



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

January 28, 2025

Kathleen Greene  
Lakeshore Caring Corp.  
4851 Lakeshore, Bldg. A  
Fort Gratiot, MI 48059

RE: License #: AL740007431  
Investigation #: 2025A0580010  
Lakeshore Woods II

Dear Kathleen Greene:

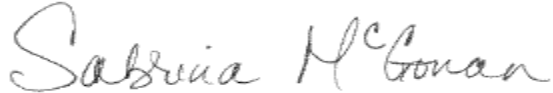
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 643-7960.

Sincerely,

A handwritten signature in cursive script that reads "Sabrina McGowan". The ink is dark and the signature is fluid.

Sabrina McGowan, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(810) 835-1019

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AL740007431
<b>Investigation #:</b>	2025A0580010
<b>Complaint Receipt Date:</b>	12/03/2024
<b>Investigation Initiation Date:</b>	12/04/2024
<b>Report Due Date:</b>	02/01/2025
<b>Licensee Name:</b>	Lakeshore Caring Corp.
<b>Licensee Address:</b>	4851 Lakeshore, Bldg. A Fort Gratiot, MI 48059
<b>Licensee Telephone #:</b>	(810) 385-3185
<b>Administrator:</b>	Kathleen Greene
<b>Licensee Designee:</b>	Kathleen Greene
<b>Name of Facility:</b>	Lakeshore Woods II
<b>Facility Address:</b>	4851 Lakeshore Blog B Fort Gratiot, MI 48059
<b>Facility Telephone #:</b>	(810) 385-3185
<b>Original Issuance Date:</b>	09/29/1995
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/14/2024
<b>Expiration Date:</b>	03/13/2026
<b>Capacity:</b>	20
<b>Program Type:</b>	PHYSICALLY HANDICAPPED AGED TRAUMATICALLY BRAIN INJURED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
There is not adequate staffing.	No
<ul style="list-style-type: none"> <li>Resident A sits in wet brief, clothes and linens when sleeping.</li> <li>Staff, Jennifer Norton wrapped a towel around Resident A's head and began squeezing due to her yelling.</li> </ul>	No
Resident A is not receiving her prescribed medications.	Yes
Staff Norton uses a deceased resident's Ativan cream on Resident A.	No
The food portions for lunch and dinner are so small residents are still hungry and for all meals.	No
Black mold under all sinks in the building.	No
Additional Findings	Yes

**III. METHODOLOGY**

12/03/2024	Special Investigation Intake 2025A0580010
12/04/2024	Special Investigation Initiated - Letter Referred to APS.
12/04/2024	APS Referral A referral sharing the allegations was made.
12/10/2024	Inspection Completed On-site Unannounced onsite inspection. Spoke with Katie Green.
12/10/2024	Contact - Face to Face Interview with Resident A.
12/10/2024	Contact - Face to Face Interview with Staff, Mike Cooley.
12/10/2024	Contact - Face to Face Interview with Staff, Katelynn Underwood.
12/10/2024	Contact - Face to Face Interview with Staff, Cylinne Tobias.
12/10/2024	Contact - Document Received Documents received.

01/15/2025	Inspection Completed On-site Unannounced follow-up onsite.
01/15/2025	Contact - Face to Face Observation of Resident A. Interview with Relative A.
01/15/2025	Contact - Face to Face Interview with Resident C.
01/15/2025	Contact - Face to Face Observation of Resident D.
01/15/2025	Contact - Face to Face Observation of Resident E.
01/15/2025	Contact - Document Received Documents received.
01/15/2025	Contact - Face to Face Interview with staff, Angela Ibarra.
01/22/2025	Contact - Telephone call made Call to Accent Care Hospice.
01/22/2025	Contact - Telephone call made Call to Relative C.
01/22/2025	Contact - Telephone call made Call to Relative D.
01/22/2025	Contact - Telephone call made Call to Relative E.
01/24/2025	Contact - Telephone call made Call to staff, Jennifer Norton
01/28/2025	Exit Conference Exit with Steven Larsen, Owner.

## **ALLEGATION:**

**There is not adequate staffing.**

## **INVESTIGATION:**

On 12/03/2024, I received a complaint via LARA-BCHS-Complaints.

