GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 24, 2025

Aniema Ubom
Care First Group Living & In-Home Services, Inc.
24111 Southfield Road
Southfield, MI 48075

RE: License #: AS630406615
Investigation #: 2025A0626020
The Tutbury Residence
AMENDED REPORT
Original report date: 09/18/2025

Dear Mr. Ubom:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

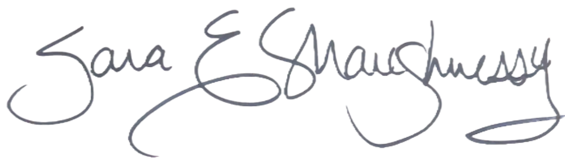
A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even

if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 972-9136.

Sincerely,



Sara Shaughnessy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 320-3721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630406615
Investigation #:	2025A0626020
Complaint Receipt Date:	06/26/2025
Investigation Initiation Date:	06/26/2025
Report Due Date:	08/25/2025
Licensee Name:	Care First Group Living & In-Home Services, Inc. Group Living & In-Home Services, Inc.
Licensee Address:	24111 Southfield Road Southfield, MI 48075
Licensee Telephone #:	(248) 331-7444
Administrator:	Aniema Ubom
Licensee Designee:	Aniema Ubom
Name of Facility:	The Tutbury Residence
Facility Address:	6496 Tutbury Ln Troy, MI 48098
Facility Telephone #:	(248) 331-7444
Original Issuance Date:	08/06/2021
License **Status:**	REGULAR
Effective Date:	02/06/2024
Expiration Date:	02/05/2026
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Untrained and unqualified direct care staff members are providing care of a resident 's tracheotomy.	No
Additional Findings	Yes

III. METHODOLOGY

06/26/2025	Special Investigation Intake 2025A0626020
06/26/2025	APS Referral I made an adult protective services (APS) referral via telephone.
06/26/2025	Special Investigation Initiated - Telephone Special investigation was initiated via telephone interview with the complainant.
06/27/2025	Contact - Face to Face Completed an unannounced onsite investigation at The Tutbury Residence. An interview was completed with supervisor, Kristina Hedtke.
06/27/2025	Contact - Face to Face Completed an unannounced visit to Care First Group Living & In-Home Services, Inc. Group Living & In-Home Services, Inc. Rehabilitation Services to complete an interview with Resident A and Leslie Ubom, co-owner.
06/30/2025	Contact - Document Received Documents were received, via email, from Merima Zander, program director. The documents included the discharge summary from Resident A's hospital stay from May, Resident A's signed Resident care agreement, Resident A's resident information record, and the incident report from when Resident A went to the hospital for the urinary tract infection.
07/01/2025	Contact - Telephone call made A telephone conference was completed with APS investigator, Tracey Anderson.

07/08/2025	Contact - Telephone call made Completed telephone interviews with the following nurses, employed by Care First Group Living & In-Home Services, Inc. Group Living & In-Home Services, Inc. Rehabilitation: Antoniette Fairely, Jasmine White, and DaShaSha Ward.
07/08/2025	Contact - Telephone call made Completed telephone interviews with Richard Lyons and Relative A1.
07/17/2025	Contact - Document Sent I sent an email to the program director, Merima Zander, requesting staff schedules for May and June, staff contact information, and nursing notes pertaining to Resident A.
07/18/2025	Contact - Document Sent I sent an email to Merima Zander, Aniema Ubom (licensee designee), Leslie Ubom, and Ime Ubom, requesting the documents that were requested on 07/17/2025.
07/23/2025	Contact - Telephone call made I made a telephone call was made to Merima Zander. A message was left requesting a return call.
07/23/2025	Contact - Telephone call made A phone call was attempted with Resident A's nurse case manager, Kathy Merillat. A message was left requesting a return call.
07/25/2025	Contact - Telephone call made Completed phone interviews with current Care First Group Living & In-Home Services, Inc. Group Living & In-Home Services, Inc. employee, Sharmia Sinclair and former employee, Nerissa Dorris.
07/25/2025	Contact - Telephone call received A telephone interview was completed with Resident A's nurse case manager Kathy Merillat.
07/28/2025	Contact - Telephone call received A telephone conference took place with APS investigator, Tracey Anderson.
07/29/2025	Contact - Face to Face I conducted an unannounced, onsite investigation at The Tutbury Residence.

07/30/2025	Contact- Document received I received, via email, the requested work schedule and nursing notes.
08/04/2025	Contact- Document sent I sent an email to Anemia Ubom, Merima Zander, and Leslie Ubom, requesting the behavior plan for Resident A.
08/07/2025	Contact- Document received The behavior plan for Resident A was received via email.
08/22/2025	Exit conference I conducted an exit, via telephone, with licensee designee, Aneima Ubom. The findings and recommendations were discussed.

ALLEGATION:

Untrained and unqualified direct care staff members are providing care of a Resident 's tracheotomy.

INVESTIGATION:

On 06/26/2025, I received a complaint, via email, indicating Resident A has a tracheotomy and untrained/unqualified direct care staff members are providing care for his tracheotomy.

On 06/26/2025, I initiated my investigation via a telephone interview with Care First Group Living & In-Home Services, Inc. nurse, DaShaSha Ward. Ms. Ward stated there are concerns that Resident A is not receiving proper management of his tracheotomy. Ms. Ward stated direct care staff members were assisting Resident A with getting into his pajamas the night before and accidentally pulled out his tracheotomy. Ms. Ward stated that the direct care staff members did not know how to reinsert Resident A's tracheotomy and Resident A was lucky Ms. Ward was there to do it, as Ms. Ward is a trained nurse. Ms. Ward informed me that if direct care staff members are going to be trained in tracheotomy management, it should be by a registered nurse or a respiratory therapist. Ms. Ward stated the home has three nurses that visit approximately eight or nine homes to provide nursing care, from 7am-11:30 pm. Ms. Ward stated there is not a nurse with the Resident s full-time. Ms. Ward informed me that Resident A should not be in their care, as they are not equipped to properly care for him.

