STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

June 8, 2026

Pamela Hurley
Innovative Lifestyles, Inc.
PO Box 1258
Clarkston, MI 48347

RE: License #: AS630074810
Investigation #: 2026A0605018
Kurtz Home

Dear Pamela Hurley:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days.

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 (248) 972-9136.

Sincerely,

Frodet Dawisha

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3044 W. Grand Blvd.
2nd Floor Annex, Suite 2-730
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630074810
Investigation #:	2026A0605018
Complaint Receipt Date:	05/04/2026
Investigation Initiation Date:	05/05/2026
Report Due Date:	07/03/2026
Licensee Name:	Innovative Lifestyles, Inc.
Licensee Address:	Suite 1 5490 Dixie Hwy Waterford, MI 48329
Licensee Telephone #:	(248) 931-2061
Administrator/Licensee Designee:	Pamela Hurley
Name of Facility:	Kurtz Home
Facility Address:	1499 Kurtz Road Holly, MI 48442
Facility Telephone #:	(810) 373-6123
Original Issuance Date:	01/15/1997
License Status:	REGULAR
Effective Date:	08/22/2025
Expiration Date:	08/21/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was taken to the emergency room at Henry Ford Hospital-Genesys on 05/02/2026 due to arm pain. It was found that Resident A's left arm is broken above the elbow. It is unknown what happened as there were no incident reports filed by the group home.	Yes
Resident A was found malnourished during her emergency room visit on 05/02/2026.	Yes
Resident A had a stage two bedsore on her buttocks during her emergency room visit on 05/02/2026 that appeared to have not been cared for properly.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/04/2026	Special Investigation Intake 2026A0605018
05/05/2026	APS Referral Adult Protective Services (APS) made referral and are investigating these allegations
05/05/2026	Special Investigation Initiated - Telephone Discussed allegations with both APS Ra'Shawnda Robertson and Oakland County Office of Recipient Rights (ORR) Katie Garcia.
05/05/2026	Contact - Telephone call made Discussed allegations with licensee designee Pam Hurley
05/05/2026	Contact - Document Sent Email to Henry Ford Hospital- Genesee County case manager Veronica Presnall
05/06/2026	Contact - Telephone call received Case manager Veronica Presnall regarding the allegations
05/06/2026	Contact - Document Received Email from licensee designee Pam Hurley
05/06/2026	Contact - Face to Face

	With Resident A, case manager Veronica Presnall, and registered nurse (RN) Brooke at Henry Ford Hospital- Genesys.
05/06/2026	Inspection Completed On-site Conducted on-site investigation
05/11/2026	Contact - Telephone call made Discussed allegations with direct care staff (DCS) and followed up with ORR Katie Garcia
05/11/2026	Contact - Document Sent Email to licensee designee Pam Hurley
05/15/2026	Contact - Document Received Email from APS
05/21/2026	Contact - Document Received Email from APS
06/03/2026	Contact - Telephone call made Discussed allegations with Resident A's co-guardian and left message for Easterseals support coordinator Kristel Lynn
06/03/2026	Contact – Telephone call received Interviewed Resident A’s legal guardian
06/04/2026	Exit Conference Left detailed message for licensee designee Pamela Hurley with my findings and recommendations.

ALLEGATION:

Resident A was taken to the emergency room on 05/02/2026 due to arm pain. It was found that Resident A’s left arm is broken above the elbow. It is unknown what happened as there were no incident reports filed by the group home.

INVESTIGATION:

On 05/05/2026, intake #210549 was referred by Adult Protective Services (APS). APS worker Ra’Shawnda Robertson was assigned this case and investigating these allegations.

On 05/05/2026, I discussed allegations with both APS Ra'Shawnda Robertson and Oakland County Office of Recipient Rights (ORR) Katie Garcia. On 05/03/2026, Resident A was observed with bruises on her left arm by direct care staff (DCS) Twanshe (also known as (AKA) Keke) Durkins. Twanshe reported the bruises to the home manager (HM) LaShonda Marve. HM advised Twanshe to call an ambulance. The ambulance was called and transported Resident A to Henry Ford Hospital (HFH)-Genesys, which is in Genesse County. At the hospital, it was discovered that Resident A sustained a broken left arm. Ms. Robertson left a message for the HFH case manager (CM) Veronica Presnall. Resident A is non-verbal and non-ambulatory, wheelchair bound requiring total care by staff; therefore, the injury must have been caused by someone else other than Resident A. There are four residents that reside at Kurtz Home and all the residents except for one is verbal. Resident A's sister is the legal guardian. No one knows how Resident A sustained the injury and there are inconsistencies in who was working between 04/30/2026-05/03/2026 and how long each staff member was working during those dates and during each shift. Ms. Garcia requested the staff schedule and time punch cards from licensee designee Pam Hurley for these dates. DCS DaLisa Redick and DCS Aerie Pittman who worked midnight shift have been suspended; however, after Ms. Robertson and Ms. Garcia interviewed several DCS, they advised Ms. Hurley to also suspend Twanshe Durkins and Rashayla (AKA Shay) Byas who worked every day from 04/30/2026-05/03/2026. Ms. Robertson and Ms. Garcia were informed by DCS that whoever is responsible for medication administration during their shift is responsible for providing care to Resident A. Resident A does not use a Hoyer lift during transfers; however, HM has requested a script for a Hoyer lift from the family as they were responsible for Resident A's medical care, but according to HM, family did not want Resident A to have a Hoyer lift. It is unknown why, but HM informed Ms. Garcia and Ms. Robertson that several staff members have had miscarriages after transferring Resident A. I was emailed the incident report (IR) dated 05/03/2026. Ms. Hurley was unable to provide any insight into what happened to Resident A.

On 05/05/2026, I interviewed licensee designee Pam Hurley regarding the allegations. There are three shifts at Kurtz Home, 7AM-3PM, 3PM-11PM, 11PM to 7AM and two DCS per shift. On 05/03/2026, Ms. Hurley was contacted by HM LaShonda Marve informing her that bruising was observed on Resident A's left arm. HM forwarded pictures of the bruises and when Ms. Hurley reviewed the pictures, it also appeared that Resident A's left arm was swollen. Ms. Hurley and HM initially thought it was cellulitis, but to be safe, they had Resident A transported to HFH-Geneysis by ambulance. At the hospital, it was discovered after an X-ray that Resident A sustained a fractured arm. Ms. Hurley suspended the DCS from the midnight shift, DaLisa Redick and Aerie Pittman. She stated, "I assumed it happened the night before during Resident A's shower." DaLisa was responsible for showering Resident A while Aerie was responsible for the other residents. However, APS and ORR advised Ms. Hurley to also suspend DCS Twanshe Durkins and DCS Rashayla Byas, which Ms. Hurley did. Ms. Hurley attempted to review the staff time in and out cards but was unable to determine who was working during 04/30/26-05/03/2026; however, she will email the time punch cards and April 2026-May 2026 staff schedules to me. Ms. Hurley agreed to a scheduled on-sight investigation tomorrow 05/06/2026 and will have her staff present at Kurtz Home to be interviewed regarding the allegations.

