GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 3, 2025

Katie Edwards
Symphony of Linden Health Care Center, LLC
30150 Telegraph Rd
Suite 167
Bingham Farms, MI 48025

RE: License #:	AL250331306
Investigation #:	2025A1039020
	Degas House Inn

Dear Katie Edwards:

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,

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250331306
Investigation #:	2025A1039020
Complaint Receipt Date:	04/16/2025
Investigation Initiation Date:	04/17/2025
Report Due Date:	06/15/2025
Licensee Name:	Symphony of Linden Health Care Center, LLC
Licensee Address:	7257 N. Lincoln Lincolnwood, IL 60712
Licensee Telephone #:	(810) 735-9400
Administrator:	Katie Edwards
Licensee Designee:	Katie Edwards
Name of Facility:	Degas House Inn
Facility Address:	202 S Bridge Street Linden, MI 48451
Facility Telephone #:	(810) 735-9400
Original Issuance Date:	05/01/2014
License Status:	1ST PROVISIONAL
Effective Date:	04/28/2025
Expiration Date:	10/27/2025
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
• **Residents are neglected, they sit in urine and feces for hours. Residents have wounds that are untreated.**	No
• **Medications are missing and medication cart is not locked.**	No
• **Residents are not being fed.**	No
• **Cleaning is not done daily; cleaning chemicals are in reach of residents' rooms.**	No
• **Staff broke resident confidentiality rules.**	Yes

III. METHODOLOGY

04/16/2025	Special Investigation Intake 2025A1039020
04/17/2025	APS Referral Called in via phone hotline.
04/17/2025	Special Investigation Initiated - Telephone APS referral called in via phone.
04/29/2025	Inspection Completed On-site Interviewed Administrator, Assistant Director, Direct Care Workers and Residents A, B, and C.
04/29/2025	Contact - Telephone call made Attempted to call former staff Haley Taylor. No answer left message.
05/19/2025	Contact - Telephone call made Attempted to call former staff Haley Taylor. No answer left message.
05/19/2025	Contact - Telephone call received Completed phone interview with former staff Haley Taylor.
05/22/2025	Contact - Telephone call made Completed phone interview with DHHS APS worker Melanie Gallego. She did not substantiate for any complaints at Degas House.

05/29/2025	Exit Conference Completed via phone and email with Licensee Designee Katie Edwards.
05/29/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

- **Residents are neglected, they sit in urine and feces for hours. Residents have wounds that are untreated.**
- **Medications are missing.**
- **Medication cart is not locked.**
- **Residents are not being fed.**
- **Cleaning is not done daily; cleaning chemicals are in reach of residents' rooms.**
- **Staff broke resident confidentiality rules.**

INVESTIGATION:

On 04/16/2025, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that Residents are neglected, they sit in urine and feces for hours. Residents have wounds that are untreated. Medications are missing and the medication cart is not locked. Cleaning is not done daily; cleaning chemicals are in reach of resident's rooms. Residents are not being fed. Staff broke resident confidentiality rules.

On 04/29/2025, I completed an unannounced investigation at Degas House. The home was neat and clean and there was no trash piled up. I viewed five random resident rooms and there was no trash, no cleaning supplies left out, it was free of clutter, and no leftover food was left out. The rooms appeared to meet all criteria for resident living conditions. I viewed the kitchen, and the kitchen was clean, and all food was appropriately dated in the refrigerator, freezer and pantry. There appeared to be an adequate amount of food for the residents in the refrigerator and freezer and there was an ample supply of food in the pantry. I inspected all the appliances in the kitchen, and they were all in working order. The staff were preparing lunch when I arrived to complete my interview, and the food appeared fresh and warm and was cooked in accordance with the menu that was posted for the residents. The menu appeared to have nutritious well balanced meals for the residents.

I interviewed the following people: Administrator Bowe Davey, Assistant Director Jessica Butler, Medical Technician Tracey Mitchell, Direct Care Worker Brianna Blue, Resident A, Resident B and Resident C.

