GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 8, 2025

Vashu Patel
SUNFIELD MEADOWS INC
10900 JAMES WAY
PORTAGE, MI 49002

RE: License #: AL230417474
Investigation #: 2025A1024038
STANFORD LODGE SUNFIELD

Dear Vashu Patel:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On July 30, 2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL230417474
Investigation #:	2025A1024038
Complaint Receipt Date:	06/18/2025
Investigation Initiation Date:	06/19/2025
Report Due Date:	08/17/2025
Licensee Name:	SUNFIELD MEADOWS INC
Licensee Address:	10900 JAMES WAY PORTAGE, MI 49002
Licensee Telephone #:	(269) 718-9040
Administrator:	Vashu Patel
Licensee Designee:	Vashu Patel
Name of Facility:	STANFORD LODGE SUNFIELD
Facility Address:	241 W GRAND LEDGE HWY SUNFIELD, MI 48890
Facility Telephone #:	(269) 718-9040
Original Issuance Date:	09/05/2024
License Status:	REGULAR
Effective Date:	03/05/2025
Expiration Date:	03/04/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has not been treated with dignity and her protection, safety and personal care needs have not been adequately attended to.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/18/2025	Special Investigation Intake 2025A1024038
06/19/2025	APS Referral already involved
06/19/2025	Special Investigation Initiated – Telephone with Adult Protective Service (APS) Specialist Shelly Stratz
06/19/2025	Contact - Telephone call made with hospice worker Kristen Hetzer of Hartland Hospice.
06/24/2025	Contact-Document Received-AFC Licensing Division-Incident/Accident Report
07/03/2025	Contact - Telephone call made with direct care staff member Todd Patrick
07/10/2025	Inspection Completed On-site with Rhonda Thompson, Megan O'Brien, Dawn Robinson
07/10/2025	Contact - Telephone call received with Relative A1 and A2
07/14/2025	Contact - Telephone call received with Relative A3
07/21/2025	Contact - Telephone call made with direct care staff member Dani Hudson
07/22/2025	Contact - Document Received-Todd Patrick’s employment application
07/28/2025	Contact - Document Received-Todd Patrick’s training
07/29/2025	Contact - Document Received-Resident A's Medication Administration Record (MAR), *Assessment Plan for AFC Residents*, and *Health Care Appraisal* (HCA)

07/30/2025	Exit Conference with licensee designee Vashu Patel and Danie Hudson
07/30/2025	Inspection Completed-BCAL Sub. Compliance
07/30/2025	Corrective Action Plan Requested and Due on 8/4/2025
07/30/2025	Corrective Action Plan Received
07/30/2025	Corrective Action Plan Approved

ALLEGATION: Resident A has not been treated with dignity and her protection, safety and personal care needs have not been adequately attended to.

INVESTIGATION:

On 6/18/2025, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged Resident A has not been treated with dignity and her protection, safety and personal care needs have not been adequately attended to.

On 6/19/2025, I conducted an interview with APS Specialist Shelly Stratz who stated she is also investigating this allegation and will be working with Michigan State Police to determine any substantial evidence therefore she has not conducted any interviews. Shelly Stratz stated that Resident A participates in hospice, and it was reported that excessive bruising was observed on Resident A's abdominal area. Shelly Stratz stated this initially prompted concerns from hospice workers as staff member Todd Patrick was observed using excessive force when providing care to Resident A. Shelly Stratz stated that Resident A is in the process of dying and is in a significant amount of pain therefore further testing or x-rays have not been performed due to her condition. Shelly Stratz also stated if Resident A passes away her, she will no longer be involved as the resident will be deceased.

On 6/19/2025, I conducted an interview with hospice worker Kristen Hetzer who stated that Resident A receives hospice services and hospice staff members visit Resident A at the facility weekly. Kristen Hetzer stated that a few weeks ago, exact date unknown, Resident A was observed with a small bruise near her left side of her breast which was of no concern to hospice staff members. However, recently, Kristen Hetzer stated hospice staff members observed major bruising to Resident A's abdominal area and it is believed this may have been caused by direct care staff member Todd Patrick because hospice workers observed him transferring Resident A in a rough manner and not moving her with care. Kristen Hetzer stated that Resident A is very thin, fragile and staff members often used a gait belt to assist Resident A with transferring, however, the use of a gait belt was not prescribed by hospice. Kristen Hetzer stated the use of the gait belt was discontinued due to the excessive bruising in Resident A's abdominal area as it

was thought the gait belt contributed to the bruising. Kristen Hetzer stated the bruise observed on Resident A's abdominal area, spread from a small area on Resident A's chest which is very unusual given the size of the bruise therefore hospice staff members believed direct care staff member Todd Patrick used excessive force when transferring Resident A and this was possibly due to not knowing how to use the gait belt appropriately. Kristen Hetzer stated that Resident A is in a significant amount of pain therefore x-rays have not been completed due to Resident A's condition. Kristen Hetzer further stated she does not believe medications contributed to Resident A's bruising due to the size of the bruise.

