GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 7, 2025

Anna Masambaji
PO Box 26243
Lansing, MI 48909

RE: License #: AS230306306
Investigation #: 2025A0577040
Sunshine AFC Home II

Dear Mrs Masambaji:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, 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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS230306306
Investigation #:	2025A0577040
Complaint Receipt Date:	05/21/2025
Investigation Initiation Date:	05/22/2025
Report Due Date:	07/20/2025
Licensee Name:	Anna Masambaji
Licensee Address:	2109 Walmar Estate Drive Lansing, MI 48917
Licensee Telephone #:	(517) 980-1925
Licensee Designee:	Anna Masambaji
Administrator:	Anna Masambaji
Name of Facility:	Sunshine AFC Home II
Facility Address:	4106 Bridgeport Lansing, MI 48911
Facility Telephone #:	(517) 980-1925
Original Issuance Date:	07/28/2010
License Status:	REGULAR
Effective Date:	03/20/2025
Expiration Date:	03/19/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is not receiving assistance with personal care from direct care staff.	Yes
Residents are told they cannot use the phone or call their guardians as needed.	No
DCS Celina Saunders is yelling and swearing at the residents.	Yes
Resident B administered Resident C's medications on May 18, 2025, while out of the facility.	Yes
Resident A, Resident B, and Resident C are not being provided with breakfast prior to attending church.	Yes
Residents' clothes are not being routinely laundered, causing residents to have to wear dirty clothing.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/21/2025	Special Investigation Intake 2025A0577040
05/22/2025	Special Investigation Initiated – Letter- Email to Complainant.
05/23/2025	Contact - Document Sent to Concerned Citizen 1.
05/27/2025	Contact - Document Sent- Via Email with Concerned Citizen 1 and Complainant.
06/10/2025	Contact - Face to Face- Interviews with Resident A, Resident B, Resident C, Guardian A1 and Guardian B1.
06/13/2025	APS Referral
06/13/2025	Referral - Recipient Rights
06/16/2025	Contact - Document Received- Ashlee Biley, ORR-CEI, copy of PCP.
06/17/2025	Inspection Completed On-site- Review of Resident files and interview with DCS.

06/17/2025	Contact - Telephone call made- Attempted interview with Concerned Citizen 3.
06/23/2025	Contact-Telephone call made- Interview with Guardian D and Guardian E.
06/23/2025	Exit Conference with licensee designee Anna Masambaji.

ALLEGATION: Resident A is not receiving assistance with personal care from direct care staff.

INVESTIGATION:

On May 21, 2025, a complaint was received alleging that Resident A smelled of urine, body odor, and unbrushed teeth causing bad breath when Resident A attended church on May 18, 2025. There is additional concern direct care staff are not helping Resident A with her personal hygiene.

On May 22, 2025, I interviewed Complainant who reported there has been a decrease in the quality care for residents over the past few months but specifically since direct care staff (DCS) Celina Saunders transferred to work in this facility in February 2025. Complainant reported Resident A, Resident B, and Resident C often arrive to church with their hair not combed or styled, with their clothing smelling and appearing dirty, and having bad breath. Complainant reported this is happening more often with Resident A than Resident B and Resident C due to Resident A requiring more hands-on direct care staff assistance with personal care needs. Complainant reported on May 18, 2025, Resident A, Resident B, and Resident C arrived at church upset, reporting DCS Saunders would not get out of bed to assist residents with getting ready for church. Resident A reported she often asks DCS Saunders for assistance with brushing Resident A's hair and DCS Saunders tells Resident A "no, I will not help you."

On June 10, 2025, I interviewed Resident A, Resident B, and Resident C who reported DCS Celina Saunders is mean to residents, especially Resident A. Resident B reported Resident A requires more hands-on assistance and DCS Saunders refuses to assist Resident A when Resident A needs help. Resident B reported DCS Saunders will yell at Resident A, “go find someone to help you, that is not my job.” Resident A reported Resident B assists Resident A with getting dressed or picking out her clothes, sometimes by taking a shower, doing her hair, and reminds her to brush her teeth. Resident C reported Resident B does most of the care and watches over four other residents currently admitted to the facility. Resident C reported that when she needs help with something, she asks Resident B to help her because she does not want to be yelled at by DCS Saunders.

