GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 2, 2025

Janette Thiel
Macomb Family Services Inc
124 West Gates
Romeo, MI 48065

RE: License #: AS500378403
Investigation #: 2025A0604016
Junction

Dear Ms. Thiel:

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

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

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

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

Sincerely,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 West Grand Blvd Ste 9-100
Detroit, MI 48202
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500378403
Investigation #:	2025A0604016
Complaint Receipt Date:	07/15/2025
Investigation Initiation Date:	07/16/2025
Report Due Date:	09/13/2025
Licensee Name:	Macomb Family Services Inc
Licensee Address:	124 West Gates Romeo, MI 48065
Licensee Telephone #:	(586) 246-1378
Administrator:	Janette Thiel
Licensee Designee:	Janette Thiel
Name of Facility:	Junction
Facility Address:	50494 Ruedisale New Baltimore, MI 48047
Facility Telephone #:	(586) 716-8570
Original Issuance Date:	02/17/2016
License Status:	REGULAR
Effective Date:	08/17/2024
Expiration Date:	08/16/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
The group home smells like marijuana and smoke in the home and in the garage.	Yes
Resident A is supposed to wear a boot for broken foot. The staff took the boot off and as a result, Resident A's fracture has gotten worse.	No
Resident A was taken to a Tiger's game and that morning he was not given his morning medication.	No
Resident A was placed on a special diet by his primary care physician and the facility is not providing Resident A with the correct food for his diet.	No
Resident A had multiple unexplained transactions on his food benefits card.	No

III. METHODOLOGY

07/15/2025	Special Investigation Intake 2025A0604016
07/15/2025	APS Referral Referral received from Adult Protective Services (APS)
07/16/2025	Special Investigation Initiated - Letter Special investigation initiated by Eric Johnson. Email sent to Janette Thiel
07/16/2025	Contact - Document Sent Email to Janette Thiel. Requested Funds forms
07/17/2025	Contact - Document Received Email from Janette Thiel. Sent return email.
07/17/2025	Contact - Document Sent Email to APS Worker, Emily Poley re: assigned APS worker
07/17/2025	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Home Manager, Cederic Williams. Resident A at school.
07/21/2025	Contact - Document Received Email from Janette Thiel. Received staff, list, resident register and resident information records

08/01/2025	Contact - Document Received Second intake received #206699. Will dismiss and add allegations to open investigation. Allegations regarding same resident.
08/04/2025	Contact - Document Sent Email to Janette Thiel requesting documents
08/05/2025	Contact - Document Received Email from Janette Thiel. Received copies of Funds Part 1 and 2 forms, incident reports, Individual Plan of Service (IPOS) and crisis plan, health care appraisal, health care chronological (HCC), medication administration record and EBT transaction history.
08/06/2025	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Home Manager, Cederic Williams. Resident A at school.
08/06/2025	Contact - Document Sent Email to and from Janette Thiel
08/07/2025	Contact - Document Received Email from Janette Thiel
08/25/2025	Contact - Document Received Dismissed intake #207083. SI already exits.
08/29/2025	Contact - Document Sent Email to APS Worker, Christina Gregory
08/29/2025	Contact - Document Sent Email to Janette Thiel
09/02/2025	Contact - Document Received Email from Janette Thiel. Sent return email.
09/02/2025	Contact - Document Sent Email to Case Manager, Susan Polakowski
09/02/2025	Contact - Document Received Email from Susan Polakowski
09/02/2025	Contact - Document Received Email from APS Worker, Christina Gregory
09/02/2025	Contact - Document Sent Email to APS Worker, Christina Gregory

09/03/2025	Contact- Document Sent Email to Janette Thiel
09/04/2025	Contact- Document Received Email from Janette Thiel. Sent return emails.
09/04/2025	Contact- Document Sent Email to APS Worker, Jose Garcia
09/05/2025	Contact- Document Received Email from APS Worker, Jose Garcia
09/10/2025	Contact- Document Sent Email to Janette Thiel
09/11/2025	Contact- Document Received Received email from Janette Thiel with staff write up, funds form and HCC notes
09/30/2025	Contact- Telephone call made Received return call from Relative 1
10/01/2025	Exit Conference I completed exit conference with licensee designee, Janette Thiel

ALLEGATION:

The group home smells like marijuana and smoke in the home and in the garage.

