GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 8, 2026

Justin Nelson
6043 Kingsbury St
KINGSTON, MI 48741

RE: License #: AS790418538
Investigation #: 2026A0779049
Whisper Ridge Senior Living

Dear Justin Nelson:

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:

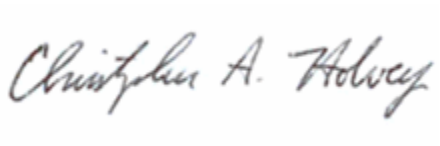
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once 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 (517) 335-5985.

Sincerely,



Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS790418538
Investigation #:	2026A0779049
Complaint Receipt Date:	08/25/2026
Investigation Initiation Date:	08/25/2026
Report Due Date:	10/24/2026
Licensee Name:	Justin Nelson
Licensee Address:	6043 Kingsbury St KINGSTON, MI 48741
Licensee Telephone #:	(989) 912-9800
Administrator:	Alyssa Wark
Licensee Designee:	Justin Nelson
Name of Facility:	Whisper Ridge Senior Living
Facility Address:	324 Roller Way Mayville, MI 48744
Facility Telephone #:	(989) 528-9498
Original Issuance Date:	03/25/2025
License **Status:**	REGULAR
Effective Date:	09/25/2025
Expiration Date:	09/24/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
The home did not seek proper medical care and Resident A passed away with malnutrition as a contributing factor.	Yes
The home was using a strap to restrain Resident A to her bed at night.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/25/2026	Special Investigation Intake 2026A0779049
08/25/2026	Special Investigation Initiated - Telephone Spoke to law enforcement.
08/27/2026	Contact - Telephone call made Spoke to staff person, Angela Esch.
08/27/2026	Contact - Telephone call made Spoke to staff person, Jennifer Palmateer.
09/02/2026	APS Referral Complaint was referred to APS centralized intake.
09/02/2026	Inspection Completed On-site
09/03/2026	Contact - Telephone call made Spoke to law enforcement.
09/03/2026	Contact - Telephone call made Spoke to staff person, Laura Stadnika.
09/03/2026	Contact - Telephone call made Spoke to staff person, Brandon Dewitt.
09/04/2026	Contact - Face to Face In-person with Detective Timothy Zube.
09/09/2026	Contact - Telephone call made Spoke to Detective Zube.

09/09/2026	Contact - Telephone call made Spoke to Resident A's Respite Care Coordinator.
09/15/2026	Contact - Document Received Received email from Detective Zube.
10/08/2026	Exit conference Held with licensee Justin Nelson.
10/08/2026	Contact - Telephone call made Spoke to administrator, Alyssa Wark.

ALLEGATION:

The home did not seek proper medical care and Resident A passed away with malnutrition as a contributing factor.

INVESTIGATION:

On 8/25/2026, a phone call was made to Tuscola County Sheriff Detective, Timothy Zube, who confirmed that he was investigating the same allegations. Detective Zube stated that licensee, Justin Nelson, was the legal guardian of his half-sister, Resident A, that he claims was staying at this AFC home on a part-time basis. Detective Zube stated that Resident A had extreme cognitive deficiencies, was non-verbal and passed away at this AFC home on 8/6/2026. Detective Zube stated that administrator, Alyssa Wark, told him that they were caring for Resident A at this home thirty-six hours a week and claimed that Licensee Nelson dropped Resident A off at this home at 8:00am on 8/6/2026. Detective Zube reported that he had spoken to 3rd shift staff person, Jennifer Palmateer, who told him that when she arrived at this home at 11:00pm on 8/6/2026, Resident A was cold to the touch but was still breathing. Detective Zube stated that Staff Palmateer said that she called Admin Wark to express her concerns regarding Resident A and that Admin Wark told her to check on Resident A once every hour. Detective Zube stated that Staff Palmateer informed him that she found Resident A to be deceased in bed at 11:50pm. Detective Zube reported that the preliminary autopsy completed on Resident A showed pneumonia and malnutrition as factors in her death. Detective Zube stated that Resident A only weighed 49 pounds and that Medicaid and Resident A's primary care physician (PCP), Dr. Putnam, has confirmed that Resident A had not seen Dr. Putnam in over 1 ½ years since November 2024. Detective Zube stated that Dr. Putnam reported that Resident A weighed 80 pounds at the November 2024 appointment.