On June 10, 2025, I interviewed Guardian A1and Guardian C1, dual guardians of Resident A and Resident C, who both reported Resident A requires more hands-on assistance especially as she is getting older whereas Resident C requires more verbal reminders and verbal queuing with personal care. Guardian A1 and Guardian C1 reported Resident A and Resident C reported DCS Celina Saunders will tell residents “no” when they ask for help from DCS Saunders. Guardian A1 and Guardian C1 reported that neither has witnessed these concerns but both have witnessed resident’s personal care needs not being attended to regularly as evidenced by their hair not being brushed and clothes being wrinkly and dirty with food on them. Guardian A1 and Guardian C1 reported Resident A does not like being reminded to brush her teeth and does get upset when this happens, but this does not mean direct care staff should not continue to let Resident A go without brushing her teeth.

On June 10, 2025, I interviewed Guardian B1 who reported she has recently moved Resident B to another facility due to the decline in the quality of care DCS Celina Saunders provides. Guardian B1 reported DCS Celina Saunders does not want to assist residents with personal care and will have the resident ask Resident B to assist the resident causing Resident B to become upset. Guardian B1 reported Resident B is very independent and does not require any hands-on care with personal care, but Guardian B1 reported she does know that Resident B will assist Resident A with picking out clothes or doing Resident A’s hair. Guardian B1 reported she observed Resident A, Resident B, and Resident C coming to church on May 18, 2025, smelling of body odor and the residents’ clothing was dirty with old food. Guardian B1 reported Resident A and Resident C’s hair had not been brushed in a while and was matted in multiple sections. Guardian B1 reported she asked the residents what happened, and they said, “the laundry had not been done, and their extra clothes were in the garage where they could not get to them.”

On June 16, 2025, I interviewed Concerned Citizen 2, who reported Resident A, more so than Resident C, often arrives to church smelling of urine and body odor, with unbrushed hair, and unbrushed teeth. Concerned Citizen 2 reported Resident B recently moved out and Resident A asked Concerned Citizen 2 “who is going to take care of me now?” Concerned Citizen 2 reported since DCS Celina Saunders has taken over, there

has been a significant decline in physical and emotional care of each resident, stating, “the ladies just do not come to church put together like they used to.”

On June 17, 2025, I left a message for Concerned Citizen 3 with no return call.

On June 16, 2025, Ashlee Bailey, Office of Recipient Rights with Clinton, Eaton, and Ingham County Community Mental Health provided me with a copy of Resident A’s Treatment Plan and commented Goal 3, page 3, “this is an ongoing issue with [Resident A] accusing staff of being mean or rude to her, her personal care is also listed as a goal, not to prompt her.” Per Resident A’s Treatment Plan, the following is documented:

- “[Resident A] likes to be well-groomed and put together. [Resident A] benefits from daily personal care assistance through the home. [Resident A] sometimes needs encouragement and remainders to complete her personal care tasks such as applying lotion and brushing her teeth. [Resident A] can get upset or angry with staff when she is reminded of these things because she feels that they are “being mean” or “bossing” her around. Staff will provide verbal reminders and physical assistance when necessary.”

Ms. Bailey also reported Resident A’s most recent case manager note speaks of these issues. Per progress note from Ashlee Bailey, written by case manager on May 23, 2025, the note documents:

- “Met with [Resident A] at her home, Sunshine II AFC. Asked [Resident A] how she has been doing, she said, “pretty good!” Asked her how work has been going, she said, “pretty good. There’s a new person at work. She’s nice.” CM asked [Resident A] if she has been showering and brushing her teeth daily, [Resident A] appeared defensive and said, “yes I have.” AFC staff, Celina, reports that [Resident A] has not been showering or brushing her teeth, “as often as she should be.” Celina reports that [Resident A] is “being mean” whenever Celina tries to remind or verbally prompt [Resident A] to take a shower. Celina said that [Resident A] will get upset and accuse Celina of “bossing” her around. CM informed Celina that this is historical behavior for [Resident A] as she has done this to various staff over the years. CM suggested Celina approach it in a different way such as reminding [Resident A] that before she leaves for work, she needs to have showered and brushed her teeth. This way [Resident A] won’t interpret the suggestion as a demand. Celina did not respond. CM reminded [Resident A] that it’s important that she showers at least 3x a week in order to be clean and healthy. [Resident A] said, “yeah, yeah. I’ll try.” No other questions/concerns at this time.”