On 04/29/2025, I interviewed Administrator Bowe Davey concerning the allegations. Administrator Davey stated that he was aware of the allegations but did not believe that they were true and that he would provide as much assistance as possible. Administrator Davey stated that residents are not neglected at the home and that the staff check on them regularly and change the residents as needed. Administrator Davey stated that residents do not sit in urine for several hours. Staff check and change them every two hours but some residents may be heavy wetters so it may appear that they have not been serviced properly. Administrator Davey stated that all residents there wear briefs of some sort. Administrator Davey stated that some residents do have bed sores and that is due to them not being mobile and having to be in bed or sitting in a wheelchair/chair all day long. Administrator Davey stated that a lot of the residents come into the home with bed sores as they are an aged home, and they have staff trained to care for this population of residents. Administrator Davey stated that they also have residents on hospice care, and they receive additional care from hospice nurses as well. Administrator Davey stated that if a resident moves into the home and they have an open wound or bed sore that they will take pictures of the wound to document it for their files. Administrator Davey stated that staff treat the residents' wounds and bed sores daily and that some residents' bed sores will get worse even while they receive treatment due to being in bed all day long.

Administrator Davey stated that they have had one reported issues with alleged missing medication. Administrator Davey stated that a family brought in medication for a resident and when the staff counted the medication it was 10 pills short of what the family said was in the bottle. Administrator Davey stated that they completed an internal investigation but found no evidence that the pills were taken by staff or another resident. Administrator Davey stated that they have a video camera in the medication room and the video was reviewed. The video did not show that any pills were taken by staff when they were counted upon being received from the family. Administrator Davey stated that they had no evidence that any medication was missing. Administrator Davey had the Medical Technician (MT) Tracey Mitchell take me to the medication cart so that I could review resident medication. Upon arriving at the medication cart, I saw that the cart was locked. MT Mitchell unlocked the medication cart for me to review the medication and the Medication Administration Record (MARs). I reviewed 5 random resident's medication and the corresponding MARs. There did not appear to be any missing medication, and all of the MARs matched the medication that was in the medication cabinet.

Administrator Davey stated that the staff clean the rooms daily and that there are no cleaning supplies in the residents' rooms. Administrator Davey stated that the residents receive fresh meals daily and that they have no issues with their food or menus. Administrator Davey stated that the residents are served three meals a day and can have snacks when hungry. Administrator Davey stated that he is aware that a former staff member posted a picture of a resident's open wound online on Facebook.

Administrator Davey stated that the staff member involved has been terminated for violating the resident's bill of rights. Administrator Davey stated that the staff member

was speaking inappropriately with residents' families, residents and posted a picture of a residents wound online. Administrator Davey stated that the staff member was Haley Taylor, and she was terminated on 04/14/2025. Administrator Davey provided me with the Employee Termination Form dated 04/14/2025.

On 04/29/2025, I interviewed Assistant Director (AD) Jessica Butler concerning the allegations. AD Butler stated that she was familiar with the allegations but did not believe that they were true. AD Butler stated that most of the residents wear some type of briefs and if they don't wear them during the day then they wear them at night. AD Butler stated that they serve an aged population, and it is very common for them to wear briefs. AD Butler stated that the residents are checked every two hours and that some residents are checked more because they are heavy wetters but that they do not have anything specific in their treatment plans for being checked more often, they just do it because they recognize that some residents need to be checked more than others.

AD Butler stated that there are residents in the home with bed sores and open wounds. AD Butler stated that due to residents being bedridden that they often times move into the facility with an open bed sore. AD Butler stated that they take pictures and document any bed sores or open wounds when a resident moves into the facility. AD Butler stated that the staff their treat any resident with bed sores or open wounds daily and that they ensure that the residents are receiving the best care possible. AD Butler stated that bed sores can get worse due to residents not being able to get out of bed or their wheelchairs to let the wounds heal.

AD Butler stated that they have had no issues with missing medication and that there was a past incident of a family dropping off medication for a resident and when staff counted the pills that there were 10 pills less than what was expected. AD Butler stated that there was an internal investigation into the allegation that 10 pills were missing but that after reviewing the camera footage from the medication room they did not see that staff took any of the pills. AD Butler stated that they spoke with the staff that were involved but did not find any evidence to suspect that they took the medication. AD Butler stated that they typically get their medication from a pharmacy, but in this case, it was dropped off by a third party family member. AD Butler stated that they have never had any issues with missing medication or residents not receiving their medication. AD Butler stated that the medical technician has the key to the medication cart and that the medication room has a camera in it. AD Butler stated that the only time she can think of where there is an issue with medication is when they place an order for a new medication. AD Butler stated that if they order medication before 10 a.m. they will get the medication the same day, but if they order medication after 10 a.m. then they will typically get the medication the next day.