On 8/27/2026, a phone interview was conducted with staff person, Angela Esch, who stated that her last day of employment at this AFC home was in early August 2026. Staff Esch stated that she worked approximately 10-25 hours per week at this home,

that Resident A was always there when she worked and that Resident A had her own room. Staff Esch stated that Resident A was mentally impaired, non-verbal, and could walk with staff assistance. Staff Esch reported that Resident A was treated like any other resident, but that she was not aware of Resident A having any care plan for staff to follow. Staff Esch stated that she remembers Resident A having a fall at this home a few months ago but could not remember the date of the fall. Staff Esch stated that Resident A hit her head and had a cut above her eye but did not receive medical treatment from a physician. Staff Esch reported that Resident A never had any medications to pass. When asked about Resident A's eating habits, Staff Esch stated that Resident A ate with her hands but seemed to have a good appetite and ate well.

On 8/27/2026, a phone interview was conducted with staff person, Jennifer Palmateer, who confirmed that she worked 3rd shift and 40-hours per week at this home and that Resident A was always there when she worked. Staff Palmateer stated that Resident A was non-verbal and required full care in order to complete all her activities of daily living (ADLs). Staff Palmateer stated that Resident A was mentally impaired but that she was not aware of Resident A's diagnosis or of a care plan for her. Staff Palmateer reported that Resident A had a good appetite and always ate her meals but did not receive any medications. Staff Palmateer confirmed that she arrived at this home at approximately 10:30pm on 8/6/2026 and observed Resident A had labored breathing and was cold to the touch. Staff Palmateer stated that she called Admin Wark about her concerns regarding Resident A and Admin Wark just told her to check on Resident A every hour. Staff Palmateer claimed that she asked Admin Wark if Resident A had a do not resuscitate (DNR) order, but she never got a response from Admin Wark. Staff Palmateer stated that she observed Resident A moving in her bed at 11:20pm but that at 11:55pm, Resident A had no pulse. Staff Palmateer reported that she called Admin Wark, who provided no guidance except to say that she was on her way to the home. Staff Palmateer stated that she did not call 911 but that someone from Caro central dispatch called the home a few minutes after she spoke with Admin Wark. Staff Palmateer admitted that she never performed CPR on Resident A and claimed that she didn't because she did not know if Resident A had a DNR or not.

On 9/2/2026, an unannounced on-site inspection was conducted, and Resident B, Resident C and Resident D were interviewed separately. All three residents stated that they are getting good care at this home, that staff are always there when needed, that they are getting three quality meals daily and that they are getting all their prescribed medications. All three residents stated that they like living at this home. When asked about Resident A, Resident B reported that Resident A was at this home a lot, that staff helped her with care, but that Resident A did not always spend the night.

On 9/2/2026, licensee Justin Nelson confirmed that he was the guardian legal for Resident A, who was his half-sister. Licensee Nelson stated that he works a full-time job outside of this AFC home and that Resident A stayed at the AFC home whenever he was at work and occasionally sometimes overnight. Licensee Nelson estimated that Resident A spent 75% of the time at the AFC home and the other 25% at his personal residence. Licensee Nelson confirmed that Resident A was developmentally disabled

and non-verbal but said that he did not know her actual medical diagnosis. Licensee Nelson stated that he became Resident A's legal guardian two years ago and that Resident A weighed 80 pounds then. Licensee Nelson reported that prior to Resident A beginning to stay at this AFC home, Admin Wark was providing respite care services to Resident A at his personal residence. Licensee Nelson claimed that he considered Resident A as respite care at the AFC home but does admit that Resident A was provided care by AFC home staff. Licensee Nelson confirmed that Resident A was not on any prescribed medications and stated that she ate well every day. Licensee Nelson stated that he had a telehealth appointment scheduled with Resident A's PCP, Dr. Putnam, for 8/13/2026, due to her recent weight loss, but that Resident A passed away before that appointment. Licensee Nelson stated that Resident A last saw Dr. Putnam back in early 2025 but that he does not remember the exact date and that Resident A had not seen any other physician since. Licensee Nelson claimed that Resident A had no known health issues, besides the weight loss that he noticed over the last couple weeks, and that it was a shock to learn that law enforcement had opened an investigation. Licensee Nelson then stated that Resident A stopped having her monthly menstrual cycle a few months ago and that her weight loss may have started then. When asked why a medical appointment was not made for Resident A for over a year, Licensee Nelson said that Resident A showed no signs of having health issues, other than the weight loss at the end of her life.

