GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 2, 2025

Shannon White-Schellenberger
Angels' Place
Suite 2
29299 Franklin Road
Southfield, MI 48034

RE: License #: AS630072584
Investigation #: 2025A0605018
Lopez Family Home

Dear Shannon White-Schellenberger:

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,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630072584
Investigation #:	2025A0605018
Complaint Receipt Date:	08/22/2025
Investigation Initiation Date:	08/26/2025
Report Due Date:	10/21/2025
Licensee Name:	Angels' Place
Licensee Address:	Suite 2 29299 Franklin Road Southfield, MI 48034
Licensee Telephone #:	(248) 350-2203
Administrator/Licensee Designee:	Shannon White-Schellenberger
Name of Facility:	Lopez Family Home
Facility Address:	16022 Webster Ave Southfield, MI 48076
Facility Telephone #:	(248) 594-6794
Original Issuance Date:	02/14/1997
License Status:	REGULAR
Effective Date:	11/29/2023
Expiration Date:	11/28/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
The work environment is hostile, often arguing, unable to provide proper care.	Yes
Residents are soiled.	No
Staff do not follow the discontinued script.	No

III. METHODOLOGY

08/22/2025	Special Investigation Intake 2025A0605018
08/26/2025	Special Investigation Initiated - Letter Emailed Oakland County Office of Recipient Rights (ORR)
08/27/2025	Inspection Completed On-site Conducted unannounced on-site investigation
09/02/2025	Contact - Telephone call made Conducted interviews with DCS in corroboration with ORR Amber Oliver
09/04/2025	Contact - Face to Face Conducted announced visit at this home with ORR Amber Oliver
09/11/2025	Contact - Telephone call made Discussed allegations with DCS and followed up with ORR worker Amber Oliver
09/22/2025	Exit Conference Conducted exit conference with licensee designee Shannon White-Schellenberger with my findings

ALLEGATION:

The work environment is hostile, often arguing, unable to provide proper care.

INVESTIGATION:

On 08/22/2025, intake #207054 was assigned for investigation regarding Lopez Family Home being a hostile work environment, residents are not cared for properly and this home does not follow discontinued scripts.

On 08/26/2025, I emailed Oakland County Office of Recipient Rights (ORR) this complaint. I was informed that ORR worker Amber Oliver is assigned to this investigation.

On 08/27/2025, I conducted an unannounced on-site investigation. The individuals present were direct care staff (DCS), Mary Green, Iesha Hall and Mirta Van Etten. Also at the home was Resident A. Residents B and C were at New Horizons and Resident D and E were at New Gateway. Resident F has been at a nursing home since December 2024.

I interviewed DCS Mary Green regarding the allegations. Ms. Green has been working for Angel's Place since November 2024. She was working the afternoon shift but then her schedule changed to days about three months ago. She currently works 7AM-3PM. There are three DCS per day shift. Ms. Green gets along with staff at Lopez Family Home. All the staff are female and with that sometimes staff do not agree but Ms. Green stated that their disagreements do not occur in front of the residents, nor does it interrupt the caring of the residents. For example, Ms. Green stated if she did not want to cook that day, she would ask another member of staff to take over that role which other staff usually agree. She has heard from other DCS but never witnessed herself that DCS Pamela Lucas argues with staff because "Palma just doesn't want to work or do stuff." Ms. Lucas usually complains about Resident E and how staff at Lopez Family Home are not nurses and should not provide care for Resident E. Ms. Lucas complained about Resident E wanting to return with a colostomy bag when no staff here is trained. Ms. Green does not know if Ms. Lucas' arguments with other staff were in front of the residents. Ms. Lucas quit employment here in July 2025 for reasons unknown by Ms. Green.

I interviewed DCS Mirta Van Etten regarding the allegations. Ms. Van Etten has worked for Angel's Place for about one year and four months. She usually works afternoon shifts from 3PM-10PM, but today she is covering someone else's day shift. She covers about two-three shifts per week. Ms. Van Etten gets along with everyone. The arguments were regarding "what staff are not going to do." Ms. Van Etten stated, "we are all here to do a job and take care of the ladies and go home. Some staff didn't want to take care of the ladies." Ms. Van Etten stated that DCS Palma Lucas, Tiffany Mauldin and Scekella Dyess were complaining, talking about other staff and the manager Ashley Gist to Ms. Van Etten. Ms. Lucas' arguments with other staff occurred in front of the residents. All the residents are non-verbal except for Resident B. Resident B "would repeat somethings she would hear." Ms. Van Etten never reported the arguments she

would witness to anyone in management. During the midnight shifts when Ms. Etten would work with Ms. Lucas, Ms. Lucas would sleep. Ms. Lucas sleeps from 1AM-5AM. While Ms. Lucas is sleeping, Ms. Etten is providing care to all the residents. Ms. Etten checked and changed the residents every two hours. Ms. Etten stated she did not want any tension between herself and Ms. Lucas, so she never reported these issues to anyone. After Ms. Lucas, Ms. Mauldin, and Ms. Dyess quit, there were not been any staff arguments or staff sleeping.