On 06/26/2025, I contacted Centralized Intake, via telephone, to submit a referral for Adult Protective Services (APS), due to the level of concern.

On 06/27/2025, I completed an onsite investigation and an interview with home supervisor, Kristina Hedtke. Ms. Hedtke has been in her position since April 2025. Ms.

Hedtke stated she is trained to care for Resident A's tracheotomy, as is the nighttime supervisor. She stated the nurses, Antoinette Fairley and Jasmine White, are training supervisors first, and they will then train the direct care staff members. She insisted the only people caring for Resident A's tracheotomy are the supervisors and nurses. Ms. Hedtke stated they always have extra tracheotomies with them when they take Resident A out of the home and denied that they take his suction machine with them. Ms. Hedtke stated Resident A does have a bed sore and it is cleaned once per day, in the morning. Ms. Hedtke denied knowing the details regarding the night Resident A went to the hospital for his urinary tract infection and the night his tracheotomy came out.

Ms. Hedtke showed me Resident A's bedroom to view his supplies. I observed two machines that Ms. Hedtke identified as Resident A's suction machines, and she showed me his tracheotomy tubes, and other supplies.

On 06/27/2025, I completed an announced onsite investigation at Care First Group Living & In-Home Services, Inc. to complete a private interview with Resident A. Resident A informed me that direct care staff members were changing his tracheotomy tube and they are not supposed to. He stated it is only supposed to be changed by nursing staff. He stated he has a suction machine here at the rehabilitation center. He stated they do not use the proper gloves when caring for his tracheotomy, and the direct care staff members do not do it right, they put it in too far and hurt him. He stated he is 100% certain they are direct care staff members. He revealed he only feels safe when certain people are away, the only elaboration he could provide was that some of the women have smart mouths and they do his suctioning when needed. He confirmed he does have a wound and they are washing it and caring for it twice per day.

On 06/27/2025, during the onsite investigation at Care First Group Living & In-Home Services, Inc., I completed an interview with co-owner, Leslie Ubom. Ms. Ubom stated that they are training direct care staff members on how to care for Resident A's tracheotomy. She stated he has an order for four hours a day of nursing care to manage his wound care. She stated Resident A1 does not require deep suctioning and it is usually superficial, so the staff can do that, but the nurses change his tube.

On 07/01/2025, I completed a phone conference with assigned APS investigator, Tracey Anderson. Ms. Anderson informed me that she went to the home to see Resident A on Saturday. She stated he appears to know what is going on and told her that direct care staff members have inserted his tracheotomy tube. She stated he knew there were cameras outside, so he asked her to speak with him in an area in the backyard where they would not be able to be heard by the camera. She stated he shared with her the same information he told me. She denied having met with the licensee. She stated from her conversation with Resident A; she is planning on substantiating her investigation.

On 07/08/2025, I completed a telephone interview with Antoniette Fairley, nurse for Care First Group Living & In-Home Services, Inc. Ms. Fairley is a licensed practical

nurse (LPN). She stated she has trained supervisors and two other direct care staff members on how to care for Resident A's tracheotomy.

On 07/08/2025, I completed a telephone interview with Jasmine White, nurse for Care First Group Living & In-Home Services, Inc. She denied concerns with the care Resident A is receiving. She informed me that Resident A is vocal and is 100% aware of what is going on. She stated she has been training supervisors in caring for his tracheotomy. She denied having trained everyone and stated that she will not be training everyone, as she doesn't want it to be something they "play with".

On 07/14/2025, I completed a phone interview with the public guardian to Resident A, Richard Lyons. He denied any concerns with the care Resident A is receiving. He believes the issue with the tracheotomy tube not being correctly inserted was due to the nurses at the hospital. Mr. Lyons stated he believes the issues are coming from Resident A's younger daughter, but he has communicated the most with the older daughter. He stated Resident A is well taken care of.

On 07/25/2025, I completed a telephone interview with direct care staff member, Sharmia Sinclair. She stated the nurses take care of the tracheotomy and the direct care staff members do not. She stated the only duty she performs with Resident A is opening his catheter bag. She stated the day shift nurse was supposed to see Resident A earlier that day and did not. She stated he was not seen by a nurse until the next shift.

On 07/25/2025, I completed a phone interview with Resident A's nurse case manager, Kathy Merillat. As for Resident A's tracheotomy, she stated direct care workers should not be performing tracheotomy care outside of suctioning. The tracheotomy is supposed to be changed only by a respiratory therapist. She explained that there is a difference between tracheotomy care and changing the tracheotomy. She stated more information is needed to assess this allegation. Ms. Merillat agreed to go to The Tutbury Residence with me on Tuesday, 07/29/2025, to get further clarification from Resident A as to what is going on due to her knowledge of his medical treatment and she has an established relationship with him.

On 07/29/2025, I completed a follow-up, unannounced, investigation at The Tutbury Residence, with nurse case manager, Kathy Merillat. We completed a private interview with Resident A. Resident A informed me that the direct care staff members are learning how to suction his tracheotomy, but not all seem to comprehend the directions. He stated they were going too far with the suctioning then changed the tube to one that is labeled where to stop, which has solved that issue. He stated only his respiratory therapist, or a nurse changes the actual tracheotomy.

On 07/29/2025, during the follow-up visit, I interviewed direct care staff member, Jaslyn Teasley. Ms. Teasley has worked for Care First Group Living & In-Home Services, Inc. for approximately three months. She stated she floats to all of the other homes as well. She denied ever changing Resident A's tracheotomy and stated that it is only done by the nurses, to her knowledge.