On 6/24/2025, I reviewed the facility's *AFC Licensing Division-Incident/Accident Report* dated 6/16/2025 written by staff member Dawn Robinson. This report stated that hospice nurse Katie, last name unknown, showed her pictures of the bruising in Resident A's abdominal area. The *AFC Licensing Division-Incident/Accident Report* documented that Dawn Robinson reported this to the facility manager and explained how the bruising looked like an injury caused by the use of a gait belt when transferring Resident A. The *AFC Licensing Division-Incident/Accident Report* also documented that Dawn Robinson also reported this to regional director Dani Hudson while hospice staff were in the bedroom with Resident A evaluating the bruised area.

I also reviewed the facility's *AFC Licensing Division-Incident/Accident Report* dated 5/21/2025 and written by staff member Aubry Falor. This report stated that Resident A called out for help while she was in her bedroom and said that she needed to use the bathroom. The *AFC Licensing Division-Incident/Accident Report* documented that when Aubry Falor sat Resident A up, she complained of pain to her chest/left breast area. The *AFC Licensing Division-Incident/Accident Report* documented that Aubry Falor looked at this area and observed a lump forming with some light bruising on top of her pacemaker. The *AFC Licensing Division-Incident/Accident Report* documented that Aubry Falor called the previous staff person who was on shift, Todd Patrick, who reported to Aubry Falor that he had not noticed anything and that Resident A had not complained of being in pain during his shift. The *AFC Licensing Division-Incident/Accident Report* documented that Relative A1 and Relative A2 were called and then came to look at the area.

On 7/3/2025, I conducted an interview with direct care staff member Todd Patrick who stated that he does not believe he used excessive force when providing care to Resident A. Todd Patrick stated he used the facility's gait belt to assist Resident A with transferring and did not have any issues with using the gait belt including during the weekend of 6/14/2025 at which time he was the only staff member working. Todd Patrick stated direct care staff eventually discontinued using the gait belt when hospice staff noticed bruising around Resident A's left breast area on 6/16/2025. Todd Patrick stated he believes the bruising was caused by the medication Coumadin that Resident A was taking and not the use of the gait belt. Todd Patrick stated the prescribed Coumadin was also eventually discontinued from Resident A's medication regimen. Todd Patrick stated that he tried to be as gentle as possible when providing care to

Resident A and he did not intentionally harm her in any way. Todd Patrick stated that he appropriately attended to her needs.

On 7/10/2025, I conducted an onsite investigation at the facility with direct care staff members Rhonda Thompson, Megan O'Brien, and Dawn Robinson. Rhonda Thompson stated that she has never directly observed Todd Patrick being rough with Resident A, however, she did have to talk to him about being rough with another resident. Rhonda Thompson stated that she heard complaints about staff member Todd Patrick after she returned from vacation. Rhonda Thompson stated that bruising was observed on Resident A's chest and abdomen which is believed to be caused by using the facility's gait belt, so direct care staff members stopped using the gait belt after the bruising was observed. Rhonda Thompson stated that Relative A1 and Relative A2 reported to her that while they were visiting with Resident A, she was found soaked in urine due to direct care staff member Todd Patrick not changing Resident A in a timely manner. Rhonda Thompson stated that she was not working when this incident occurred and reported this concern to appropriate management staff. Rhonda Thompson stated that all residents are required to be checked for changes every two hours and she has not witnessed Resident A soaked in urine at any time when she has worked with Resident A and she has no concerns regarding the care provided by Todd Patrick.