On 12/04/2024, I made a referral to Adult Protective Services (APS) sharing the allegations.

On 12/12/2024, I received an additional allegation, intake #203631, which was combined with this investigation.

On 12/13/2024, I placed a call to the complainant. A voice mail message was left requesting a return phone call.

On 01/15/2024, I conducted an unannounced onsite inspection at Lakeshore Woods II. Contact was made with Katie Greene, newly designated Licensee Designee and Administrator. LD Greene stated that there are 12 current residents, 3 of which require a 2-person assist. There are 2 staff on duty, while 1 staff floats between the adjoining licensed facility to assist staff as needed. LD Greene stated that lunch and dinner are prepared in another facility and transported to the residents. Morning staff do assist with the preparing and serving of breakfast.

On 01/15/2025, while onsite, I interviewed Resident C, who stated that he requires a 2-person assist for mobility. Resident C denied waiting for long periods of time for staff assistance adding that he is being treated good at this facility. Resident C was observed in his bedroom adequately dressed and groomed. There were no concerns noted regarding his care.

The AFC Assessment Plan reviewed for Resident C indicates that Resident C is confused at times, however, he can communicate his needs and understands verbal communication. Resident C requires a 2-person assist for toileting. Due to physical limitations, Resident C requires a 2-person transfer due to weakness and unsteady gait.

On 01/15/2025, while onsite, I observed Resident D, identified as a resident requiring assistance. Resident D was observed while sitting in his lounge chair in his room. No concerns with his appearance were noted. He appears to be receiving proper care. An attempt to engage Resident D in conversation was made. Resident D was not able to answer any questions.

The AFC Assessment Plan reviewed for Resident D indicates that Resident D is unable to communicate his needs, mostly answering with phrases yes or no. Resident D does not understand verbal communication as his dementia diagnosis interfered with his understanding of and communication. Resident D requires uses a walker and requires

staff assistance for mobility. Staff will cue Resident D or help him from a seated position. Resident D is then able to ambulate on his own.

On 01/15/2025, while onsite, I observed Resident E, identified as a resident requiring a 2-person assist for mobility. Resident E was observed lying in bed whole sleeping. No immediate concerns regarding her care were noted.

The AFC Assessment Plan reviewed for Resident E indicates that Resident E is very confused, and unable to communicate her needs, or understand verbal communication. Resident E requires a 2-person assist for toileting and transfers. Resident A is bed bound and does not walk. Staff to assist with changing positions.

On 01/15/2025, while onsite, I interviewed direct staff, Angela Ybarra who stated that she has been employed by the corporation for 10 years. Staff Ybarra stated that Residents typically do not wait long for assistance and estimates a 10-minute wait between residents. Staff Ybarra stated that there are 2 staff working each shift and 3 residents who require 2-persons assist.

On 01/15/2025, I reviewed a copy of the staff schedules dated December 11, 2024-February 9, 2025. The schedule reviewed reflects that there are 2 staff working each shift.

On 01/22/2025, I spoke with Relative Guardian C, who stated, “none at all”, when asked if there were any concerns regarding the care Resident C receives at the facility. Relative Guardian C stated that Relative C receives good care, appears well- care for and is always in good spirits when she visits. Staff are kind to him and they appear to be hard workers. Resident C has never expressed that he has had to wait long periods of time for staff assistance. Relative Guardian C stated that she not sure about short staffing. Resident C requires a 2-person assist for mobility.

On 01/22/2025, I spoke with Relative Guardian D, who stated that she believes that the facility does not schedule enough staff. If the 2 staff that are working are busy with Resident D, then other residents have to wait. Relative Guardian D denied that Resident D has experienced any long wait times to her knowledge. Relative Guardian D added that when visiting, she will assist with Resident D’s care when needed.

On 01/22/2025, I spoke with Relative Guardian E, who stated that Resident E is fairly new to the facility, having moved in on 11/30/2024. Relative Guardian E stated that she has not experienced any long wait times when visiting and has no current complaints.