INVESTIGATION:

I received a licensing complaint regarding the Junction Home on 07/15/2025. It was alleged that Resident A has a food benefits card. His card is not really used by the group home. It is typically only used for emergencies at the group Home. It was recently discovered that there have been other transactions on Resident A's food benefits card over the last few months. On 07/03/2025, $72.00 was used. Last month there were two transactions, one for $72.00 and the other for $38.00. Another month, $89.00 of the benefits were used. None of those transactions were to purchase food for the group home. It is unknown who may be using Resident A's card. The card is usually locked away in the lock drawer in the group home and it has never come up missing in the group home. No one in the group home has the code for the card. There is concern someone may have been using Resident A's food benefits card without permission.

I received a second licensing complaint regarding the Junction Home on 08/01/2025. It is alleged that Resident A is supposed to wear a boot because of a broken foot. The

staff took the boot off and as a result, Resident A's fracture has gotten worse. Resident A has suffered a setback resulting in Resident A wearing the boot longer and requiring additional X-rays. Recently, Resident A was taken to a Tiger's game and that morning he was not given his morning medication. Relative 1 was not notified, and she was given the medication. The staff did not report to Relative 1 that Resident A did not receive the medication prior to being picked up. It is also alleged that there are workers that smoke marijuana while in the garage. There is a staff member named Latonya that defies the rules and goes in the garage and smokes.

I received a third licensing complaint regarding Junction Home on 08/25/2025. It was alleged that Resident A was placed on a special diet by his primary care physician and the facility is not providing Resident A with the correct food for his diet. Resident A's foot is broken and his doctor placed Resident A's foot in a boot. It is ordered for Resident A to keep his foot in the boot and the staff disregarded the order from the doctor and Resident A's break has gotten worse. An argument ensued between a staff member and guardian regarding Resident A keeping the boot on his foot. The staff member reported he believed Resident A did not need the boot because Resident A was walking ok. The staff member that was on shift was observed to be walking out of the home to take care of a personal matter and that is when Resident A's family realized that Resident A did not have the boot on. The group home smells like marijuana and smoke in the home and in the garage.

I completed an unannounced onsite investigation on 07/17/2025. I interviewed the Home Manager, Cederic Williams. Resident A was at school. I did not smell any marijuana in the home during the onsite investigation or see any signs of marijuana use.

I completed a second unannounced onsite investigation on 08/06/2025. I interviewed staff, Jhaymi Roberts and Larry Behem. I did not smell any marijuana in the home during the onsite investigation or see any signs of marijuana use.

On 08/06/2025, I interviewed staff, Jhaymi Roberts. He stated that he does not smoke cigarettes or marijuana. Mr. Roberts stated that he did smell marijuana occasionally. He was unsure when, however, believed it was less than a year ago. He has not smelled any marijuana recently. He stated that they have one resident who smokes cigarettes but was unaware of any residents using marijuana. He did not have any concerns regarding the home.

On 08/06/2025, I interviewed Staff, Larry Behem. He stated that he is on the fire department and does not use marijuana. He has never seen any staff using marijuana, however, has smelled it in the home. He has not smelled it recently since one staff member left the home. Mr. Behem stated that about nine months ago a complaint was made regarding marijuana use and recipient rights investigated. He also indicated that staff are not supposed to smoke in the garage.

On 09/02/2025, I received an email from APS Worker, Christina Gregory. She was informed that the caregiver who smoked marijuana no longer works at the home. She is

not substantiating allegations regarding Junction Home. Client reported feeling safe in the home.

