GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 5, 2026

Prabhjot Singh
Park Place OPCO LLC
PO BOX 1568
Portage, MI 49081

RE: License #: AL390418621
Investigation #: 2026A0581032
Park Place Senior Living B

Dear Prabhjot Singh:

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390418621
Investigation #:	2026A0581032
Complaint Receipt Date:	06/22/2026
Investigation Initiation Date:	06/23/2026
Report Due Date:	08/21/2026
Licensee Name:	Park Place OPCO LLC
Licensee Address:	4218 S Westnedge Ave Kalamazoo, MI 49008
Licensee Telephone #:	(269) 329-8187
Administrator:	Prabhjot Singh
Licensee Designee:	Prabhjot Singh
Name of Facility:	Park Place Senior Living B
Facility Address:	4218 S Westnedge Ave Kalamazoo, MI 49008
Facility Telephone #:	(269) 329-8187
Original Issuance Date:	12/20/2024
License Status:	REGULAR
Effective Date:	06/20/2025
Expiration Date:	06/19/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION

	Violation Established?
There is insufficient staff during overnight shifts to address Resident A's care and needs.	Yes
On or around 06/14/2026, direct care staff yelled at and shamed Resident A after he fell and had a bowel movement on himself.	No
Direct care staff left Resident A on the floor after a fall for an extended period.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/22/2026	Special Investigation Intake - 2026A0581032
06/22/2026	APS Referral - APS received the allegations but are not investigating.
06/23/2026	Special Investigation Initiated - On Site - Interview with staff and observed resident.
06/24/2026	Contact - Document Sent - Email to Tabitha Watts, facility's Executive Director.
06/25/2026	Contact - Telephone call made - I attempted to contact direct care staff, Isreal McCurtis
06/25/2026	Contact - Telephone call made - Interview with direct care staff, Shelly Simmons
06/25/2026	Contact - Telephone call made - Attempted to contact direct care staff, Kanecia Ligon
06/25/2026	Contact - Telephone call made - Interview with direct care staff, Tristan Sigsbee
06/25/2026	Contact - Telephone call received - Interview with direct care staff, Isreal McCurtis
06/25/2026	Contact - Document Sent - Email to licensee designee, Prabhjot Singh.
06/25/2026	Contact - Telephone call made - Attempted to contact direct care staff, Ariana Sykes

06/25/2026	Contact - Telephone call made - Interview with direct care staff, Alexander Brooks.
06/25/2026	Contact – Document Sent – Made an additional APS referral.
06/30/2026	Contact - Face to Face - Attempted to review video footage from facility with licensee designee; however, it was unavailable. Interview with Prabhjot Singh and Tabitha Watts.
07/02/2026	Contact - Telephone call made - Interview with Ariana Sykes.
07/09/2026	Contact - Face to Face - Re-attempted to interview Resident A.
07/27/2026	Contact - Telephone call made - Interview with APS specialist, Mara Asher.
07/30/2026	Inspection Completed-BCAL Sub. Compliance
08/04/2026	Contact – Telephone call made – Interview with direct care staff, Shantel Gray and Kanecia Ligon.
08/05/2026	Exit conference with the licensee designee, Prabhjot Singh.

ALLEGATION:

- **There is insufficient staff during overnight shifts to address Resident A's care and needs.**

- **On or around 06/14/2026, direct care staff yelled at and shamed Resident A after he fell and had a bowel movement on himself.**

- **Direct care staff left Resident A on the floor after a fall for an extended period.**

INVESTIGATION: On 06/22/2026, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on 06/14/2026, during the night shift, Resident A's call light was turned off, preventing him from requesting assistance. The complaint alleged Resident A required staff assistance with transfers and activities of daily living and uses a wheelchair for mobility. The complaint alleged Resident A attempted to transfer independently to use the bathroom, fell, and had a bowel movement on himself. The

complaint alleged that staff entered his room, yelled at him, and shamed him regarding the incident.

The complaint further alleged that an unidentified direct care staff was later terminated and that incident reports were completed regarding the fall and alleged neglect.