On 07/29/2025, during the follow-up onsite investigation, I interviewed night home manager, Zabrina Gilbert. Ms. Gilbert stated she is in the home until 1:30 am and she suctions Resident A's tracheotomy while she is there. She stated if she is not there and he needs suctioning; there is a nurse on call 24/7. Ms. Gilbert denied having access to the nursing notes I requested for Resident A.

On 07/29/2025, while leaving the follow-up onsite investigation, I had a conference with Ms. Merillat. She informed me that she no longer has concerns regarding Resident A's tracheotomy care, as she explained that it sounds as though they are properly caring for it.

On 08/22/2025, I completed an exit conference, via telephone, with licensee designee, Anemia Ubom. The findings and recommendations were discussed. Mr. Ubom was in agreement with the original findings, but stated he was contesting the findings regarding the care Resident A received for his urinary tract infection, insisting they called the doctor the day he went to the hospital. Mr. Ubom did not verbalize acceptance regarding the other findings. Mr. Ubom did not state whether or not he would accept the provisional license that is being recommended, but he was informed of his right to not accept it and was informed that if he did not accept it, he would be afforded the opportunity to plead his case at a compliance conference.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; Resident assessment plan; emergency admission; Resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a Resident for care unless and until the licensee has completed a written assessment of the Resident and determined that the Resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the Resident is available in the home.**
ANALYSIS:	Based on the information gathered in my investigation, there is not sufficient evidence to support the finding that the amount of personal care, supervision, and protection that is required by the resident is available in the home regarding his tracheotomy. Resident A clarified that the direct care staff members are not changing his tracheotomy, just his respiratory therapist and the nurses. Resident A has been suctioned by direct care staff members, which was reported to be appropriate by his nurse case manager.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/26/2025, I initiated my investigation via a telephone interview with Care First Group Living & In-Home Services, Inc. Group Living & In-Home Services, Inc. nurse, DaShaSha Ward. Ms. Ward informed me that approximately one month ago, Resident A had blood in his catheter bag and his urologist was called. The urologist advised them to take Resident A to the hospital if the bleeding did not stop. Ms. Ward did not see Resident A for a few days and when Ms. Ward did see him, there was a significant amount of blood in Resident A's brief and catheter bag. Ms. Ward stated Resident A had diminished lung sounds and was not acting right and Ms. Ward was advised to administer a breathing treatment. Ms. Ward stated they eventually got permission to call an ambulance for Resident A and he was diagnosed with a urinary tract infection and had gone septic.

On 06/26/2025, I received the following nursing assessment note from Ms. Ward, via email, regarding Resident A:

> "At 4:40 pm I received a call from the day shift nurse to assess Resident A. Day nurse stated that she received a call that Resident A was breathing funny and sweating really bad.
>
> Earlier in the day, Resident A's urologist was contacted about the presence of blood in Resident A's urine. An order was sent to Care First Group Living & In-Home Services, Inc. from the urologist to obtain a urine sample and to take it to Beaumont labs to rule out an UTI. Per the urologist office, if Resident A's Sx worsen or if he gets a fever or chills, Resident A is to be taken to the ER.
>
> I arrived at Resident A's home at 5:00 pm. Upon arrival Resident A was being put in bed by staff. I could visually see that Resident A was breathing harder than usual and was sweating. He also appeared diaphoretic. I asked Resident A if he was having trouble breathing and he stated "a little." The head of his bed was raised to help with his breathing. Resident A's vitas were Temp 97.5 BP 89/68, O2 93, P88. A second set of vitals were taken to confirm BP. BP 92/71, P 87. I also noticed that Resident A's brief was saturated with blood. I assessed the cath site, but there was no blood present at the insertion site. I assessed his cath bag and noticed a scant amount of bloody urine. As his brief was being changed, there was a large amount of blood with many large blood clots noted in his brief.
>
> As staff was cleaning and changing Resident A's brief to prepare him for transport to the hospital, I noted that there was a clamp on Resident A's cath tube. The clamp was blocking the flow of urine from Resident A's bladder from going into his urine bag. I asked the staff who put the clamp on him, but they all answered that they were not sure. The staff did state that his cath was flushed

> earlier that morning by the day nurse. The clamp was immediately removed, at that time, bloody urine flowed down Resident A's cath tubing into the urine bag. When Resident A was rolled onto his side, for the placement of a new brief, a large amount of blood flowed from his penis. An abdomen pad was placed inside of the clean brief to help absorb the blood flow until Resident A gets to the hospital."

On 06/27/2025, during the onsite investigation at Care First Group Living & In-Home Services, Inc. rehabilitation center, I completed a private interview with Resident A. He stated he was septic in May and stated he had been telling staff he was in pain and his eyes were bloodshot for 2-3 weeks before they did anything besides checking his vitals. He stated he was bleeding for a while.

On 06/27/2025, during the onsite investigation at Care First Group Living & In-Home Services, Inc., I completed an interview with co-owner, Leslie Ubom. She stated when they saw blood in Resident A's catheter bag, they contacted the urologist who recommended a urine sample be collected to rule out a urinary tract infection. She stated the urologist instructed them to take Resident A to the emergency room if the symptoms worsened. She stated nursing had contacted her and stated he had blood clots in his brief and diminished lung sounds, so they sent him to the emergency room, via ambulance.

On 06/30/2025, I received the incident report, discharge papers, and assessment plan, via email, from Merima Zander, program director for Care First Group Living & In-Home Services, Inc. The incident report is dated 05/27/2025 and is regarding Resident A going to the hospital. The explanation section stated the following:

> "Dr. Cameron's office (Urologist) recommended obtaining a urine sample when contacted regarding blood in urine earlier. After a nursing assessment, it was noted that Resident A had diminished lung sounds and blood clots in his urine catheter bag. His vitals were stable, and he did not complain of any pain."

The section for action taken by staff/ treatment given, states the following:

> "EMS was contacted as recommended by Dr. Cameron's office who advised that if he started to develop any symptoms such as fever or chills, or if anything worsened, he should be sent to the emergency room for further evaluation for a possible UTI or infection."

