GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 14, 2026

Nancy Posey
Theresa Posey
POSEY'S SENIOR CARE HOMES, L.L.C.
8470 Parshallville
Fenton, MI 48430

RE: License #: AS470419051
Investigation #: 2026A0466041
Posey's

Dear Ms. Nancy Posey and Ms. Theresa Posey:

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 feel free to 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 (517) 335-5985.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS470419051
Investigation #:	2026A0466041
Complaint Receipt Date:	05/21/2026
Investigation Initiation Date:	05/26/2026
Report Due Date:	07/20/2026
Licensee Name:	POSEY'S SENIOR CARE HOMES, L.L.C.
Licensee Address:	8470 Parshallville Fenton, MI 48430
Licensee Telephone #:	(810) 869-3556
Administrator:	Theresa Posey
Licensee Designee:	Nancy Posey Theresa Posey
Name of Facility:	Posey's
Facility Address:	9191 Parshallville Fenton, MI 48430
Facility Telephone #:	(810) 869-3556
Original Issuance Date:	06/13/2025
License Status:	REGULAR
Effective Date:	12/16/2025
Expiration Date:	12/15/2027
Capacity:	6
Program Type:	AGED

II. ALLEGATIONS

	Violation Established?
Resident A is being verbally abused.	No
On 5/20/2026, Resident A was observed crying in pain while holding her left hip/leg.	No
Resident A is being doubled briefed.	No
Additional Findings	Yes

III. METHODOLOGY

05/21/2026	Special Investigation Intake 2026A0466041.
05/21/2026	APS Referral Denied.
05/26/2026	Special Investigation Initiated – Telephone Complainant, message left.
05/26/2026	Contact- email sent to Complainant.
05/27/2026	Inspection Completed On-site.
07/06/2026	Contact- email sent to Complainant, second time.
07/06/2026	Contact- email sent to Nancy Posey.
07/08/2026	Contact- telephone call to DCW Jacqueline (Jackie) Diaz interviewed.
07/08/2026	Contact- telephone call to Trinity Health Hospice, message left.
07/08/2026	Contact- telephone call to Relative A1, interviewed.
07/08/2026	Contact- telephone call to Relative A2, message left.
07/08/2026	Contact- telephone call to DCW Deborah Ziola, message left.
07/08/2026	Interview with licensee designee Nancy Posey. Exit Conference with licensee designee Nancy Posey

07/09/2026	Contact- telephone call to Relative A2, interviewed.

ALLEGATION: Resident A is being verbally abused.

INVESTIGATION:
On 05/21/2026, Complainant reported that direct care worker (DCW) by the name of Jackie (last name not known) did not know Complainant had walked into the facility early on 5/14/2026 and heard DCS Jackie (last name unknown) screaming at Resident A, "you are a nasty lady, a nasty fucking woman." I later learned through the investigation that this is DCW Jackie Diaz. Complainant reported coming down the hallway, opening Resident A's door and telling DCW Jackie Diaz that Complainant was there and would take over Resident A's care. Complainant reported that the same morning Complainant witnessed DCW Jackie Diaz screaming and verbally abusing Resident A, there was another DCW in the room as well. Complainant did not report the name of the second DCW in the room. Complainant reported that Resident A had tears running down her face. Complainant reported that Resident A is diagnosed with dementia and she is a vulnerable adult. I attempted to contact Complainant by both phone and email on 5/26/2026 and I sent a second email on 7/6/2026 to gather additional information and neither time were the phone messages or emails returned/responded to. Additionally, on 05/21/2026, I received a denied Adult Protective Service (APS) referral transferred to the Department of Licensing and Regulatory Affairs (LARA) for investigation.

On 5/27/2026, I conducted an unannounced investigation and DCW Sueanne Talmadge was on duty. DCW Talmadge reported that there is one DCW staff per shift on duty at this facility. DCW Talmadge reported that no resident, DCW, family member or hospice personnel reported to her that DCW Jacqueline (Jackie) Diaz was verbally abusive toward Resident A. Although DCW Talmadge reported that she only interacts with DCW Diaz at shift change she reported that DCW Diaz takes good care of the residents. DCW Talmadge reported that DCW Diza is a loud person, but she has never witnessed her yelling, screaming, swearing or verbally abusing Resident A or any other resident.

I reviewed Resident A's record which documented that she was admitted to the facility on 5/11/2026. Resident A is diagnosed with Alzheimer's disease and receives services from Trinty Health Hospice. Resident A's record did not contain any documentation or shift notes regarding the alleged incident from 5/14/2026.