On 06/23/2026, I conducted an unannounced inspection. I interviewed Tabatha Watts, who identified herself as the facility's Administrator. Tabatha Watts stated Resident A reportedly fell twice on 06/14/2026. She stated the first fall occurred sometime between 3 pm and 11pm, while direct care staff, Tristan Sigsbee and Ariana Sykes worked from 3 pm to 11 pm and Shelley Simmons worked from 11 am to 7 pm. She stated two male staff, Alexander Brooks and Isreal McCurtis, from the neighboring facility owned and operated by the licensee, came over and assisted Resident A back into bed.

According to Tabatha Watts, Resident A fell a second time, but stated this incident occurred after 7 pm. She stated direct care staff, Tristan Sigsbee, placed a pillow under Resident A's head after the second fall and left him on the floor for an unknown amount of time. She stated Resident A was back in bed by the time 3rd shift staff arrived at 11 pm. She stated no other staff could explain how Resident A returned to bed before third shift staff arrived and that no incident report had been completed regarding Resident A's first fall.

Tabatha Watts stated Hayley Shook, the facility's Resident Care Manager, later completed an incident report based on the information reported to her and terminated Tristan Sigsbee following the incident of her leaving Resident A on the floor with a pillow. Tabatha Watts further stated Resident A was a two person assist for transfers at the time of the incident and that staff were expected to get Resident A out of bed by holding onto his arms or using a gait belt as the facility does not utilize Hoyer lifts. She also stated Resident A's call light in his room was functioning properly.

Tabatha Watts stated she was informed fecal matter was present throughout Resident A's bathroom following the incident and that Resident A reopened a scab on his knee during the fall.

I interviewed the facility's Resident Care Manager, Hayley Shook. She stated Tristan Sigsbee contacted her at approximately 10:13 pm on 06/14/2026 to report Resident A had fallen multiple times that evening and asked what she wanted her to do to get Resident A up. Hayley Shook stated Tristan Sigsbee reported to her that she placed a pillow under Resident A's head after his most recent fall and expressed she did not want to keep lifting him. Hayley Shook stated she instructed Tristan Sigsbee that leaving Resident A on the floor was unacceptable and directed her to obtain assistance from staff at neighboring facilities. Hayley Shook stated Tristan Sigsbee reported she sought assistance from neighboring staff, but they advised they had

already assisted Resident A earlier that evening. Hayley Shook stated after she got off the phone with Tristan Sigsbee she acknowledged she did not follow up with her but did not hear back from her either.

Hayley Shook stated Resident A required a minimum of two direct care staff to assist with transfers, but could require three to four staff when unable to bear weight and while on the floor. She stated Resident A weighed approximately 160 pounds and was unable to support himself during transfers. Hayley Shook further stated Resident A had become increasingly confused and often attempted to transfer independently despite requiring staff assistance.

Hayley Shook stated she interviewed several staff regarding Resident A's falls on 06/14/2026, but she was unsure exactly how many times Resident A fell throughout that evening. She stated Shelly Simmons reported Resident A was in bed by the time she left the facility at approximately 7:30 pm and both 3rd shift staff, Kanecia Ligon and Jerlean Lewis, reported to her that Resident A was already in bed when they began their shift at 11 pm.

Hayley Shook stated she interviewed Tristan Sigsbee on 06/15/2026. According to Hayley Shook, Tristan Sigsbee provided little explanation regarding the incident and expressed concern about getting into trouble. Hayley Shook stated she also interviewed Isreal McCurtis, who reported he and Alexander Brooks assisted Resident A only once by transferring Resident A from the bathroom after Tristan Sigsbee requested their help. Isreal McCurtis further reported to Hayley Shook that Resident A had fecal matter on him, but they also assisted with cleaning him, and then he and Alexander Brooks then returned to their building. Hayley Shook stated she did not interview Ariana Sykes or Alexander Brooks.

I attempted to interview Resident A during the inspection; however, he was unable to answer basic questions. Subsequently, I was unable to obtain relevant information. During the inspection, I tested Resident A's call light and found it was functioning properly after it was reset.

I attempted to interview Resident B; however, she was also unable to answer basic questions, and I was therefore unable to obtain relevant information.

I attempted to interview Resident C, who had limited information regarding the allegations. Resident C stated she had never observed Resident A fall within the facility.