The incident report indicates the witnesses who were there when Resident A was taken to the hospital on 05/27/2025 are Sharmia Sinclair, George Hutchison and DaShaSha Ward.

The discharge papers indicated that Resident A was admitted to the hospital from 05/27/2025-06/06/2025. The records indicate that he was diagnosed with sepsis and urosepsis.

The assessment plan does not include anything about tracheotomy care for Resident A.

On 06/27/2025, during the onsite investigation at Care First Group Living & In-Home Services, Inc., rehabilitation center, I completed an interview with co-owner, Leslie Ubom. She stated when they saw blood in Resident A's catheter bag, they contacted the urologist who recommended a urine sample be collected to rule out a urinary tract infection. She stated the urologist instructed them to take Resident A to the emergency room if the symptoms worsened. She stated nursing had contacted her and stated he had blood clots in his brief and diminished lung sounds, so they sent him to the emergency room, via ambulance.

On 07/08/2025, I completed a telephone interview with Antoniette Fairley, nurse for Care First Group Living & In-Home Services, Inc. She denied any concerns regarding his care and denied being there when he went to the hospital. She stated the blood was noticed and reported, but denied knowing how long it was after the blood was observed until he was taken to the hospital

On 07/08/2025, I completed a telephone interview with Jasmine White, nurse for Care First Group Living & In-Home Services, Inc. Ms. White is an LPN. Ms. White denied knowing about Resident A being septic. She stated she worked that day, but he went to the emergency room after her shift. She stated she did see some blood-tinged urine that day and denied knowing what happened. She denied concerns with the care Resident A is receiving. She informed me that Resident A is vocal and is 100% aware of what is going on.

On 07/18/2025, I sent an email to Ms. Ward, requesting any other nursing notes she may have. She replied, stating she did not, but she did provide this statement:

> "I don't have any more notes that I would have access to. I do know that I assessed him for bleeding the Friday before him going to the hospital. He had blood in his urine bag then. I flushed his catheter and there was no more bleeding noted at that time. I gave a report to the COO.
>
> But over that weekend (that was my weekend off) the house supervisor at that time reported to the COO that he was still bleeding. (I saw it on the group chat.) Another nurse, Antoinette assessed him and flushed his cath again. She did complete a note on him that day. From my understanding, he continued to have bleeding over the entire weekend. The house supervisor told me that she continued to report her concern about Resident A’s bleeding to the COO, but the COO would not listen to her. You may want to speak with her as well, I just don't have her information."

On 07/25/2025, I completed a telephone interview with direct care staff member, Sharmia Sinclair. Ms. Sinclair stated she is employed by Care First Group Living & In-Home Services, Inc., but does not have one home she works at. She stated all the direct care staff float from home to home and they are usually not at the same home for

more than a couple of days. She informed me she was at The Tutbury Residence the day Resident A was taken to the hospital. She stated when she arrived that day, Resident A seemed tired and was like that all day. She stated she checked his vitals a few times and they were going down.

On 07/25/2025, I completed a telephone interview with Resident A’s nurse case manager, Kathy Merillat. Ms. Merrillat denied knowing when the bleeding in Resident A's catheter began and relayed that he has a history of blood in his urine. She stated it usually goes away after his catheter is flushed and that it can be caused by irritation. She stated that if the flushing does not work, they are to get orders for a urinalysis to check for urinary tract infections. She explained that Resident A is screened for stones regularly and was last screened in July, with no stones present. He goes to all doctor appointments.

Ms. Merillat stated that she was looking at the hospital records for Resident A and they reported that Resident A had started bleeding on 05/23/2025. She explained that it would not have been reported to his urologist if it was intermittent and stopped after being flushed. She stated the records also indicate that Resident A had a clamped catheter that day, which is not related to bleeding or urosepsis, unless it was clamped for a day or two, but could make him uncomfortable. She stated the records also indicate that Resident A had saturated two briefs with blood that was coming from his penis. She informed me that his catheter is not in his penis, but in his pubic area. The records further indicated that Resident A was hypotensive, and his hemoglobin had dropped to the point where he required blood transfusions. He had a high white blood cell count that indicated a definite infection. Furthermore, the records indicate Resident A was bleeding so much that the hospital staff had to do a bed change. The records indicate George Hutchison, Resident A's internal case manager, had contacted the urologist on 5/27/2025, at 8:45 am, 11:45 am, and 2:35 pm, due to the concerns with the bleeding. Mr. Hutchison spoke with the doctor at 3:44 pm and reported Resident A had blood in his urine and was sweating. Ms. Merillat explained that it is common for those with spinal cord injuries to sweat and it could be due to many different things, such as irritation. Ms. Merillat explained that Resident A's catheter is flushed more often than most due to his frequent urinary tract infections. She relayed that Resident A is usually in tune with his body when something is wrong and is usually pretty verbal about it.

On 07/29/2025, I completed a follow-up, unannounced, investigation at The Tutbury Residence, with nurse case manager, Kathy Merillat. We completed a private interview with Resident A. We asked clarifying questions regarding the incident on 05/27/2025, when he was hospitalized for the urinary tract infection. Resident A stated he had blood in his in his catheter bag where? for two weeks before he went to the hospital. He stated there was blood coming from his penis and that it was thick and cherry red. He stated the thick and red blood started that Monday, the day before the hospitalization. He stated he had been in pain for about a week, and the nurses were monitoring him. He could tell it was a "bladder situation" and it took 5-6 days before they did anything.

On 07/29/2025, while leaving the follow-up onsite investigation, I had a conference with Ms. Merillat. She stated she did not have enough information to determine whether they responded appropriately to Resident A's incident with his urinary tract infection. She stated, in her experience with Resident A, that he seemed to be confused and she is concerned with his ability to properly recall and explain what happened. Resident A did not appear to be confused to me, he did have trouble recalling dates and times, but he appeared to know what it was he was talking about.