On June 17, 2025, I completed an unannounced onsite investigation and observed Resident A, Resident C, and Resident D who were all in their pajamas. DCS Saunders reported she is awake every morning to assist the residents and denied refusing to assist when a resident asks for help with personal care or any other need. I reviewed and received copies of *the Assessment Plan for AFC Residents* for Resident A, Resident C, Resident D, and Resident E which documented the following:

- For Resident A under the section titled: "*Self Care Skill Assessment"*, the section was marked "yes: Bathing-needs to be told when to shower; Grooming-needs hairbrush and to be told to brush teeth; Personal Hygiene-needs to be told."
- For Resident B under the section titled: "*Self Care Skill Assess*ment, no: [Resident B] does not regularly need any assistance with her personal care."
- For Resident C under the section titled: "Self Care Skill Assessment, no: [Resident C] does not regularly need any assistance with her personal care."
- For Resident D under the section titled: "Self Care Skill Assessment, yes: Toileting, Bathing, Grooming, Dressing, and Personal Hygiene all require hands on assistance from direct care staff."
- For Resident E under section titled: "Self Care Skill Assessment, yes: Toileting, Bathing, Grooming, Dressing, and Personal Hygiene all require hands on assistance from direct care staff."

During the onsite investigation Resident E was not available to be interviewed. Resident D reported DCS Celina Saunders helps her sometimes with getting dressed, showering, or toileting.

On June 17, 2025, I interviewed DCS Celina Saunders who reported she is not aware of the residents smelling of body odor and hair not being brushed. DCS Saunders reported Resident A often refuses to take a shower when reminded. DCS Saunders reported she is not aware of Resident A, Resident B and Resident C attending church and smelling of body odor with their hair not brushed. DCS Saunders reported she does assist Resident A with styling her hair because Resident A cannot do this on her own. DCS Saunders reported if the residents are wearing dirty clothing this is because they were not brought to DCS Saunders to be laundered on Sundays when laundry is done. DCS Saunders reported she reminds all of the residents in the morning and evening to brush their teeth.

On June 23, 2025, I interviewed Guardian D1 who reported hygiene has always been a concern of hers at the facility and she is at the facility at least every two weeks visiting Resident D. Guardian D1 reported that when picking up Resident D for the day, she often wears dirty clothes, and her teeth are not brushed. Guardian A1 stated she has addressed these concerns many times with DCS Celina Saunders with no improvement in Resident D's personal hygiene. Guardian D1 stated that on June 21, 2025, Resident D's hair was so matted and snarled it could not be brushed. Due to the condition of Resident D's hair, Guardian D1 stated she had Resident D's hair cut off.

On June 23, 2025, Guardian E1 reported seeing Resident E quarterly and has not had any concerns regarding Resident E's care. Guardian E1 reported Resident E's clothes

have been cleaned, her person has been clean, and her teeth appeared to be brushed when she saw Resident E.

