GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 14, 2025

Angela Hall
Angela Hall Inc.
3234 Nestrom Rd.
Whitehall, MI 49461

RE: License #:	AS610264254
Investigation #:	2025A0356040
	Pinewood Retirement Home

Dear Ms. Hall:

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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610264254
Investigation #:	2025A0356040
Complaint Receipt Date:	06/03/2025
Investigation Initiation Date:	06/03/2025
Report Due Date:	08/02/2025
Licensee Name:	Angela Hall Inc.
Licensee Address:	3234 Nestrom Rd. Whitehall, MI 49461
Licensee Telephone #:	(231) 766-3807
Administrator:	Angela Hall, Administrator
Licensee Designee:	Angela Hall, Designee
Name of Facility:	Pinewood Retirement Home
Facility Address:	3234 Nestrom Whitehall, MI 49461
Facility Telephone #:	(231) 766-3807
Original Issuance Date:	06/02/2004
License Status:	REGULAR
Effective Date:	12/17/2023
Expiration Date:	12/16/2025
Capacity:	6
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's care needs were not met by staff at the facility.	No
Resident A is excluded from activities.	No
Resident A's medications were not administered as prescribed.	No
Additional Finding	Yes

III. METHODOLOGY

06/03/2025	Special Investigation Intake 2025A0356040
06/03/2025	APS Referral Sent to LARA from APS.
06/03/2025	Special Investigation Initiated - Telephone Reliance Case Manager, Tammy Kastelic.
06/03/2025	Contact - Document Sent Sarah Brown, Clinician/Therapist, Health West.
06/04/2025	Telephone call received Ms. Brown, Health West.
06/18/2025	Inspection Completed On-site
06/18/2025	Contact - Face to Face Lyndsee Phillipo, DCW, Residents B, C, D. Resident A no longer resides in the facility.
06/18/2025	Contact - Telephone call received Stephanie Arnold, home manager. Angela Hall, LD and Admin.
07/03/2025	Contact - Telephone call made Stephanie Arnold, home manager, requested documents. Autumn Kraus, Harmony Cares RN.
07/03/2025	Contact-Telephone call received Autumn Kraus, Harmony Cares RN.
07/07/2025	Contact-Telephone call made Relative #1

07/10/2025	Contact-Telephone call made Relative #1, message left, no response.
07/14/2025	Exit Conference-LD, A. Hall.

ALLEGATION: Resident A's care needs were not met by staff at the facility.

INVESTIGATION: On 06/03/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community and Health Systems online complaint. The complainant reported that staff at the facility failed to provide Resident A with the contracted movement therapy at the intervals agreed upon in her plan of service and within the first three months Resident A resided in the facility, she was only moved therapeutically 3 times. The complainant reported Resident A was only given bed baths and not bathed in the shower, that staff did not get her up and into her wheelchair except to get her to the dinner table. The complainant reported Resident A's catheter is not changed at night unless she requests it changed and Resident A is fearful of getting a UTI (urinary tract infection). The complainant reported staff refused to assist an unknown resident up when they had fallen and staff yelled "bullshit" at the resident when they said they could not get up.

On 06/03/2025, I interviewed Tammy Kastelic, Reliance Case Manager via telephone. Ms. Kastelic stated Resident A was a challenging and difficult resident who used a high back wheelchair and required a lot of care. Ms. Kastelic stated she had never heard of movement therapy or that staff did not provide Resident A with the required movement therapy. Ms. Kastelic stated Resident A told her that she only liked to be up once daily and she (Ms. Kastelic) stated she observed Resident A in her wheelchair and out of bed when she saw her. Ms. Kastelic stated this was the first time she heard Resident A was concerned about her catheter and explained that only a doctor or nurse could change the catheter and staff at the facility emptied and changed the bag on the catheter. Ms. Kastelic stated the catheter bag was cleaned and emptied appropriately whenever she saw Resident A. Ms. Kastelic stated this was the first time she had heard Resident A was given bed baths instead of actual showers and stated Resident A never told her about this as an issue. Ms. Kastelic stated it took 2 staff to bathe Resident A, and showers were given during shift change when 2 staff were on duty. Ms. Kastelic stated the facility had the appropriate shower chair for Resident A and Resident A was well cared for, clean, and her personal hygiene was good.