On 07/30/2025, I received, via email, nursing notes for Resident A for 05/23/2025-05/27/2025. The note for 05/23/2025 for Resident A, written by Antoinette Fairley, indicated Resident A had labored breathing and his urine color was within normal limits. On 05/27/2025, there is a nursing note, written by Jasmine White, indicating there was no blood in Resident A's urine. Ms. Fairley completed a note for 05/26/2025, indicating no blood in his urine.

On 08/04/2025, I completed a phone interview with Zabrina Gilbert, night manager at The Tutbury Residence. Ms. Gilbert was on duty the weekend of May 23-26. Ms. Gilbert confirmed that she had concerns regarding Resident A during that weekend. She stated he was bleeding, wasn't acting like himself and had stopped eating. She reported her concerns to the nursing line and was instructed to keep checking his vitals and to report to the nursing line.

On 08/04/2025, I completed a phone interview with the care coordinator for Care First Group Living & In-Home Services, Inc., George Hutchison. Mr. Hutchison stated that Resident A started bleeding on Sunday, 5/25/2025, and he contacted the urologist on Monday, 5/26/2025, then stated it might have been the 27th. He started calling around 8:30am. He stated if there are concerns with a resident's health, the direct care staff members are instructed to contact the nursing line for guidance. He stated that they will sometimes send a nurse out to evaluate the resident or instruct them to call 911.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a Resident 's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the evidence obtained during the investigation, there is sufficient evidence to show that Resident A did not receive care immediately after his condition worsened. Blood was first noted in his urine on 05/23/2025, as indicated by DaShaSha Ward and that the home manager was concerned about his condition over the weekend. On 05/27/2025, the case manager, George Hutchison, contacted the urologist at 8:45 am, 11:45 am, and 2:35 pm. Mr. Hutchison did not receive a call back from the urologist's office until 3:44pm and informed them that

	Resident A was sweaty and had blood in his urine. According to the incident report, Resident A did not go to the hospital until 5 pm. The hospital records indicate Resident A had been bleeding since 05/23/2025; he needed a blood transfusion and was septic. The home manager on the night shift reported having had concerns with Resident A's condition due to Resident A bleeding, not acting like himself, and was not eating. She reported it to the nursing line and was instructed to monitor vitals. By the time Resident A arrived at the hospital, he was already in urosepsis and required a blood transfusion. Resident A disclosed that he had been telling staff for 5-6 days that something was wrong, most likely bladder related, his timeline matches the timeline provided by Ms. Ward and Ms. Merillat, via the hospital records.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 06/27/2025, during my onsite investigation at The Tutbury Residence, I completed an interview with home manager, Kristina Hedtke. I requested to see the incident report from Resident A's hospitalization, discharge papers, assessment plan, and resident care agreement. She stated she did not have them at the home and they would need to be requested at their rehabilitation center.

On 06/27/2025, during the onsite investigation at Care First Group Living & In-Home Services, Inc. I completed an interview with co-owner, Leslie Ubom. Ms. Ubom stated there should be an incident report and agreed to send it to me, along with Resident A's discharge paperwork from the hospital, his assessment plan, resident care agreement, and incident report.

On 06/30/2025, I received documents, via email, from Merima Zander, PTA Program Director for Care First Group Living & In-Home Services, Inc. The documents included the discharge summary from Resident A's hospital stay from May, Resident A's signed resident care agreement, Resident A's assessment, and the incident report from when Resident A went to the hospital for the urinary tract infection.

The following details from the documents were noted:

> The resident care agreement was electronically signed. The date was 12/14/2024, but when I validated the signatures through DocuSign, it showed the document was signed on 06/30/2025.
>
> The signatures on the Resident Care Agreement and assessment plan are the guardian of Resident A1 and a signature that I could not decipher.

The incident report was signed via DocuSign and the date listed on the report was for 05/27/2025, when the signature verification was checked, it was completed on 06/30/2025. The signatures on the report are Merima Zander and Aniema Ubom.

On 07/14/2025, I completed a telephone interview with Resident A's public guardian, Richard Lyons. Mr. Lyons stated he received an incident report regarding Resident A's hospitalization. He stated he received it via email and could not remember the date, he agreed to forward the email to me. He stated he did sign the documents that were sent to him but could not remember the date.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; Resident assessment plan; emergency admission; Resident care agreement; physician's instructions; health care appraisal.**
	(8) A copy of the signed Resident care agreement shall be provided to the Resident or the Resident 's designated representative. A copy of the Resident care agreement shall be maintained in the Resident 's record.
ANALYSIS:	Based on the information gathered in my investigation, there is sufficient evidence to support that Resident A did not have a signed resident care agreement.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Licensing Study Report 02/13/2024, CAP dated 02/23/2024.**

On 07/15/2025, I received a text message from Mr. Lyons, informing me that he did not receive the incident report. The last thing he received regarding Resident A was his annual paperwork received on 06/30/2025.

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(1) If a Resident has a representative identified in writing on the Resident 's care agreement, a licensee shall report to

	the Resident 's representative within 48 hours after any of the following: **(b) Unexpected and preventable inpatient hospital admission.**
ANALYSIS:	Based upon information gathered during my investigation, there is sufficient evidence to support that a required incident report was not completed, nor sent to the resident's representative within 48 hours. During my onsite investigation, I requested a copy of the incident report (IR) from home manager Kristina Hedtke, who was not able to find one in the system. I requested an IR from Leslie Ubom, co-owner, and when it was emailed to me, the DocuSign validation indicated the incident report was signed on 06/30/2025 and not 05/27/2025, the date the signatures were backdated to. Adobe indicated that the incident report was created on 06/30/2025. Furthermore, Resident A's guardian confirmed that he did not receive the incident report.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 07/17/2025, I sent an email to Merima Zander, program director at Care First Group Living & In-Home Services, Inc., requesting the staff schedule for the months of May and June, the contact information for the staff who worked in May and June, and nursing notes pertaining to Resident A.