On 05/05/2026, I emailed CM Veronica Presnall with HFH-Genesys requesting a call back regarding the allegations.

On 05/06/2026, I received a telephone call from the CM, Veronica Presnall with HFH-Genesys. Resident A is still at the hospital. Ms. Presnall thought APS was coming out to see Resident A but has not yet. I advised Ms. Presnall that according to Oakland County APS, Ms. Robertson, Genesee County APS did see Resident A at the hospital at the time the complaint was filed. Ms. Presnall reviewed the chart notes and did see that Genesee County APS was at the hospital, but they never spoke with case management regarding Resident A. When Resident A was brought to the hospital, staff members were unable to provide any explanation of how Resident A, who is non-verbal and non-mobile, had a fractured arm. Ms. Presnall was unable to provide me with any other information via telephone, so I advised her that I would be coming to HFH-Genesys to see Resident A and speak with her. She acknowledged.

On 05/06/2026, I conducted a face-to-face visit with Resident A in her hospital room at HFH-Geneysis. Resident A is non-verbal. She was lying in bed, wearing a large mitten on her right hand and her left arm was bandaged up. Resident A was smiling.
I briefly spoke with her registered nurse (RN) Brooke. Resident A was admitted into the hospital on 05/03/2026. She was in the emergency room for a couple of days, but then admitted due to a humerus fracture comminuted distal, severe protein calorie malnutrition, and a stage two pressure sore on the left buttocks area. A comminuted distal means, “a severe high energy break, bone shatters into three or more pieces.” Brooke was unable to state exactly what may have happened to Resident A, that resulted in a broken, shattered arm, but that it was not caused by Resident A herself who is non-ambulatory and wheelchair bound.

I interviewed the CM Veronica Presnall regarding the allegations. Resident A was brought to the hospital via ambulance. DCS Kenyonna Joiner was present with her. Kenyonna reported she began her shift on 05/03/2026 at 4PM and drove directly to the hospital to be with Resident A to relieve the other DCS. Kenyonna was unable to provide an explanation regarding Resident A’s injury. Kenyonna was asked if Resident A was “dropped,” during transfer or in the shower, but that was denied. The doctor’s note indicated the following concerns: unexplained injury, lack of incident reporting, inconsistent reporting of mechanism, circumstances of abuse/neglect, patient is non-verbal and non-mobile. Ms. Presnall also reported concerns of severe protein calorie malnutrition as Resident A weighed 31KG at admission. Resident A currently requires a higher level of care, and a nursing home will be discussed. Ms. Presnall will follow up with APS. I was provided with Resident A’s problem/assessment plan and imaging diagnostics.

Note: I reviewed the problem/assessment plan and imaging diagnostics received from HFH-Geneysis. Resident A is being treated for the following:

1. Fracture of distal end of humerus- likely due to unwitnessed mechanical fall versus neglect
2. Hypernatremia
3. Decubitus ulcer of buttock- stage two decubitus due to bedbound status, tissue trauma consulted
4. Adult neglect or abandonment, suspected, initial encounter- unknown history of trauma or fall due to suspected neglect, unexplained distal humerus fracture, no other fractures seen on imaging
5. Anemia- likely due to vitamin deficiency due to malnutrition
6. Severe protein-calorie malnutrition- likely due to cerebral palsy and down's syndrome and poor oral intake
7. Cerebral Palsy
8. Down syndrome
9. Bedbound

On 05/06/2026, I conducted a scheduled on-site investigation. The following DCS were present, HM LaShonda Marve, DCS Rashayla Byas, Lonesha Rushin, Jaclyn Worley, Twanshe Durkins, Dalisa Redick, and Aerie Pittman. Also present were Pam Hurley, and area supervisor Deborah Oliver and Program Director Michelle Bailey.

I interviewed DCS Rashayla Byas regarding the allegations. Rashayla goes by Shay. Rashayla has been working for this corporation for two years. She works first shift 8AM-4PM and second shift 4PM-12AM. There are two DCS working per shift. Rashayla worked a double on 04/30/2026, 8AM-12AM. She worked with Lonesha Rushin. Whoever administers medications is responsible for providing care to Resident A. Resident A's body is contracted due to her diagnosis of Cerebral Palsy. Resident A cannot move her body, only her head. Resident A cannot assist with transfers. When Rashayla arrived at 8AM, Resident A was already in her wheelchair dressed. Rashayla always showered Resident A in the AM but on this day, she cannot recall if she had showered her. Throughout the shift, Rashayla transferred Resident A to and from the wheelchair into her bed when she was changing her briefs. Rashayla demonstrated how she transferred Resident A from the bed into the wheelchair and vice versa. I observed Rashayla reclined Resident A's wheelchair. She then stood next to Resident A's bed, then she took her left arm and stated that she placed it underneath Resident A's head to support her head and neck, the left arm is then placed in the crease where her legs are contracted, picks her up, in a cradling position, pivots and then places Resident A in her wheelchair, then put her seatbelt on. Rashayla denied that during any of the transfers, she dropped Resident A or caused Resident A's left arm fracture. Rashayla denied observing any bruise on Resident A's left arm on this day. Rashayla was off on 05/01/2026 but did work a double on 05/02/2026 from 8AM-12AM. She was working with Twanshe Durkins. Twanshe passed medications so she was responsible for Resident A on this day. She did not shower Resident A, nor did she assist with any transfers. There were no incidents pertaining to Resident A falling or being dropped. She did not notice any bruises on this day either. Rashayla worked a double again on 05/03/2026 from 8AM-12AM. She worked with Twanshe. Resident A was sitting in her wheelchair in front of the TV. Twanshe went to check on Resident A and noticed the bruises on her left arm. Twanshe called the HM who asked, “What happened?” Twanshe explained that she observed bruises on Resident A’s left arm. The HM advised Twanshe to call an ambulance, which she did and was transported to Henry Ford Hospital- Genesys. Rashayla did not see the bruises. Rashayla stated she was never informed by the midnight staff during any of the days she was on shift that an incident occurred with Resident A. No staff took responsibility for what happened. Her bed rails are always in the up position when she is in bed and Resident A does not move other than her head so she cannot roll out of bed. Resident A has never fallen out of her wheelchair because her seat belt is always on.