On 06/04/2025, I interviewed Sarah Brown, Health West Clinician via telephone. Ms. Brown stated she has seen Resident A three times via telehealth appointments. Ms. Brown reported on the third appointment, Resident A reported to her that she was being evicted from the facility and since the eviction, staff only got her out of bed and in her wheelchair once daily, and she was getting bed baths and no showers. Ms. Brown reported that Resident A said there is another resident in the facility that had fallen. She was not given a resident name and does not know who Resident A was

referring to, and staff scream at the resident and say, “bullshit, you can get up.” Ms. Brown stated Resident A reported many of the staff are related to one another or are friends with the owner of the facility, so things go unreported because of the friendships.

On 06/18/2025, I interviewed Angela Hall, Licensee via telephone. Ms. Hall stated Resident A refused care often and refused to allow staff to get her up and out of bed. Ms. Hall stated Resident A was showered, clean and cared for by staff. Ms. Hall stated a 30-day notice was issued on 02/07/2025 and she moved out of the facility on 06/05/2025.

On 06/18/2025, I conducted an unannounced inspection at the facility and interviewed DCW (direct care staff), Lyndsey Phillipo. Ms. Phillipo stated Resident A moved into the facility in September 2024 and the range of motion (ROM) therapy was not ordered by her doctor until April 2025. Ms. Phillipo stated the ROM was on the MAR (medication administration record) so staff would have completed it as ordered and signed off on it on the MAR. Ms. Phillipo stated that Resident A was bathed twice weekly, once on Monday and again on Friday. Ms. Phillipo stated Resident A required 2 staff to transfer her to the wheelchair and to the shower chair. Ms. Phillipo stated if Resident A did not get into the shower on one of the days, either Monday or Friday, because she refused or there was not a 2nd staff member on duty, then she got a bed bath. Ms. Phillipo stated the next time, she would always get a shower so she did not have bed baths in succession. Ms. Phillipo stated she gave Resident A showers “all the time” so she got showered and not just bed baths. Ms. Phillipo stated Resident A often refused to get into her wheelchair.

Ms. Phillipo stated Resident A’s catheter always got emptied by staff at bedtime, in the morning and evening. Ms. Phillipo stated staff did not change the catheter, as that was done by a medical professional, Autumn Kraus, RN from Harmony Home Care but otherwise, staff emptied the catheter bag and kept it clean.

Ms. Phillipo stated she heard from Resident A that staff yelled at a resident and used the word “bullshit”, but Ms. Phillipo stated she does not know who the resident may have been, or the staff and she had never heard or saw this incident occur.

On 06/18/2025, Resident A was not available for an interview, Resident A moved out of the facility on 06/05/2025.

On 06/18/2025, I interviewed Resident B, C and D individually at the facility. Resident B requires the use of a wheelchair and relies on staff to provide all aspects of personal care, including showers. Resident B reported his care is good and staff get him out of bed and into his wheelchair, give him showers and provide the assistance he requires with ADL’s (activities of daily living).

Residents C and D stated their care at the facility was good, that they are more independent with their personal care, that staff were always helpful and available to

assist them.

Resident B, C and D stated they have never seen a resident fall or heard staff swear at any of the residents by using the word, “bullshit.”

