
ANALYSIS:	Resident A's Assessment Plan signed 01/12/2026 states staff must assist Resident A with toileting in the form of "verbal prompts before leaving, bedtime, etc". The document states staff assist Resident with bathing in the form of "prompts and cuing needed for thoroughness". Relative 1 stated on 04/08/2026 she observed Resident A displaying "foul body odor" indicative of a lack of showering and grooming. She stated she observed Resident A's adult brief was soiled with "dried" feces on Resident A's buttocks. Staff Sarah Husman stated she verbally prompted Resident A to shower and change her adult brief. She stated she did not provide hands-on care which is in accordance with Resident A's Assessment Plan. She stated on 04/08/2026 Resident A was properly showered and groomed prior to her medical appointment. Based upon my investigation, which includes interviews and a review of pertinent documentation, a preponderance of evidence does not support that a violation of the applicable rule occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A does not receive her medications at the proper times.

INVESTIGATION: On 04/15/2026 I observed that the complaint alleged, "medications are not given at the proper times".

While onsite on 04/15/2026 Ms. Husman stated she administers Resident A's medications at the proper times. She stated Resident A's medications do not require that they be administered at specified times however certain medications are ordered to be administered in the "morning", "afternoon", "bedtime," or "evenings".

While onsite I observed Resident A's MAR indicates Resident A is prescribed Atorvastatin 40MG 1 tablet at bedtime, Digoxin .0125MG once daily, Furosemide 20MG one half tablet every morning and I tablet every evening, Hydroxyzine 25MG 1 capsule once daily in the afternoon, Melatonin 5MG 1 tablet every night at bedtime, Metoprol 100 MG 1 tablet twice daily, POT CL Micro 10MEQ tablet daily,

Risperidone 1MG 1 tablet every night at bedtime, Sertraline 100MG 2 tablets every morning, and Xarelto 20MG 1 tablet with evening meal. Per Resident A's MAR, all prescribed medications are being administered during the timeframes ordered by their prescribers.

Resident A, Resident B, and Resident C each stated that to their knowledge, Ms. Husman administers their medications at the ordered times.

On 05/06/2026 I received a voicemail message from Network 180 Recipient Rights Melissa Gekeler. She confirmed that she is investigating allegations related to Resident A's medications.

On 05/15/2026 I completed an exit conference via telephone with administrator Benjamin Visel. He agreed with the special investigation finding.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Resident A's MAR indicates Resident A is prescribed Atorvastatin 40MG 1 tablet at bedtime, Digoxin .0125MG once daily, Furosemide 20MG one half tablet every morning and 1 tablet every evening, Hydroxyzine 25MG 1 capsule once daily in the afternoon, Melatonin 5MG 1 tablet every night at bedtime, Metoprol 100 MG 1 tablet twice daily, POT CL Micro 10MEQ tablet daily, Risperidone 1MG 1 tablet every night at bedtime, Sertraline 100MG 2 tablets every morning, and Xarelto 20MG 1 tablet with evening meal. Resident A's MAR indicates all prescribed medications are being administered during the timeframes ordered by their prescribers. Ms. Husman stated she administers Resident A's medications at the proper times according to the prescribers' orders. Based upon my investigation, which included interviews and a review of pertinent documentation, a preponderance of evidence does not support that a violation of the applicable rule occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A does not receive her medication as prescribed.

INVESTIGATION: On 04/16/2026 an intake was received from Adult Protective Services. The allegations stated the following, *"(Resident A) (38) has congenital intellectual disability. (Resident A) is also medically fragile with history of two strokes, resulting in further cognitive impairment. (Resident A) lives in Swanberg AFC-Springwood, a medium group home (capacity 7-12; license AM410008670). (Resident A's) sister, (Relative 1), is her legal guardian. Staff at Swanberg have not been giving (Resident A) her blood thinning medication that she has to take to help prevent further stroke. This month, the medication log for the home shows (Resident A) has not had it all month long. When questioned, the worker Sarah (who lives in the home with the residents) said that they hadn't given (Resident A) the medication because it hadn't been delivered by the pharmacy yet. When the home was checked on 4/15/26 the medication was found to be there, but it's unclear when it was delivered or if it has since been administered to (Resident A). When (Resident A) was in the ED on 4/10/26, medical examination showed that (Resident A) has had more strokes. It cannot be stated directly at this time that the lack of medication caused more strokes, but (Resident A) has had more of them. (Resident A) has been on this blood thinning medication since the end of her last hospitalization on 3/31/26. The home is in the process of getting services from a new pharmacy".*

On 04/21/2026 I completed an unannounced onsite investigation at the facility and privately interviewed Ms. Husman. Ms. Husman stated Resident A moved out of the facility yesterday. Ms. Husman confirmed that Resident A did not receive her prescribed once daily Xarelto 20 MG from 04/01/2026 through 04/11/2026 because the facility ran out of the medication. Ms. Husman confirmed that she was tasked with administering the medication from 04/01/2026-04/11/20206.