Megan O'Brien stated that she worked regularly with direct care staff member Todd Patrick and would often see him provide care to Resident A in a rough manner which was very concerning to her. Megan O'Brien stated since she is a household member and easily available, there were multiple occasions when Todd Patrick called her to assist with providing care to Resident A even though she was not scheduled to work. Megan O'Brien stated she recalls one incident when Todd Patrick called her to help with transferring Resident A from the toilet at which time Megan O'Brien observed Todd Patrick grab Resident A with excessive force and jerk her off the toilet without talking to her or making her feel comfortable during the process. Megan O'Brien stated he then pulled her walker and guided her with the walker in a very fast motion. Megan O'Brien stated this action put Resident A's safety at risk because she constantly fears that she will fall. Megan O'Brien stated she also assisted Todd Patrick during a recent time she was not scheduled to work when Todd Patrick banged on her door asking her to help while Relative A1 and Relative A2 were visiting Resident A. Megan O'Brien stated during this time, Relative A1 and Relative A2 came to the facility around 2pm and found Resident A soaked in urine. Megan O'Brien stated she observed Todd Patrick change Resident A's bedding and while doing so, he forcefully flopped her legs over to remove the bedding and when he lifted her head to complete the removal of the bedding, Todd Patrick did not put a pillow under Resident A's head and allowed her head to roughly flop down on the bed. Megan O'Brien stated during this time she also observed that Resident A's gown was soaked in urine, there was a pool of urine on the mattress and her bedroom smelled like ammonia from the urine that was soaked in Resident A's clothing and bedding. Megan O'Brien stated that Relative A1 and Relative A2 were very upset to see Resident A in this condition, and it appeared that Todd Patrick acted as if he didn't care. Megan O'Brien further stated that Resident A was supposed to be changed as needed or every two hours and she does not believe Todd Patrick checked

Resident A since 8am that morning. Megan O'Brien stated she was "taken back" on seeing how Todd Patrick handled Resident A and assisted as much possible to keep Resident A safe however she immediately reported her observation of concerns for Todd Patrick to management because she did not feel comfortable with the care that she observed provided by Todd Patrick.

Dawn Robinson stated she has worked with Todd Patrick in the past and has not directly seen him be rough with Resident A, however, she does suspect that the bruising to Resident A's abdominal area was caused by Todd Patrick using the gait belt to assist Resident A with transferring. Dawn Robinson stated on 6/16/2025 Resident A was observed to have major bruising across her abdominal area which was unusual because on Friday 6/13/2025 there was no bruising observed in this area. Dawn Robinson stated Todd Patrick was the staff member that worked the weekend of 6/16/2025 therefore she believes the bruising was caused by Todd Patrick using the gait belt to assist Resident A with transferring. Dawn Robinson stated that Todd Patrick did not report that he saw any bruising on Resident A and when the bruising was brought to his attention, he stated he thought it was from Resident A's blood thinner medication Coumadin.

On 7/10/2025, I conducted interviews with Relative A1 and Relative A2. Relative A1 stated that he believes staff member Todd Patrick used excessive force while providing care to Resident A and neglected Resident A prior to her death. Relative A1 stated he and Relative A2 brought their concerns regarding Todd Patrick to management staff members, however nothing was done about it. Relative A1 stated during a recent afternoon visit on or around 6/12/025, Resident A was found soaked in urine while she was in bed and her bedroom smelled of strong odor. Relative A1 stated this concern was immediately reported to Dani Hudson however Dani Hudson left the facility without addressing or acknowledging their concerns. Relative A1 stated when they brought this issue to Todd Patrick's attention, he admitted that he did not get a chance to change Resident A due to being busy and had not changed her since 8am. Relative A1 stated Todd Patrick then went to get another staff member to assist him with changing Resident A. Relative A1 stated it was during this time that Relative A1 observed Todd Patrick moving Resident A in a rough manner. Relative A1 stated there was also a large bruise found on Resident A's abdominal area on a different day caused by a gait belt used by direct care staff to assist Resident A with transferring. Relative A1 believes the bruising was caused due to Todd Patrick applying excessive force when providing care to Resident A based on the previous observations of Todd Patrick providing care to Resident A in a rough manner. Relative A1 believes that although Resident A had hospice in place, the maltreatment care provided to Resident A by Todd Patrick caused Resident A to pass away sooner than expected. It should be noted Relative A1 could not provide direct evidence that the bruising led to an earlier death to Resident A.

Relative A2 stated that she was very upset when she came to visit with Resident A and found Resident A soaked in urine with her bedroom having a strong urine odor. Relative A2 stated that she addressed this with Todd Patrick and other staff members, and nothing was done about it, however, it was discovered that Todd Patrick had not

changed Resident A as part of his routine daily tasks, leaving Resident A to sit in her urine for hours. Relative A2 further stated when Todd Patrick changed Resident A's bedding after she requested him to do so, he rolled her face against the bed rail and did not handle her with care while changing her.