On June 23, 2025, I completed an exit conference with Anna Masambaji, Licensee Designee who reported Resident A has a history of refusing to take a shower when prompted and refused to allow any assistance from DCS Saunders when attempted. Ms. Masambaji reported she was not made aware of these concerns by any guardians or case managers and does not believe these allegations to be true. Ms. Masambaji reported DCS Saunders cares about the residents' appearance when they go out in public and Ms. Masambaji has not witnessed the residents' smell of body odor, clothes dirty, teeth not brushed, or hair not brushed or styled. Ms. Masambaji stated, "Celina needs to be provided some grace, because the residents in the home are not always cooperative with care." Ms. Masambaji reported she was not aware of Resident D needing a hair cut due to her matting of her hair from lack of care.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based on the information gathered during the investigation, I determined that Resident A, Resident C, and Resident D were not provided personal care as specified in each residents' *Assessment Plan for AFC Residents.* Per the assessment plans, Resident A requires verbal direction to complete most personal care tasks and Resident D requires hands-on assistance with all parts of personal care. Resident B reported frequently assisting Resident A and Resident C with personal hygiene tasks because DCS Celina Saunders refused to assist stating, "go find someone to help you, it's not my job" to Resident A. Resident A and Resident C both confirmed that Resident B assisted with personal care tasks when DCS Celina Saunders would not. Citizen 2 reported observing Resident A and Resident C smelling of urine and body odor on multiple occasions while at church. Per the *Assessment Plan for AFC Residents* which documents Resident A and Resident D require hands on assistance from direct care staff with brushing their hair. On 06/21/2025, Resident D's hair was so matted it had to be cut to remove the mats. DCS Celina Saunders and Licensee Designee, Anna Masambaji denied the allegations of residents not being provided care according to the *Assessment Plan for AFC.* However based on resident and guardian interviews, I determined residents were not being provided with personal care per their assessment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are told they cannot use the phone or call their guardians as needed.

INVESTIGATION:

The complaint received on May 21, 2025, alleged that Celina Saunders denied allowing residents to use the facility phone.

On May 22, 2025, I interviewed Complainant who reported Resident A, Resident B, and Resident C stated DCS Celina Saunders does not always allow residents to use the phone when they ask, nor do they always have access to the facility phone because it gets locked in the medication cart.

On June 10, 2025, I interviewed Resident A, Resident B, and Resident C who reported the facility phone gets locked up at night, so residents do not have access to the phone during that time only. Resident A, Resident B, and Resident C reported DCS Saunders often tells residents they cannot use the phone or DCS Saunders will ask who they want to call to determine if the resident can use the phone. Resident A and Resident B reported that DCS Saunders always tells Resident A and Resident C they do not need to talk with their guardian and will not allow Resident A and Resident C to call their guardians. Resident B reported she has witnessed DCS Saunders telling residents they cannot use the phone. Resident C reported she was trying to call her guardian when DCS Saunders grabbed the phone out of Resident C's hand to prevent Resident C from calling her guardian. Resident A and Resident B reported they witnessed DCS Saunders taking the phone from Resident C. Resident B reported she has a personal cell phone and sometimes lets Resident A and Resident C use her cell phone to make a phone call. Resident A, Resident B, and Resident C all reported they have heard DCS Saunders answer the facility telephone and tell the caller the resident is not available to talk when the resident actually was available.

On June 10, 2025, I interviewed Guardian A1and Guardian C1 both stated there have been instances when they have each asked their respective resident why they did not contact the guardian sooner about an incident and both Resident A and Resident C stated DCS Saunders would not let them use the telephone or told Resident A or Resident C that "your guardian does not need to know about this."

On June 10, 2025, Guardian B1 reported Resident B has her own cell phone, but Resident B reported to Guardian B1 that DCS Saunders did not allow residents to use the facility telephone. Guardian B1 reported Resident B did notify Guardian B1 of the argument between DCS Saunders and Resident C and DCS Saunders grabbing the phone from Resident C.

On June 10, 2025, Concerned Citizen 1 reported Resident A and Resident B reported they have been denied use of the facility telephone to call their guardian or case manager. Concerned Citizen 1 denied ever observing this during visits to the facility.

On June 17, 2025, I interviewed Concerned Citizen 2 who reported not having any knowledge about this allegation.

On June 17, 2025, during the onsite investigation, I observed the facility telephone sitting on the medication cart accessible to residents. I interviewed DCS Celina Saunders who stated, "why would I deny them access to the phone, it sits right there all of the time." DCS Saunders reported residents have access to the facility telephone as they wish and stated, "I do not tell them no, they cannot use the phone, nor do I take it away from them when they are trying to make call." DCS Saunders reported she does not tell any resident that the resident cannot call or talk with their guardians, nor does she screen their calls. I interviewed Resident D who reported that she talks on the facility telephone all the time and regularly calls her family using the facility telephone.