On 07/03/2025, I interviewed Autumn Kraus, RN, Harmony Cares, home care nurse via telephone. Ms. Kraus stated she saw Resident A twice weekly on Tuesdays and Fridays while Resident A was in this facility and Resident A was always clean. Ms. Kraus stated Resident A’s daughter would spend all day with her and visited often and Resident A refused care and showers when her daughter was there. Ms. Kraus stated when Resident A’s daughter left for the day, it usually was when 1st shift staff were ending their work shift and 2nd shift was coming on and that is when Resident A would want to receive care so if staff asked her to wait until shift change, she considered that as staff refusing to provide care to her. Ms. Kraus stated staff do not change Resident A’s catheter, it is changed every 30 days, and she (Mr. Kraus) changes it. Ms. Kraus confirmed staff emptied the catheter bag and cleaned it. Ms. Kraus stated Resident A was well cared for at this facility and she (Ms. Kraus) did not have any complaints about Resident A’s care at this facility.

On 07/10/2025, I reviewed Resident A’s assessment plan for AFC residents dated 09/30/2024. The assessment plan is signed by Relative #1 and Ms. Hall. The assessment plan did not have any documentation for ROM therapy. The assessment plan documented that Resident A required “1-2 staff assist” with all ADL’s (activities of daily living) including bathing, grooming, dressing, personal hygiene and walking/mobility. The assessment plan does not describe Resident A’s needs or how they will be met and it only documented that she requires 1-2 person assistance with all ADL’s. Resident A is documented as quadriplegic, requiring the use of a wheelchair, hospital bed, Hoyer and shower chair.

On 07/10/2025, I reviewed the Daily Care Plan (DCP) for Resident A for the months of May and June 2025. The DCP documented Resident A required a 1 person assist with all activities of daily living except for showering/bathing where she required a 2 person assist. The DCP documented Resident A as a 1 person assist with transfers. The DCP documented Resident A as getting a shower/shave every Monday and Friday throughout May 2025 and to the date of discharge in June 2025.

On 07/10/2025, I reviewed Resident A’s MAR for the months of May and June 2025 and there is not a prescription for ROM therapy documented on the MARs for May or June 2025.

On 07/10/2025, I reviewed the staff schedules for May and June 2025. The staff schedules showed one staff on 1st shift from 6:00a.m.-2:00p.m. and one 2nd shift staff from 1:45p.m.-9:30p.m. The staff schedule also documented Ms. Harper on duty as the activities coordinator 1st shift most of the days, but not every day, Ms. Harper is also a trained DCW. The schedule showed Stephanie Arnold, home

manager, is on the schedule from 1:45p.m.-9:30p.m. some days but not daily. The schedules document two staff on duty together for 15 minutes daily which would be the window of time when Resident A would have received a shower or been bathed. The schedules do not document 2 staff on duty each shift for the entire shift and there is one staff on duty during the nighttime hours.

On 07/10/2025, I interviewed DCW, Robin Harper via telephone. Ms. Harper stated she is a trained DCW but mainly works as the activities coordinator for the facility but is available to work the floor at any time. Ms. Harper stated Resident A was given a shower and a bed bath weekly. It was a schedule she agreed to, and Ms. Harper stated Resident A never complained to her or stated she did not agree with it. Ms. Harper stated Resident A required two staff to transfer from her bed to her wheelchair and from the wheelchair to the shower chair. Ms. Harper is not aware of any movement therapy that was ordered or prescribed for Resident A but they attempted more than one time daily to get Resident A up and, in her wheelchair, but she did not always agree to it. Ms. Harper stated Resident A's catheter bag was changed and cleaned several times daily, the changing of the catheter bag was done by the in-home nurse.

On 07/14/2025, I conducted an exit conference with Licensee Designee, Angela Hall via telephone. Ms. Hall stated she agreed with the information, analysis, and conclusion of this applicable rule.