On 01/24/2025, I spoke with direct staff, Jennifer Norton, who stated that she has worked for the corporation for 5 years, having worked in the AFC field for the past 20 years. Staff Norton works either mornings or evenings. Staff Norton stated that there are typically 2 staff working, with everyone being trained as either a Care Aid or Med Tech. Staff Norton stated if staff are working with a resident who requires a 2-person assist, it can take upwards of 25 minutes before they are able to assist other residents. Passing

medication and providing care can sometimes be a lot. Staff Norton stated that it's rare that staff have to cook breakfast for the residents.

On 01/2/2025, I conducted an exit conference with the corporation owner, Steve Larsen, who shared that the facility is in the process of hiring several new staff members. Mr. Larsen also stated that he intends to apply for an HFA license in an effort to run more efficiently.

<b>APPLICABLE RULE</b>	
<b>R 400.15206</b>	<b>Staffing requirements.</b>
	<b>(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.</b>
<b>ANALYSIS:</b>	<p>It was alleged that there is not adequate staffing.</p> <p>Administrator. LD Greene stated that there are 12 current residents, 3 of which require a 2-person assist. There are 2 staff on duty, while 1 staff floats between the adjoined licensed facility to assist staff as needed. LD Greene stated that lunch and dinner are prepared in another facility and transported to the residents. Morning staff do assist with the preparing and serving of breakfast.</p> <p>Resident C denied waiting for long periods of time for staff assistance adding that he is being treated good at this facility.</p> <p>The AFC Assessment Plans for Resident C, D and E were reviewed.</p> <p>Resident D was observed while sitting in his lounge chair in his room. No concerns with his appearance were noted. He appears to be receiving proper care. An attempt to engage Resident D in conversation was made. Resident D was not able to answer any questions.</p> <p>Resident E was observed lying in bed while sleeping. No immediate concerns regarding her care were noted.</p> <p>Staff, Angela Ybarra stated that there are 2 staff working each shift and 3 residents who require 2-persons assist. Residents</p>



	<p>typically do not wait long for assistance and estimates a 10-minute wait between residents.</p> <p>Staff schedules dated December 11, 2024-January 11, 2025, indicate that there are 2 staff per shift.</p> <p>Relative Guardian C stated that Relative C receives good care, appears well- care for and is always in good spirits when she visits. Staff are kind to him and they appear to be hard workers. Resident C has never expressed that he has had to wait long periods of time for staff assistance.</p> <p>Relative Guardian D stated that she believes that the facility does not schedule enough staff. If the 2 staff that are working are busy with Resident D, then other residents have to wait. Relative Guardian D denied that Resident D has experienced any long wait times to her knowledge. Relative Guardian D adds that when visiting, she will assist with Resident D's care when needed.</p> <p>Relative Guardian E stated that Resident E is fairly new to the facility, has not experienced any long wait times when visiting, and has no current complaints.</p> <p>Staff, Jennifer Norton stated that if staff are working with a resident who requires a 2-person assist, it can take upwards of 25 minutes before they are able to assist other residents. Passing medication and providing care can sometimes be a lot. Staff Norton stated that it's rare that staff have to cook breakfast for the residents.</p> <p>Based on the interviews conducted and the documents reviewed, there is not enough evidence to support the rule violation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

- Resident A sits in wet brief, clothes and linens when sleeping.
- Staff, Jennifer Norton wrapped a towel around Resident A's head and began squeezing due to her yelling.

## **INVESTIGATION:**

On 12/10/2024, I conducted an unannounced onsite inspection at Lakeshore Woods II. Contact was made with Katie Greene, currently serving in the role of Executive Director. Director Greene is in process of completing the fingerprints and required documentation in order to become the Licensee Designee and Administrator of this license. Director Greene denied the allegation that Resident A sits in wet brief, clothes and linens, adding that Resident A is combative at times. Staff retry if their first attempts are unsuccessful.

On 12/10/2024, while onsite, I conducted an interview with direct staff, Mike Cooley, who stated that he does provide care for Resident A at times, upon his arrival to work, as he is a 1<sup>st</sup> shift staff. Staff Cooley denied the allegations that Resident A is left in wet briefs, adding that if so, it was an accident.

