GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 4, 2025

Elonda Grubbe
Macomb Residential Opportunities Inc.
Suite #102
14 Belleview
Mt Clemens, MI 48043

RE: License #: AS500396954
Investigation #: 2025A0990008
Parkway

Dear Ms. Grubbe:

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.

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 (248) 975-5053.

Sincerely,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500396954
Investigation #:	2025A0990008
Complaint Receipt Date:	01/23/2025
Investigation Initiation Date:	01/23/2025
Report Due Date:	03/24/2025
Licensee Name:	Macomb Residential Opportunities Inc.
Licensee Address:	Suite #102 - 14 Belleview Mt. Clemens, MI 48043
Licensee Telephone #:	(586) 469-4480
Administrator:	Elonda Grubbe
Licensee Designee:	Elonda Grubbe
Name of Facility:	Parkway
Facility Address:	21614 S. Nunnelly Clinton Township, MI 48035
Facility Telephone #:	(586) 948-8271
Original Issuance Date:	05/14/2019
License Status:	REGULAR
Effective Date:	11/14/2023
Expiration Date:	11/13/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A suffered bites, marks on his arms, bruising and laceration on his arms, right wrist was broken, and he had scrapes on his knees.	Yes
Resident A was left alone at the hospital to advocate for himself.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/23/2025	Special Investigation Intake 2025A0990008
01/23/2025	Special Investigation Initiated - Telephone I received a phone call and email from Relative A1. Relative A1 contacted the licensing unit on 01/22/2025. I was informed that Jose Garcia is the Adult Protective Services (APS) investigator.
01/23/2025	APS Referral Adult Protective Services (APS) investigation assigned at intake.
01/23/2025	Contact - Document Sent I emailed Jose Garcia, APS Investigator. Mr. Garcia forwarded my email to the assigned APS Investigator Nuha Shamoon.
01/23/2025	Contact - Document Received I received an email from Ms. Shamoon.
01/23/2025	Contact- Document Sent I emailed Relative A1.
01/24/2025	Contact - Face to Face I conducted an unannounced onsite investigation. I interviewed home manager Pricella Pruit, Resident B and Resident C.
01/24/2025	Contact - Document Sent I requested resident records and employee information from licensee designee Ted DeVantier.

01/26/2025	Contact - Document Received I received an email from Relative A1.
02/26/2025	Contact – Document Received I received an email from Relative A1.
02/28/2025	Contact - Document Received I reviewed Resident A's resident record., staff schedule and Elonca Heard’s trainings.
03/05/2025	Contact - Telephone call made I conducted a phone interview with Elanca Heard.
03/05/2025	Contact - Telephone call made I conducted a follow-up interview with Relative A1. Relative A1 sent photos of Resident A’s injuries.
03/05/2025	Contact - Face to Face I conducted an unannounced follow-up onsite. I briefly interviewed Ms. Pruitt. Ms. Pruitt said that Resident A discharged from the home.
03/05/2025	Contact - Telephone call made I conducted a phone interview with Ashley Latrana, Behavior Therapist.
03/05/2025	Contact - Telephone call made I conducted a phone interview with Leslie Sebastian, Supports Coordinator.
03/05/2025	Contact - Document Received I received documents from Relative A1.
03/06/2025	Contact - Document Sent I emailed Ms. Grubbe. I requested Resident A's staff IPOS in-service training verification.
03/06/2025	Contact - Document Sent I emailed Amber Sultes, Office of Recipient Rights Specialist. Ms. Sultes replied and informed me that Susan Feld is the assigned investigator.
03/06/2025	Contact- Document Received I received photos of Resident A’s injuries from Relative A1.

03/07/2025	Contact - Document Sent I emailed Susan Feld, ORR Investigator.
03/07/2025	Contact - Document Sent I forwarded an email to Mr. DeVantier.
03/07/2025	Contact- Document Sent I emailed Ms. Shamoon. Ms. Shamoon said that the APS investigations was unsubstantiated.
03/11/2025	Contact- Document Received I received an updated IPOS and police report for Resident A from Kathleen Makara Area Supervisor.
03/12/2025	Contact- Document Received Relative A1 sent a voice recording of the 911 call.
03/12/2025	Contact – Telephone call made I called Clinton Township Police Department. I was informed that there was no detective assigned.
03/13/2025	Contact – Document Sent I contacted Ms. Grubbe to reschedule and exit conference. Ms. Grubbe provided a disconnected phone number.
03/14/2025	Contact- Telephone call made I called Relative A. The phone number is disconnected.
03/20/2025	Exit conference I conducted an exit conference with Ms. Grubbe.