On 07/06/2026, I conducted a review of the Michigan Workforce Background Check and DCW Diaz is eligible to work in an adult foster care facility.

On 07/08/2026, I interviewed DCW Diaz who denied that she ever yells or swears at Resident A or any other resident. DCW Diaz denied that she said, "you are a nasty lady, a nasty fucking woman" to Resident A. DCW Diaz reported that she does talk

loudly and she reported that that she stated to Resident A, “be nice, you don’t have to be nasty to us when we are trying to help you.” DCW Diaz reported that Resident A becomes combative when she is being cared for. DCW Diaz reported that Resident A does not like to have her adult incontinence brief changed. DCW Diaz reported that when Resident A is upset, she bites, pulls hair, grabs clothing, scratches and digs her nails into your arm. DCW Diaz remembered that one day (date unknown) as she was starting her shift and DCW Deborah Ziola was changing Resident A, she observed Resident A grabbed DCW Ziola’s shirt and not let go. DCW Diaz reported that she and DCW Ziola were changing her together as Resident A had a bowel movement and DCW Ziola could not change her by herself. DCW Diaz reported that this was when she asked Resident A to “stop being a nasty woman as they are being nice to her.” DCW Diaz reported that she has a good relationship with Resident A as she always tells her what is going to do before she does it. DCW Diaz reported that Resident A has only been at the facility for a couple of months and Resident A’s behavior has improved since she has become more comfortable with her living arrangement.

On 07/06/2026, I conducted a review of the Michigan Workforce Background Check and DCW Ziola is eligible to work in an adult foster care facility.

On 07/08/2026, I interviewed licensee designee Nancy Posey who reported that DCW Diaz denied that she ever yells or swears at Resident A. Licensee designee Nancy Posey reported that DCW Diaz denied that she said, “you are a nasty lady, a nasty fucking woman” to Resident A. Licensee designee Nancy Posey reported that DCW Diaz does talk loudly and DCW Diaz reported to her that she told Resident A she didn’t have to be nasty while they were trying to help her. Licensee designee Nancy Posey reported that she interviewed DCW Ziola who was with DCW Diaz when it was alleged that DCW Diaz was yelling and swearing at Resident A. Licensee designee Nancy Posey reported that DCW Ziola denied that DCW Diaz ever yelled or swore at Resident A.

Realtive A1 reported that she visits the facility often and she has never observed DCW Diaz ever yelling or swearing at Resident A. Realtive A1 reported that DCW Diaz is a loud person.

On 07/09/2026, Realtive A2 reported that she visits the facility often and she has never observed DCW Diaz yelling or swearing at Resident A. Realtive A2 reported that DCW Diaz is a loud person. Realtive A2 reported that she has always observed DCW Diaz to be kind and supportive of Resident A.

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:	DCW Diaz denied that she has ever yelled and/or swore at Resident A. Licensee designee Nancy Posey reported that DCW Diaz denied that she ever yells or swears at Resident A. Licensee designee Nancy Posey reported that she interviewed DCW Ziola, who was working with DCW Diaz when this allegedly occurred, and DCW Ziola denied this happened. Lastly, both Relatives A1 and A2 denied ever hearing DCW Diaz yell or swear at Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On 5/20/2026, Resident A was observed crying in pain while holding her left hip/leg.

INVESTIGATION:
On 05/21/2026, Complainant reported that on 5/20/2026 Resident A was in a recliner crying in pain, holding her left hip and leg. I contacted Complainant by phone and email on 5/26/2026 and by email again on 7/6/2026 and neither the phone message nor emails were returned. Additionally, on 05/21/2026, I received a denied APS referral which was transferred to LARA for investigation.

On 5/27/2026, I conducted an unannounced investigation and DCW Talmadge was on duty and reported that Resident A did not have a fall nor has she had a hip injury. DCW Talmadge reported that there was a day (could not recall date) when Resident A was holding her crotch, but she was not able to answer questions if anything was bothering her. DCW Talmadge reported that Resident A was prescribed an antibiotic and then she no longer held her private area and she was able to talk and answer questions. DCW Talmadge reported that this medical intervention resolved Resident A's pain.

I reviewed Resident A's record which contained a medication administration record (MAR) for May 2025 which documented that she was prescribed "Cephalexin 500 mg capsule, take 1 capsule by mouth twice daily for urinary tract infection for 7 days." This was prescribed on 5/20/2026 and was administered as prescribed. Resident A is also prescribed "Morphine 15mg tablet. Give1 tablet by mouth every four hours as needed for moderate to severe pain or shortness of breath." Per the MAR, Morphine was administered to Resident A on "5/20/2026 at 10am for leg pain." Morphine was not administered to Resident A again the rest of the month rather 5/20/2026 was the only time Morphine was administered to Resident A. The MAR documented that all Resident A's medications from May 2026 were administered by either DCW Talmadge or DCW Diaz.