On 12/10/2024, while onsite, I conducted an interview with direct staff, Katelynn Underwood. Staff Underwood who stated that Resident A gets her briefs checked and changed every 2 hours, if she lets them. Admittedly, Resident A is more agitated at night. Staff try to keep Resident A changed and clean as much as possible.

On 12/10/2024, while onsite, I conducted an interview with direct staff, Cylinne Tobias, who stated that brief changes are conducted every 2 hours, however, Resident A is a hard sleeper and hard to wake up in the middle of the night. When Resident A does wake up at night, Resident A freaks out. Staff will then allow Resident A time to wake up on her own before providing care.

On 12/10/2024, while onsite, I conducted an interview with Resident A, who stated that the staff take good care of her and staff response times are pretty fast, adding that they do a good job.

On 12/10/2024 while onsite I obtained a copy of the AFC Assessment Plan for Resident A, which indicates that Resident A requires staff assistance with toileting.

On 01/15/2025, while onsite, LD Greene shared that there was an internal investigation conducted on staff Jennifer Norton based on the allegations, which she denied. Staff Norton was suspended during the investigation. Several staff were interviewed and no evidence or validity to the claims were found. Staff Norton was allowed to return on a Personal Improvement Plan (PIP) Staff Norton has also had to complete Dementia training. LD Greene will also meet with staff Norton on weekly basis for 8 weeks until the plan is complete.

On 01/15/2025, while onsite, I conducted a follow-up observation of Resident A, who is reportedly in her last stages of life. Resident A was observed adequately dressed and groomed while sleeping. Sitting with Resident was her guardian, identified as Relative Guardian A. Relative Guardian A stated that she had not heard any information regarding the allegations. Relative A stated that she had no concerns or complaints regarding the care Resident A has received while residing in this home.

On 01/22/2025, I spoke with RN Steve Ciochon, of Accent are Hospice. RN Ciochon, who stated that Resident A began hospice services on October 18, 2024, with visits being conducted 2 times a week. Services for Resident A were terminated effective 01/20/2025, the date of her passing. RN Ciochon stated that Resident A passed away on 01/20/25 at 10:45am. RN Ciochon called her time of death at 11:30am. RN Ciochon stated that while providing hospice services for Resident A, there was never any skin irritations or concerns regarding being left in wet briefs.

On 01/24/2025, staff Norton denied the allegations that Resident A is being left in wet briefs, stating that she always changes residents so they don't get "broke butt".

Staff Norton stated that Residents with Dementia often don't know when to close their eyes when their hair is being washed. Staff Norton denied the allegations, stating that she uses a towel to cover the residents' eyes when washing their hair. Yes, Resident A did yell, scream, however, not due to squeezing her head as alleged. Staff Norton stated that she was investigated internally and there were no findings.

<b>APPLICABLE RULE</b>	
<b>R 400.15305</b>	<b>Resident protection.</b>
	<b>(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.</b>
<b>ANALYSIS:</b>	<p>It was alleged that Resident A sits in wet brief, clothes and linens when sleeping.</p> <p>It was alleged that staff, Jennifer Norton wrapped a towel around Resident A's head and began squeezing due to her yelling.</p> <p>LD Greene denied the allegation that Resident A sits in wet brief, clothes and linens. LD Greene also denied the allegations that staff, Jennifer Norton wrapped a towel around Resident A's head and began squeezing.</p> <p>Staff member, Mike Cooley, denied the allegation. Staff member, Katelynn Underwood, stated that Resident A gets her briefs checked/changed every 2 hours, if she lets them. Resident A is more agitated at night. Staff tried to keep her changed/clean as much as possible.</p> <p>Staff member, Cylinne Tobias, stated that brief changes are every 2 hours, however, Resident A is a hard sleeper and hard to wake up in the middle of the night. Staff will then allow Resident A time to wake up on her own before providing care.</p>