ALLEGATION:

- **Resident A suffered bites, marks on his arms, bruising and laceration on his arms, right wrist was broken, and he had scrapes on his knees.**
- **Resident A was left alone at the hospital to advocate for himself.**

INVESTIGATION:

On 01/23/2025, I received the complaint via email. Resident A had an outburst. The outburst went on for 45 minutes. Resident A was taken to the hospital via EMS. He went to the hospital alone. Resident A cannot communicate with the hospital about what has happened to him. The family was notified after Resident A left the group home.

On 01/23/2025, I received an email from Ms. Shamoon, APS worker. Ms. Shamoon said her allegations are as follows: Resident A became upset and attacked staff. The staff couldn't get him under control, so they called Law Enforcement (LE). Resident A was taken to McLaren Hospital for an evaluation before returning to the group home. Resident A's relative took photos of him, showing extensive marks on his arm. The marks were oddly shaped, such as five rectangles up and down his arm from wrist to bicep. The Home Manager (Pricilla Pruitt) was not present during the incident; however, she had been there earlier in the day, and she reported that Resident A didn't have the marks on his arm then. The marks are suspicious. The marks are not shaped as if he had cut himself on something.

On 01/23/2025, I received an emailed from Relative A1. Relative A1 stated Resident A has lived in the home for 11 months. Relative A1 confirmed that the incident occurred on 01/15/2025. Relative A1 said she was contacted by "Ms. T" (Elanca Heard) on her cell phone at 8:43 PM about the incident. Resident A was taken to McLaren Hospital and stayed overnight. Two other residents were involved in the incident - Resident B and Resident C. Relative A1 said that Resident A has a behavior plan, and his Behavior Therapist is Ashley Labrana. Resident A's Support/Case Coordinator is Leslie Sebastian. Relative A1 said an incident report was not received, although it was requested five times. Relative A1 provided a copy of Resident A's hospital discharge summary.

On 01/24/2025, I conducted an unannounced onsite investigation. I interviewed Pricilla Pruit, the home manager. Ms. Pruit said that Resident A is away with his family. Ms. Pruit was not present when the incident occurred. Elanca Heard, the direct care staff member, was present. Ms. Pruit said that on 01/15/2025, she received a phone call from Ms. Heard informing her that Resident A refused to take his medications and pushed her. Ms. Heard told her that Resident A pulled Resident B's hair and hit Resident C. Resident A pulled out so much of Resident B's hair that it was all over the floor. Ms. Pruit said that Ms. Heard informed her that the police were called, and Resident A was taken to the hospital. Ms. Pruit said that the staff did not go with Resident A to the hospital, but the staff went to check on him the following day.

Ms. Pruit said that Resident A had one other aggressive episode in December 2024 in which he hit direct care staff Latisse Heard. Ms. Pruit said that, according to Ms. Heard, she called Relative A to inform of the incident that evening. Ms. Pruit said she does not know how Resident A received a bite mark. Resident A picks his skin when he is under stress. Ms. Pruit said that she did not know how Resident A received lacerations and bruises. Ms. Pruit said Resident A wears gloves daily because he scratches himself. The family made this request. Resident A does have a fractured wrist and is wearing a cast. Resident A is nonverbal and usually says one-word responses such as "Mom" or "Dad." Ms. Pruit said that Ms. Heard told her that before the incident, Resident A kept saying, "Mom."

On 01/24/2025, I attempted to interview Resident B. An interview could not be conducted due to several intellectual disabilities. Resident B kept saying "coffee". I did not observe any marks or bruises on Resident B.

On 01/24/2025, I attempted to interview Resident C. Resident C could only say three-word sentences. Resident C said Resident A "hit." Due to Resident C's limited cognitive abilities, no further information was received. I did not observe any marks or bruises on Resident C.

On 02/26/2025, I received an email from Relative A1. Relative A1 said that she also has a recording of the 911 call made by Ms. Heard and body camera footage from the officer. Resident A is still with family and is doing well. Relative A1 said it was concerning that no one in the home, including the staff, had visible abrasions. However, Resident A was full of bruises, cuts, scrapes, and what appeared to be bite marks on his person and a broken wrist. Relative A1 said that there was no way that Resident A could have given himself these cuts, bite marks, bruises, etc.

On 02/28/2025, I reviewed Resident A's resident record, staff schedule, and Elanca Heard's training. Ms. Heard is trained in Crisis Prevention and Behavior Techniques.