Note: Rashayla appeared “high,” as if she was under the influence of an unknown substance. Her eyes were glassy and she was slurring her words. Rashayla denied being intoxicated or under the influence of any unknown and/or illegal substances. She stated, “I woke up early to be here, but no I’m not on anything.”

On 05/06/2026, I interviewed DCS Lonesha Rushin regarding the allegations. Lonesha has been working for this corporation for one year. She works first shift from 8AM-4PM and sometimes second shift from 4PM-12AM. She works full-time. On 04/30/2026, Lonesha worked from 8AM-4PM with Rashayla who picked up Twanshe’s shift. Rashayla was responsible for Resident A on this day. Lonesha observed Rashayla transfer Resident A from the wheelchair to her bed and during that transfer any all-other transfers this day, Rashayla never dropped Resident A. Lonesha stated, “I work with Rashayla a lot and she is pretty good.” Lonesha never observed any bruises on Resident A. On 05/01/2026, Lonesha worked from 8AM-7PM with Twanshe from 8AM-5PM and Aerie came around 5PM to relieve Twanshe. Twanshe was responsible for Resident A, then Aerie took over caring for Resident A at 5PM. During this shift, Lonesha denied observing Twanshe drop Resident A during any transfer. Twanshe transferred Resident A to her bed at 5PM before she left. Aerie arrived; Resident A was in bed from 5PM-7PM. Aerie never transferred Resident A but was providing care to Resident A. Lonesha does not know what happened after she left her shift. On 05/02/2026, Lonesha worked 4PM-12AM with Rashayla and during this shift, Rashayla was responsible for Resident A. Resident A was never dropped and there were no incidents during this shift. Again, she did not observe any bruises on Resident A. Lonesha did not work on 05/03/2026. Lonesha does not know what happened to Resident A that resulted in a fractured left arm. Resident A is always smiling and because she is non-verbal, Resident A cries when she is in pain or if something is wrong. Resident A never cried during the days Lonesha worked, nor did Resident A exhibit any behaviors that was indicate something was wrong.

On 05/06/2026, I interviewed DCS Jaclyn Worley regarding the allegations. Jaclyn has been working for this company since July 2025. She only works two days a week Tuesdays from 4PM-8AM and Fridays from 8AM-4PM. there are always two DCS per shift when all four residents are home. Jaclyn was off on 04/30/2026 but worked on 05/01/2026 from 11PM-8AM. When she arrived at the group home, DCS Aerie was working by herself. She is unsure how long Aerie had been working alone. Jaclyn was responsible for Resident A. Resident A was sleeping during the night, but Jaclyn checked on her periodically. In the morning, Resident A was not showered but Jaclyn transferred her from her bed into her wheelchair. Jaclyn demonstrated in front of Resident A's bed how she transferred her. Jaclyn leaned the wheelchair back and positioned it near the bed. She then placed her left arm underneath where Resident A's head would be and her right arm under Resident A's legs where there is a crease due to Resident A's legs are contracted. Jaclyn lifts Resident A up in a "cradling," position, pivots her around and places her in the wheelchair. She then puts her seatbelt on. Jaclyn denied dropping Resident A and stated there was no incident on this day. Jaclyn did not notice any bruises on Resident A. On 05/03/2026, Jaclyn received a group text message from the HM about Resident A taken to the hospital and HM asked if anyone knew what happened to Resident A. Jaclyn stated, "if anything would have happened during my shift with Resident A, I would have written an incident report and informed the HM immediately. Jaclyn stated that no staff reported anything via text messages that anything happened during any of their shifts. She does not know how Resident A fractured her left arm and she denied causing the fracture. No staff took responsibility for what happened. Her bed rails are always in the up position when she is in bed and Resident A does not move other than her head so she cannot roll out of bed. Resident A has never fallen out of her wheelchair because her seat belt is always on.

On 05/06/2026, I interviewed DCS Twanshe Durkins regarding the allegations. Twanshe has been working for this corporation since July 2025. She works from 8AM-4PM Tuesdays, Thursdays, Saturdays, and Sundays. She is currently suspended because "I found the bruising, so they (management) believe it happened during my shifts." On 04/30/2026, Twanshe worked with the HM LaShonda Marve from 8AM-4PM. Resident A was up and in her wheelchair. Twanshe and HM were both responsible for providing care to Resident A. She has transferred Resident A numerous times and has never dropped her. Twanshe demonstrated how she transferred Resident A from her bed to the wheelchair and it was the exact same way that had been demonstrated by all the other staff. Twanshe does not recall if the HM transferred Resident A on this day but stated there were no incidents and she did not observe any bruises on Resident A's left arm. On 05/01/2026, Twanshe picked up this shift from 8AM-4PM and worked with DCS Lonesha. Twanshe was responsible for Resident A. Resident A was up and, in her wheelchair, when she arrived. Again, she transferred her like any other day, changed her, and there were no incidents. Twanshe did not observe any bruises on Resident A's arm on this day. On 05/02/2026, Twanshe worked from 8AM-4PM with DCS Lashayla. Both she and Lashayla were responsible for providing care for Resident A. Resident A was in her wheelchair dressed when she arrived. Both transferred Resident A to and from her wheelchair and changed her without incident. Again, she did not observe any bruises on Resident A's left arm on this day. On 05/03/2026, Twanshe worked with Lashayla from 8AM-4PM. Resident A was sitting in her wheelchair in the living room watching TV. Dalisa was in the kitchen, and Aerie was in the back with another resident. Resident A appeared fine, her left arm was sitting inside the wheelchair, and her right arm was resting on her chest. Twanshe completed her chores and around 10AM, she rolled Resident A back to her bedroom to check her brief, she was not soiled so she rolled back to the living room. Twanshe began preparing lunch and afterwards came to Resident A to reposition her because she appeared, "angled on the wheelchair."

Twanshe demonstrated on me on she was trying to reposition Resident A. Twanshe placed both her arms underneath my arms and stated that that is when she felt Resident A’s arm was warm to the touch, which then prompted her to check her left arm. She checked her arm and saw bruises and swelling. She immediately called HM LaShonda around 1PM-1:15PM advising her what she observed. Twanshe asked the HM if an IR had been written and the HM stated no. The HM advised Twanshe to call an ambulance which she did. The ambulance arrived and transported Resident A to the hospital. Twanshe followed and was at the hospital with Resident A. Twanshe denied any incident occurring with Resident A that resulted in bruises and the fractured left arm. She has never observed any staff drop Resident A. She does not know how Resident A fractured her arm had but does believe something happened to her but does not know what happened. No staff took responsibility for what happened. Her bed rails are always in the up position when she is in bed and Resident A does not move other than her head so she cannot roll out of bed. Resident A has never fallen out of her wheelchair because her seat belt is always on.