	<p>Resident A stated that the staff take good care of her and staff response times are pretty fast, adding that they do a good job.</p> <p>The AFC Assessment Plan indicates that Resident A requires staff assistance with toileting.</p> <p>Relative Guardian A stated that she had not heard any information regarding the allegations and has no concerns or complaints regarding the care Resident A has received while residing in this home.</p> <p>RN Steve Ciochon, of Accent are Hospice, stated that while providing hospice services for Resident A, there was never any skin irritations or concerns regarding her being left in wet briefs.</p> <p>Staff Norton denied the allegations that Resident A is being left in wet briefs, stating that she always changes residents so they don't get "broke butt". Staff Norton denied the allegations, stating that she uses a towel to cover the residents' eyes when washing their hair. Yes, Resident A did yell, scream, however, not due to squeezing her head as alleged.</p> <p>Based on the interviews conducted and the documents reviewed, there is not enough evidence to support the rule violation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### **ALLEGATION:**

**Resident A is not receiving her prescribed medications.**

#### **INVESTIGATION:**

On 12/10/2024, LD Greene stated that Resident A is combative and will resist assistance from staff. Staff in the home have been directed to go back and retry when/if she resists.

On 12/10/2024, while onsite, staff Cylinne Tobias stated that Resident A is a hard sleeper and hard to wake up at night and will refuse her medication.

On 12/10/2024, while onsite, I obtained a copy of the November Medication Logs for Resident A. The log indicates that Resident A is prescribed Acetamin 160 MG, with instruction to be given by mouth every 8 hours around the clock for pain, (8a, 2p, 10p) effective 11/21/2025. The log reflects that Resident A was not given her medication on

11/29/2024. No initials verifying administration were present. The log, nor code sheet provided does not indicate why she was not given this medication. The log also indicates that Resident A is prescribed Divalproex 125MG capsule by mouth daily, to be taken in the evening. The log reflects that Resident A was not given her medication on 11/03, 11/14, 11/25, 11/26, and 11/29/2025. The log, nor code sheet, provided does not indicate why she was not given this medication.

On 01/15/2025, while onsite, I addressed the inconsistencies in the medication logs for Resident A. LD Greene admitted that staff are not using the correct coding on the medication log and will be retrained in that area.

On 01/15/2025, while onsite, direct staff, Angela Ybarra stated that if it is a 12am or 2am medication and the resident is sleeping, staff do not wake residents up. 9 out of 10 times Resident A refuses by swatting staff away.

On 01/15/2025, Relative Guardian A stated that she had not heard any information regarding the allegations. Relative A stated that she had no concerns or complaints regarding the care Resident A has received while residing in this home.

On 01/15/2025, RN Steve Ciochon stated that Resident A was diagnosed with dementia and had a history of sleeping for extended periods of time, almost as if in a comatose state. Resident a was also known to be restless at times, very agitated and combative. Medications geared towards her behaviors were prescribed. RN Ciochon added that he is aware that at times staff had problems getting Resident A to take her medications and they were not given consistently.

On 01/24/2025, I staff Norton stated that Resident A always received her medications when they were due to be taken. However, if she is not awake or unable to be aroused then staff have no choice and consider it a refusal.

On 01/28/2025, while conducting the exit conference with Steve Larsen, I explained the rationale behind the licensing rule violation. Owner Lasen understands the rationale and will address corrective measures applied in his corrective action plan.

<b>APPLICABLE RULE</b>	
<b>R 400.15312</b>	<b>Resident medications.</b>
	<b>(2) Medication shall be given, taken, or applied pursuant to label instructions.</b>
<b>ANALYSIS:</b>	It was alleged that Resident A is not receiving her prescribed medications.  LD Greene stated that Resident A is combative and will resist assistance from staff. Staff in the home have been directed to go back and retry when/if she resists. LD Greene admitted that