On 09/11/2025, I received an email from licensee designee, Janette Thiel, with staff write up for Thomas Parker dated 02/26/2024. The write-up was due to an incident on 01/29/2024 when Mr. Parker was working and there was found to be a strong smell of marijuana in the garage. Ms. Thiel indicated that the Macomb Family Services administrative office was contacted by relatives who reported that as they walked up the driveway they were able to smell marijuana. They complained that the staff, Thomas Parker Ogle, appeared to be under the influence of marijuana and was very argumentative. They also complained that the house was not cleaned properly. Amy Noble, Director of Residential, and Ms. Thiel then went out to the home unannounced to check on the home and it's staff several times. Each time they visited the smell of marijuana was not present. They spoke to the manager, Cedric Williams, concerning the issue and he said that he did not think this was true. Therefore, at that time they put in writing Macomb Family Services' policies on smoking and staff duties with Thomas and stated that if any of these should arise further disciplinary action will be taken up to and including termination. Thomas Parker Ogle has since resigned from his position. Ms. Thiel indicated that she went out to the home to speak with the manager, Cedric Williams, on 09/05/2025 regarding allegation of staff, Latonya Wilson, smoking in the garage. She asked Mr. Williams if he had ever seen her smoking, and if so where. Ms. Wilson only works the Saturday daytime shift and Mr. Williams does not work that shift, nor have staff reported this to him. Ms. Thiel indicated that they are bringing in a covered smoking container and placing it in the backyard in the smoking area. An administrative memo will be placed in their communication log explaining the company policy, and staff will be asked to read and sign the memo.

On 09/30/2025, I interviewed Relative 1 by phone. Relative 1 indicated that she has smelled both marijuana and cigarette smoke at the home. She could smell marijuana when the garage door was open. Relative 1 believed she last smelled marijuana about three to four weeks ago.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	On 08/06/2025, I interviewed staff, Jhaymi Roberts and Larry Behem. Both staff reported that they have smelled marijuana in the home. Licensee designee, Janette Thiel, provided a copy of staff write-up for Thomas Parker Ogle. It was believed that he was using marijuana during this shift on 01/29/2024 and was reported to be argumentative. Mr. Parker is no longer working at

	home, however, staff and Relative 1 both reported smelling marijuana at the home within the past year. In regard to smoking cigarettes in the garage, Ms. Thiel indicated that they are bringing in a covered smoking container and placing it in the backyard in smoking area. An administrative memo will be placed in their communication log explaining the company policy, and staff will be asked to read and sign the memo.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Resident A is supposed to wear a boot for broken foot. The staff took the boot off and as a result, Resident A's fracture has gotten worse.**
- **Resident A was taken to a Tiger's game and that morning he was not given his morning medication.**
- **Resident A was placed on a special diet by his primary care physician and the facility is not providing Resident A with the correct food for his diet.**

INVESTIGATION:

I completed an unannounced onsite investigation on 07/17/2025. I interviewed the Home Manager, Cederic Williams. Mr. Williams stated that Resident A eats Nutrisystem meals. The meals are delivered by his mother.

On 08/05/2025, I received email from licensee designee, Janette Thiel. Ms. Thiel indicated that staff had initialed all medications as passed the morning Resident A went to Tiger's game on 07/26/2025. When Resident A returned home on the 07/27/2025, his guardians reported that the meds for the 26th morning pass had not been given. The medication packet showed that the 26th medications were punched but the 27th were still in their packets. From what was returned the home could not determine who had made the error.

On 08/05/2025, Janette Thiel emailed copies of Resident A's Funds Part 1 and 2 forms, incident reports, IPOS and crisis plan, health care appraisal, health care chronological, medication administration record and EBT transaction history.

On 8/05/20225, I received a copy of Resident A's July 2025 medication log from licensee designee, Janette Thiel. Medication log indicates that morning medications were passed on 07/26/2025.