I interviewed DCS Iesha Hall regarding the allegations. Ms. Hall has been working for Angel's Place for two years. She works six days a week during day shift from 7AM-3PM. There are three DCS during the day shift. There are no issues during the day shift as all staff get along with each other. Ms. Hall has not witnessed any DCS arguing and stated she did not want to provide any hearsay because, she doesn't listen to gossip." Ms. Hall did not provide anything further regarding these allegations.

I was unable to interview Resident A as she is non-verbal. Resident A was sitting in her wheelchair and appeared to be happy and smiling.

On 09/02/2025, I interviewed DCS Palma Lucas via telephone along with ORR worker Amber Oliver regarding the allegations. Ms. Lucas worked for Angel's Place for about four years before she quit in July 2025. She stated, "I left Lopez for the rumors, the gossiping." She worked afternoon shifts from 11PM-7AM. There were two DCS during midnight shifts. Ms. Lucas got along with DCS during her shift, but she does not know how other staff members got along. She denied arguing in front of the residents. Ms. Lucas stated she and all the other DCS get a 30-minute break. During Ms. Lucas' breaks she "dozes off." She stated, "I would doze off on my 30 minutes. That's all I would do. I only got one break."

On 09/02/2025, I interviewed DCS Tiffany Mauldin via telephone along with ORR worker Amber Oliver regarding the allegations. Ms. Mauldin was working for Angel's Place for two years before she left in May 2025. She was working both day and midnight shifts. Ms. Mauldin got along with all the staff except for the manager Ashley Gist. She did not agree with Ms. Gist's management style. Ms. Gist favored some staff over other staff and would share information about staff to the staff she favored and then arguments would occur. Ms. Mauldin stated, "that's why I quit. She (Ashley Gist) was very unfair." These arguments would occur in front of the residents. Ms. Mauldin denied sleeping during her shifts and denied knowing any other staff that would sleep during their shift.

On 09/02/2025, I interviewed the assistant manager Ebony Knott via telephone along with ORR worker Amber Oliver regarding the allegations. Ms. Knott has been working for Angel's Place for five years but only as the assistant manager at Lopez Family Home for two months. She works afternoon shifts from 3PM-11PM. When she began working at Lopez Family Home, some DCS were complaining about the day shift not wanting to complete their work; get residents up in the morning so day shift would complain to Ashley Gist who then would make the midnight shift wake up the residents

and get them ready before day shift arrived. The arguments would occur between day shift and midnight shift staff. There was a lot of bickering and going back and forth between staff. Many of the staff quit because of the issues they had with Ashley Gist. Ms. Knott has worked the midnight shift and during those shifts, she has never seen any DCS sleep. She stated, “if I had seen a staff sleeping, I would have sent them home immediately.” She does recall a staff member (name unknown) who mentioned that staff receive a 30-minute break during each shift, but she is not clear if this is policy or not.

On 09/04/2025, I, along with ORR Amber Oliver conducted a face-to-face visit at Lopez Family Home. We attempted to interview Resident B regarding the allegations, but due to her disability, Resident B stated, “staff are good to me,” and said, “they (staff) don’t argue.”

On 09/04/2025, DCS Carmen Ozuna was interviewed at Lopez Family Home regarding the allegations. Ms. Ozuna has been working for Angel’s Place over one year. She works Tuesdays-Saturdays from 6AM-2PM; however, she is a one-to-one for Resident E who is currently in a nursing home. Ms. Ozuna gets along with the staff great during her shift. However, there are a lot of new staff that come and go, and she heard that there is a lot of miscommunications during the afternoon shift staff. She is unsure what the miscommunications are but believes it is regarding who does what for the residents. She does not know anything about the 30-minute break but stated that she is aware that staff get a 15-minute break, but she never takes her break because “there’s so much to do.” She has never slept during her shift and has not heard about any other staff sleeping during their shifts.

On 09/04/20205, we followed up with DCS Mary Green at Lopez Family Home. Ms. Green stated that all staff have a 15-minute break, but staff cannot leave the premises. She has never slept during her shift but heard that DCS Pamla Lucas had been sleeping during her shift. She does not have any other information.

On 09/11/2025, I received a telephone call from DCS Carmen Ozuna. Ms. Ozuna wanted to share concerns she had that she did not want to talk at Lopez Family Home on 09/04/2025. Ms. Ozuna stated that day shift staff Mary Green, Iesha Hall, and the manager Ashley Gist talked about Ms. Ozuna to other staff. These DCS argue and complain in front of the residents. Last Thursday or Friday, she was present when Ms. Green confronted another staff member about going to the office and complaint about the van. Both Ms. Green and the other staff members were arguing back and forth. Residents A and B were present.

On 09/11/2025, I interviewed DCS Kenyanna Riley via telephone regarding the allegations. Ms. Riley has worked for Angel’s Place since April 2025 during the afternoon shift from 3PM-11PM but for about two months or so, her times changed to 2PM-10PM. Ms. Riley for the most part, “gets along with everybody.” There have been some arguments between staff, mostly day shift complaining about midnight shift leaving trash in the bedrooms and clothes still in the hampers. These arguments are in front of the residents. She stated, “all staff including myself argue and raise our voices.”