	<p>staff are not using the correct coding on the medication log and will be retained in that area.</p> <p>Staff, Cylinne Tobias stated that Resident A is a hard sleeper and hard to wake up at night. She refuses her medication.</p> <p>The November 2025 Medication Log reviewed for Resident A reflects that she was not given her medication as prescribed.</p> <p>Staff, Angela Ybarra stated that if it is a 12am or 2am medication and the resident is sleeping, staff do not wake residents up. 9 out of 10 times Resident A refuses by swatting staffs had away.</p> <p>Relative A stated that she had no concerns or complaints regarding the care Resident A has received while residing in this home.</p> <p>RN Steve Ciochon stated that Resident A was diagnosed with dementia and had a history of sleeping for extended periods of time, almost as if in a comatose state. Resident a was also known to be restless at times, very agitated and combative. Medications geared towards her behaviors were prescribed. RN Ciochon added that he is aware that at times staff had problems getting Resident A to take her medications and they were not given consistently.</p> <p>Staff Norton stated that Resident A always received her medications when they were due to be taken, however, if she is not awake or unable to be aroused then staff have no choice and consider it a refusal.</p> <p>Based on the interviews conducted and the documents reviewed there is sufficient evidence to support the rule violation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Staff Jennifer Norton uses a deceased resident's Ativan cream on Resident A.**

## INVESTIGATION:

On 01/15/2024, while onsite, LD Greene shared that staff, Jennifer Norton admitted to having an old prescription of Ativan Cream on the medication cart, belonging to a former resident, Resident B, who passed away on 08/30/2024. Staff Norton denied using the medication on Resident A or any other resident. Ativan Gel is a prescribed PRN for Resident A. No one had made her aware that the medication had not been disposed. A new medication policy has been developed as well.

Current Physician's Orders reviewed for Resident A indicate that she is prescribed Ativan Gel, 1MG/ML to be applied every 3 hours as needed for anxiety.

On 01/24/2025, staff Norton stated that she did pull the Ativan Cream from the medication cart, however, she got busy and forgot to dispose of it. Yes, she had the cream, however, she denies using it on any resident. Staff Norton stated that she made a mistake and was written up for it.

<b>APPLICABLE RULE</b>	
<b>R 400.15312</b>	<b>Resident medications.</b>
	<b>(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.</b>
<b>ANALYSIS:</b>	<p>It was alleged that staff, Jennifer Norton, uses a deceased residents Ativan cream on Resident A to try and calm her down.</p> <p>LD Greene shared that staff, Jennifer Norton admitted to having an old prescription on the medication cart, belonging to a former resident, who passed away. Staff Norton denied using the medication on Resident A or any other resident.</p> <p>Current Physician's Orders reviewed for Resident A indicate that she is prescribed Ativan Gel, 1MG/ML to be applied every 3 hours as needed for anxiety.</p> <p>Staff Norton stated that "yes", she had the cream, however, she denies using it on any resident. Staff Norton stated that she made a mistake and was written up for it.</p> <p>Based on the interviews conducted and the documents reviewed, there is not enough evidence to support the rule violation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

## **ALLEGATION:**

**The food portions for lunch and dinner are so small residents are still hungry and for all meals.**

## **INVESTIGATION:**

On 01/15/2024, while onsite, LD Greene denied the allegations of small portions and hungry residents, stating that there was a cook who was recently let go due to not giving residents second portions when asked.

On 01/15/2025, while onsite, I interviewed Resident C who denied the allegations indicating that he gets plenty of food to eat.

On 01/15/2025, I reviewed the December and January 2025 menus for the facility. The menu reflects a variety of foods from each food group being served daily, meeting the daily nutritional allowance contained in the publication entitled "Basic Nutrition Facts: A Nutrition Reference.

On 01/15/2025, I reviewed the Weight Log records for Residents C, D, and E. The log for Resident C indicates that he weighed 229.8lbs. in November 2024, 229lbs. in December 2024 and 228lbs. in January 2025. The log for Resident D indicates that he entered the facility weighing 207lbs. in November of 2023. Resident D weighed his lowest weight of 185lbs, in November and December 2024. Resident D's weight for January 2025 is recorded as 186lbs. The log for Weight Record for Resident E indicates that she weighed 112 lbs. in December 2024 and 113 lbs. in January 2025.

On 01/22/2025, I spoke with Relative Guardian C, who stated that Resident C has not complained about the food and she has no concerns.

On 01/22/2025, I spoke with Relative Guardian D who stated that Resident D has had some weight loss, however, it is contributed to by the progression of his disease. Relative Guardian D has no concerns with the food being served.