On 05/06/2026, I interviewed DCS Dalisa Redick regarding the allegations. Dalisa has been working for this corporation since June/July 2025. She works third shift from 12AM-8AM, but there are times when she does 16-hour shifts. On 04/30/2026 she worked with DCS Aerie Pittman from 12AM-8AM. Dalisa was responsible for Resident A. Resident A was in bed when she arrived. She checks on her periodically throughout the night, checks her brief and changes as needed. Around 7AM, she gets Resident A up and demonstrates how she transfers Resident A from the bed into her wheelchair. The transfer was the same, cradled Resident A as all other DCS did. She did not observe any bruises on Resident A’s arm. Resident A was not dropped nor did any incident occur during this shift. Dalisa was off on 05/01/2026 but worked on 05/02/2026 with Aerie again from 12AM-8AM. Resident A was sleeping in her bed. Dalisa periodically checked on her and around 2AM recalled changing her brief because she was wet. Around 7AM, she woke Resident A up and gave her a bed bath. She stripped her down and did not observe any bruises. She then got her dressed and transferred into her wheelchair without any incident. During shower days, which is usually Sundays, Dalisa wheels Resident A into the bathroom and transfers her onto the shower bed in the bathroom. She never dropped her during this transfer. The shower bed has rails and when Resident A is on it, Dalisa holds her with one hand and uses the handheld shower with the other and gives her a shower. There has never been an incident during showers. On 05/03/2026, around 1:45PM, a group chat text with all staff and HM notifying staff that Resident A’s left arm was swollen and had bruises. Dalisa does not know what happened to Resident A’s arm and how it was fractured. No staff took responsibility for what happened. Her bed rails are always in the up position when she is in bed and Resident A does not move other than her head so she cannot roll out of bed. Resident A has never fallen out of her wheelchair because her seat belt is always on.

On 05/06/2026, I interviewed DCS Aerie Pittman regarding the allegations. Aerie has been working for this corporation for over one year. She works third shift from 12AM-8AM but sometimes she also works 16-hour shifts. She is trained in passing medications. Aerie stated she has never been assigned to provide care for Resident A; therefore, she has never passed medications to Resident A. On 04/30/2026, she worked with Dalisa from 12AM-8AM. Dalisa was responsible for Resident A and during the shift, Resident A was sleeping but Dalisa would periodically check on her. Around 7:15AM-7:30AM, Dalisa wheeled Resident A to the dining room table. There was no incident during this shift nor were any injuries observed. On 05/01/2026, Aerie worked from 5:30PM-8AM. She began working with Lonesha until 6:30PM when Lonesha left, leaving Aerie alone until Jaclyn arrived around 10:30PM. However, Twanshe arrived at 8PM and administered medications to the residents and left. Again, leaving Aerie alone. Aerie stated she only checked on Resident A who had been in bed and never transferred Resident A. She denied that Resident A fell out of bed and stated, “Resident A had her hand in her mouth sleeping.” When Jaclyn arrived, she was responsible for Resident A’s care. Jaclyn transferred Resident A into her wheelchair around 7:30AM and brought Resident A into the dining room area. There was no incident on this day. She did not observe any bruises on Resident A. On 05/02/2026, she worked with Dalisa from 12AM-8AM. Dalisa was responsible for Resident A. Resident A received another bed bath in the morning and there was no incident when Dalisa transferred Resident A from the bed and into the wheelchair. She brought Resident A out into the living room in front of the TV. She did not observe any bruises. No one from previous shifts reported any incidents that had occurred during their shifts. There was no IR written by anyone and she learned of the fractured arm by receiving a text message from the HM. No staff took responsibility for what happened. Her bed rails are always in the up position when she is in bed and Resident A does not move other than her head so she cannot roll out of bed. Resident A has never fallen out of her wheelchair because her seat belt is always on.

On 05/06/2026, I interviewed HM Lashonda Marve-Austin regarding the allegations. HM has been working for this corporation since October 2022. She works Mondays/Wednesdays from 8AM-8PM and Tuesdays/Thursdays from 8AM-4PM-5PM and depending on DCS Jaclyn’s schedule, HM may work on Fridays. On 04/30/2026, HM worked with Twanshe but denied providing care for Resident A as Twanshe reported. HM stated she is on workers’ compensation due to an injury and cannot provide any care, specifically transferring any resident until she is cleared. She never transferred Resident A during this shift nor was there any incident during this shift. On 05/01/2026, around 8:30-8:45 both Twanshe and Rashayla were present to go over medications. Rashayla told HM everyone was sleeping accept for Resident A who was in the wheelchair sitting in the living room watching TV. Resident A is always cold, so she was wearing long sleeves, and HM did not observe any bruises. Resident A had her mittens in her hands. Around 11:30, she and Twanshe left. On 05/03/2026, around 11:30AM, HM received a telephone call from Twanshe asking her if she received any IRs regarding Resident A. HM said no. Twanshe explained that she went to reposition Resident A in her wheelchair, felt her left arm warm and then observed the bruises. HM had Twanshe Facetime her and HM observed yellowish color bruises on her left arm and then Twanshe pulled the mittens down, raised Resident A’s arm and HM observed significant bruising along the bottom of the arm. HM stated, Resident A “whimpered and had a tear come down her face.” HM advised Twanshe to call an ambulance and go to the hospital with Resident A, which Twanshe did. It was discovered that Resident A had a fractured arm. HM sent a text message out to all the staff informing them of the fracture and asking for an explanation of what happened. No one responded that any incident occurred during their shifts. HM believes that someone “stumbled,” with Resident A during a transfer and “possibly,” during that stumbling, may have landed on Resident A’s left arm as they placed her in her bed. HM stated, “I’ve stumbled with her before because of the area rug underneath the bed, so I can see that happening.” She does not recall when she stumbled with Resident A but stated “it was a while ago.” Again, she reiterated that she did not transfer nor provide care to Resident A from 04/30/2026-05/03/2026. HM does not know which staff may have stumbled with her but would have hoped that the person who did would have written an IR and just said what happened because it appeared to be an accident.

Note: I reviewed the staff communication logs and there was nothing significant regarding Resident A during any of the shifts regarding falls or any incidents that may have occurred during the shifts.

On 05/06/2026, licensee designee Pamela Hurley, program director Tonya Tyree, and area supervisor Deborah Oliver did not have any insight regarding how Resident A sustained a fracture. Resident A is non-mobile and requires full assistance from caregivers; therefore, Resident A could not have sustained the fracture on her own, but there were no IRs written and no staff reported anything had occurred during their shifts. Ms. Hurley understands and acknowledges that there is a concern regarding Resident A’s fracture and that someone caused it accidentally or negligently but are not willing to come forward. Ms. Hurley asked if she could have the staff, she suspended return to work. I advised her that the investigation is still ongoing and she will need to speak with the APS worker for further instructions as they were still investigating these allegations. 05/11/2026, I contacted Michigan State Police and spoke with Sergeant Morrison who stated that their department will not be investigating these allegations due to it being a non-criminal incident.