On 08/05/2025, I received a copy of Resident A's July 2025 Health Care Chronological notes. Note from 07/18/2025 indicates that Resident A walked out of house without boot on and the guardian was upset about it and came into the house and talked with staff.

Note from 07/27/2025 indicates that when Resident A's mother returned Resident A from an overnight leave of absence, she told staff that Resident A's AM medications for 07/26/2025 were not passed. She noticed it when she passed AM medications on the 27th. She told staff she passed the 26th meds on the 27th and left the 27th meds in the blister packs. Note on 07/08/2025 indicates that Resident A's mother brought him back home with a hard removeable cast on his right foot. Resident A had been taken to urgent care due to him hurting himself at camp. Resident A was seen by a doctor. She had no other printout or documentation to share with staff other than how to remove and replace the cast boot. She said the only time he is to remove the cast is to hand wash his foot daily while showering. Staff need to put a garbage bag over the cast and tape the top or rubber band it. He can have Tylenol for pain SMO and has a return appointment on 08/05/2025. An appointment information record was received dated 07/25/2025 where Resident A was seen for fracture and X-ray of right foot. Record states that treatment is immobilization in the CAMboot. Bone fractures take 6-8 weeks to heal and follow up in four weeks. Instructions include weight bear in the boot and no walking without the boot. A current health care appraisal was provided for Resident A dated 03/31/2025.

On 08/06/2025, I interviewed staff, Jhaymi Roberts. He stated that Resident A broke his foot at camp. He went to an urgent care and a foot doctor with his family. Resident A's mother gave them instructions regarding foot. Mr. Roberts indicated that Resident A is still wearing boot. It was reported that he was picked up on one occasion and was running up to the car not wearing boot. Mr. Roberts indicated that Resident A put on boot this morning and wore it to school. Mr. Roberts indicated that there was a concern regarding one of Resident A's morning medications on 07/26 and 07/27. Resident A went on an outing and when he returned his mother said she gave him his medication for 07/26 on 07/27. Resident A's medication log indicated that the medication was passed.

On 08/06/2025, I interviewed staff, Larry Behem. He stated that Resident A was on vacation when he broke foot. He was working when Resident A returned home. Resident A had a boot for broken foot and was trying to take it off. Resident A is redirected when he tries to take boot off. Mr. Behem indicated that staff asked mother for documentation from doctor and she only had an X-ray disk. Last week they received papers from doctor regarding Resident A's foot. Mr. Behem stated that he has seen Resident A wearing boot lately. In the beginning he tried to take it off more and they continue to redirect him. They also put a bag on his foot so it does not get wet in shower. Mr. Behem indicated that he arrived at work as Resident A was going out to Tiger's game on 07/26/2025. He did not pass medications that day and did not see if Resident A took his morning medications. He indicated that the medications were signed as passed, however, Resident A's mother reported an issue when he returned.

On 09/02/2025, I received an email from Resident A's Macomb County Community Mental Health Case Manager, Susan Polakowski. She indicated that Resident A is a super young man and she couldn't be happier with the gains he has made. She did not have any information regarding missed medication, however, believed it was likely just

an error. She also indicated that she knew that there was an issue regarding Resident A's boot initially, but she was later told that the doctor's note was not given to the home when he was dropped off by guardian. She also heard that home manager told the guardian that Resident A was refusing to wear it. Ms. Polakowski indicated that she has informed Resident A's parents that they can take him home if they would like if they are not pleased with the care at the home.

On 09/02/2025, I received a copy of prescription for Resident A's diet from Licensee Designee, Janette Thiel, by email. The prescription is dated 01/19/2023 and states that it is medically necessary for patient to participate with the Nutrisystem program, no fast food and he should go to the gym at least three times per week.

On 09/02/2025, I received an email from APS Worker, Christina Gregory. Ms. Gregory indicated that she saw Resident A and guardian on Friday at the group home. Resident A no longer has to wear the boot. She is not substantiating allegations.