AD Butler stated that she does not believe that they have any issues with cleanliness or having cleaning chemicals in the reach of residents. AD Butler stated that the staff clean the room daily and that the home gets deep cleaned once a week. AD Butler stated that there is not trash buildup of any kind around the home. After our interview, AD Butler took me around the home so that I could inspect the rooms, kitchen and other

areas. There was no trash buildup of any kind, the resident rooms were very clean and there were no cleaning chemicals in any of the residents' rooms.

AD Butler stated that they have no issues with residents not getting enough food. AD Butler stated that the residents get all of their meals, and they can have snacks at any time. AD Butler stated that many residents have snacks in their room also if they get hungry. AD Butler stated that residents not getting fed properly has never been an issues there.

AD Butler stated that they did have an issue with a staff member talking inappropriately around residents and their families and that the information that was shared broke the rules of their confidentiality. AD Buter stated that the staff member was terminated and no longer works at the home. AD Butler stated that the staff member posted a picture of a residents wound on Facebook and this also violated confidentiality. AD Butler stated that the picture that was posted was a picture that was taken of a residents wound when they were admitted to the home.

On 04/29/2025, I interviewed Medical Technician (MT) Tracey Mitchell concerning the allegations. MT Mitchell stated that she did not really believe that the residents are being neglected and not changed properly. MT Mitchell stated that she also works as a direct care worker and provides care to the residents on a daily basis. MT Mitchell stated that the staff check on the residents hourly and they change their briefs every two hours and ensure that any needed toiletry is completed. MT Mitchell stated that if a resident needs to be changed more than every two hours then staff will change them as needed. MT Mitchell stated that they have several residents who are considered heavy wetters and staff check on them more regularly. MT Mitchell stated that when they use the bathroom, they just have more fluid release than other residents and it may look like they have not been changed.

MT Mitchell stated that they do have multiple residents with bed sores but that does not mean that they are not taken care of. MT Mitchell stated that they are very well taken care of, and their bed sores are treated daily by staff and also their hospice nurse if they have one. MT Mitchell stated that some of the bed sores will not get better and they just do the best they can to make the residents comfortable.

MT Mitchell stated that she does not believe that the home has an issue with missing medication. MT Mitchell stated that she is aware of one issue they had with reported missing medication. MT Mitchell stated that when the family brought the medication to the home it was brought to the medication room and counted by the night staff MT. The night shift MT notified supervision that the bottle was 10 pills short of what was expected. MT Mitchell stated that she along with another staff reviewed the camera footage from that evening and did not see anyone take any pills out of the bottle. MT Mitchell stated that she is not sure what supervision did after that, but she did not find any video evidence that showed that the staff member took any pills out of the bottle. MT Mitchell showed me the medication room and it was locked. MT Mitchell took me to the medication cart that was locked and unlocked and opened up the Medication

Administration Records (MARs) and I reviewed five random resident records and medication. The MARs and the medication were up to date with no discrepancies.

MT Mitchell stated that she has not seen any issues with the home being dirty or trash piling up anywhere. MT Mitchell stated that the staff clean daily and that the home is deep cleaned once a week. MT Mitchell stated that the residents get two showers per week and that staff clean the room and change the bedding during that time. MT Mitchell stated that the residents do not have any cleaning chemicals in their rooms and that staff put any cleaning chemicals away after they use them. MT Mitchell stated that she has not seen any cleaning chemicals left in any of the residents' rooms and she has not heard of any staff leaving cleaning chemicals in any residents' rooms.

MT Mitchell stated that there are no issues with the food and that the residents get three meals a day and snacks if they want. MT Mitchell stated that the food is really good and fresh, and she has not heard any complaints from the residents. MT Mitchell stated that residents also have snacks in their room. MT Mitchell stated that the menu is always posted with options for the residents and that the pantry is full of fresh food in case that want something else.