Resident A's record contained an *Inter-Disciplinary Team Progress Note* for 5/20/2026 written by nurse Paula Sebastian that stated:

> *"Routine SW visit. Hospice aid was present for care this morning and reported that patient was grabbing left leg and crying in pain. Arrived to find patient lying*

sleeping in bed. Hospice aid and husband at bedside. Pain at 5/10. Writer was able to manipulate both legs and hips without difficulty, no swelling or bruising noted. Facility staff member Susan administered Morphine patient accepted well. Staff states patient was transferred this morning placed in recliner then was showing signs of pain. Facility staff reports no falls or injury. Pain at 0/10 upon nurse departure."

Resident A's record did not contain any documentation that would indicate she fell or had an injured leg. Resident A's record did not contain any *Incident Reports* (IRs), Emergency Room (ER) Visit Reports, *Health Care Appraisal* or any medical documentation except what was completed by hospice at the time of admission.

On 07/08/2026, I interviewed DCW Diaz who reported that she did not ever observe Resident A holding her vagina but rather heard about this behavior. DCW Diaz reported that Resident A was prescribed an antibiotic for a (UTI). DCW Diaz denied being aware of any fall or injury experienced by Resident A since admission.

Relative A1 reported that she was not aware of any fall or injury that has occurred to Resident A while she has been living at the facility. Relative A1 reported Resident A was diagnosed with a UTI and she was aware that an antibiotic was ordered by hospice on 5/20/2026. Relative A reported that this resolved Resident A's pain.

On 07/09/2026, Realtive A2 stated not being aware of any fall or injury that occurred while Resident A has been living at the facility. Realtive A2 reported that she was at the facility on 5/20/2026 when Resident A was in pain and when hospice nurse Sebastian examined Resident A, advised DCW Talmadge to administer the PRN Morphine and prescribed an antibiotic for the UTI. Relative A2 reported that this resolved Resident A's pain.

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:	DCW Talmadge, DCW Diaz, Realtive A1 and Relative A2 all reported not being aware of Resident A experiencing any fall or injury to her leg while living at the facility. Realtive A2 reported that she was at the facility on 5/20/2026 when Resident A was in pain and when hospice nurse Sebastian examined Resident A. Relative A2 reported that nurse Sebastian instructed DCW Talmadge to administer PRN Morphine to Resident A and prescribed an antibiotic for a UTI. DCW Talmadge, Relative A and Relative B reported that this resolved Resident A's pain. Resident A's record contained an *Inter-Disciplinary Team Progress Note* dated 5/20/2026 that documented that Resident A was assessed by the hospice nurse Sebastian that same day therefore Resident A's change in medical condition was addressed timely and there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A is being double briefed.

INVESTIGATION:
On 05/21/2026, Complainant reported that she observed Resident A being double briefed which is a concern as this may lead to Resident A being changed less frequently. Complainant reported Resident A is diagnosed with dementia and she can be combative during brief changes. Complainant reported she comes to the facility five days a week and Resident A is always double briefed upon Complainant's arrival. I contacted Complainant by phone and email on 5/26/2026 and by email for a second time on 7/6/2026 to gather some additional information and Complainant did not respond to any communication. Additionally, on 05/21/2026, I received a denied APS referral which transferred to LARA for investigation.

On 5/27/2026, I conducted an unannounced investigation and DCW Talmadge was on duty and reported that on 5/19/2026 she did double brief and use pads with Resident A because she was having difficulty having bowel movement. DCW Talmadge stated she took this action after administering Resident A MiraLAX. DCW Talmadge reported that Resident A had not had a bowel movement in the five days and although she had given Resident A prune juice it did not help move her bowels. DCW Talmadge reported that Resident A did have a bowel movement later that evening. DCW Talmadge reported that double briefing was an isolated incident and not standard practice. DCW Talmadge reported that she has not double briefed Resident A since.

I reviewed Resident A's record which contained a MAR for May 2025 which documented that she was prescribed "Polyethylene Glycol (MiraLAX) 17g. Mix with 4

to 8 oz liquid by mouth daily for constipation." The MAR documented that this medication had been administered daily from 5/11/2026-5/27/2026 by either DCW Talmadge or DCW Diaz as this is a daily prescribed medication.

At the time of the unannounced investigation Resident A's record did not contain a written assessment plan so the agreed upon "toileting plan" for Resident A was not able to be reviewed.