I reviewed the incident report for 01/15/2025 written by Ms. Heard, which indicates that Resident A attacked her after refusing medications. In a review of Resident A's Individual Plan of Service (IPOS), Resident A was admitted to the home after receiving a 30-day discharge notice from a different licensed adult foster home due to aggressive behaviors. Resident A's admission date to the house was 02/01/2024. Resident A is ambulatory and is diagnosed with autism, cerebral palsy, obsessive-compulsive disorder, attention deficit disorder, moderate intellectual disabilities, epilepsy, excoriation (skin picking), panic disorder, and unspecified personality disorder with changes in mental state. Resident A cannot be left alone at any time. When Resident A becomes agitated or starts repeating words, that is a sign that he is overwhelmed and needs to leave his environment. Staff are to pay attention as this is one of his triggers to become violent. Resident A has a history of verbal aggression, physical aggression, and property destruction. Resident A has difficulty with sharing and taking turns. Resident A does not like loud noises, yelling, or crowds. When Resident A is aggressive, the staff are to do the following: move vulnerable people and dangerous objects, approach calmly, speak in a low, quiet voice, do not argue or command, disagree or say no, never scold, do not turn back on him, block attempts at hitting or throwing objects, (never grab or strike him), remove objects from the environment that may be easily thrown or broken. The home provides 24/7 staffing, and staff should not leave until the next shift arrives. If the following staff member does not arrive, the staff member must call the manager. If staff know they will be late or unable to make their shift, they must contact the manager to cover the change. If the manager cannot make their shift, they must find coverage.

I observed the staff schedule for 01/15/2025 as follows: Pricilla Pruit is scheduled to work 8 AM to 3 PM; Elanca Heard will work 7 AM to 3 PM and 6 PM to 10 PM; and Latisse Heard will work 3 PM to 10 PM.

Resident A is assigned a Behaviorist to help decrease aggression. I received the body scan report, which documented the following: a large bruise on the upper front left arm, a light bruise on the front lower left (circular-red), and a right fractured wrist. I reviewed Resident A's hospital discharge summary from McLaren Hospital dated 01/15/2025. The final diagnosis was distal radius fracture, right-side, and aggressive behavior.

On 03/05/2025, I conducted a phone interview with Elanca Heard. Ms. Heard said that she is currently on medical leave. Ms. Heard said on the day of the incident, Resident A was trying to touch the other residents. Ms. Heard said that she was preparing to do medications after dinner. She noticed Resident A staring intensely at her and picking his skin. Ms. Heard said that Resident A began growling. Ms. Heard said she was about to pass meds to Resident B and Resident C but decided to give Resident A's meds first because she could see him agitated and began repeating "bed."

Resident A then came close to her and lunged at her. Ms. Heard said that she immediately closed the medication cart and was about to move Resident B and Resident C to their bedrooms away from Resident A. Ms. Heard said that Resident A followed her and was trying to swing at her. She redirected him to go to his bedroom. Resident A then went over to Resident C and began punching him. Ms. Heard said that she jumped in between Resident A and Resident C as Resident A then began punching her. Ms. Heard said that she and Resident C fell onto the floor. Ms. Heard said Resident A then moved over to Resident B and aggressively pulled her hair. Ms. Heard said that she was getting up from the floor, and Resident A threw the home telephone at her, hitting her. Ms. Heard said that the telephone broke. Ms. Heard said she crawled on the floor to retrieve her cell phone. Ms. Heard said that as she was crawling towards the hallways, Resident A kicked her in the back of her head and proceeded to punch Resident C. Ms. Heard said that Resident A then grabbed the stapler that was on the desk and hit her with it on the back of her head. Ms. Heard said that at this point, Resident A was beating her badly as she was still on the floor. Ms. Heard finally got away and called 911 from her cell phone. Ms. Heard said that the entire incident went on for about 25 minutes. Ms. Heard said that she was working alone, but another person was on shift (Latisse Heard), her daughter. Latisse Heard had to leave her shift because her baby was ill. Ms. Heard said that when the police arrived, Resident A refused to cooperate and had to be removed from the home. Ms. Heard said that Resident A became aggressive with the police. Ms. Heard said that after Resident A was removed from the house, she contacted Ms. Pruit and Relative A to report the incident. Ms. Heard said that it took 25 minutes to call the police because Resident A broke the home phone, and she could not get to her cell phone because she was on the floor, shielding herself from Resident A's blows. Ms. Heard said that Resident A has a history of aggressive behavior. Resident A attacked the former home manager (Alethea) in the first incident. Ms. Heard said that she has observed at least six aggressive

episodes. Ms. Heard said she was never in-serviced or trained regarding Resident A's IPOS/Crisis & Safeguard Plan.