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:	The complainant reported Resident A's care needs are not met at the facility. Ms. Brown reported that Resident A stated staff only got her out of bed and in her wheelchair once a day, and she was getting bed baths and no showers. Ms. Kastelic, Ms. Hall, Ms. Phillipo, Ms. Kraus, and Ms. Harper stated Resident A was well cared for, clean, and her personal hygiene was attended to by staff at the facility. Residents B, C and D stated their care at the facility is good, and staff are always available to assist them. The assessment plan documented that Resident A required "1-2 staff assist" with all ADL's including bathing, grooming, dressing,

	personal hygiene and walking/mobility. The DCP documented Resident A required a 1 person assist with all activities of daily living except for showering/bathing where she required a 2 person assist. The DCP documented Resident A as getting a shower/shave every Monday and Friday throughout May 2025 and to the date of discharge in June 2025. Resident A's MAR for the months of May and June 2025 does not document a requirement for ROM therapy. The staff schedules document two staff on duty together for 15 minutes daily which would be the window of time when Resident A would have to receive a shower or be bathed. Based on interviews with staff, Resident A's nurse, and social worker and a review of Resident A's assessment plan, Resident A's personal care is provided by staff at the facility as documented on the assessment plan.
CONCLUSION:	VIOLATION NOT 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:	The complainant reported unknown staff yelled "bullshit" at an unknown resident when the unknown resident fell and stated they could not get up. Ms. Brown stated Resident A reported an unknown staff screamed at an unknown resident after they fell and said, "bullshit, you can get up." Ms. Phillipo stated she heard from Resident A that staff yelled at a resident and used the word "bullshit", but Ms. Phillipo stated she never heard of or saw this incident occur.

	Residents B, C and D stated they have never seen a resident fall or heard staff swear at any of the residents by using the word, “bullshit.” It was determined through this investigation that there is no evidence to support a violation of this applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A is excluded from activities.

INVESTIGATION: On 06/03/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community and Health Systems online complaint. The complainant reported Resident A is purposefully excluded from house activities.

On 06/03/2025, I interviewed Tammy Kastelic, Reliance Case Manager via telephone. Ms. Kastelic stated Resident A did not complain to her about being excluded from house activities or outings.

On 06/04/2025, I interviewed Sarah Brown, Health West Clinician via telephone. Ms. Brown stated Resident A reported that staff were scheduling Resident A’s appointments during facility activities and outings so she could not attend.

On 06/18/2025, I interviewed Angela Hall, Licensee via telephone. Ms. Hall stated Resident A often refused to participate in facility activities or outings.

On 06/18/2025, I conducted an unannounced inspection at the facility and interviewed Ms. Phillipo. Ms. Phillipo stated Resident A was not excluded from activities within the facility. Resident A was not interested in some of the activities they planned and refused to join. Ms. Phillipo stated Resident A watched movies with other residents and staff and went on some of the outings, but it was up to her if she wanted to go and she refused often. Ms. Phillipo stated Resident A never told her that she felt excluded from any of the facility activities.

On 06/18/2025, Resident A was not available for an interview, Resident A moved out of the facility on 06/05/2025.

On 06/18/2025, I interviewed Resident B, C and D individually at the facility. Resident B, C and D reported they had no complaints about being included in activities in the facility and never noticed staff excluding any of the residents including Resident A from facility activities or outings.

On 07/03/2025, I interviewed Ms. Kraus via telephone. Ms. Kraus stated she had no knowledge of Resident A being excluded from facility activities or outings.

On 07/10/2025, I reviewed Resident A's assessment plan. The assessment plan documented that Resident A participated in hobbies, special interests, social activities and recreation. The assessment plan documented activities Resident A was interested in and/or participated in were games, TV, arts and crafts, music, bingo and outings as desired.

On 07/10/2025, I reviewed Resident A's Resident Care Agreement dated 09/30/2024. It documented that resident rights were reviewed with Resident A, a copy of the AFC resident rights rules was provided to Resident A and the form documented the licensee agreed to respect and safeguard the rights.

On 07/10/2025, I reviewed the staff schedules for May and June 2025. The staff schedule documented Ms. Harper as the facility activities coordinator.