On 07/18/2025, I sent an email to Merima Zander, Aniema Ubom (licensee designee), Leslie Ubom, and Ime Ubom, requesting the documents.

On 07/23/2025, I attempted to make phone contact with Ms. Zander to request the documents. A voicemail was left requesting a return call.

On 07/25/2025, I completed a telephone interview with direct care staff member, Sharmia Sinclair. Ms. Sinclair stated she is employed by Care First Group Living & In-Home Services, Inc., but does not have one home she works at. She stated all the direct care staff float from home to home and they are usually not at the same home for more than a couple of days.

On 07/25/2025, I completed a telephone interview with former Care First Group Living & In-Home Services, Inc., direct care staff member, Nerissa Dorris. Ms. Dorris stated the staff rotated from home to home and there were scheduling issues, she did not work at one home.

On 07/30/2025, due to being informed that the direct care staff float from home to home, I cross referenced the names on the May work schedule for The Tutbury Residence with those who have completed background checks. The following results were found.

Direct care staff members with completed background checks for The Tutbury Residence:

1. Jasmine Colson
2. Deaundra Lee
3. Porsche Foster
4. Kiarra Dailey
5. Denaisha Moore
6. Tiara Odom.

Direct care staff members with completed background checks through Care First Group Living & In-Home Services, Inc., but under one of their other licenses:

1. Tina Willis
2. Alicia White
3. Wynter Montgomery
4. Tarmars Terry
5. LaNesha Parham
6. Kristina Hedtke
7. Amber Respress
8. Tayvonna Dorris
9. Jasmine Colson
10. Kennedie Collins
11. Jameela Johnson
12. Nareisha Sain
13. Nikeya McPherson
14. Brielle Stephens
15. Sharmia Sinclair
16. Jayla Carr
17. Shayla R. Jones
18. Malik Greason
19. Cheyenne Gaines
20. Katrina Howell
21. Zabrina Gilbert
22. Regina Dixon
23. Danielle Thompson
24. Marcus Lovelace
25. Shantaque Askew-Broadus
26. Bianca Gee
27. Monique Carter
28. Rodnae Chapman
29. Bijon Luster

30. Kenya Saine
31. Danielle Carson
32. Tiffany Burt

Direct care staff members without any background checks completed by Care First Group Living & In-Home Services, Inc.:

1. Cierra Barron
2. Shawnquilla McKnight
3. Nazayia Brand
4. Destini Tyler
5. Nakisha L. Crumsby
6. Dnyla Williams
7. Chicquitta Gillette
8. Khady Diaw
9. Tynitta Perry
10. Elinor Taylor Stoval
11. Emari Chambers
12. Miracle White
13. Carmon Jackson
14. Justice Moore
15. Shareah Page
16. Tarryona Gavin
17. Italy Aron
18. Marcianna Edwards
19. Ja'Kayla Green
20. Tashanti Jackson
21. Dejanique Williams
22. Jasilyn Teasley
23. Shkai Simmons-White
24. Chelsea Holiday
25. Chanel Purdy
26. Toni Hockett
27. LaKira Johnson
28. Erica Berrien
29. Sharane Smith
30. Annette Perry
31. Deniea Williams
32. Tuniesia Nelson
33. Ciara Hunter
34. Keisha Lindsey
35. Brittany Gaut
36. Myonia Jackson
37. Mariah Bush
38. Leroy Harris
39. Quasheena Weaks

40. Kiarra Dailey
41. Jestiny Rouser
42. Daisianae Martin
43. Fredricka Al-Gaith
44. Georgia Knight
45. Shaniece Moore
46. Asya Taylor
47. Malisha Pouncey
48. Allison Hunter
49. Grace Quarker
50. Erika Robinson
51. Deana Hale
52. Victoria Williams
53. L'Shanta Chattard
54. Jayla Henry
55. Deeda La Browning
56. Naiya Lofton
57. Quanisha Golden
58. AnDrea M. Jackson

In the month of May 2025, at The Tutbury Residence, the following shifts/days were worked by those with no background checks completed by Care First Group Living & In-Home Services, Inc. and without supervision by someone who has had a completed background check:

1. 05/01: Ciera Barron, Shawnquilla McKnight, and Nazayla Brand.
2. 05/02: Destini Tyler, Nakisha L. Crumsby, and Dnyla Williams
3. 05/13: Ellinor Taylor Stoval, Shawnquilla McKnight, and Tashanti Jackson.
4. 05/14: Jasmine Pope
5. 05/19: Tynitta Perry
6. 05/22: Mariah Bush, Deeda La Browning, Ellinor Taylor Stoval, and LeRoy Harris.
7. 05/23: Naiya Lofton and Quasheena Weaks.
8. 05/31: Chicquita Gillette, Shareah Page, and Toni Hockett.

On 07/31/2025, I sent an email to Uniema Ubom, Leslie Ubom, and Marima Zander informing them of the concerns due to the background checks not being completed for more than half of the direct care staff members not having background checks. I advised them to start on them as soon as possible. I also informed them that the direct care staff members who do not have completed background checks would only be allowed to work if they sign an attestation that they have lived in Michigan for the past 12 months, conduct an Internet Criminal History Access Tool (IChat) for each of them, and they must be supervised by someone who they have completed background checks for.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to Resident s; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to Resident s until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006, but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.