Note: I reviewed the pictures of Resident A’s left arm. There is significant bruising, purplish yellow green in color from her hand towards the inside of her upper arm in addition to her arm appearing swollen. There is also a picture of the outside of her arm and there is little to no discoloration. It is unclear how DCS did not see her arm if she was getting showered and/or received bed baths.

Note: I also reviewed the IR written on 05/03/2026 by Twanshe Durkins regarding her discovering the bruises and swelling of her arm when she went to adjust Resident A in her wheelchair. Resident A was sent to the hospital via ambulance.

On 05/11/2026, I interviewed via telephone DCS Kenyonna Joiner regarding the allegations. Kenyonna has been working for this corporation since 03/08/2026. She works second shift from 4PM-12AM and works three days a week. Kenyonna stated she has never provided care for Resident A because “she was never trained.” On 04/30/2026, Kenyonna worked with Jaclyn from 4PM-12AM. Jaclyn was responsible for

Resident A's care. Resident A was sitting in the living room in her wheelchair watching TV. She had short sleeves on, and her arm was visible, but Kenyonna did not observe any bruises; however, Kenyonna did not examine her. Kenyonna stated, "Jaclyn is good with Resident A. Everybody else leaves Resident A in her bedroom or in her chair, but I've seen how Jaclyn and even Twanshe are with Resident A. They both provide compassionate care to Resident A." She observed Jaclyn transferred Resident A and there was no incident. Kenyonna did not work next until 05/03/2026; however, she never reported to the group home. Instead, she was told to relieve Twanshe at the hospital with Resident A, which she did. At the hospital, she learned that Resident A sustained a fractured arm. Hospital staff asked Kenyonna what happened and she told them, "I don't know." Kenyonna stated that Resident A is always smiling and has never shown any signs of hurt. She has never seen Resident A cry or make a whimpering sound. Kenyonna does not know what happened to Resident A but when asked if there were any concerns about any staff, she stated Lonesha. Kenyonna reported that every time she works with Lonesha, Kenyonna has observed Resident C "covered in feces." She reported this to the HM.

On 05/11/2026, I interviewed DCS Denise Marley regarding the allegations. Denise has been working for this corporation since June 2025. She works Saturday-Tuesday from 12AM-8AM. Denise did not work 04/30/2026-05/03/2026. The last time she worked was 04/29/2026 and at 8AM, there was no bruising on Resident A. She did not provide care for Resident A as she was working with Jaclyn who was responsible for caring for Resident A. Jaclyn never dropped nor did she stubble while transferring Resident A from her bed to the wheelchair and vice versa. Whenever Denise arrives for her shift, Resident A is in bed. Denise checks on Resident A and all the other residents. Every two hours, all the residents get checked and/or checked and repositions if needed. At 6:30AM, if it is a shower day, Resident A gets showered first, dressed and placed in a wheelchair before the other residents are up and showered. Resident A was never dropped by Denise when she provided care. Denise stated, "Do I think somebody hurt Resident A, no. Do I believe someone did this on purpose? No. I think someone bumped her on the door or while repositioning her, by getting her arm out of the way and fractured the arm." DCS must guide Resident A's arm because Resident A cannot move it from underneath herself. Resident A is so fragile and constricted that any wrong move or repositioning can possibly cause injury. Denise stated that no DCS reported to her that an incident had occurred during their shift.

On 05/11/2026, I followed up with ORR Katie Garcia. Ms. Garcia stated that she is still investigating these allegations and without a specific DCS taking responsibility for Resident A's left arm fracture, she may not be able to substantiate her case.

On 05/08/2026, I received from licensee designee Pamela Hurley via email April 2026 staff schedule. The staff schedule for 04/30/2026 did not match the time punch in/out as to which staff worked that day. According to my interviews with DCS, there have a total of four staff reporting that they were on shift from 8AM-4PM except for Lonesha who worked 8A-12PM. Rashayla worked 8AM-12AM, Twanshe worked 8A-4PM and the HM LaShonda worked 8A-4PM. The timesheet somewhat shows that these three staff, I don't have the HM's timesheet either punched in or out during this time. Pamela Hurley and her management team had no idea why there were so many staff punching in and out during this time but believe there was a glitch in the system. They are looking into this issue. The staff schedule did not reflect the changes of those who worked on 04/30/2026.

On 05/15/2026, I received the following email from APS worker Ra'Shawnda Robertson. "APS received a call from social worker, Bria Finley. Bria reported that they've been working with her Easterseals Macomb-Oakland Regional Center (MORC) case worker. She reported that they found another group Home that will be able to provide higher level of care for Resident A. Bria reported that they were going to be discharging Resident A today, but she had a fever. She reported that she would be discharged soon and Bria advised that she would contact APS as soon as she is ready. "

On 05/21/2026, I received an email from APS worker Ra'Shawnda Robertson. She sent her interview with Resident A's physician, Dr. Bethany Hill. "APS placed a call to Dr. Bethany Hill, Home MD, 855-466-3631. Dr. Hill advised that she saw Resident A on 04/29/2026. She reported that this was her first visit. Dr. Hill reported that when she came into the home Resident A was sitting in front of the TV. She reported that she did a physical assessment. Dr. Hill reported that she looked at her hands. She reported that Resident A was constricted in her legs. Dr. Hill reported that she noticed bilateral foot drop. She reported that it has probably been that way for a long time. Dr. Hill also reported that her chart says she has osteoarthritis (unspecified location). She denied that she saw any injuries or bruises. Dr. Hill reported that she prescribed Niccole 50 mg of Zoloft. She also did state that she feels that Resident A has adult failure to thrive. APS thanked her for her time."

On 06/03/2026, I interviewed Resident A's co-guardian regarding the allegations. The co-guardian stated that she has only visited Resident A "a handful of times," since she moved into this group home because co-guardian lives in Rochester. Co-guardian stated the hospital staff informed her that someone at the group home either dropped Resident A or pulled Resident A's left arm causing the fracture. It was "outside force." She is unsure what happened to Resident A but stated that Resident A could not have caused the injury because she is non-mobile and relies on DCS for all her care.

On 06/03/2026, I received a return call from the legal guardian. The legal guardian did not visit "a lot," with Resident A when she moved into Kurtz Home. She wishes she did after learning that Resident A had a left arm fracture. The legal guardian was informed by the orthopedic surgeon that he believed the fracture was either that Resident A was dropped/fall or an aggressive force repositioning her arm, but he most likely believed it was a fall.