On 7/14/2025, I conducted an interview with Relative A3 who stated that he called staff member Dani Hudson who is part of the management team to report concerns about Todd Patrick's care of Resident A, after Relative A1 and Relative A2 found Resident A soaked in urine. Relative A3 stated Dani Hudson reported that she did not believe Todd Patrick was equipped to care for residents who participated in hospice services. Relative A3 stated that he believes given the strong urine odor in Resident A's bedroom and the amount of urine found on Resident A's clothes and bedding that Resident A had not been changed for a long period of time or every two hours as required by staff members. Relative A3 also stated that he is concerned about reports he has received from other relatives concerning Resident A being handled in a rough manner including the incident when Todd Patrick allowed Resident A's head to hit the side of the bed rail when changing her bed linens. Relative A3 stated he does not believe staff Todd Patrick properly attended to Resident A's needs.

On 7/21/2025, I conducted an interview with direct care staff member Dani Hudson who stated she is the regional director of the facility. Dani Hudson stated that concerns were brought to her attention from Resident A's relatives that Todd Patrick left Resident A soaked in urine. Dani Hudson stated when she addressed these concerns with Todd Patrick, he stated that he did get busy and was not able to check Resident A to see if she needed to be changed every two hours as required. Dani Hudson stated Todd Patrick received a verbal warning regarding this issue, however no documentation to reflect this warning was provided to Todd Patrick. Dani Hudson stated she has not directly seen Todd Patrick be rough with Resident A or any other resident and believes Resident A may have gotten the bruising on her abdomen area from direct care staff using a gait belt to help with transferring. Dani Hudson further stated she does not believe Todd Patrick did anything to intentionally harm Resident A.

On 7/29/2025, I reviewed Resident A's *Health Care Appraisal* (HCA) dated 6/18/2025 written by nurse Katelin Decamp which stated that Resident A has fragile skin, has bruising on her chest and breast and is unable to bear weight. The HCA stated that Resident A uses a walker, wheelchair and her general appearance is "sickly." The HCA further stated that the hospice will provide a hospital bed and the facility has a gait belt.

I also reviewed Resident A's *Assessment Plan for AFC Residents* dated 2/26/2025 which stated that Resident A needs assistance with all self-care tasks including toileting and Resident A must be prompted to use the toilet and is "always wet". Resident A has a walker for special equipment. It should be noted this assessment plan does not mention the use of a gait belt. The assessment plan also does not mention checking Resident A every two hours.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on my investigation, which included interviews with direct care staff members Todd Patrick, Rhonda Thompson, Megan O'Brien, Dawn Robinson, APS Specialist Shelly Stratz, and hospice nurse Kristen Hetzer, along with my review of Resident A's *Assessment Plan for AFC Residents* and *Health Care Appraisal*, there is evidence to support the allegation Resident A has not been treated with dignity and her protection, safety and personal care needs were not attended to adequately. Megan O'Brien, Relative A1 and Relative A2 all stated they observed Resident A soaked in urine with a strong urine odor in her bedroom and direct care staff member Todd Patrick received a verbal warning after stating he was not able to check and/or change Resident A's brief every two hours as required. Therefore, Resident A's personal care needs, safety and protection were not attended to at all times and Resident A was not treated with dignity. Regarding the bruising observed on Resident A's abdominal area, there is not enough evidence that direct care staff member Todd Patrick was solely responsible for the bruising as all direct care staff used the gait belt to transfer Resident A. Direct care staff member Todd Patrick denied intentionally harming Resident A in any way.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 7/21/2025 and 7/27/2025, I requested training for Todd Patrick and licensee designee Vashu Patel was unable to provide verification of required trainings for Todd Patrick. It should also be noted that Todd Patrick, Megan O'Brien, and Dawn Robinson all stated that they were not trained to use the facility's gait belt with Resident A by licensee designee Vashu Patel. However, all reported having previous work experience using a gait belt.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	On 7/21/2025 and 7/27/2025, I requested training for Todd Patrick but licensee designee Vashu Patel was unable to provide verification of required trainings for Todd Patrick. It should also be noted that Todd Patrick, Megan O'Brien, and Dawn Robinson all stated that they did not receive training on the use of a gait belt from licensee designee Vashu Patel.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 7/22/2025, I reviewed Todd Patrick's employee records, and no verification of reference checks were found.

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(f) Verification of reference checks.**
ANALYSIS:	I reviewed Todd Patrick's employee records, and no verification of reference checks were found.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I reviewed Resident A's *Assessment Plan for AFC Residents* and was not able to verify that the plan was completed with the licensee designee due to the licensee designee's signature missing and no other documentation verifying licensee designee Vashu Patel's participation.