I observed Resident A's MAR indicates Resident A is prescribed Xarelto 20 MG TAB take 1 tablet by mouth once daily with evening meal and Furosemide 20 MG TAB take 1 tablet by mouth every evening. The MAR indicates Resident A did not receive Xarelto from 04/01/2026 through 04/11/2026 and 04/13/2026. I observed Resident A did not receive Furosemide on 4/13/26. There is no documentation in the MAR indicating why the medications were not administered on these dates.

On 05/04/2026 Relative 1 stated via telephone that she requested and received copies of Resident A's MAR from Mr. Visel. She stated the first MAR she received contained blanks in the daily boxes of administration of Resident A's Xarelto 04/01/2026-04/11/2026 and the subsequent MAR contained circles in the boxes of administration from 04/01/026-04/11/2026. Relative 1 stated the second MAR contained both a circle and Ms. Husman's initials for Resident A's 4/11/2026 Xarelto administration. Relative 1 stated Resident A's 03/2026 MAR indicated Resident A received Xarelto as prescribed, however she contacted Horizon pharmacy who confirmed that Resident A did not receive Xarelto from 03/19/2026-04/11/2062 because the facility did not have the medication. Relative 1 stated Resident A is prescribed Xarelto (blood thinner) due to a history of stroke and not receiving the medication likely contributed to Resident A's 03/27/2026 stoke.

On 05/05/2026 I interviewed Horizon Pharmacy Shane via telephone. He stated that Resident A's Xarelto was delivered to the facility on 03/15/2026 PM and included a 14-day supply that should to have been dispensed 03/16/2026 through 03/29/2026. He stated the pharmacy did not receive a refill from Resident A's physician until 04/12/2026 and the medication was delivered to the facility on 04/12/2026 PM. He stated facility staff could not have administered Resident A's Xarelto 04/01 through 04/13/2026 because the facility did not have it.

On 05/06/2026 Ms. Husman stated via telephone that she worked independently at the facility 04/01/2026-04/11/2026 and doesn't know who wrote "circles" on Resident A's MAR from 04/01/2026-04/11/2026. She stated that she worked independently at the facility and passed resident medications on 04/13/2026. She stated Resident A's MAR indicates on 04/13/2026, Resident A did not receive her daily doses of Xarelto and Furosemide. Ms. Husman stated that on 04/13/2026 Resident A did not receive Xarelto and Furosemide, and she has "no idea why" Resident A did not get the medications.

On 05/06/2026 Mr. Visel stated via telephone that Resident A did not receive her prescribed Xarelto 04/01-04/11/2026 because the facility ran out of the medication. He confirmed on 04/13/2026 Resident A did not receive Xarelto and Furosemide because Resident A was on an outing with Relative 1 and Ms. Husman failed to administer the medications upon Resident A's return to the facility that same day.

On 05/15/2026 I completed an exit conference via telephone with administrator Benjamin Visel. He stated that he did not dispute the findings and would submit a Corrective Action Plan.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Resident A's MAR indicates Resident A is prescribed Xarelto 20 MG TAB take 1 tablet by mouth once daily with evening meal and Furosemide 20 MG TAB take 1 tablet by mouth every evening. The MAR indicates Resident A did not receive Xarelto 20 MG from 04/01 through 04/11/2026 and 04/13/2026 or her Furosemide 20 MG on 4/13/26. Staff Sarah Husman confirmed that Resident A did not receive her prescribed once daily Xarelto 20 MG from 04/01/2026 through 04/11/2026 because the facility ran out of the medication. She stated Resident A did not receive her Xarelto 20 MG and Furosemide 20 MG on 04/13/2026.

	Based upon my investigation, which included interviews and a review of pertinent documentation, a preponderance of evidence does indicate that a violation of the applicable rule occurred. Resident A did not receive her prescribed Xarelto 20 MG 04/01/2026-04/11/2062, 04/13/2026 and Furosemide 20 MG 04/13/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A suffered a stroke and staff failed to obtain timely medical care.

INVESTIGATION: While onsite on 04/15/2026 Ms. Husman stated that Resident A has a history of "several strokes". She stated on 03/27/2026 Resident A spoke to Relative 1 on the telephone while Ms. Husman was assisting other residents. She stated Resident A set the telephone down and went to the bathroom. Ms. Husman stated that while assisting the other residents, she received a text message from Relative 1 advising Resident A "did not sound right". Ms. Husman stated that while Resident A was still in the bathroom, Relative1 contacted EMS services. Ms. Husman stated Resident A exited the bathroom just before EMS arrived and did not appear "different" than her baseline. She stated EMS arrived moments after Resident A exited the bathroom and transported her to the emergency department for evaluation. Ms. Husman stated Resident A was diagnosed as suffering from a stroke. Ms. Husman stated that she was new to her position at the facility and acknowledged that she was not familiar with Resident A's baseline behavior. She stated that on that date she did not observe Resident A displaying signs of stroke, however Relative 1 is familiar with Resident A's baseline and acted expediently.