On 9/2/2026, administrator, Alyssa Wark, stated that Resident A was non-verbal, developmentally disabled and not able to communicate her needs and/or health issues. Admin Wark stated that other than the recent weight loss, Resident A was eating well daily and acting like her normal self, without any visible health changes. Admin Wark stated that Licensee Nelson dropped Resident A off at the AFC home at 8:00am on 8/6/2026 and that Resident A ate breakfast, had no breathing issues and appeared to be doing fine when she left the home at 11:00am. Admin Wark stated that the 1st and 2nd shift staff did not contact her regarding any concerns with Resident A that day. Admin Wark reported that 3rd shift Staff Palmateer texted her around 11:00pm saying that Resident A was cold, that her head was shaking and that her breathing seemed a little heavy. Admin Wark stated that it was normal for Resident A's head to shake a little and that she confirmed that she told Staff Palmateer to check on Resident A every hour. Admin Wark claimed that Staff Palmateer called about 10-15 minutes later saying that Resident A had passed away, so she quickly got off the phone, called 911 and rushed over to the AFC home. Admin Wark does not remember Staff Palmateer asking her anything about whether Resident A had a DNR order.

On 9/3/2026, a phone call was made to Detective Zube, who stated that he believes that when the official autopsy report is completed it will say that Resident A's cause of death was due to neglect. Detective Nelson stated that Licensee Nelson told him that Resident A was constipated 2-weeks prior to her death and that resident A did not eat well when she was constipated. Detective Zube stated that text records from Admin Wark's phone show that Staff Palmateer asked her if Resident A had a DNR and Admin Wark never answered the question. Detective Zube stated that Staff Palmateer's phone call to Admin Wark about Resident A's death took place approximately one hour, not

10-15 minutes, after Staff Palmateer's initial texts. Detective Zube reported that Dr. Putnam has confirmed that Licensee Nelson tried to obtain Hospice services for Resident A two days prior to her death, but that those services were denied by Dr. Putnam due to Resident A not being an active patient of his since 2024. Detective Zube stated that Licensee Nelson seemed to give conflicting information regarding Resident A's weight loss when speaking with the medical examiner. Detective Zube stated that the medical examiner told him that Licensee Nelson initially told him Resident A's weight loss started 2-months prior to her death and then changed it to 2-weeks prior.

On 9/3/2026, a phone interview was conducted with staff person, Brandon Dewitt, who confirmed that he started work at this home at 11:00am on 8/6/2026. Staff Dewitt claims that Resident A was alert sitting in her chair watching a movie during his shift. Staff Dewitt stated that Resident A normally had a big appetite but did not want to eat lunch that day. Staff Dewitt reported that he checked and changed Resident A every two hours that day and that Resident A seemed fine when he left the home at 5:00pm. When asked if he had noticed any weight loss with Resident A, Staff Dewitt said that Resident A had always been tiny and that he did not notice any significant weight loss. Staff Dewitt stated that Resident A's death was a shock and caught everyone off guard.

On 9/3/2026, a phone interview was conducted with staff person, Laura Stadnika, who confirmed that she worked 5:00-11:00pm on 8/6/2026. Staff Stadnika stated that when she arrived at work, Staff Dewitt told her that Resident A was not walking well that day and that she did not eat lunch. Staff Stadnika stated Resident A normally ate and drank very well but Resident A refused to eat dinner. Staff Stadnika reported that she had to carry Resident A to her bed at approximately 7:00-8:00pm and that Resident A's head was shaking a little more than normal and that her stomach area appeared to be cold to the touch. Staff Stadnika stated that Resident A's legs and feet were always cold, so she did not think much about it. Staff Stadnika stated that she did not notice Resident A to have any labored breathing. Staff Stadnika confirmed that Resident A was always very skinny but that she never saw Resident A fully unclothed and did not notice Resident A having any significant weight loss. Staff Stadnika stated that she did not call Admin Wark about any concerns regarding Resident A that night.