Resident D denied that DCS Saunders refuses to allow residents to use the facility telephone.

On June 23, 2025, I interviewed Guardian D1 who reported Resident D has never complained of not being able to use the telephone. Guardian D1 reported Resident D uses the facility telephone regularly to call family members.

On June 23, 2025, Guardian E1 reported Resident E has limited verbal abilities and does not communicate by phone so this would not be a concern of Guardian E1's.

On June 23, 2025, Anna Masambaji denied the allegations of the residents not having access to the phone at all times and denied herself of DCS Celina Saunders telling residents they cannot use the phone to call their guardians.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.** **(g) The right to associate and have private communications and consultations with his or her physician, attorney, or any other person of his or her choice.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	There was insufficient evidence found that DCS Celina Saunders prohibited residents from using the facility telephone or did not allow residents to communicate with their guardians as needed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: DCS Celina Saunders is yelling and swearing at the residents.

INVESTIGATION:

On May 22, 2025, Complainant reported that upon Resident A, Resident B, and Resident C arriving to church on May 18, 2025, the residents reported to Complainant that Resident B called DCS Saunders from Resident B's cell phone to wake her up and DCS Saunders called Resident B a "bitch" for waking her up.

On June 10, 2025, I interviewed Guardian A1 and Guardian C1, dual guardians of Resident A and Resident C, reported around May 20, 2025, a message was received from their respective residents and while leaving the message, Guardian A1 reported she could hear DCS Celina Saunders yelling at both residents saying, "don't lie." Guardian A1 and Guardian C1 reported Resident A and Resident C often report to Guardian A1and Guardian C1 of DCS Saunders yelling at residents and being mean. Guardian A1 and Guardian C1 reported DCS Saunders does not ask residents to do something, but orders residents by saying "go do it right now, you cannot do that, stop talking." Guardian A1 and Guardian C1 reported they have seen a mental decline in Resident A and Resident C because Resident A is crying more often, and Resident C is withdrawn.

On June 10, 2025, I interviewed Guardian B1 who reported she has been on the phone with Resident B often and will hear someone screaming in the background. Guardian B1 stated Resident B reported it is DCS Saunders screaming at another resident. Guardian B1 reported she has heard DCS Saunders screaming, "what are you doing, I told you no, go to your bedroom, I said no, stop asking."

On June 10, 2025, I interviewed Resident A, Resident B, and Resident C who all reported DCS Saunders is mean to residents, especially towards Resident A. Resident B reported that on the morning of May 18, 2025, because she and other residents needed their morning medications before going to church, DCS Saunders called Resident B a "bitch" for waking DCS Saunders up. Resident B reported Resident A requires more hands-on assistance but DCS Saunders refuses to assist Resident A when Resident A needs help. Resident B reported DCS Saunders yells at Resident A to "go find someone else to help you, that is not my job." During my interview, Resident A started crying stating, "Celina yells at me, I do not like that, and I do not deserve it." Resident A, Resident B, and Resident C all reported DCS Saunders yells such things like, "go do it right now, you better stop doing that, no you cannot do that, get off the phone right now, because I said so, mind your own business, go to your room." Resident A, Resident B, and Resident C reported they are not allowed to wake DCS Saunders up and if they do, she swears at them. Resident B reported DCS Saunders came into Resident B's bedroom and told Resident B to get off the phone or to stop playing her gaming system. Resident A, Resident B, and Resident C reported DCS Saunders yells at all of the residents all of the time. Resident A reported she is having a hard time sleeping due to the stress of DCS Saunders being mean to everyone.

On June 10, 2025, I interviewed Concerned Citizen 1 who reported being at the facility at least one time a month, if not more, and has not witnessed DCS Celina Saunders

screaming or yelling at residents. Concerned Citizen 1 reported while at the facility DCS Saunders avoids having to speak with Concerned Citizen 1. Concerned Citizen 1 reported Resident A, Resident B, Resident C and Resident D expressed concern that DCS Saunders yelled at residents.