APPLICABLE RULE	
R 400.639	**Staff records**
	(3) A licensee shall maintain for 90 days a daily work schedule and assignments that includes all of the following: **(e) Scheduling changes when made.**
ANALYSIS:	Based on my review of DCS April 2026 staff schedule and time sheet punch in/out for 04/30/2026, it was unclear who actually worked first shift from 8AM-4PM. There were four DCS who stated they were working that shift, but according to the time punch in/out sheets, DCS Twanshe Durkins, Lonesha Rushin and Rashayla Byas worked, but the staff schedule for April 2026 showed, DCS Twanshe and Lonesha worked 8AM-4PM with the home manager Lashonda Marve-Austin. Scheduling changes were made on 04/30/2026 from 8AM-4PM but never updated on the staff schedule to reflect the DCS that worked during those hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(4) Direct care staff shall possess all of the following qualifications before working independently: **(a) Be capable of meeting the physical, emotional, intellectual, and social needs of each resident.**

ANALYSIS:	Based on my investigation and information gathered, DCS at Kurtz Home are not capable of meeting the physical, emotional, intellectual, and social needs of Resident A. Resident A was taken to HFH-Genesys on 05/03/2026 when bruising and swelling was observed on her left arm. It was discovered that Resident A had a fractured left arm. According to hospital staff, Resident A was dropped or had a fall. I interviewed all the DCS who worked at Kurtz Home, and no one could provide an explanation as how Resident A, a non-verbal, non-mobile, is 100% dependent on DCS for all her care fractured her arm. If staff do not know or explain how an injury occurred, it increases the likelihood of mistreatment and neglect by DCS which questions the ability of the DCS to provide care to the residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED; SIR 2023A0611018 dated 05/04/2023, CAP dated 06/06/2023**

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on my investigation and findings, Resident A was not protected and safe at Kurtz Home. Resident A sustained a fractured left arm. She is dependent on DCS for all her care. DCS, not being able to explain how the injury occurred results in a ponderance of evidence that neglect and improper care occurred. It indicates that DCS failed to provide continual safety and adequate supervision to Resident A.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED: SIR 2023A0611018 dated 05/04/2023, CAP dated 06/06/2023**

ALLEGATION:

Resident A was found malnourished during her emergency room visit on 05/02/2026.

INVESTIGATION:

On 05/06/2026, I interviewed DCS Rashayla Byas regarding the allegations. Resident A is on a purred diet. She uses a straw or sippy cup during her meals. Whenever Rashayla works, Resident A is fed three times per day plus snacks and fluids. Resident A has never refused any meal and always eats 100% of her food. Rashayla documents in the progress logs whenever she feeds Resident A and documents the percentage of food Resident A consumes at a meal. Resident A is weighed monthly. Rashayla stated, “I have noticed weight loss from her stomach, but I’m not sure if I told anyone or if her doctor knows.”

On 05/06/2026, I interviewed DCS Lonesha Rushin regarding the allegations. Resident A is on a pureed diet and is fed with either a spoon or with a straw in a sippy cup. Resident A has refused to eat sometimes and when this happens, Lonesha documents it in the staff log. Also, documented in the staff log is how much Resident A ate. Resident A is weighed monthly and there was a discussion last week with HM Lashonda about Resident A’s weight loss. The HM stated she will talk to management about weight loss. She was not informed of anything yet about weight loss.

On 05/06/2026, I interviewed DCS Jaclyn Worley regarding the allegations. Resident A is on a pureed diet. All her meals are put in a blender and fed to Resident A either by a spoon or put in a sippy cup and Resident A uses a straw. During Jacklyn’s shifts, she would feed Resident A, and Resident A ate fine and drank fluids fine. Jacklyn never observed weight loss because she works two days a week but received a group text message from the HM about increasing Resident A’s food intake because there was noticeable weight loss. Resident A was being weighed monthly. Jacklyn does not know if the weight loss was brought to the doctor’s attention.

On 05/06/2026, I interviewed DCS Twanshe Durkins regarding the allegations. Resident A’s food is pureed, smoothie like texture. She typically eats, so she is unsure why Resident A was losing weight. Within the last two months, Resident A lost weight but during Twanshe’s shifts, Resident A eats 100% of her food. She cannot speak as to the other shifts but reported no concerns. She does not know if HM has reported the weight loss to Resident A’s physician.

On 05/06/2026, I interviewed DCS Dalisa Redick regarding the allegations. During the midnight shift, there are no meals until breakfast; however, Delisa stated that Resident A has always been small, so she did not notice weight loss and there have not been discussions about Resident A losing weight. Dalisa feeds Resident A breakfast she pureed and when she feeds her, Resident A eats 100% of her meal. If she does not finish her breakfast before Dalisa’s shift ends, then the staff that arrive for the day shift will take over and feed Resident A.

On 05/06/2026, I interviewed DCS Aerie Pittman regarding the allegations. Aerie has never fed Resident A but has observed other staff feed Resident A during the morning shifts. She does not know if Resident A is or has lost weight and has not heard anything about Resident A’s weight loss.

On 05/06/2026, I interviewed HM Lashonda Marve-Austin regarding the allegations. Resident A gets weighed monthly. There have been “spurts,” of her not eating. She picks and chooses what she eats so there are times she eats 100% of her meals and other times she does not. HM has advised all staff via text messages to give Resident A additional snacks, smoothies, ensure and boost if needed. Resident A began losing weight in February 2026, but because her legal guardian was responsible for taking her to the doctor's office, Resident A had not been seen by a doctor since moving into this group home. The legal guardian was not cooperating with the group home when they recommended Resident A to see the visiting physician until recently. The visiting physician saw Resident A on 04/29/2026 for the first time and prior to this no concerns regarding the weight loss was informed to Resident A's doctor. HM stated she had been in touch with the legal guardian numerous times regarding Resident A needing to see a doctor, but the legal guardian again was not cooperating and would cancel appointments when they were scheduled. She has text messages between her and the legal guardian. I advised her to forward those messages to me via email.

Note: I reviewed Resident A's weight records since admission into the home on 05/07/2025 and the weights are as follows: No weight at admission, wheelchair weight is 70.4 pounds. On 05/2025 (73 pounds), 06/2025 (76 pounds), 07/2025 (74 pounds), 08/2025 (80 pounds), 09/2025 (84.3 pounds), 10/2025 (84.1 pounds), 11/2025 (82.2 pounds), 12/2025 (80.8 pounds), 01/2026 (84.4 pounds), 02/2026 (85.4 pounds), 03/2026 (64 pounds), and 04/2026 (60 pounds).