On 9/4/2026, a visit was made to the Tuscola County Sheriff's Department and Detective Zube's interview with Licensee Nelson was observed. Licensee Nelson told Detective Zube that Resident A stayed at the AFC home about four nights a week and about 75% of the time, with Admin Wark and other AFC staff providing care. Licensee Nelson said that Resident A got involved with Tuscola Behavioral Health System in 2024, who paid up to $1500 annually for whoever provided respite care, which was always Admin Wark. Licensee Nelson told Detective Zube that Resident A would have annual checkups with Dr. Putnam starting in 2023 and that Resident A's last appointment with Dr. Putnam was in late 2024 or early 2025, where they had discussions about Resident A's weight. Detective Zube asked Licensee Nelson several times when he first noticing Resident A's weight loss. Licensee Nelson initially told Detective Zube that he noticed Resident A was starting to lose weight over the last month of her life but that she was not eating any less. Licensee Nelson than said that

he could notice visible weight loss approximately 2-3 weeks before her death, maybe in the middle of July. Licensee Nelson then said that Resident A stopped having her monthly menstrual cycle around June 2026 and that he thinks her weight loss may have started then. Licensee Nelson told Detective Zube that about 2-3 weeks before her death, he made a telehealth appointment with Dr. Putnam's office, but the appointment wasn't until 8/13/2026, because they only do those types of appointments on certain days. Licensee Nelson stated that Resident A was still walking, but maybe a little slower than usual. When further talking about potential health issues with Resident A, Licensee Nelson told Detective Zube that it was not uncommon for Resident A to be constipated and go 3-4 days without a bowel movement, when they would then give her stool softeners. Licensee Nelson stated that the first time they heard any concerns about Resident A on 8/6/2026, is when Staff Palmateer called Admin Wark. Licensee Nelson stated that he thinks he heard Admin Wark tell Staff Palmateer to perform CPR on Resident A but that he is not sure if Staff Palmateer did. Due to technical difficulties and time restraints, Detective Zube's entire interview with Licensee Nelson could not be observed.

On 9/9/2026, a phone conversation took place with Detective Zube, who stated that he had spoken to Heartland Hospice, who confirmed that Licensee Nelson and Admin Wark called them in an attempt to obtain Hospice services for Resident A. Hospice told Detective Zube that Licensee Nelson and Admin Wark wanted the services involved due to Resident A's weight loss over the last several months. Detective Zube stated that Hospice confirmed that Dr. Putnam would not authorize the services. Detective Zube stated that the completed autopsy report has Resident A's cause of death as pneumonia, malnutrition and failure to thrive.

On 9/9/2026, a phone call was made to Tuscola Behavioral Health Systems and Resident A's respite care coordinator, Josh Williams. Coordinator Williams stated that he oversees Resident A's respite care services, that he physically sees Resident A once yearly and has monthly phone meetings with Resident A's guardian Justin Nelson. Coordinator Williams stated that he last saw Resident A on 7/14/2026 and that resident A appeared to be thinner than usual and that Licensee Nelson told him that Resident A was seeing Dr. Putnam for this issue and that they were giving Resident A protein shakes. Coordinator Williams stated that Licensee Nelson talked to him about possibly moving Resident A into another AFC home but that did not happen.

On 9/15/2026, an email was received from Detective Zube. The email contained a formal copy of Resident A's autopsy report, which was completed by the Office of Medical Examiner for Tuscola County. The medical examiner's final diagnoses of Resident A were acute pneumonia in right lung, Inanition/failure to thrive, malnutrition, dehydration, hydrocephalus, and a cyst in the right fallopian tube. The cause of death on the report was acute pneumonia complicated by Inanition with malnutrition and dehydration. The medical examiner's opinion was one of neglect.