On 05/04/2026 Relative 1 stated via telephone that the end of March, facility staff reported Resident A was refusing to shower and defecating on herself which is not her baseline. Relative 1 stated that she visited the facility to assess and assist Resident A with showering on 03/27/2026. Relative 1 stated that Resident A appeared "out of it" and "off balance". Relative 1 stated she assisted Resident A with showering, put her to bed, and left. Relative 1 stated later that same day she spoke to Ms. Husman via telephone and Ms. Husman stated Resident A was still acting like she had been earlier. Relative 1 requested that Ms. Husman check Resident A's blood pressure, but Ms. Husman refused to do so. Relative 1 then spoke to Resident A on the telephone and Resident A was "whispering" and "dropped" the telephone. Relative 1 stated she telephoned 911 and requested emergency services assess Resident A at the facility. Relative 1 stated EMS arrived at the facility and transported Resident A to the hospital where she was diagnosed as suffering from two strokes. Relative 1 stated that Resident A spent approximately five days inpatient.

On 05/07/2026 I received and reviewed an email message from Mr. Visel. The email

included an Incident Report signed by Ms. Husman 03/28/2026 and Mr. Visel 03/30/2026. The Incident Report stated on 03/27/2026 Resident A was transported to U of M Health West by ambulance and was admitted for testing.

On 05/15/2026 I completed an exit conference via telephone with administrator Benjamin Visel. He agreed with the special investigation finding.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	An Incident Report signed by Ms. Husman 03/28/2026 and Mr. Visel 03/30/2026 stated on 03/27/2026 Resident A was transported to U of M Health West by ambulance and was admitted for testing. Relative 1 visited the facility on 03/27/2026 and observed Resident A appeared “out of it” and “off balance”. Relative 1 stated she assisted Resident A with showering and put her to bed. Later that same day she spoke to Ms. Husman via telephone who stated Resident A was still acting like she been earlier. Relative 1 then spoke to Resident A on the telephone and Resident A “was whispering” and “dropped” the telephone. Relative 1 telephoned 911 and requested emergency services assess Resident A at the facility. Relative 1 stated EMS arrived at the facility and transported Resident A to the hospital where she was diagnosed as suffering from two strokes. Based upon my investigation, which includes interviews and a review of pertinent documentation, a preponderance of evidence does not support that a violation of the applicable rule occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

Additional Findings: Facility staff did not contact an appropriate medical provider.

INVESTIGATION: While onsite on 04/21/2026 I observed Resident A’s MAR indicates Resident A is prescribed Xarelto 20 MG TAB take 1 tablet by mouth once daily with evening meal and Furosemide 20 MG TAB take 1 tablet by mouth every evening. I observed that Resident A did not receive Xarelto 20 MG and Furosemide 20 MG on 04/13/2026.

On 05/06/2026 Ms. Husman stated via telephone that she worked independently at the facility on 04/13/2026. She stated Resident A's MAR indicates on 04/13/2026, Resident A did not receive her daily doses of Xarelto 20 MG and Furosemide 20 MG. Ms. Husman stated that she has "no idea why" Resident A did not receive the medications, and she did not contact a health care professional to discuss the missed medication administrations.

On 05/06/2026 Mr. Visel stated via telephone that Resident A did not receive her prescribed Xarelto 20 MG and Furosemide 20 MG on 04/13/2026 because Resident A was on an outing with Relative 1. He stated Ms. Husman failed to administer the medications upon Resident A's return to the facility that same day.

On 05/15/2026 I completed an exit conference via telephone with administrator Benjamin Visel. He stated that he did not dispute the findings and would submit a Corrective Action Plan.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(f) Contact the resident's licensed health care professional or the appropriately licensed health care professional who prescribed the medication when a medication error occurs.**
ANALYSIS:	Staff Sarah Husman stated that she worked independently at the facility on 04/13/2026. She stated Resident A's MAR indicates on 04/13/2026, Resident A did not receive her daily doses of Xarelto 20 MG and Furosemide 20 MG. Ms. Husman stated she had "no idea why" Resident A did not receive the medication, and she did not contact a health care professional to discuss the missed medication administrations. Based upon my investigation, which included interviews and a review of pertinent documentation, it has been established that facility staff failed to contact an appropriate health care professional after Resident A did not receive her prescribed Xarelto 20 MG and Furosemide 20 MG Furosemide on 04/13/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

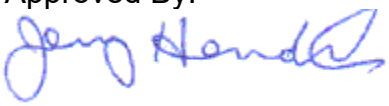
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license.

05/15/2026

Toya Zylstra Date
Licensing Consultant

Approved By:



05/15/2026

Jerry Hendrick Date
Area Manager