On 07/10/2025, I interviewed Ms. Harper, via telephone. Ms. Harper stated when Resident A initially moved into the facility, she participated in Bingo, arts and crafts and music as much as possible given her disability. Ms. Harper stated as time went on, she began to refuse to participate in facility activities and wanted to remain in her room with the door closed. Ms. Harper stated Resident A did not complain about not being included in the facility activities but refused to participate. Ms. Harper stated outings were scheduled for every 3rd Wednesday and Thursday of every month, residents went to the Museum and the VFW via a transportation company and Resident A would participate in those outings. Ms. Harper stated toward the end of Resident A's stay at the facility, she began to make demands on who she would or would not ride with on the outings and refused to ride in the van with certain residents, so adjusting and coordinating the transportation was attempted but did not always work out the way Resident A wanted. Ms. Harper stated she did not know why Resident A did not want to ride with certain residents. Ms. Harper stated they rotated residents on their outings because not all the residents went at the same time to the same place because they did outings with the residents of two other facilities. Ms. Harper stated they did not exclude Resident A from activities in the facility or outings outside of the facility. Ms. Harper stated Resident A decided when she wanted to participate and when she did not want to participate.

On 07/14/2025, I conducted an exit conference with Licensee Designee, Angela Hall via telephone. Ms. Hall stated she agreed with the information, analysis, and conclusion of this 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 the following resident rights: (h) The right to participate in the activities of social, religious, and community groups at his or her own discretion. (2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.
ANALYSIS:	The complainant reported Resident A is purposefully excluded from activities. Ms. Brown stated Resident A reported that staff were scheduling Resident A's appointments during facility activities and outings so she could not attend. Ms. Kastelic, Ms. Kraus, Ms. Phillipo, and Ms. Harper stated Resident A was not excluded from outings and did not voice concern about missing them. Ms. Hall stated Resident A refused to participate in facility activities or outings. Resident A was not available for an interview. Resident A moved out of the facility on 06/05/2025. Resident B, C and D reported they had no complaints about being included in activities and have no knowledge of staff excluding any of the residents including Resident A from facility activities or outings. Resident A's Resident Care Agreement documented that resident rights were reviewed with Resident A. A copy of the AFC resident rights rules was provided to Resident A and the form documented the licensee agreed to respect and safeguard the rights. Based on investigative findings, there is not a preponderance of evidence to support that staff at the facility excluded Resident A from facility activities or outings. Therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A's medications were not administered as prescribed.

INVESTIGATION: On 06/03/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community and Health Systems) online complaint. The complainant reported Resident A received the wrong medications multiple times and when staff were told about it, they responded by telling her to stop making them feel inadequate. The complainant reported Resident A's nighttime medications are consistently late.

On 06/03/2025, I interviewed Ms. Kastelic who stated many of the same allegations were made to her by Resident A. Ms. Kastelic stated Resident A claimed staff gave her the wrong inhaler but when she (Ms. Kastelic) investigated Resident A's complaint, she discovered that it was a different color inhaler from a different pharmacy, but the medication was correct. Ms. Kastelic stated staff stated they gave Resident A the correct inhaler, Resident A claimed it was the wrong one and Ms. Kastelic stated it was a "he said/she said" type allegation and she found nothing to support that Resident A was given the wrong inhaler.

On 06/18/2025, I conducted an unannounced inspection at the facility and interviewed Ms. Phillipo. Ms. Phillipo stated all the medications are documented on the computerized MAR (medication administration record) and giving a resident wrong medication or late medication is not possible if you follow the computer MAR. Ms. Phillipo stated if the medication were administered late, or not at all, it would show on the MAR system. Ms. Phillipo stated she administered Resident A's morning medications as they were prescribed, and Resident A's medications were not late or administered incorrectly. Ms. Phillipo stated her shift ends at 2:00p.m. each day and Resident A requested that she get her 2:00p.m. meds at 2:30p.m. so the 2nd shift staff would have administered those medications. Ms. Phillipo stated Resident A complained about the 2nd shift staff not administering her medications on time. Ms. Phillipo stated they have an hour before and an hour after the prescribed time to administer Resident A's medications and there is nothing she has seen on the MAR to indicate Resident A's medications were ever administered late.