APPLICABLE RULE	
R 400.15301	**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:	I reviewed Resident A's *Assessment Plan for AFC Residents* and was not able to verify that the plan was completed with the licensee designee due to licensee designee Vashu Patel's signature missing and no other documentation verifying licensee designee Vashu Patel's participation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Direct care staff members Rhoda Thompson and Dani Hudson both reported that they did not have a physician order for Resident A to use the gait belt. Hospice worker Kristen Hetzer of Hartland Hospice stated that there was no physician order from hospice for the use of the gait belt for Resident A and staff members were already using the gait belt at the time hospice got involved.

Rhonda Thompson, Dani Hudson, Megan O'Brien, and Dawn Robinson all stated that it is suspected that the use of the gait belt caused bruising to Resident A's abdominal area.

Resident A's *Assessment Plan for AFC Residents* does not discuss the use of a gait belt for Resident A to assist with transferring or mobility.

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(1) An assistive device shall only be used to promote the enhanced mobility, physical comfort, and well-being of a resident. **(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.** **(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.**
ANALYSIS:	Direct care staff members Rhoda Thompson and Dani Hudson both reported there was no physician order for Resident A to use the gait belt. Hospice worker Kristen Hetzer of Hartland Hospice stated that there was no physician order from hospice for the use of the gait belt for Resident A and direct care staff members were already using the gait belt at the time hospice got involved. Direct care staff members Rhonda Thompson, Dani Hudson, Megan O'Brien, and Dawn Robinson also all stated that it is suspected that the use of the gait belt caused bruising to Resident A's abdominal area. In addition, Resident A's *Assessment Plan for AFC Residents* does not discuss the use of a gait belt for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Relative A1 and Relative A2 both stated when they went to visit with Resident A on or around 6/12/2025 at 2pm, they noticed items in her mouth while she was lying down along with several medication pills on her bed. Relative A1 and Relative A2 also both stated when they addressed this concern with direct care staff member Todd Patrick, who was working at the time, he evaluated Resident A's mouth and saw that Resident A had some of the pills still in her mouth from when it was administered to her that morning at 8am. Relative A1 and Relative A2 stated based on this it was clear Todd Patrick did not supervise Resident A to make sure that Resident A swallowed the pills. Relative A1 and Relative A2 stated this concern was also brought to the attention of management.

Dani Hudson stated that it was reported to her by Resident A's relatives that during a visit, Resident A was found with medication pills in her mouth that were administered by Todd Patrick earlier in the day. Dani Hudson stated when she addressed this issue with

Todd Patrick, he stated that he failed to supervise Resident A to ensure that all the medications were dissolved and/or swallowed. Dani Hudson stated that Todd Patrick was ultimately terminated from the facility for this offense.

I reviewed Resident A's MAR which documented that she is prescribed the following medications: Donepezil 5mg, Ferrous Sulfate 325mg, Furosemide 20mg, Ketoconazole Cream 2%, Miconazole Cream 2%, Nystatin Cream, Oxybutynin 10mg, Pantoprazole 40mg, Pot Cl Micro 20MEQ ER, Pravastatin 80mg, Preservision Areds 2 (LTC), Sertraline 25mg, Sertraline 50mg, Spironolact 25mg, Vitamin D3 50MCG, Warfarin 3MG, Warfarin 4MG, Aceamin 500MG, Tramadol 50mg, Tylenol 500MG,

APPLICABLE RULE	
R 400.15312	**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:	Relative A1 and Relative A2 both stated when they went to visit with Resident A on or around 6/12/2025 at 2pm, they noticed items in her mouth while she was lying down along with several medication pills on her bed. Relative A1 and Relative A2 also both stated when they addressed this concern with Todd Patrick, who was working at the time, he evaluated Resident A's mouth and saw that Resident A had some of the pills still in her mouth from when it was administered to her that morning at 8am. Consequently, Todd Patrick did not supervise Resident A to make sure that Resident A swallowed the pills. Dani Hudson stated that it was reported to her by relatives of Resident A that during a visit, Resident A was found with medication pills in her mouth that were administered earlier in the day and when she addressed this issue with Todd Patrick, he confirmed he did not supervise Resident A to ensure that all the medications were dissolved or swallowed. After this incident, Todd Patrick was ultimately terminated from the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/30/2025, I conducted an exit conference with licensee designee Vashu Patel. I informed Vashu Patel of my findings and allowed her an opportunity to ask questions or make comments. On 7/30/2025, I approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was received; therefore I recommend the current license status remain unchanged.

8/4/2025

Ondrea Johnson
Licensing Consultant

Date

Approved By:

08/08/2025

_____

Dawn N. Timm
Area Manager

Date