On 03/05/2025, I conducted a follow-up interview with Relative A1. Relative A1 said that Resident A did not return to the home after the incident and is living with family. Relative A1 said that they decided to discharge him because a lot was going on with the home. Relative A1 said Amber Sultes from the Office of Recipient Rights (ORR) is investigating allegations that occurred after the 01/15/2025 incident. Relative A1 emailed the allegations. The allegations are regarding an incident involving staff and a visitor.

On 03/05/2025, I conducted a phone interview with Ashley Labrana, a Behaviorist. Ms. Labrana said that she met with Resident A once a month and trained the home manager on Resident A's behavior treatment plan.

On 03/05/2025, I conducted a phone interview with Leslie Sebastian, Supports Coordinator. Ms. Sebastian is aware of the incident that occurred with Resident A and said that she is aware that APS and ORR are involved as well. Ms. Sebastian said that Ms. Labrana trained the home manager on Resident A's IPOS, which includes his behavior treatment plan. Ms. Sebastian said a new placement is being sought for Resident A.

On 03/06/2025. I received photos of Resident A's injuries from Relative A1. There were 13 photos of Resident A's injuries. I observed that Resident A's arms had multiple oddly shaped bruises, lacerations, and scratches. I observed that both knees had scrapes, as did the lower legs. I observed a bite mark on Resident A upper outer arm above the elbow. I observed that many of the bruises looked like long rectangles.

On 03/11/2025, I received an updated IPOS for Resident A and a police report from Kathleen Makara, Area Supervisor. Ms. Makara sent the in-service training for Resident A's IPOS, and Ms. Heard was not in attendance. The IPOS instructions read: The IPOS serves as a training record to evidence aid-level staff's ability to implement the IPOS and must be retained in the Resident's file. The staff are to be trained on the IPOS or amended IPOS. The staff documented as trained on the form as Certified Trained Staff.

I observed that Leslie Sebatian, the support coordinator, trained Ms. Pruitt, the home manager. No staff names were signed on the IPOS training log in section two. Ms. Pruit was trained on 10/21/2024. The IPOS documents require that staff use gentle redirection. Non-routine transitions trigger Resident A. In a review of the police report, the officer documented hearing commotion entering the home. The officer observed an adult male crawling on the floor (Resident A) and a female pacing back and forth (Ms. Heard). Ms. Heard told the officer that she was trying to give Resident A medications, and he attacked her. Ms. Heard said she used a wooden broom handle as a brace to keep him away from her. Ms. Heard said it's not the first time Resident A has shown aggression. The officer could not interview Resident A due to "a severe speech impediment." Resident A was transported to the hospital.

On 03/12/2025, Relative A1 sent a voice recording of the 911 call. Ms. Heard could be heard repeatedly yelling, "Stop Resident A" and asking for a police car. You can hear pounding sounds. Ms. Heard said, "Resident A is attacking everybody." Ms. Heard could be heard yelling, "Stop". Ms. Heard repeatedly told Resident A to sit down. The operator told her to stop engaging Resident A. Ms. Heard said, "I'm not going to let him beat me down." The operator told her to separate from Resident A. Ms. Heard responded, "I'm trying to." You can hear hitting sounds as Ms. Heard is telling Resident A to stop. Ms. Heard told the operator that Resident A was pulling a resident's hair. Ms. Heard said that she was hurt.

On 03/14/2025, I received an email from Relative A1. Relative A1 said she had the officer's body cam footage and agreed to send it. In reviewing the video, Relative A1 said Resident A was on his knees heading into his bedroom while police arrived. Relative A1 said that Resident A is never on his knees. Relative A1 said that Resident A had multiple abrasions and a bite mark that he could not do to himself.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment.**

ANALYSIS:	Based on the investigation, sufficient evidence supports that Ms. Heard used a form of punishment towards Resident A on 01/15/2005 during an aggressive episode. Ms. Heard said that Resident A attacked her, Resident B and Resident C. Ms. Heard said that Resident A threw the home phone and a stapler at her. According to the police report, Ms. Heard informed the responding officers that she used a wooden broom handle to keep him away from her by using it as a brace. Resident A had multiple bruises, lacerations, scrapes, and a bite mark on his arms and legs. I observed that the bite mark was on the area of Resident A's arm that could not have been self-inflicted. Resident A also was diagnosed with a fractured right wrist. Additionally, when the police officers arrived on the scene, Resident A was observed crawling on the floor according to the police report. Relative A1 said that she observed the officers body camera footage and observed Resident A on the floor crawling in which, he never does. At the same time, Ms. Heard paced back and forth. Lastly, in a voice recording of the 911 call, Ms. Heard could be heard yelling, and there were thumping sounds as she yelled at Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.