MT Mitchell stated that she did not know much about the staff member that was terminated but she did hear that a staff member was let go for confidentiality issues. MT Mitchell stated that she did not know any other details about the incident. MT Mitchell stated that supervision has gone over confidentiality policy and resident bill of right with the staff. MT Mitchell stated that they receive training concerning confidentiality also.

On 04/29/2025, I interviewed Direct Care Worker (DCW) Brianna Blue concerning the allegations. DCW Blue stated that she was not familiar with all of the allegations but a few of them. DCW Blue stated that she did not believe that they were true. DCW Blue stated that the residents do not sit in urine for hours. DCW Blue stated that the residents get changed every two hours and that they often change them more if needed. DCW Blue stated that the staff really care for the residents and make sure that they take good care of them.

DCW Blue stated that some residents do have bed sores and open wounds but it's because some of them can't get up and move around anymore so they are not going to get better. DCW Blue stated the staff do the best they can to keep the wounds as clean as they can, so they don't get infected. DCW Blue stated that they treat the bed sores daily and that the residents also get treatment from a hospice nurse if they have one.

DCW Blue stated that she has not heard of any issues with residents' medication. DCW Blue stated that only the Medical Technicians administer medication to residents. DCW Blue stated that the medication room and the medical cart are locked at all times and only the Medical Technicians have the keys. DCW Blue stated that she did not have any information on any missing medication from any residents.

DCW Blue stated that the home is clean, the resident rooms are clean and that there are no cleaning chemicals left out where the residents could get them. DCW Blue stated that they clean the rooms every day and that they also clean them when the residents get showers. DCW Blue stated that the home is deep cleaning weekly.

DCW Blue did not have any information on any staff members breaking any confidentiality rules. DCW Blue stated she heard something about another staff getting in trouble, but she did not know any details. DCW Blue stated that they get trained on that when they get hired. DCW Blue stated that she has not heard any staff member talking about residents' care inappropriately.

I reviewed Resident A, B and C's weight records. Resident A has gained 2 lbs., Resident B has gained 6 lbs., and Resident C has maintained the same weight for the previous 6 months.

On 04/29/2025, I interviewed Resident A in her room. Resident A was in her wheelchair at the time of our interview. Resident A appeared neat and clean and was able to communicate with no issues. Resident A's room was clean and there was no trash or cleaning chemicals visible. Resident A stated that staff help her with changing her briefs and using the toilet. Resident A stated that staff come right away when she calls for any help and has never had any issues with the care they provide. Resident A stated that staff do a good job of doing their resident checks and they never forget to check on her. Resident A stated that they even come in at night and make sure to check on them. Resident A stated that she currently has bed sores, and the staff do a great job of treating the bed sore and keeping it clean, so it doesn't get worse. Resident A stated that she never worries about it getting worse. Resident A stated that she has had bed sores since she was admitted to the home and that they took pictures of her bed sores for her file.

Resident A stated that she doesn't know much about the medication room or the medication cart because the staff always brings her medication to her room. Resident A stated they bring it every day and sometimes have to wake her up because she is still sleeping. Resident A stated that she has not heard of anyone missing medication and she does not believe she has had any missing medication because she gets her medication every day.

Resident A stated that the staff keep her room clean, and they clean and pick up things every day. Resident A stated that she does not remember seeing any cleaning supplies in her room. Resident A stated that she loves it at the home, and she loves the staff. Resident A stated that that she gets three meals a day and snacks if she gets hungry. Resident A stated that the food is very good, and she has no complaints. Resident A stated that she has not heard any staff talk inappropriate about residents or their medical issues.

On 04/29/2025, I completed an interview with Resident B in his room. Resident B was sitting in his recliner at the time of the interview. Resident B appeared neat and clean

and was able to communicate with no issues. Resident B's room was clean and there was no trash or cleaning chemicals visible. Resident B stated that he does not have any bed sores and is able to move around the home on his own. Resident B stated that staff come in and check on him regularly and if he needs help with the using the bathroom that they will help him. Resident B stated he doesn't know if any other residents have had issues sitting in urine because he can do most everything on his own. Resident B stated that if he needs any help, he can buzz staff, and they will come right away and take care of him. Resident B stated that staff treat him good.