On 07/08/2026, I interviewed DCW Diaz who denied that she has ever double briefed Resident A and denied that she has ever observed Resident A being double briefed.

I interviewed licensee designee Nancy Posey who reported that DCW Talmadge reported double briefing Resident A but it was an isolated incident and not standard practice. Licensee designee Nancy Posey reported that after her discussion with DCW Talmadge she has not double briefed since.

I interviewed Relative A1 who reported that when Resident A was first admitted to the facility that she was told by the hospice nurse aid Bittner that Resident A was being double briefed. Relative A1 reported that she never observed Resident A being double briefed. Relative A1 reported that since this was reported and addressed with administration and DCWs are no longer double briefing Resident A. Realtive A1 reported that she was told by licensee designee Nancy Posey that all residents are checked and changed every two to four hours.

On 07/09/2026, Realtive A2 reported that when Resident A was first admitted to the facility that she was told by the hospice nurse aid Bittner that Resident A was being double briefed. Realtive A2 reported that DCW Talmadge admitted that she did double brief and use pads with Resident A because she was having difficulty having bowel movement and she did this after administering her prune juice and MiraLAX in the event of an explosive bowel movement. Realtive A2 reported that DCW Talmadge reported that double briefing was an isolated incident and not standard practice. Realtive A2 reported that she has not observed or had any knowledge of anyone double briefing Resident A since.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.**

ANALYSIS:	DCW Diaz denied that she has double briefed Resident A and reported that she has never observed Resident A being double briefed. DCW Talmadge reported that she did double brief and use pads with Resident A after administering both prune juice and MiraLAX as Resident A had not had a bowel movement in five days. DCW Talmadge reported that double briefing was an isolated incident and she has not done it since. Relative A1 and Realtive A2 both reported that when Resident A was first admitted to the facility they were told by hospice nurse aid Bittner that Resident A was being double briefed. Relative A1 reported that she never observed Resident A being double briefed. Relative A1 and Realtive A2 reported that since double briefing was reported and addressed with administration DCWs are no longer double briefing Resident A therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 5/27/2026, I conducted an unannounced investigation and DCW Talmadge was on duty and reported that there is one DCW per shift at this facility. DCW Talmadge reported that Resident A requires the assistance of two DCWs for transferring and showering. DCW Talmadge reported that the hospice nurse aid Bittner is at the facility five days a week. DCW Talmadge reported that Resident A can pivot and stand to help hold her weight sometimes. DCW Talmadge reported that Relative A1, Realtive A2, Realtive A3 and Realtive A4 help with transfers and showers when they are here also. DCW Talmadge reported that when she needs assistance and she is on shift alone a DCW from another licensed facility, that is close by and run by the same owner, will come over to help. DCW Talmadge reported that there was not a *Staff Schedule* at the facility available for review. The *Staff Schedule* was needed to determine how many DCWs were being scheduled per shift.

I reviewed Resident A's record which contained a *Hospice Facility Admission Order & Interim Plan of Care* which documented in the "functional limitations" section, "non-ambulatory, 2-person assistance with transfers. Up as tolerated." Resident A's record did not contain a written assessment plan.

On 07/08/2026, I interviewed DCW Diaz who reported there is one DCW per shift. DCW Diaz reported that she can transfer and change Resident A by herself. DCW Diaz remembered that one day (date unknown) when her and DCW Ziola were changing Resident A together as Resident A had a bowel movement and DCW Ziola

could not change her by herself. DCW Diaz reported that Resident A requires the assistance of two people to shower. DCW Diaz reported that some DCWs believe that Resident A requires two-person assistance because Resident A can be physically combative when DCWs are providing personal care. DCW Diaz reported that the shower aid from hospice comes to the facility five days a week and Relative A3 will be at the facility at the same time to assist with the shower. DCW Diaz reported that Realtive A1, Realtive A2, Realtive A3 and Relative A4 visit often and they help to transfer Resident A as needed. DCW Diaz reported that Resident A is not ambulatory and she does not pivot for transfers.

I interviewed licensee designee Nancy Posey who reported that there is only one DCW per shift but that there are periods at shift change when two DCWs can work together to meet the needs of the residents. Licensee designee Nancy Posey reported that she was not aware of the hospice documentation that required two-person assistance for transfers.

Relative A1 reported that there is one DCW on duty per shift.

On 07/09/2026, Realtive A2 reported that there is one DCW on duty shift.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(b) 12 residents for small group and family homes.**
ANALYSIS:	DCW Talmadge, DCW Diaz, licensee designee Nancy Posey, Realtive A1 and Realtive A2 all reported that the facility is staffed with one direct care worker per shift. Therefore, a violation has been established as Resident A requires two direct care workers to meet her needs per written physician instructions and this was not provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.