ANALYSIS:	Based on the information gathered during my investigation, there is sufficient evidence to support that there were employees working at The Tutbury Residence who were not the subject of a criminal history check conducted in compliance with this section. I reviewed the May work schedule for The Tutbury Residence and cross referenced it with the Workforce Background Check website. Of the 96 people who worked at The Tutbury Residence during the month of May 2025, Care First Group Living & In-Home Services, Inc. did not complete the required background checks and fingerprinting of 58 employees and 30 of them had completed background checks for other homes owned by Care First Group Living & In-Home Services, Inc.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to Resident s; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(c) Except as otherwise provided in this subdivision, the adult foster care facility does not permit the individual to have regular direct access to or provide direct services to Resident s in the adult foster care facility without supervision until the criminal history check or criminal history record information is obtained and the individual is eligible for that employment. If required under this subdivision, the adult foster care facility shall provide on-site supervision of an individual in the facility on a conditional basis under this subsection by an individual who has undergone a criminal history check conducted in compliance with this section. An adult foster care facility may permit an individual in the facility on a conditional basis under this subsection to have regular direct access to or provide direct services to Resident s in the adult foster care facility without supervision if all of the following conditions are met:

	(i) The adult foster care facility, at its own expense and before the individual has direct access to or provides direct services to Resident s of the facility, conducts a search of public records on that individual through the internet criminal history access tool maintained by the department of state police and the results of that search do not uncover any information that would indicate that the individual is not eligible to have Rendered Monday, July 7, 2025 Page 27 Michigan Compiled Laws Complete Through PA 5 of 2025 Courtesy of www.legislature.mi.gov regular direct access to or provide direct services to Resident s under this section. **(ii) Before the individual has direct access to or provides direct services to Resident s of the adult foster care facility, the individual signs a statement in writing that he or she has resided in this state without interruption for at least the immediately preceding 12-month period.**
ANALYSIS:	Based on the evidence and information obtained during my investigation, there is sufficient evidence to support that Care First Group Living & In-Home Services, Inc. allowed employees who had not completed background checks to work unsupervised at The Tutbury Residence during the month of May during eight shifts.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 07/14/2025, I completed a phone interview with Relative A1. She stated she has a couple of complaints and is currently trying to be her father's co-guardian. Relative A1 expressed concerns regarding discipline at the home. She stated her father will get written up for his "behavior" and they will refuse to take him on outings and not allow him visits with family.

On 07/29/2025, I completed an unannounced, in person, interview with Resident A at The Tutbury Residence, with nurse case manager, Kathy Merillat. Resident A stated they restrict his family from visiting if he does not behave and he is not allowed to participate in community outings if he has misbehaved.

On 07/29/2025, while leaving the follow-up interview at The Tutbury Residence, I had an in-person conference with Ms. Merillat. Ms. Merillat explained that the only restrictions Resident A has regarding family visits is the number of visitors at one time and they do not allow him to go to his brother’s home, due to him providing marijuana to Resident A. Ms. Merillat informed me that Resident A does have his community outings suspended for 30 days if he is not behaving properly. She stated it is in his behavior plan.

On 08/07/2025, I received the behavior plan for Resident A. The list of targeted behaviors includes non-compliance and refusals, which is described as ignoring staff's repeated prompt to participate in a scheduled or necessary task, such as refusing medication, refusing medical care provided by assigned staff, or attempting to elope from staff using his wheelchair. The behavior plan indicates it was modified to exclude him from outings for 30 days and will get extended with the continued engagement in behavioral episodes or incidents. A differential reinforcement of alternative behaviors was implemented and if Resident A does not engage in his behaviors, he can reverse the number of days.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment.**
ANALYSIS:	Based on the information gathered during my investigation, it has been determined that there is enough evidence to conclude the staff is using punishment with Resident A as a way to handle his behaviors. Staff not allowing Resident A to participate in community outings for 30 days if he engages in unwanted behaviors, they are in fact instituting a punishment.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

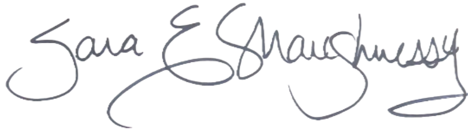
On 08/21/2025, I reviewed my concurrent investigations of the licensee's other homes and determined there are concerns regarding the suitability of the licensee. Mr. Ubom signed and backdated the documents after I had requested signed copies. He did not send an incident report to the guardian and the one he sent me, was created on 06/30/2025, when the incident occurred on 05/27/2025. Mr. Ubom failed to obtain immediate treatment for Resident A, after concerns were raised about blood in his catheter bag and change in his behavior and appetite. Mr. Ubom waited almost 10 days to instruct his program manager, Merima Zander, to provide me with the requested information and left out a crucial nursing note from the day Resident A was taken to the hospital. Furthermore, Mr. Ubom did not run background checks on more than half of his direct care staff members, even though he was aware of it being required. He did not get statements in writing indicating the direct care staff members were residents of Michigan for 12 months, nor did he complete any ICHAT searches to determine if they

were eligible for a conditional offer of employment. Mr. Ubom is the licensee designee for four other adult foster care homes as follows: The Winchester Residence, Boulan Residence, The Hawthorne Residence, and The Trevino Residence, and there were direct care staff members working in those homes without background checks being completed as well.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(9) A licensee and the administrator shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.**
ANALYSIS:	Based on the information gathered during my investigation, there is sufficient evidence to establish the violation regarding licensee/administrator qualification of being suitable. The program manager, Merima Zander, emailed me a resident care agreement, incident report, and assessment plan for Resident A. The assessment plan and care agreement were dated as signed on 12/14/2024, but they were signed with Docu Sign and the verification indicated that they were both signed on 06/30/2025, following my request. Resident A's guardian confirmed that he received the documents on 06/30/2025. The incident report was dated 05/27/2025. Docu Sign indicated it was signed on 06/30/2025 and Adobe indicated the incident report was created on 06/30/2025. When I requested nursing notes for Resident A, I did not receive the notes for almost 10 days after the request was made and one crucial nursing note completed by Ms. Ward on 05/27/2025 was missing Furthermore, the licensee had 58 employees working with residents during the month of May who have not had a criminal background check completed. These facts show there is a lack of suitability of the licensee, Aneima Ubom.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

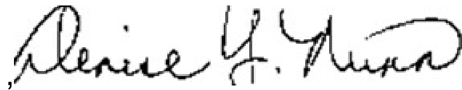
Contingent upon receiving an acceptable corrective action plan, issuance of a provisional license is recommended.