According to HM, she believes that the scale they had to weigh residents in their wheelchairs was "broken." There were other residents that also had a 20 pounds drop in weight around that time. I observed Resident B's weight records, and he also had a 20 pounds drop in weight in February 2026. However, the scale was not repaired/replaced until May 2026 but now the monitor on the scale does not work. In addition, HM stated that since Resident A's admission into this home, Resident A was supposed to be seen by a doctor sometime in November/December 2025, but the legal guardian did not get all the information switched over until January/February 2026 to allow Resident A to be seen by the visiting physician. Last month, there was a flood at this group home, so all the doctors' appointments were cancelled as the residents had to stay at a hotel. On 04/29/2026, the visiting physician, Dr. Bethany Hill assessed Resident A for the first time at the group home.

On 05/06/2026, I interviewed DCS Kenyonna Joiner regarding the allegations. Resident A is on a pureed diet. Kenyonna stated, "I'm responsible for dinner and when I cook, I make real meals, but when other staff cook, they do not." Kenyonna does not believe that Resident A gets enough nutrients when she is fed by other staff even though Resident A eats the food. She does not know anything about her losing weight but believes it is due to not having enough nutrients.

On 05/11/2026, I interviewed DCS Denise Marley regarding the allegations. Resident A is on a pureed diet. Whenever Denise feeds her, she eats 100% of her food in addition to about six-10 ounces of water. Denise did not notice weight loss as Resident A is small in stature; however, a couple of weeks ago, HM asked Denise if Resident A eats during her shift. Denise advised the HM yes; Resident A eats everything. Denise does not know if Resident A is eating during other staff shifts because she is not there. The HM did not say anything further.

Note: I reviewed Resident A's Easterseals/MORC individual plan of service (IPOS) dated 09/01/2025 that stated, "Resident A will agree to be weighed by caregivers at least once per week and recorded on the weight sheets for the next 12 months. If there is a notice of weight loss or gain by 10 pounds or more in a month, then staff will report to the home manager, who will then schedule a doctor's visit to rule out medical cause." Kurtz Home was not weighing Resident A weekly. She was only weighed monthly.

On 06/03/2026, I interviewed Resident A's co-guardian regarding the allegations. Co-guardian stated that her aunt, Resident A's legal guardian wanted to oversee Resident A's medical appointments but was not following through with taking Resident A to the doctors so co-guardian suggested to the aunt to have the group home be responsible for Resident A's medical care. Co-guardian does not know when the aunt gave authorization to the group home to oversee Resident A's medical appointments. She did not know about Resident A's weight loss until she was informed that by the hospital staff. Co-guardian stated she talked to the group home about feeding Resident A "extra," and giving her fluids, but believed that staff were doing these things, but after speaking with hospital staff, it appeared that Resident A was not getting fed because she was malnourished.

On 06/03/2026, I received a call from Resident A's legal guardian. She was unaware that Resident A was malnourished until it was reported to her by hospital staff. She stated that Resident A had been hospitalized at HFHWB from 12/04/2025-12/10/2025 for dehydration and at that time, she did not want Resident A to return to this group home, but do to some unforeseen circumstances, she was unable to relocate her, so she was discharged back to Kurtz Home. The legal guardian stated that she was never informed of Resident A's weight loss by anyone from the group home. She stated that initially she wanted to oversee Resident A's medical needs, but due to her own medical issues, she agreed to have the group home begin to allow their visiting physicians to see Resident A. She believes this agreement took place before April 2026 and possibly around February 2026 as she recalls it still being winter outside.

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:	Based on my investigation and review of Resident A's IPOS completed by Easterseals MORC on 09/01/2025, Resident A's personal care was not attended to as specified in her IPOS. According to the IPOS, Resident A was supposed to be weighed once a week, but I reviewed Resident A's weight records, and she was weighed monthly from 09/2025-04/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based on my investigation and review of Resident A's weight records, there was a sudden adverse change in Resident A's weight between February 2026 and March 2026. The weight records showed a 20-pound weight loss. The HM Lashonda Marve-Austin stated it was probably a "defective scale," however, no one from Kurtz Home contacted Resident A's physician regarding this concern to ensure there was no medical reason for this significant weight loss.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A had a stage two bedsore on her buttocks during her emergency room visit on 05/02/2026 that appeared to have not been cared for properly.

INVESTIGATION:

On 05/06/2026, I interviewed DCS Rashayla Byas regarding the allegations. Resident A has a pressure sore on the left side of her buttocks. She is repositioned every two hours and when she is sitting in her wheelchair, Rashayla repositions the chair, either leaning back or sitting straight up to ensure she is being repositioned. While Resident A is in bed, pillows are used when she is repositioned on her sides and between her knees. A cream (unknown name) is put on the pressure sore after being cleaned. To Rashayla's knowledge, there was no wound care or home care providing any care for Resident A's pressure sore. Rashayla cannot recall if it was open or close, but stated, she was changing the dressing and applying the cream. The cream was over the counter, and it was not prescribed by a doctor for Resident A's pressure sore.

On 05/06/2026, I interviewed DCS Lonesha Rushin regarding the allegations. Rashayla discovered the pressure sore on Resident A on Monday 05/04/2026 when she was changing her. Lonesha did not see the pressure sore. She does not provide care to Resident A but has observed Rashayla reposition Resident A, then place pillows between her legs and on her sides. She is unsure how often Rashayla repositions Resident A during their shift. Lonesha does not watch Rashayla change Resident A, so she is unsure how the pressure sore being cared for.

On 05/06/2026, I interviewed DCS Jaclyn Worley regarding the allegations. Jaclyn provides care to Resident A. Resident A had an appointment with the visiting physician regarding the pressure sore on her bottom but in the meantime, during Jaclyn's shifts, she repositions Resident A every hour. During brief changes, Jaclyn ensures the wound is clean and dry and applies a barrier cream. The cream was not prescribed, just over the counter cream was being applied when the wound was open. She does not know if other staff were applying the cream or what they did during their shifts.

On 05/06/2026, I interviewed DCS Twanshe Durkins regarding the allegations. Twanshe noticed a pressure sore forming on Resident A's buttocks area after Resident A returned from HFHWB about two months ago, but the pressure sore was red, not open. IR was not written; however, an over-the-counter cream was being applied on the wound, kept clean and dry. Resident A was seen by a visiting physician either last Wednesday or the Wednesday before, but Twanshe does not know if the pressure sore was discussed. However, Resident A was repositioned every two hours. She does not know how other staff were caring for the wound and how often they were repositioning Resident A.

On 05/06/2026, I interviewed DCS Delisa Redick regarding the allegations. During Delisa's shifts, she would reposition Resident A every one hour. She placed pillows between her knees and on either side of Resident A. Delisa recalls the pressure sore was not present until Resident A returned from HFHWB two months ago. Delisa changed the wound on Resident A's buttocks during each brief change then applied an over-the-counter ointment cream that is in her bedroom. I observed the cream in a tote in Resident A's bedroom. The cream is Triamcinolone Acetonide Moisture Barrier Cream. She is unsure if there is a script for this cream.