ANALYSIS:	Resident A's *Hospice Facility Admission Order & Interim Plan of Care* documented in the "functional limitations" section, "non-ambulatory, 2-person assistance with transfers." DCW Talmadge, DCW Diaz, licensee designee Nancy Posey, Realtive A1 and Realtive A2 all reported that the facility is staffed with one direct care worker per shift. Therefore, a violation has been established as Resident A requires two direct care workers to meet her needs per written physician instructions and this was not provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(a) Names of staff on duty.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.**
ANALYSIS:	At the time of the unannounced investigation there was not a *Staff Schedule* available for departmental review.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 5/27/2026, I conducted an unannounced investigation and I observed a walker, hospital bed with bed rails, and Gerry chair tray in Resident A's bedroom. I observed Resident A sleeping in the living room in a Gerry chair.

I reviewed Resident A's record and there was a *Physician Communication Form* that was dated 5/11/2026 and signed by Paula Sebastian, RN which stated, "follow up needed by staff, full bed rails ordered." This documentation did not state the term of the authorization for this assistive device.

Additionally, there was no written physician documentation for Resident A's walker, Gerry chair and tray that were observed either in Resident A's room or devices that Resident A was observed using during the unannounced investigation. Resident A's record did not contain any authorization/reason nor was the term of the authorization documented in writing for the walker, Gerry chair and tray. Resident A's record did not contain a written assessment plan therefore there was no documentation that assistive devices were agreed on by the resident or resident's designated representative. Additionally, Resident A's record did not contain a *Health Care Appraisal* which sometimes documents the use/terms of assistive devices.

I interviewed DCW Talmadge who reported that she does not complete any admission paperwork. DCW Talmadge reported that all paperwork completed on behalf of Resident A is either in Resident A's record or off site with licensee designee Nancy Posey. DCW Talmadge reported that despite not having access to the written assessment plan, she talks with hospice about Resident A's care and that is how she knows how to meet her needs.

On 07/08/2026, Realtive A1 reported that Resident A has a gait belt in her drawer at the facility, but she reported that the DCWs report that they cannot use a gait belt. Realtive A1 reported that the gait belt was a great tool when Resident A was at home to assist with her transfers.

APPLICABLE RULE	
R 400.673	**Use of assistive devices, therapeutic support.**
	(1) An assistive device or therapeutic support intended to achieve or maintain a resident's proper position to enhance mobility, physical comfort, safety, and well-being must be specified in the resident's assessment plan and agreed on by the resident or resident's designated representative. **(2) An assistive device or therapeutic support must be authorized in writing by an appropriately licensed health care professional and the authorization must state the reason for and the term of the authorization.**
ANALYSIS:	Resident A's record did not contain written physician orders/documentation for using assistive devices including a walker, Gerry chair and tray. Resident A's record did not contain any authorization/reason for use nor was the term of the authorization documented in writing for the walker, Gerry chair and tray. Resident A's record did not contain a written assessment plan therefore there was no documentation confirming that assistive devices were agreed on by the resident or resident's designated representative. Resident A's record contained a *Physician Communication Form* dated 5/11/2026 and signed by Paula Sebastian, RN which stated in the "follow up needed by staff, full bed rails ordered." This documentation did not state the term of authorization therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	On 5/27/2026, I conducted an unannounced investigation and reviewed Resident A's record which did not contain a written assessment plan as required. DCW Talmadge reported that she does not complete any admission paperwork. DCW Talmadge reported that all the paperwork that has been completed on behalf of Resident A is either in the resident record or off site with licensee designee Nancy Posey, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 5/27/2026, I conducted an unannounced investigation and interviewed DCW Talmadge who reported that she does not know where the *Resident Register* is therefore it could not be reviewed at the time of investigation.

APPLICABLE RULE	
R 400.615	**Resident register.**
	A licensee shall maintain a chronological register of all residents admitted that includes the following information for each resident: **(a) Resident full name.** **(b) Resident date of birth.** **(c) Date of admission.** **(d) Date of discharge and location, if known, where the resident moved.**
ANALYSIS:	At the time of the unannounced investigation a *Resident Register* was not available for departmental review.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/08/2026, I conducted an exit conference with licensee designee Nancy Posey who understood the violations that were established and she agreed to assign a

second direct care worker to work at the facility for each shift so that Resident A's need for two-person assistance could be met.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in license status.

07/09/2026

_____

Julie Elkins Date
Licensing Consultant

Approved By:

07/14/2026

_____

Dawn N. Timm Date
Area Manager