Resident B stated that he receives his medication every day and that staff are very good about bringing it to him in his room. Resident B stated he does not know if any resident medication has gone missing. Resident B stated that he has never had any issues with his medication. Resident B stated that he thinks staff has a key to the medication, but he isn't sure because the staff bring it to his room for him.

Resident B stated that the home is clean, and his room is clean. Resident B stated that staff come clean his room during his shower time. Resident B stated that he has never seen trash piled up anywhere in the home. Resident B stated that the food is good, and they get three meals a day. Resident B stated that if he gets hungry, he can ask for snacks and the staff will bring him something to eat. Resident B stated that he does not know of any staff or confidentiality issues at the home.

On 04/29/2025, I completed an interview with Resident C in her room. Resident C was sitting on her bed at the time of the interview. Resident C appeared neat and clean and was able to communicate with no issues. Resident C's room was clean and there was no trash or cleaning chemicals visible. Resident C stated that she does not currently have any bed sores. Resident C stated that the staff come check on her regularly and if she need help with changing her briefs or using the bathroom then staff will help her. Resident C stated that she has never had to wait hours for staff to come check on her. Resident C stated that staff are really good and take good care of all the residents.

Resident C stated that she has had no issues with her medication, and she does not believe that she has every had any missing medication. Resident C stated that staff come to her room every morning and give her medication. Resident C stated that the staff know what they are doing when they give her medication, and she has no concerns. Resident C stated that home is very clean, and her room is always pretty clean. Resident C stated that staff come in and out a lot and clean up while they are in there. Resident C stated that she gets three meals a day but that she is not always hungry so sometimes she does not eat breakfast. Resident C stated that staff will bring some food to her room if she is hungry.

Resident C stated that she doesn't know anything about any staff member with confidentiality issues and she has not heard anything about it. Resident C stated that the staff she deals with do a good job overall.

On 05/19/2025, I completed a phone interview with Residential Hospice Senior Clinical Director Michelle Bedford concerning the allegations. Director Bedford stated that they have several residents in care at Degas House. Director Bedford stated that nothing specific sticks out to her regarding anything that concerns her about care being given at Degas House. Director Bedford stated that nothing has happened there that would make them not want to do business with them. Director Bedford stated that it appears that the staff at Degas House provide appropriate care to the residents, and she has had no reports of their patients being neglected in any way. Director Bedford stated that they have no concerns regarding the residents' bed sores as that is common for people who are bedridden. Director Bedford stated that bed sores can actually get worse for residents who are at the end of life.

On 05/19/2025, I completed a phone interview with former staff (FS) Haley Taylor regarding the allegations. FS Taylor stated that she was familiar with the allegations and did believe that they were true. FS Taylor stated that she used to work at Degas House and that she had to clean up in the residents' rooms and there were cleaning supplies in rooms that were not put away. FS Taylor stated that there was expired medication in the medication cart. FS Taylor stated that the residents were served three meals a day but that there were really small portions and that the residents could not get snacks if they were hungry. FS Taylor stated that the refrigerator had expired food. FS Taylor stated that she no longer works at Degas House and is currently working another job helping people out and keeping them safe.

On 05/22/2025, Department of Health and Human Services Adult Protective Services Worker (APS) Melanie Gallego informed me of the results of her investigation. APS Gallego stated that she did not substantiate any complaints regarding Degas House.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(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.
ANALYSIS:	It is alleged that Residents are neglected, they sit in urine and feces for hours. Residents have wounds that are untreated. I interviewed Administrator Bowe Davey, Assistant Director Jessica Butler, Medical Technician Tracey Mitchell, Direct Care Worker Brianna Blue, Residential Hospice Senior Clinical Director Michelle Bedford, Former Staff Haley Taylor, APS worker Melanie Gallego, Resident A, Resident B and Resident C. The Degas Staff, residents and Hospice Clinical Director indicated that there was no rule violation. The former staff did state concerns that were investigated. During the onsite