On 10/8/2026, an exit conference was held with licensee, Justin Nelson. Licensee Nelson confirmed that they were not weighing Resident A to have evidence of her losing

weight but that they started giving her Ensure nutritious drinks to help with her weight. Licensee Nelson stated that Resident A did not see a physician regrading her stopping her menstrual cycle or regarding her frequent constipation issues, but that constipation was an on-going thing and was talked about with Dr. Putnam back in November 2024 and Dr. Putnam just told them to give Resident A stool softeners. Licensee Nelson reported that none of their AFC staff mentioned having any concerns with Resident A's weight or health in general to give them a reason to seek medical treatment for her. When asked if he had contacted Heartland Hospice regarding Resident A, Licensee Nelson adamantly denied that he ever made that call, but he was not sure if Admin Wark did or not.

On 10/8/2026, a phone call was made to Admin Wark to gain clarification on few issues. Admin Wark stated that she is not aware of Resident A seeing her PCP regarding the menstrual cycle and constipation issues. Admin Wark admitted that she spoke with Heartland Hospice regarding a couple of her residents, including Resident A. Admin Wark could not remember the exact date of the call but said that it could have been in early August 2026. Admin Wark stated that she spoke with Heartland about their palliative services and not about Hospice services.

On 10/8/2026, an exit conference was held with licensee Justin Nelson. Licensee Nelson was informed that a written correction action plan was required to address these licensing rule violations and that the result of this investigation will be a recommendation of a six-month provisional license. Licensee Nelson stated that he understood the results and did not verbally object to the provisional license.

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:	It was confirmed that Resident A passed away at this AFC home on 8/6/2026. The completed autopsy report for Resident A states that the cause of death was acute pneumonia complicated by Inanition/failure to thrive with malnutrition and dehydration. The medical examiner's opinion was one of neglect. Licensee, Justin Nelson, stated that Resident A was staying at this AFC home 75% of the time and being provided care by AFC staff, which made Resident A a resident of this home. It was confirmed that Resident A had not been seen by a physician since November 2024 and that her weight at death was only 49 pounds, which was half of her normal body weight.

	Licensee Nelson gave various accounts as to when he first noticed Resident A's weight loss, which were anywhere from as early as June 2026 to 2-3 weeks before her death on 8/6/2026. Licensee Nelson had discussions regarding concerns of Resident A's weight with respite care coordinator, Josh Williams on 7/14/2026. Licensee Nelson stated that it is not uncommon for Resident A to be constipated and go without a bowel movement for 3-4 days. Licensee Nelson stated that Resident A had stopped having her monthly menstrual cycles back in June 2026. Resident A did not see a physician for the issues of constipation, menstrual cycle issues or her significant weight loss, prior to her death. There was sufficient evidence that Resident A had several adverse changes in her health condition and that she did not receive the healthcare services she needed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The home was using a strap to restrain Resident A to her bed at night.

INVESTIGATION:

On 8/25/2026, Detective Zube stated that as part of his initial investigation, he learned that the home was using a padded strap across Resident A during the night as a restraint. Detective Zube stated that Dr. Putnam confirmed that he did not provide a physician order for the use of such a strap.

On 8/27/2026, Staff Palmateer stated that there was a strap that was used for Resident A that went over her hip area and all the way around the bed to keep Resident A in bed during the night. Staff Palmateer stated that Resident A was not physically able to unstrap/remove the device on her own.

On 9/2/2026, Licensee Nelson stated that Resident A would sit up in bed and rock back and forth and had a history of falling out of bed, so they used a strap that he bought online that would keep Resident A in bed. Licensee Nelson stated that he did not have a physician order for the use of the strap.

APPLICABLE RULE	
R 400.641	**Resident behavior intervention**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(b) Use any form restraint without an order from an appropriate licensed health care professional or physical force, other than physical restraint for crisis intervention.**
ANALYSIS:	It was confirmed that a strap was being used to keep Resident A restrained to her bed at night and that Resident A could not remove the strap on her own. Licensee, Justin Nelson, stated that he bought the strap online and did not have a written order from an appropriate licensed health care professional authorizing the use of the strap.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 8/25/2026, Detective Zube stated that licensee, Justin Nelson, and administrator, Alyssa Wark, did not have any AFC licensing paperwork, resident file or health care documentation regarding Resident A available for him to review. Detective Zube stated that the only documentation the home had mentioning Resident A was daily logs that staff used to document what personal care they provided to Resident A. Detective Zube stated that he took those daily logs as part of his investigation.