Based on my observations and interactions with the remaining residents, I was unable to obtain relevant information from them. Direct care staff reported that many residents residing in the facility have diagnoses of dementia or Alzheimer's disease.

On 06/25/2026, I interviewed direct care staff, Shelley Simmons who confirmed she worked at the facility 11 am – 7 pm on 06/14/2026. Shelley Simmons stated

Resident A was discovered on his bathroom floor by Ariana Sykes. Shelley Simmons stated she and Ariana Sykes determined Resident A fell while attempting to transfer himself from his wheelchair to the toilet. She stated when they discovered Resident A, there was fecal matter throughout his bathroom and all over his body. She stated she and direct care staff, Ariana Sykes, cleaned Resident A while he remained on the floor, but requested assistance from two male staff working in the neighboring facility to help transfer Resident A from the floor back into his wheelchair and subsequently into bed. Shelley Simmons stated when she left the facility at approximately 7:30 pm, Resident A was still on the floor, but she observed both Alexander Brooks and Isreal McCurtis walking into the building to assist with transferring him.

Shelley Simmons stated Resident A required at least a two person direct care staff assistance for transfers and that, if he was on the floor, more than two staff were often needed to lift him. She stated it was common practice to request assistance from male staff working in neighboring facilities, owned and operated by the licensee, because Resident A was “dead weight” while on the floor. She stated Hoyer lifts were not utilized in the facility for transferring assistance. Shelley Simmons stated she and Tristan Sigsbee were unable to lift Resident A because she has her own physical limitations and Tristan Sigsbee was pregnant.

Shelley Simmons stated she did not observe anyone yell at Resident A, although she acknowledged she has a naturally loud voice and recalled telling him to “lay down”. She stated Resident A falls approximately two to three times per week and believed his physical condition had declined since approximately April 2026, increasing the number of staff needed to transfer him.

Shelley Simmons stated she did not observe any injuries to Resident A before leaving and later learned he fell a second time after her shift ended.

On 06/25/2026, I interviewed direct care staff, Tristan Sigsbee. She stated she worked at the facility for approximately four weeks and typically worked second shift from 3 pm -11 pm administering medications.

Tristan Sigsbee’s statement was generally consistent with Shelley Simmons’ statement. She stated at approximately 7:30 pm, Shelley Simmons left the facility after assisting in cleaning Resident A with Ariana Sykes, but Alexander Brooks and Isreal McCurtis came over from the neighboring facility to assist in moving Resident A from the floor, into his wheelchair and then into his bed. She stated Resident A required at least a two direct care staff person assistance because he was “dead weight” and she could not safely lift due to her pregnancy.

Tristan Sigsbee stated she later found Resident A on the floor again between approximately 9 pm and 10 pm with a scraped knee bleeding. She stated only she and Ariana Sykes were working in the facility at that time. Tristan Sigsbee stated she requested assistance again from Alexander Brooks and Isreal McCurtis in the

neighboring facility, but they declined to assist her because they reported to her they helped her earlier. She stated she then sought assistance from staff, Shantel Gray, in another neighboring facility owned and operated by the licensee. Tristan Sigsbee stated she placed a pillow behind Resident A's back while he remained on his bedroom floor and checked on him until Shantel Gray arrived to assist her. She estimated Resident A remained on the floor approximately 45 minutes to an hour.

Tristan Sigsbee stated she attempted to contact Tabatha Watts without success before contacting Hayley Shook at approximately 10 pm. She acknowledged she considered calling 911 because Resident A could not be lifted safely but did not do so and could not explain why. She also acknowledged she did not complete an Incident Report that evening because she intended to wait for management the following day.

Tristan Sigsbee stated Resident A required two or more staff for transfers and that male staff from neighboring buildings routinely assisted in transferring him. She stated she relied on male staff approximately three times per week. She denied hearing staff yell at Resident A or making inappropriate comments towards him.

On 06/25/2026, I interviewed Isreal McCurtis. Isreal McCurtis stated at approximately 6:45 pm on 06/14/2026, Ariana Sykes, came to the building he was working in and requested his and Alexander Brooks' assistance with Resident A. He stated both he and Alexander Brooks went to Park Place Senior Living B with Ariana Sykes. He stated both he and Alexander Brooks were gone for approximately 20 – 25 minutes, but the whole situation lasted approximately one hour.