On June 16, 2025, Concerned Citizen 2 reported Resident A and Resident C are crying more frequently. Concerned Citizen 2 reported she had heard yelling in the background when on the phone with Resident A or Resident C. Concerned Citizen 2 stated Resident A and Resident C reported it was DCS Celina Saunders yelling in the background.

On June 17, 2025, I interviewed DCS Celina Saunders who denied yelling and swearing at residents. DCS Saunders stated, “why would I yell and swear, there is no reason for this.” DCS Saunders reported that she sometimes speaks in a direct manner to the residents due to their ability to understand and speaks louder to Resident C because Resident C has trouble hearing.

On June 23, 2025, Guardian D1 reported she has not observed DCS Celina Saunders yelling or swearing at the residents and nor has Resident D reported this to Guardian D1 of happening. Guardian D1 reported when she was on the phone with Resident D, Guardian D1 reported she has heard people in the background screaming and yelling at each other but has not thought to ask Resident D who it was. Guardian D1 stated, “something different has happened, for the first time ever I heard [Resident D] swear and I was so shocked I did not think to ask questions.” Guardian D1 stated, “I wonder where she is hearing this language from.”

On June 23, 2025, Guardian E1 reported Resident E does not converse with Guardian E1 due to Resident E’s verbal limitations and has not heard Celina Saunders yelling or swearing during her visits with Resident E.

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: **(i) Mental or emotional cruelty.** **(ii) Verbal abuse**

ANALYSIS:	Based on the information provided, there is concern of yelling and screaming happening at the facility, but insufficient eyewitness evidence of who is doing the screaming and yelling. There is insufficient evidence of Celina Saunders, DCS causing mental, emotional cruelty or verbal abuse toward the residents in care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A, Resident B, and Resident C are not being provided breakfast prior to attending church on Sundays.

INVESTIGATION:

On May 21, 2025, the complaint reported Resident A, Resident B, and Resident C are arriving to church without having breakfast.

On May 22, 2025, I interviewed Complainant who reported many Sundays Resident A, Resident B, and Resident C arrive to church without having breakfast and are hungry. Complainant reported there is usually some kind of food available at church so Resident A, Resident B, and Resident C can get something to eat.

On June 10, 2025, I interviewed Resident A, Resident B, and Resident C who reported DCS Celina Saunders does not wake up in the morning on Sundays to provide breakfast for the residents prior to them leaving for church. Resident A, Resident B, and Resident C reported they cannot wake DCS Saunders up in the morning or they will be yelled at and get in trouble. Resident A, Resident B, and Resident C reported they often eat breakfast at church. Resident A, Resident B, and Resident C reported they eat supper around 5:00pm and get to church around 9:30am.

On June 10, 2025, Guardian A1 and Guardian C1 acknowledged witnessing Resident A, Resident B, and Resident C arriving to church on Sundays without having eaten breakfast. Guardian A1 and Guardian C1 reported they have been told by the residents this is due to DCS Saunders not waking up to provide breakfast.

On June 10, 2025, I interviewed Guarding B1 who reported Resident A, Resident B, and Resident C will arrive to church on Sunday's without having breakfast. Guardian B1 reported she has known DCS Saunders to make supper anywhere between 4:00pm and 6:00pm. Guardian B1 reported she is told by Resident B they do not have breakfast prior to attending church due to DCS Celina Saunders not waking up in time to make breakfast.

On June 17, 2025, Concerned Citizen 2 reported they transport the residents to church around 9:00am. Concerned Citizen 2 reported the church personnel assume the residents have not been fed, due to a history of residents coming to church

hungry and reporting they had not been fed breakfast due to direct care staff not being awake. Concerned Citizen 2 reported they have not ever seen DCS Saunders in the mornings when picking up the residents.

On June 17, 2025, I interviewed DCS Celina Saunders during the onsite investigation stated, “I was just notified of breakfast not being served at church, I always thought breakfast was served.” DCS Saunders reported she will now ensure the residents receive breakfast prior to attending church service on Sunday mornings. DCS Saunders reported the residents have also denied wanting to eat breakfast in the morning at the facility and told DCS Saunders they will eat something at church. DCS Saunders reported they eat supper around 5:00pm every evening.