	inspection the residents appeared to be receiving adequate care and supervision by staff that were working. Upon completion of my investigation, it was determined that there was no preponderance of evidence to conclude that a rule was violated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	It is alleged that medication cart is not locked. I interviewed Administrator Bowe Davey, Assistant Director Jessica Butler, Medical Technician Tracey Mitchell, Direct Care Worker Brianna Blue, Former Staff Haley Taylor, Resident A, Resident B and Resident C. The Administrator, Assistant Director, Medical Technician and Direct Care Worker denied that allegation and stated that the only way to get into the medication cart is for the Medical Technician to unlock it. Resident A, Resident B and Resident C stated that they were unsure if the medication cart was locked because they get their medication in their room but they have never had any issues with missing medication or getting the wrong medication. During my onsite investigation, the medication cart was locked and had to be unlocked by the medication technician in order to be viewed. Upon completion of my investigation, it was determined that there was no preponderance of evidence to conclude that a rule was violated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	It is alleged that medications are missing. I interviewed Administrator Bowe Davey, Assistant Director Jessica Butler, Medical Technician Tracey Mitchell, Direct Care Worker Brianna Blue, Former Staff Haley Taylor, Resident A, Resident B and Resident C. The Administrator, Assistant Director, Medical Technician and Direct Care Worker denied that allegation, they stated that they have had no issues with missing medication. The residents denied having any medication missing since they have been at the home. I reviewed five random resident medications and MARs and the medication appeared up to date with no discrepancies. Upon completion of my investigation, it was determined that there was no preponderance of evidence to conclude that a rule was violated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	It is alleged that Residents are not being fed. I interviewed Administrator Bowe Davey, Assistant Director Jessica Butler, Medical Technician Tracey Mitchell, Direct Care Worker Brianna Blue, Resident A, Resident B and Resident C. The Administrator, Assistant Director, Medical Technician and Direct Care Worker denied that allegation. The Assistant Director took me to the kitchen and showed me the refrigerator, freezer and pantry. There appeared to be adequate food for the residents. The menu appeared to contain nutritious meals for the residents. Resident A, B, and C stated that they are fed very well and if they want more food they can ask and staff will bring them a snack. I reviewed Resident A, B and C's weight records. Resident A has gained 2 lbs., Resident B has gained 6

	lbs., and Resident C has maintained the same weight for the previous 6 months. Upon completion of my investigation, it was determined that there was no preponderance of evidence to conclude that a rule was violated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	It is alleged that cleaning is not done daily; cleaning chemicals are in reach of resident's rooms. I interviewed Administrator Bowe Davey, Assistant Director Jessica Butler, Medical Technician Tracey Mitchell, Direct Care Worker Brianna Blue, Former Staff Haley Taylor, Resident A, Resident B and Resident C. The Administrator, Assistant Director, Medical Technician and Direct Care Worker denied that allegation and stated that the home is cleaned daily and deep cleaned once a week. On 4/29/2024, I completed an unannounced onsite investigation. The home appeared to be neat and clean and there was not noticeable trash anywhere in the home. The resident rooms were clean and I did not observe any cleaning chemicals or supplies in the resident rooms. The residents indicated that the rooms are cleaned daily and deep cleaned once a week. Upon completion of my investigation, it was determined that there was no preponderance of evidence to conclude that a rule was violated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.

ANALYSIS:	It is alleged that Staff broke resident confidentiality rules. I interviewed Administrator Bowe Davey, Assistant Director Jessica Butler, Medical Technician Tracey Mitchell, Direct Care Worker Brianna Blue, Residential Hospice Senior Clinical Director Michelle Bedford, Former Staff Haley Taylor, APS worker Melanie Gallego, Resident A, Resident B and Resident C. Administrator Davey and Assistant Director Butler stated that they were informed that former Staff Taylor was having inappropriate conversations concerning residents care on the floor. Administrator Davey and Assistant Director Butler stated that they completed an internal investigation of the incident and concluded that former Staff Talor violated resident confidentiality rules and terminated her employment on 04/14/2025. Upon completion of my investigation, it was determined that there was a preponderance of evidence to conclude that a rule was violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/23/2025, I completed an exit conference with Licensee Designee (LD) Katie Edwards. I informed LD Edwards of the results of my investigation.

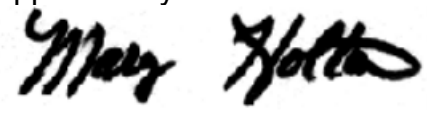
IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in licensure status.

06/02/2025

Martin Gonzales Licensing Consultant	Date

Approved By:



06/03/2025

Mary E Holton Area Manager	Date