He stated he observed Resident A on the floor covered in feces. He stated he and Alexander Brooks were needed to get Resident A picked up and put into his wheelchair. He stated Resident A also needed to be clothed and put into bed.

Isreal McCurtis stated no other staff came back over asking for additional assistance from Resident A that evening. He stated he did not recall Tristan Sigsbee coming back over and did not recall any staff calling him for assistance either. Isreal McCurtis stated he's gone over to the facility a couple of times to assist in caring for residents because the staff were unable to do it by themselves. He also stated he did not recall anyone yelling or screaming at Resident A when they were in Resident A's bedroom cleaning and transferring him.

On 06/25/2026, I interviewed direct care staff, Alexander Brooks. His statement was consistent with other staff's statements; however, he indicated Tristan Sigsbee came over to Park Place Senior Living A sometime between 3 pm and 5 pm reporting Resident A had fallen and she needed their assistance. Alexander Brooks stated both he and Isreal McCurtis went over to check on Resident A while Ariana stayed in their building. He stated they found Resident A on the bathroom floor covered in feces. He stated he instructed both Tristan Sigsbee and Shelley Simmons they needed to clean Resident A before he was going to help pick him up. He stated

Shelley Simmons declined to help Tristan Sigsbee in cleaning Resident A. He stated he and Isreal McCurtis went back to Park Place Senior Living A and reported the instruction he gave Tristan Sigsbee to Ariana Sykes. He stated Isreal McCurtis and Ariana Sykes ten went back to Park Place Senior Living B to clean up Resident A.

Alexander Brooks stated he could not recall if Tristan Sigsbee called him or if she came back over but he stated he was informed staff cleaned Resident A and that he was needed for assistance with transferring him. Alexander Brooks stated he went back over to Park Place Senior Living B and assisted with lifting Resident A into his wheelchair, getting him dressed and then putting him in bed. Alexander Brook stated he believed he was only in the facility assisting Resident A for 2-3 minutes each time.

Alexander Brooks stated Shelley Simmons was unable to assist with lifting Resident A because she's older and lifting is too much for her. Additionally, he stated Ariana Sykes just had a baby, and Tristan Sigsbee was pregnant and neither of them could lift much either.

Alexander Brooks stated a couple hours after he and Isreal McCurtis assisted Resident A the first time, Tristan Sigsbee came back over to the facility and reported Resident A fell again out of his wheelchair. Alexander Brooks stated he assisted Tristan Sigsbee with putting Resident A into bed. He stated could not recall if there was a pillow under or near Resident A's head during the second time he assisted Resident A. He stated he did not recall Tristan Sigsbee coming back over or requesting additional assistance with Resident A that evening.

Alexander Brooks stated Resident A is at least a two direct care staff person assist, but if only female staff were working then it could take all three female staff to lift him. Alexander Brooks stated he's gone over to the facility 4-5 times in the last two weeks to assist staff with getting Resident A back into bed after falling.

On 06/25/2026, I reviewed the facility's Incident Report (IR), dated 06/15/2026, which was completed by Hayley Shook. She documented she was notified by staff on duty, as well as incoming staff that Resident A was left on the floor. The IR documented it appeared Resident A was left on the floor for a period of time, and it appeared he opened an old knee wound. The IR documented staff got him off the floor and applied first aid to his knee. The IR further documented that upon speaking to staff, the staff reported to Hayley Shook that she was tired of picking Resident A up and she gave him a pillow. Furthermore, the IR documented staff on duty was immediately terminated due to Resident A's neglect. The IR did not identify the names of staff involved in the incident.

I reviewed the licensee's assessment plan titled "ECP Assess Needs (May 2025) Change in Condition", which documented it was completed 09/11/2025. The

assessment plan identified Resident A as requiring two person direct care staff assistance for toileting and transfers.