On 09/11/2025, I received email from licensee designee, Janette Thiel. Ms. Thiel indicated that there was a complaint that when Resident A was being picked up for a visit to his family's home, he did have the removeable cast on his foot. The cast was to be taken off for showers and then put back on after. The home manager, Cedric, stated that the cast was off because he had just showered in preparation for his visit home. Cedric was busy getting everything together and care for the other consumers, and the cast had not been put back on as yet. Staff stated that Resident A wore the cast around the house. Ms. Thiel indicated that Resident A is on the Nutrisystem food program. His guardians provide the program to the home, and he eats according to the plan.

On 09/202/2025, I interviewed Relative 1. She stated that Resident A is still wearing boot. He has had to go back to wearing it because injury has not healed. Relative 1 stated that there was a staff at home who did not think he needed to wear it. She indicated that she found Resident A not wearing his boot one time when she came to pick him up, however, it could have happened numerous times. Relative 1 indicated that staff at home are supposed to do checks when passing medications. She believed a new staff did not pass Resident A's morning medications when he went to the Tiger's game. She stated that when Resident A returned to the home, she brought error to Staff, Jhyami's attention. She indicated that she finds Jhyami and Larry to be very good staff. Relative 1 indicated that Resident A has told her that he has seen other staff sleeping when he gets up at night. Relative 1 stated that Resident A is on the Nutrisystem diet. He has a prescription from doctor for diet. She pays for the meals and they are delivered to the home. Relative 1 indicated that whether Resident A receives his diet depends on the staff and the day. She indicated that things seem to fall apart on Saturdays and he eats whatever he wants. Relative 1 indicated that she is aware that recipient rights allow residents to choose what they want to eat, however, Resident A is very compliant with both his medications and diet. He will gladly eat his Nutrisystem meals, however, will also eat other foods if offered to him. Relative 1 stated that she believes Resident A is eating other things because he will tell her. Resident A will tell her what he eats and has things like Burger King, pizza and pop.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	There is not enough information to determine that staff are not having Resident A wear boot for his foot, resulting in the injury getting worse. Staff interviewed indicated that they do instruct Resident A to wear boot. There is only one documented incident where Resident A was found not to be wearing boot when he was being picked up for visit and went out to the car on his own. HCC note from 07/18/2025 indicates that Resident A walked out of house without boot on and the guardian was upset about it and came into the house and talked with staff. Relative 1 stated that she found Resident A not wearing his boot one time when she came to pick him up, however, it could have happened numerous times. Staff should ensure that they follow physician instructions regarding use of boot.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	There is not enough information to determine that Resident A's medication was not given as prescribed. It could not be confirmed where error was made. Resident A went to Tiger's game on 07/26/2025. When Resident A returned home on the 07/27/2025, his guardians reported that the medications for the 26th morning pass had not been given. The medication packet showed that the 26th medications were punched but the 27th were still in their packets. From what was returned, the home could not determine who had made the error. On 8/05/20225, I

	received a copy of Resident A's July 2025 medication log from licensee designee, Janette Thiel. Medication log indicates that morning medications were passed on 07/26/2025.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	Resident A is being provided Nutrisystem meals at the home. Resident A has a prescription dated 01/19/2023 that states it is medically necessary for him to participate with the Nutrisystem program. Licensee Designee, Janette Thiel and Home Manager, Cederic Williams, reported that Resident A is receiving this diet and Nutrisystem meals are provided by his family/guardian. Relative 1 confirmed that she buys the meals and has them delivered to the home. Staff should ensure that they are not offering Resident A food that is outside of his prescribed diet.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A had multiple unexplained transactions on his food benefits card.