APPLICABLE RULE	
R 400.14313	**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 has been determined Resident A, Resident B, and Resident C were not being fed or offered breakfast prior to being transported to church at 9:00am on Sunday mornings. DCS Saunders reported she was not aware that the church did not provide breakfast. Per DCS Saunders, supper is provided around 5:00pm, allowing more than 14 hours between evening and morning meal.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite investigation on June 17, 2025, I reviewed and received copies of Resident A, Resident B, Resident C, Resident D, and Resident E’s *Assessment Plan for AFC Residents* and found Resident A and Resident D’s *Assessment Plan for AFC Residents* have not been updated annually. Resident A’s assessment plan was last updated on June 03, 2024, and Resident D’s assessment plan was last updated on June 13, 2024.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	During the onsite investigation on June 17, 2025, I observed Resident A and Resident C's written assessment plan had not been updated annually as required. Resident A's assessment plan was due to be updated on June 03, 2025, and Resident D's assessment plan was due to be updated on June 13, 2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On June 10, 2025, Resident A, Resident B, and Resident C reported they are to contact their guardians and request their guardians to purchase soap, shampoo, conditioner, and toothpaste when they need it.

Per interviews with Guardian A1, Guardian B1, and Guardian C1 on June 10, 2025, it was reported they were contacted by the facility to purchase toiletries for their residents such as shampoo, conditioner, toothpaste, and feminine products. Guardian A1, Guardian B1, and Guardian C1 reported they thought this was part of the cost of room and board. All stated the *Resident Care Agreement* did not list any additional fees for toiletries or other personal care items when each guardian signed the document.

On June 17, 2025, I reviewed and received copies of Resident A, Resident B, Resident C, Resident D, and Resident E's *Resident Care Agreement* which did not document that guardians or residents were responsible for purchasing basic personal care items or toiletries.

On June 17, 2025, I interviewed DCS Celina Saunders who reported residents are asked to purchase their own shampoos, conditioners, and toothpastes and these are not provided by the licensees.

On June 23, 2025, Guardian D1 reported there was a period in which she was required to purchase toiletries such as shampoo, conditions, soap, and toothpaste, but has not been asked to purchase these items in about two months. Guardian D1 reported these

additional charges and responsibility were not written on Resident D's annual *Resident Care Agreement.*

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(c) A description of additional costs in addition to the basic fee that is charged.**
ANALYSIS:	During the onsite investigation on June 17, 2025, I reviewed and received a copy of the Resident Care Agreements for the five residents and none provided a description of additional costs for basic shampoos, soaps or other basic toiletries.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Complainant reported that on May 18, 2025, Complainant witnessed Resident B administering Resident C her medications. Complainant reported Resident B stated DCS Celina Saunders gave Resident B Resident C's medications and told Resident B to give Resident C her medication after they eat breakfast at church.

On June 10, 2025, I interviewed Resident B and Resident C who acknowledged Resident B administering Resident C her medications at church. Resident B reported she was told by DCS Saunders to give Resident C her medication after they eat breakfast at church. Resident B reported she had Resident C's medication in the pocket of her pants and after they ate breakfast at church, she gave Resident C her medications. Resident B and Resident C reported Guardian A1, Guardian B1, Guardian C1, and Concerned Citizen 2 observed Resident B administering Resident C's medications.

On June 17, 2025, I interviewed Concerned Citizen 2 who reported they did observe Resident B administering Resident C her medications and when asked where Resident B got the medications from, Resident B reported she was provided the medications by DCS Saunders to administer to Resident C after they ate breakfast at church.

On June 17, 2025, I interviewed DCS Celina Saunders who denied the allegations and reported she administers the residents their mediations prior to them leaving the facility to go to church.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	Based on the information gathered during the investigation, it has been determined DCS Celina Saunders did not supervise Resident C taking her medications on May 18, 2025 as Resident C's medications were administered by Resident B while the residents were at church.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the current license status remains unchanged.

Bridget Vermeesch

07/07/2025

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm

07/07/2025

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Dawn N. Timm Date
Area Manager