On 06/30/2026, I conducted a face-to-face interview with the licensee designee, Prabhjot Singh. Due to the facility utilizing video surveillance, I requested to review footage from 06/14/2026. During the review attempt, Prabhjot Singh determined the system only retained approximately 13 days of footage. As a result, video footage from 06/14/2026 was unavailable for review.

During the interview, we discussed Resident A's declining condition and the facility's responsibility to update resident assessment as needed to ensure they accurately reflect the resident's current care needs. We also discussed that staff interviews indicated the number of staff required to transfer Resident A appeared to vary depending on the staff members available and their ability to safely assist him after a fall. Prabhjot Singh acknowledged the facility does not utilize Hoyer lifts and discussed whether additional staff training or equipment may have been to safely transfer Resident A.

On 07/02/2026, I interviewed direct care staff, Ariana Sykes. Ariana Sykes stated she had been employed by the facility since December 2025, primarily works first shifts and confirmed she worked on 06/14/2026 from 3 pm until 11 pm. Her statement was generally consistent with other staff's statements pertaining to Resident A's first fall.

Ariana Sykes stated at approximately 8 pm, she went to another licensed AFC on the property for approximately 45 minutes to one hour to assist Alexander Brooks with medication administration. When she returned, Tristan Sigsbee, informed her that Resident A had fallen a second time. Ariana Sykes stated when she went into Resident A's bedroom she observed him laying on his side with a pillow behind his head. She stated he had reopened sores on his knees, resulting in blood on the floor. Ariana Sykes stated she believed Tristan Sigsbee intended to call an ambulance but later learned one had not been contacted.

Ariana Sykes stated she remained with Resident A for approximately 15 minutes before responding to another resident's call light. She stated Tristan Sigsbee later returned with direct care staff, Shantel Gray, from the neighboring facility which is also owned and operated by the licensee. Ariana Sykes stated it took all three staff to lift Resident A from the floor and return him to bed by approximately 10 pm. She stated she was not aware of any additional falls before third shift arrived.

Ariana Sykes stated she does not routinely work in Resident A's building and was unsure how often staff required assistance to transfer him. She stated first shift staff generally did not experience similar issues.

08/04/2026, I interviewed direct care staff, Shantel Gray. She confirmed she was working at the neighboring facility on 06/14/2026. She stated that at approximately

8:30 pm to 9 pm, Tristan Sigsbee requested her assistance with Resident A. Shantel Gray stated she immediately responded and observed Resident A sitting on the floor in his bedroom with a bruised and scraped knee. She stated it took herself, Tristan Sigsbee, and Ariana Sykes to lift Resident A from the floor and transfer him back into bed.

Shantel Gray stated staff from Park Place Senior Living B had requested her assistance lifting Resident A on prior occasions. She stated that when male staff are unavailable, it requires three female staff to lift Resident A from the floor.

On 08/04/2026, I interviewed direct care staff, Kanecia Ligon. Kanecia Ligon confirmed she worked third shift with Jerlean Lewis on 06/14/2026. She stated that upon reporting to work at 11 pm, she observed Resident A on his bedroom floor. Kanecia Ligon stated Tristan Sigsbee reported Resident A had fallen multiple times that evening and that he had been on the floor for approximately two hours because no other staff were able to assist with lifting him. She stated Resident A did not experience any additional falls during their shift.

Kanecia Ligon stated it generally takes three to four staff to lift Resident A from the floor. When asked how she and Jerlean Lewis were able to lift him without additional assistance, she stated they were able to do so because of their physical strength. Kanecia Ligon further stated she was aware that staff routinely requested assistance from neighboring facilities to help lift and transfer Resident A.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.
ANALYSIS:	Based on my investigation, which included interviews with multiple direct care staff and a review of Resident A's assessment plan titled "ECP Assess Needs (May 2025) Change in Condition", dated 09/11/2025, there is sufficient evidence to conclude staffing was not sufficient to meet Resident A's assessed needs on 06/14/2026. Resident A's assessment plan documented he required two person direct care staff assistance for toileting and transfers and although two direct care staff were scheduled in the facility, multiple staff reported they were unable to safety transfer Resident A following his falls and repeatedly relied on staff from neighboring facilities for assistance.
CONCLUSION:	**VIOLATION ESTABLISHED**