INVESTIGATION:

I completed an unannounced onsite investigation on 07/17/2025. I interviewed the Home Manager, Cederic Williams. Resident A was at school. He stated that Resident A has limited verbal ability. Mr. Williams stated that Resident A eats Nutrisystem meals that are delivered by Relative 1. He stated that they have an EBT card for Resident A that can be used for emergencies. Relative 1 stated that they could use card for extras as needed. Mr. Williams stated that he checked funds on card and found that there was only $56.00 on card and that there was more than ten transactions. Mr. Williams stated that he checked funds on card because they were running low on food at home due to spending more for the 4th of July. Mr. Williams stated that they usually do not use Resident A's card because they do not know the code for it. Staff have been unable to get the code to work. He was unsure if Relative 1 could use the card to purchase his Nutrisystem meals. Mr. Williams stated that he never has seen card missing. It is kept locked in medication cart. Mr. Williams stated that they turn in receipts to the office when purchases are made. Mr. Williams indicated that they do not hold cash for

Resident A. He does not suspect any staff made purchases with card. Mr. Williams indicated that he informed his manager when he found charges and was instructed to make a report.

On 08/05/2025, I received copies of Resident A's Funds Part 1 and 2 forms. Funds Part 1 form indicated that licensee manages AFC payment and cash. Resident A had Funds Part 2 forms for AFC payment/Per Diem, cash and EBT. Funds Part 2 form for EBT indicated that withdrawals were made in March 2025 for $254.17 and April 2025 for $89.83.

On 08/05/2025, I received copy of Resident A's EBT transaction history by email from Janette Thiel. The EBT transaction history shows 20 purchases were made between March 2025 and August 2025. Purchases were made at Kroger and Nino Salvaggio's.

On 08/06/2025, I interviewed Staff, Jhaymi Roberts. He stated that they cannot use Resident A's card because they do not have the code. He stated that the card in kept in the medication cart. He has not used Resident A's EBT card to make any purchases.

On 08/06/2025, I interviewed Staff, Larry Behem. He stated that he never used Resident A's Bridge card. He does not have access to card. He indicated that Home Manager, Cederic, does most of the shopping.

On 08/07/2025, I received email from licensee designee, Janette Thiel with EBT transaction history. Ms. Thiel indicated that all purchases were made in city where Relative 1 lives. Transaction history shows multiple purchases made at Kroger and Nino Salvaggio's.

On 09/05/2025, I received email from APS Worker, Jose Garcia. Mr. Garcia indicated that the complaint was not assigned as request was made for it to be reconsidered. Mr. Garcia indicated that there were no concerns of any wrongdoing and the client's guardian was using the EBT card to purchase Resident A's dietary needs.

On 09/30/2025, I interviewed Relative 1 by phone. She stated that she takes Resident A to store shopping. They purchase items such as fruits and vegetables and use his Bridge card. She confirmed that the Bridge card has been used at Kroger and Nino Salvaggio's. She had no concerns regarding staff making unauthorized purchases with card. Relative 1 indicated that she gives the home cash for Resident A. She stated that the amount fluctuates but he usually has between $40.00- $100.00. She gives the home cash for Resident A 's spending about every two weeks. She had no concerns regarding the homes managing of cash for Resident A.

I completed an exit conference by phone with licensee designee, Janette Thiel, on 10/01/2025. I informed her of violation found and that a corrective action plan would be requested. I also informed her that a copy of report would be mailed once approved.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	There is no information to determine that the home is making unauthorized purchases with Resident A's Bridge card. Relative 1 confirmed that she takes Resident A shopping and is using the card. Relative 1 had no concerns regarding use of Bridge card or the management of his cash.
CONCLUSION:	VIOLATION NOT ESTABLISHED

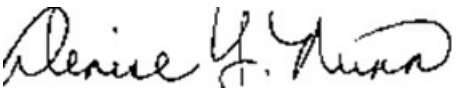
IV. RECOMMENDATION

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

10/01/2025

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



10/02/2025

Denise Y. Nunn — Date
Area Manager