On 05/06/2026, I interviewed DCS Aerie Pittman regarding the allegations. Aerie did not know Resident A had a bedsore. She never repositioned her and stated that the repositioning was only getting done when other DCS were working during her shift and they were responsible for Resident A. She has observed other staff repositioning Resident A and placing a pillow between her legs.

On 05/06/2026, I interviewed HM Lashonda Marve-Austin regarding the allegations. In February 2026, Resident A returned from HFHWB with a bedsore on her buttocks; however, the bedsore was not in the discharge paperwork. The family was responsible for her medical needs at that time and never connected with a doctor, so HM had staff use an over-the-counter cream when they changed the dressing and kept it clean and dry. There is no script for the cream. Resident A should be repositioned every one-two hour, but HM advised all staff to reposition every 45 minutes. The cream used is Triamcinolone Acetonide USP 0.1%.

On 05/06/2026, licensee designee Pamela Hurley stated that wound care protocol is what the doctor orders, but in this case because Resident A did not have a doctor nor did the family take her to the doctor, staff were providing wound care. Staff were using over-the-counter cream, checking/changing the wound and keeping it dry. There were no orders or scripts for both wound care and the moisture barrier cream.

On 05/06/2026, I interviewed DCS Kenyonna Joiner regarding the allegations. Kenyonna saw the bedsore at the hospital. During her shifts, when she works with Jaclyn, Resident A is also being transferred to and from the bed and repositioned by Jaclyn; however, Kenyonna is unsure if it is happening when other staff are providing care because she is not there. She has no other information.

On 05/11/2026, I interviewed DCS Denise Marley regarding the allegations. Denise stated that Resident A has had pressure sores on/off since she has lived at this group home. The pressure sores have been opened and after applying cream, over the counter it closes but then it opens again. She stated, “the wound was closed for a long time, but then after leaving the hospital in 02/2026, it reopened.” Denise brought it to the HM’s attention and the HM stated, “I’m aware, but continue putting Desitin cream on it.” The HM also told Denise that an IR was written regarding the opened wound, but Denise has not seen the IR. On 04/28/2026, Denise stated she saw the bedsore was “open and bleeding a bit” on the left side of the buttocks and it was the size of the tip of a pinky finger. After cleaning it, Denise applied the Desitin cream and was repositioning Resident A every two hours. She was alternating between her left and right side and placed pillows on the left side where the wound was. She does not know what other staff members do regarding the wound. However, when she arrives at her shift, she sees pillows between Resident A’s knees and a pillow on whichever side Resident A is positioned at. There are no wound care orders or script for the cream to her knowledge.

On 06/03/2026, I interviewed the co-guardian regarding the allegations. The co-guardian was told again by hospital staff that Resident A had a stage two bedsore on her buttocks, and it was because “staff were not repositioning her.” The co-guardian stated that she believed staff were taking care of Resident A but after speaking with hospital staff, it appeared that they were not. The co-guardian stated that she would have the guardian call me regarding these allegations as the guardian would have more information.

On 06/03/2026, I interviewed Resident A’s legal guardian regarding the allegations. The legal guardian was unaware of the pressure sore until she was informed by hospital staff. She believed that the group home was repositioning Resident A and providing wound care but because she was not visiting the home, she couldn’t confirm it was happening. Currently, the group home where Resident A is at has a wound care nurse coming out and providing wound care. Resident A is doing better.

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:	Based on my investigation, Resident A’s over-the-counter ointment, Triamcinolone Acetonide USP 0.1% Cream used on Resident A’s pressure sore on her buttocks was not prescribed by an appropriate licensed health care professional.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED: SIR 2023A0612025 dated 05/04/2023, CAP dated 07/07/2023; LSR dated 07/31/2023, CAP dated 07/31/2023**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(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.
ANALYSIS:	During the on-site inspection on 05/06/2026, I observed the over-the-counter ointment, Triamcinolone Acetonide USP 0.1% Cream used on Resident A’s pressure sore on her buttocks was observed in a tote in her bedroom and not kept in a locked cabinet.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(11) A licensee shall contact a resident's health care professional for instructions as to the care of the resident if the resident requires the care of a health care professional. The licensee shall record in the resident's record any instructions for the care of the resident.
ANALYSIS:	Based on my investigation and information gathered, DCS did not contact Resident A's health care professional for instructions on wound care. According to DCS, the were advised by the home manager Lashonda Marve-Austin to apply an over-the-counter ointment Triamcinolone Acetonide USP 0.1% Cream on the pressure sore. Some DCS were repositioning Resident A every two hours and others were repositioning her every hour. There were no clear/concise instructions given regarding how to care for the wound.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL ALLEGATIONS

INVESTIGATION:

During the on-site investigation on 05/06/2026, I was informed that there was a flood in the basement on 04/06/2026, causing the furnace and hot water tank not to operate properly. All four residents were moved to a hotel, Home2 Suites by Hilton in Grand Blanc from 04/06/2026-04/08/2026.

On 05/11/2026, I received a telephone call from ORR Katie Garcia asking if the department was aware or had received any contact from the licensee designee Pamela Hurley regarding the flood and that the residents had been moved outside of the group home for a short period of time. Ms. Garcia had not received any IRs or any written notification advising her about the flood from anyone from this group home. I advised Ms. Garcia that after speaking with the assigned licensing consultant of this group home, she too had not received any IRs or any written report regarding the flood.

On 05/13/2026, I received an email from licensee designee Pamela Hurley with a letter dated 04/08/2026 that was hand written regarding the flood and that the residents had to relocate to a hotel. According to the letter, the home owner, residents' guardians and management was made aware but not the responsible agency- Easterseals, ORR, nor the department.

On 06/03/2026, I received an email from licensee designee Pamela Hurley stating that she provided the written letter to Community House, support coordinator, and the guardians.

On 06/04/2026, I left a detailed message for licensee designee Pamela Hurley with my findings and recommendations.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(18) A written report must be made to the resident's designated representative; responsible agency, if applicable; and the department within 24 hours from the occurrence of property damage that impacts the facility to provide adult foster care services or relocation of a resident to a different address or any fire.
ANALYSIS:	Based on my investigation, licensee designee Pamela Hurley did not provide a written report to ORR, nor the department on 04/06/2026 when the basement flooded and the residents were relocated to a hotel from 04/06/2026-04/08/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend modification of the license to a 6-month provisional.

Frodet Dawisha 06/04/2026

Frodet Dawisha Date
Licensing Consultant

Approved By:

Jay Calewarts For 06/24/2026

Denise Y. Nunn Date
Area Manager