ANALYSIS:	Based on the investigation, there is evidence to support that Ms. Heard did not implement Resident A's IPOS and Crisis Safeguard. Resident A's IPOS reads that when Resident A becomes agitated or starts repeating words, that is a sign that he is overwhelmed and needs to leave the environment he is in. Staff are to pay attention as this is one of his triggers to become violent. Ms. Heard said Resident A began repeating "bed," staring deeply at her and growling on the day of the incident. Ms. Heard did not follow Resident A's IPOS by removing him from the environment. When Resident A is aggressive, the staff are to move vulnerable people and remove dangerous objects. Ms. Heard did not do this, and as a result, Resident B and Resident C were attacked by Resident A. Furthermore, Ms. Heard did not remove objects from the area, and as a result, Resident A hit her with the home telephone and a stapler. Lastly, Ms. Heard could be heard yelling at Resident A during the 911 recording, "Stop Resident A," as well as telling him to sit down. According to Resident A's IPOS, when Resident A is aggressive, staff are to approach him calmly, speaking in a low, quiet voice, and not arguing/scolding him. There is sufficient evidence that Ms. Heard did not follow the IPOS.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14305	**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:	Based on the investigation, sufficient evidence supports that Resident A was attended to at all times. On 01/15/2025, Resident A had an aggressive episode and was transported to McLaren Hospital for treatment. Ms. Heard said Resident A went to the hospital alone as she was the only person working

	on shift. The home manager, Ms. Pruit, said that no staff did not go with Resident A to the hospital, but staff went the following day to check on him. According to Resident A's IPOS, Resident A cannot be left alone at any time.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(3) A licensee and direct care staff who are responsible for implementing the resident's written assessment plan shall be trained in the applicable behavior intervention techniques.
ANALYSIS:	Based on the investigation, there is evidence to support that Ms. Heard and other direct care staff were not trained on Resident A's IPOS. Ms. Heard said that she was not in-serviced for Resident A's IPOS. Further, in the review of Resident A's IPOS training log, no staff were trained except for the home manager, Pricilla Pruit. Ms. Labrana, the Behaviorist, and Ms. Sebastian, the support coordinator. Ms. Latrana and Ms. Sebastian confirmed that they trained only the home managers. The staff are to be trained on the IPOS or amended IPOS.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 02/28/2025, I reviewed Resident A's IPOS and staff schedules. The home provides 24/7 staffing, and staff should not leave until the next shift arrives. If the following staff member does not arrive, the staff member must call the manager. If staff know they will be late or not able to make their shift, they must contact the manager to cover the change. If the manager cannot make their shift, they must find coverage.

I observed the staff schedule for 01/15/2025 as follows: Pricilla Pruit is scheduled to work 8 AM to 3 PM, Elanca Heard will work 7 AM to 3 PM and 6 PM to 10 PM, and Latisse Heard will work 3 PM to 10 PM.

On 03/05/2025, Ms. Heard said that she was working alone, but there was another person on shift (Latisse Heard). Latisse Heard had to leave her shift because her baby was ill. Ms. Heard said that she was on shift alone about 30 minutes before the incident occurred. Ms. Head said that she did not report to the home manager that she was

working the shift alone. Ms. Heard said that she did not report this because she had worked alone before.

On 03/20/2025, I conducted an exit conference with Ms. Grubbe. Ms. Grubbe said Latisse Heard did not follow policy when leaving her shift. Latisse Heard was terminated on 01/25/2025. Elanca Heard is on medical leave because of the altercation, although she initially refused medical treatment. Ms. Grubbe said that Ms. Heard's description of the events differed from the police report. Ms. Grubbe said the behaviorist trained the staff on Resident A's IPOS. Ms. Grubbe was informed that Ms. Labrana, the Behaviorist, only taught the home manager, and there are no staff signatures on the IPOS training log. Ms. Grubbe said that pending the outcome of the licensing, ORR, and APS investigations, Ms. Heard's disciplinary actions will be decided. Ms. Grubb said Ms. Heard would not return to the Parkway home. Ms. Grubbe said that Ms. Heard has not worked since the incident. Ms. Grubbe was informed of the findings and agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(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.
ANALYSIS:	Based on the investigation, there is sufficient evidence to support that there was insufficient staffing on 01/15/2025. Elanca Heard was working the shift alone when she was to be on shift with Latisse Heard. Latisse Heard left the shift early. According to Resident A’s IPOS, there are clear directions on staff persons being present for their shift because of his severe mental health diagnosis.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

03/21/2025

LaShonda Reed — Date
Licensing Consultant

Approved By:

For 06/05/2025

Denise Y. Nunn — Date
Area Manager