08/23/2025

Sara Shaughnessy Date
Licensing Consultant

Approved By:



09/18/2025

Denise Y. Nunn Date
Area Manager

AMENDED REPORT
SIR #2025A0626020

PURPOSE:

The purpose of this amended report is to change the violations contained in the special investigation report dated 09/18/2025 for R 400.14310 and R 400.14201(9)(a) and to reanalyze rule R 400.14308 based on new information presented by the licensee designee.

METHODOLOGY:

10/03/2025	Contact – Document received I received an email from Aniema Ubom requesting a conference with area manager.

10/27/2025	Contact – Face to face A Teams Meeting took place with Aniema Ubom (licensee designee), Leslie Ubom (chief operating officer), area manager, and licensing consultant.

DESCRIPTION OF FINDINGS AND CONCLUSIONS:

On 10/27/2025, after a conference took place with the licensee designee, he stated that he had obtained medical care for Resident A, as he had sent nurses to the home to evaluate Resident A. Due to the nurses being licensed practical nurses, it was determined that, under the rule, he did seek immediate needed care.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident 's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the evidence obtained during my investigation and the additional information obtained during the conference from the licensee designee and the chief operating officer, there is not enough evidence to support the violation that The Tutbury Residence did not obtain needed care. When the concerns regarding Resident A's health were brought to the attention of the chief operating officer, a nurse was discharged to the home to evaluate the situation. The rule does not specify who can provide the medical care and does not specify it must be a physician, therefore, instructing a licensed nurse to complete an evaluation constitutes needed care.
CONCLUSION:	VIOLATION NOT ESTABLISHED

Under heading II of the special investigation report, I cited a violation of rule R 400.14201 regarding the qualifications of administrator, direct care staff, licensee, and members of household.

Following the conference held on 10/27/2025, it was determined that the information in the report and the analysis did not reach the level of deducing that the licensee designee is not suitable to meet the physical, emotional, social, and intellectual needs of each resident.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(9) A licensee and the administrator shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.**
ANALYSIS:	Based on the information gathered during my investigation and further discussion regarding what rises to the level of this rule violation, it has been determined that there is not enough evidence to support that Mr. Ubom is not suitable to meet the physical, emotional, social, and intellectual needs of each resident.
CONCLUSION:	VIOLATION NOT ESTABLISHED

Under heading II of the special investigation report, I cited a violation of rule R 400.14311 regarding the notification of the guardian within 48 hours of an unexpected or preventable inpatient hospital admission. During the investigation, I requested a copy of the incident report regarding this notification. The licensee designee had an incident report emailed to me on 06/30/2025. The signature was Docu Signed on 06/30/2025, while the incident occurred on 05/27/2025. No additional documentation was provided until after the requested conference took place. On 10/27/2025, I received a forwarded email sent from Leslie Ubom, containing an email notification that had been sent to Resident A's guardian, Richard Lyons. The notification indicates Resident A had started bleeding on Sunday afternoon and he was taken to the hospital that Tuesday. It should be noted that during the Teams meeting, Ms. Ubom insisted that Resident A did not start bleeding until Tuesday morning.

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(1) If a Resident has a representative identified in writing on the Resident 's care agreement, a licensee shall report to the Resident 's representative within 48 hours after any of the following: **(b) Unexpected and preventable inpatient hospital admission.**

ANALYSIS:	After the conclusion of the investigation, I received a forwarded email containing the email sent to Resident A's guardian on 05/28/2025, within 48 hours of the hospitalization.
CONCLUSION:	VIOLATION NOT ESTABLISHED

Also in section II of the special investigation report, I cited a violation for rule R 400.14308 regarding resident behavior. I provided the following analysis:

> *Based on the information gathered during my investigation, it has been determined that there is enough evidence to conclude the staff is using punishment with Resident A as a way to handle his behaviors. Staff not allowing Resident A to participate in community outings for 30 days if he engages in unwanted behaviors, they are in fact instituting a punishment.*

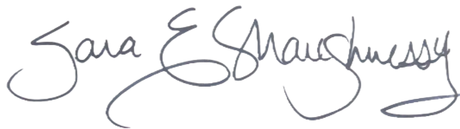
This was further discussed in the conference, and it was taken under consideration to be removed. Mr. and Ms. Ubom insisted that Resident A does not receive punishment.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment.**
ANALYSIS:	Based on the information gathered during my investigation and further discussion with the licensee designee, it is determined there is enough evidence to support the use of punishment with Resident A. I received statements from Resident A, Relative A1, and Resident A's nurse case manager that if Resident A does not follow his behavior plan, he is restricted from community outings for 30 days. I reviewed his behavior plan and some of the unwanted behaviors are within the rights of Resident A, such as refusing medication or therapy. The behavior plan also indicates that for outings and off campus opportunities, Resident A must maintain zero targets for 48 hours. Furthermore, Resident A's program was previously modified for 30 days, and that modification gets extended with the continued engagement in behavioral episodes or incidents. If he behaves, they reverse the number of days. Restricting his community access due to unwanted behaviors is a form of punishment.
CONCLUSION:	**VIOLATION ESTABLISHED**

RECOMMENDATION:

Based on further information and review of the information, I recommend the violations for rules R400.14310, R400.14311, and R 400.14201 be changed as violations. I also recommend the violation for rule R 400.1438 stand as is.

An acceptable corrective action plan has been received. There are no recommended changes to the status of the license.



11/17/2025

Sara Shaughnessy Date
Licensing Consultant

Approved by:

11/24/2025

Denise Y. Nunn Date
Area Manager