On 06/18/2025, Resident A was not available for an interview. Resident A moved out of the facility on 06/05/2025.

On 06/18/2025, I interviewed Resident B, C and D individually at the facility. The residents stated their medications are administered on time, correctly, and they did not have any complaints about the administration of their medications.

On 07/03/2025, I interviewed Ms. Kraus who stated she has no concerns about staff administering Resident A's medications incorrectly.

On 07/10/2025, I reviewed the MAR for May 2025. The May MAR documented Resident A was prescribed Ventolin HFA AER, inhale 2 puffs by mouth every 4-6 hours as needed for shortness of breath. PRN (as needed). The medication is not documented as administered during the month of May 2025. The May 2025 MAR documented all Resident A's medications administered as prescribed.

I reviewed Resident A's June 2025 MAR. The May MAR documented Resident A was prescribed Ventolin HFA AER, inhale 2 puffs by mouth every 4-6 hours as needed for shortness of breath. PRN (as needed). The medication is not documented as administered during the month of June 2025. The June 2025 MAR documented all Resident A's medications administered as prescribed.

On 07/10/2025, I interviewed Ms. Harper via telephone. Ms. Harper stated Resident A's medications were administered as prescribed and at the times prescribed.

On 07/14/2025, I conducted an exit conference with Licensee Designee, Angela Hall via telephone. Ms. Hall stated she agreed with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14312	**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:	The complainant reported Resident A received the wrong medications multiple times and nighttime medications are consistently late. After a review of Resident A's MARs for May and June 2025, interviews with staff, residents and medical professionals, there is no evidence to show that Resident A's medications were administered late or not as prescribed and therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING

INVESTIGATON: During this investigation, Ms. Kastelic, Ms. Phillipo and Ms. Harper described Resident A as requiring two-person assistance for showering. A review of the assessment plan for AFC residents documented that Resident A

required “1-2 staff assist” with all ADL’s (activities of daily living) including bathing, grooming, dressing, personal hygiene and walking/mobility. The assessment plan does not describe Resident A’s needs or how they will be met and it only documented that she requires assistance from 1-2 staff with all ADL’s. Resident A is documented as quadriplegic, requiring the use of a wheelchair, hospital bed, Hoyer and shower chair.

I conducted a review of Resident A’s Daily Care Plan (DCP) that documented Resident A required a 1 person assist with all activities of daily living except for showering/bathing where she required a 2 person assist. The DCP documented Resident A as requiring a 1 person assist with transfers.

I conducted a review of staff schedules for May and June 2025 that documented two staff on duty together overlapping for only 15 minutes daily, which would be the window of time when Resident A would have to receive a shower. The schedules do not document 2 staff on duty each shift for the entire shift and there is one staff on duty during the nighttime hours.

On 07/14/2025, I conducted an exit conference with Licensee Designee, Angela Hall via telephone. Ms. Hall stated she understood the information, analysis, and conclusion of this applicable rule and would submit an acceptable corrective action plan. Ms. Hall stated she will add to the assessment plan more information describing resident needs and how those needs will be met.

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:	Resident A’s written assessment plan documented Resident A required 1-2 staff assist with ADL’s including showering. Ms. Kastelic, Ms. Phillipo, Ms. Harper and the daily care plan described Resident A as requiring a 2-person assist for showering. However, the assessment plan does not describe Resident A’s needs or how they will be met, leaving the requirement of 1-2 staff assist ambiguous as to exactly what type of care and how many staff it would take to provide the care Resident A required. Resident A’s assessment plan did not provide an accurate depiction of Resident A’s actual care needs when it came to her ADL’s. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

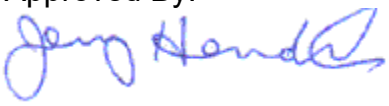
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan. I recommend the status of the license remain unchanged.

07/14/2025

Elizabeth Elliott — Date
Licensing Consultant

Approved By:



07/14/2025

Jerry Hendrick — Date
Area Manager