On 8/27/2026, staff persons, Angela Esch and Jennifer Palmateer, stated that Resident A was at this home every day that they worked and they were told to treat Resident A like any other resident and meet her care needs. Both staff stated that they were not aware of any written care plan, resident file, or health care documentation regarding Resident A being available for them to review. Staff Palmateer reported that she did record in daily logs what care she provided to Resident A whenever she worked.

On 9/2/2026, Licensee Nelson and Admin Wark stated that no AFC licensing paperwork was completed for Resident A. They stated that they had no resident file established that was available for review for Resident A. Licensee Nelson stated that he works a full-time job outside of this AFC home and that Resident A stayed at the AFC home whenever he was at work and occasionally sometimes overnight. Licensee Nelson estimated that Resident A spent 75% of the time at this home and that AFC staff provided care for Resident A, which made Resident A an official resident of this home.

On 9/3/2026, staff person, Laura Stadnika, stated that Resident A was at this home every day that she worked and that she provided care and treated her like any other resident. Staff Stadnika stated that she was never provided any written care plan or health care information to review regarding Resident A.

APPLICABLE RULE	
R 400.691	**Resident records.**
	(1) A licensee shall complete and maintain a separate record for each resident that includes all of the following: **(a) Personal information including all of the following:** **(i) Resident's full name.** **(ii) Social Security number.** **(iii) Date of birth.** **(iv) Marital status.** **(v) Veteran's status.** **(vi) Gender identity.** **(vii) Former address.** **(viii) Name, address, and contact information of identified contact or designated representative.** **(ix) Name, address, and contact information of the person and agency responsible for the resident's placement in the facility.** **(x) Funeral provisions, preferences, and contact information.** **(xi) Resident's religious preference.** **(b) Date of admission.** **(c) Date of discharge and address to where the resident moved.** **(d) Health care information including all of the following:** **(i) Health care appraisals.** **(ii) Medication administration record.** **(iii) Name, address, and contact information of the preferred health care professional and hospital.** **(iv) Medical insurance.** **(v) Statements and instructions for supervising prescribed medication including dietary supplements and medical procedures.** **(vi) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Admission and monthly weight record.** **(h) Incident reports.** **(i) Resident funds and valuables record and resident refund agreement.**

ANALYSIS:	Three separate staff stated that they were not aware of any written care plan, resident file, or health care documentation regarding Resident A being available for them to review. Licensee, Justin Nelson and administrator Alyssa Wark, stated that no AFC licensing paperwork was completed for Resident A. Licensee Nelson had no written record containing any identifying information, personal care needs, or health care information available for review for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 8/27/2026, staff person, Jennifer Palmateer, stated that she worked 3rd shift on 8/6/2026. Staff Palmateer stated that at 11:55pm, she checked on Resident A and found her in her bed and Resident A did not have a pulse. Staff Palmateer reported that she called Admin Wark, who provided no guidance except to say that she was on her way to the home. Staff Palmateer stated that she did not call 911 but that someone from Caro central dispatch called the home a few minutes after she spoke with Admin Wark and she answered a few questions they had before EMT's arrived. Staff Palmateer admitted that she never attempted to perform CPR on Resident A.

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: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Upon finding Resident A without a pulse, the only steps staff person, Jennifer Palmateer did was to call administrator, Alyssa Wark. Staff Palmateer admitted that she made no attempt to perform CPR on Resident A. There was sufficient evidence found that Staff Palmateer was not capable of appropriately handling this emergency situation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/8/2026, an exit conference was held with licensee Justin Nelson. Licensee Nelson was informed that a written correction action plan was required to address these licensing rule violations and that the result of this investigation will be a recommendation of a six-month provisional license. Licensee Nelson stated that he understood the results and did not verbally object to the provisional license.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that a temporary six-month provisional license be issued.

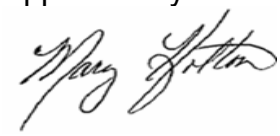


10/8/2026

_____

Christopher Holvey Date
Licensing Consultant

Approved By:



10/8/2026

_____

Mary E. Holton Date
Area Manager