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, which included interviews with multiple direct care staff, there is insufficient evidence to determine if staff yelled at verbally mistreated Resident A on 06/14/2026; however, multiple direct care staff consistently reported Resident A remained on his bedroom floor after a fall while staff sought assistance from neighboring facilities because they were unable to safely lift and transfer him. Allowing Resident A to remain on the floor for an extended period after staff became aware of his fall did not treat him with dignity and respect or provide him with the protection and safety, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION: On 06/25/2026, I reviewed the Workforce Background Check (WBC) system to obtain direct care staff contact information. During that review, I determined direct care staff, Ariana Sykes, was not listed as eligible to work at Park Place Senior Living B. The WBC system also reflected that she was no longer employed at the neighboring facility either.

On 07/02/2026, I contacted the licensee designee, Prabhjot Singh, and informed him that the WBC system reflected Ariana Sykes as no longer employed at Park Place Senior Living A and that she was not listed as eligible to work at the neighboring facility either.

On 07/03/2026, the WBC system was updated to reflect Ariana Sykes as employed at neighboring facility; however, as of the date of this report, Ariana Sykes, remains not listed as eligible to work at Park Place Senior Living B, despite her documented work shift at the facility on 06/14/2026.

APPLICABLE RULE	
400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.

ANALYSIS:	The Workforce Background Check system did not identify direct care staff, Ariana Sykes, as eligible to work at Park Place Senior Living B despite working a shift at the facility on 06/14/2026. While Ariana Sykes was approved to work at a neighboring facility, staff must be identified as eligible to work at each licensed facility where they provide direct care services or have direct access to resident information.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 06/23/2026, direct care staff, Hayley Shook provided photographs taken by third shift direct care staff, Kanecia Ligon, depicting the condition of Resident A's bathroom on 06/14/2026. Hayley Shook stated Kanecia Ligon, who began her shift at 11 pm, forwarded the photographs after arriving to work.

I reviewed the photographs, which depicted a toilet equipped with a raised toilet seat and safety rails. Fecal matter was observed on the top and front edge of the toilet seat, extending onto the front rim of the toilet. Additional fecal matter was observed on the floor directly in front of the toilet.

Interviews with direct care staff, Tristan Sigsbee, Shelley Simmons, Isreal McCurtis, Alexander Brooks, and Ariana Sykes, were generally consistent with one another. They all acknowledged observing fecal matter on Resident A's toilet seat and bathroom following his fall at approximately 7 pm on 06/14/2026; however, none of them stated that the bathroom was cleaned before the end of their shifts.

I reviewed the facility's incident report completed by Hayley Shook, which was consistent with the information she provided during her interview.

Direct care staff, Kanecia Ligon, stated she observed the condition of Resident A's bedroom upon starting her shift at 11 pm. She stated she immediately photographed the condition of the room but stated Jerlean Lewis immediately cleaned Resident A's bathroom. Kanecia Ligon's description of Resident A's bathroom was consistent with the photographs she sent to Hayley Shook.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.

ANALYSIS:	Based on my investigation, which included staff interviews and review of photographs, and review of the facility's incident report, there is sufficient evidence to conclude that Resident A defecated on his toilet seat and bathroom floor at approximately 7 pm on 06/14/2026. Multiple staff acknowledged observing fecal matter; however, none of the staff reported cleaning the bathroom before the end of their shifts. Photographs taken by third shift staff confirmed that fecal matter remained on the toilet seat and bathroom floor at 11 pm. Consequently, the facility's direct care staff failed to maintain Resident A's bathroom in a clean, comfortable, and orderly condition, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 08/05/2026, I conducted the exit conference with the licensee designee, Prabhjot Singh, via telephone. He acknowledged the findings and stated he intended to issue Resident A a 30 day discharge notice. He also stated the facility would address measures to prevent recurrence in its corrective action plan. During the exit conference, we discussed that direct care staff assigned to neighboring licensed facilities are not to be relied upon to provide resident care in Park Place Senior Living B.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

Cathy Cushman

08/05/2026

Cathy Cushman — Date
Licensing Consultant

Approved By:

Dawn Timm

08/05/2026

Dawn N. Timm — Date
Area Manager