On 01/22/2025, I spoke with Relative Guardian E who stated that Resident E is newer to the facility and no concerns regarding the food have arisen.

<b>APPLICABLE RULE</b>	
<b>R 400.15313</b>	<b>Resident nutrition.</b>
	<b>(2) Meals shall meet the nutritional allowances recommended pursuant to the provisions of "Appendix I: Recommended Dietary Allowances, Revised 1980" contained in the publication entitled "Basic Nutrition Facts: A Nutrition Reference," Michigan Department of Public Health publication no. H-808, 1/89. This publication may</b>



	<b>be obtained at cost from The Division of Research and Development, Michigan Department of Public Health, P.O. Box 30195, Lansing, Michigan 48909.</b>
<b>ANALYSIS:</b>	<p>It was alleged that the food portions for lunch and dinner are so small residents are still hungry and for all meals</p> <p>LD Greene denied the allegations of small portions and hungry residents, stating that there was a cook who was recently let go due to not giving residents second portions when asked.</p> <p>Resident C denied the allegations indicting that he gets plenty of food to eat.</p> <p>The December and January 2025 menus for the facility reflect a variety of foods from each food group being served daily, meeting the daily nutritional allowance contained in the publication entitled "Basic Nutrition Facts: A Nutrition Reference.</p> <p>The Weight Log records for Residents C, D, and E were reviewed. No concerns were noted.</p> <p>Relative Guardian C stated that Resident C has not complained about the food and she has no concerns.</p> <p>Relative Guardian D stated that Resident D has had some weight loss, however, it is contributed to by the progression of his disease. Relative Guardian D has no concerns with the food being served.</p> <p>Relative Guardian E stated that Resident E is newer to the facility and no concerns regarding the food have arisen.</p> <p>Based on the documents reviewed and the interviews conducted, there is not enough evidence to support the rule violation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**There is black mold under all sinks in the building.**

**INVESTIGATION:**

On 01/15/2025, Admin Greene denied the allegations that there is mold under the sinks. Admin Greene stated that there was a small leak in the kitchen under the sink, which maintenance is addressing.

On 01/15/2024, while onsite I observed under the kitchen and under the kitchen sink cabinet. No mold was observed. While onsite I also observed under the resident bathroom sinks. The sinks are sink-only in style, containing no cabinets or drawers underneath. No mold was seen under the sinks located in the resident rooms.

<b>APPLICABLE RULE</b>	
<b>R 400.15403</b>	<b>Maintenance of premises.</b>
	<b>(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.</b>
<b>ANALYSIS:</b>	<p>It was alleged that there is black mold under all sinks in the building.</p> <p>Admin Greene denied the allegations that there is mold under the sinks.</p> <p>While onsite I observed under the kitchen and under the kitchen sink cabinet. No mold was seen. While onsite I also observed under the resident bathroom sinks. No mold was seen under the sinks located in the resident rooms.</p> <p>There is not enough evidence to support the rule violation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

## **ADDITIONAL FINDINGS**

### **INVESTIGATION:**

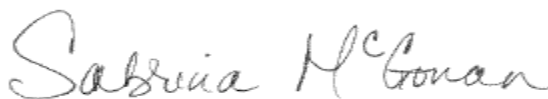
On 01/24/2025, staff Norton stated that she did pull the Ativan Cream from the medication cart, however, she got busy and forgot to dispose of it. Staff Norton stated that she made a mistake and was written up for it.

<b>APPLICABLE RULE</b>	
<b>R 400.15312</b>	<b>Resident medications.</b>
	<b>(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or pharmacist.</b>
<b>ANALYSIS:</b>	Staff, Jennifer Norton admitted to having an old prescription on the medication cart, belonging to a former resident, who passed away.  Based on the interview there is enough evidence to support the rule violation.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 01/28/2025, during the exit conference with Owner Larsen, I addressed the medication disposal policy for the facility, which does not address consultation with a physician or pharmacist. Owner Larsen will address corrective measures in the corrective action plan.

#### **IV. RECOMMENDATION**

Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.



January 28, 2025

Sabrina McGowan  
Licensing Consultant

Date

Approved By:



January 28, 2025

Mary E Holton  
Area Manager

Date