This happens when the next shift staff try to tell the previous shift staff how to do their jobs. Ms. Riley stated that the manager Ashley Gist is aware of what is happening, but because Ms. Gist is “cool,” with the day shift staff, Ms. Gist allows the day shift staff to get away everything. Ms. Riley stated, “Ashley treats us differently from Mary and Iesha and that’s not fair.” Ms. Riley does not know about any breaks that staff get because they have so much to do that there is not time for a break. She has worked with Pamla Lucas, and she has never seen Ms. Lucas sleeping during her shift.

On 09/11/2025, I followed up with ORR worker Amber Oliver via telephone. Ms. Oliver interviewed DCS Kiara Brown-Ford regarding the allegations. There are issues among staff because of Ashley Gist. When day shift staff do not want to do something, for example get a resident ready in the morning, the day shift staff complain to Ms. Gist and then Ms. Gist “makes the midnight shift staff do it.” Ms. Brown-Ford told Ms. Oliver that on 07/28/2025 that’s exactly what happened. DCS Iesha Hall did not want to get Resident B up in the morning and get her ready, so Ms. Gist had the midnight shift get Resident B up and ready in the morning before day shift arrives. Ms. Brown-Ford stated to Ms. Oliver that DCS Carmen Ozuna “gets bossed around all the time,” and that “Iesha, Mary, and Ashley are a click and will do anything to get you out of their way.” Ms. Brown-Ford worked with DCS Pamla Lucas during the midnight shift and has never observed Ms. Lucas sleeping.

Ms. Oliver also interviewed DCS Hotayi Bambara regarding the allegations. Ms. Bambara told Ms. Oliver there is sometimes bickering and arguments among staff. Ms. Bambara is there to do her job and leaves. Ms. Bambara has worked midnight with DCS Pamla Lucas, and she has never seen Ms. Lucas sleeping during their shifts.

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:	Based on my investigation and information gathered, DCS at Lopez Family Home are not suitable to meet the physical, emotional, intellectual, and social needs of each resident when staff members argue and bicker with each other in front of Residents A, B, C, D, and E. DCS Mirta Van Etten, Carmen Ozuna, Kenyanna Riley and assistant manager Ebony Knott stated that staff members argue in front of the residents. Ms. Van Etten stated that Resident B would repeat what she heard to Ms. Van Etten.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on this investigation and information gathered, there was insufficient direct care staff on duty at all times for the supervision, personal care, and protection of Residents A, B, C, D, and E when DCS Pamla Lucas sleeps during her midnight shift. DCS Mirta Van Etten reported that Ms. Lucas sleeps during the midnight shift leaving Ms. Van Etten alone with all the residents. Ms. Lucas confirmed that she “dozes off,” during her 30-minute break. Ms. Lucas quit working for Lopez Family Home sometime in July 2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on my investigation, Residents A, B, C, D, and E protection and safety were not attended to at all times when DCS Palma Lucas sleeps during her shift. Ms. Lucas confirmed that she “dozes off,” during her 30-minute breaks leaving the DCS she is working with alone with the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents are soiled.

INVESTIGATION:

On 08/27/2025, I interviewed DCS Mary Green regarding the allegations. Ms. Green had never found the residents not cared for properly by staff. She only heard while she was on vacation the end of July 2025 that DCS Pamela Lucas did not want to provide care to Resident E who was in the nursing home. Ms. Green received a call from DCS Iesha Hall when Ms. Green was on vacation advising Ms. Green that Ms. Hall found Resident C soiled when Ms. Hall begun her shift. Ms. Green cannot recall the exact date, but it was around the end of July 2025 or beginning of August 2025. She does not have any other details.

On 08/27/2025, I interviewed DCS Mirta Van Etten regarding the allegations. Ms. Van Etten stated that when she worked the day shift, she found some of the residents had been soiled when DCS Pamela Lucas had been working. She does not know if Ms. Lucas has checked and changed the residents during the required two-hour checks because there have been times that she checked and changed the resident at the two-hour check and then the resident was soiled again. She does not recall which resident she found soiled.

On 08/27/2025, I interviewed DCS Iesha Hall regarding the allegations. Whenever Ms. Hall begins her shift, she clocks in and conducts her checks with all the residents. She checks if the residents are dry and makes sure all safety measures are in place. One time around the end of July 2025, she began her 7AM shift and found Resident B and Resident C soiled. The DCS that were working the midnight shift were Pamela Lucas and Kiara Brown-Ford. Resident C is extremely active. When Ms. Hall went into Resident C's bedroom, the room appeared to be disheveled. Things were out of the closet and on the floor. Ms. Hall did not know who took Resident C's stuff out of her closet. This was an isolated incident. Ms. Hall changed both Resident B and Resident C.

On 08/27/2025, I observed Resident A in her wheelchair. Resident A appeared to be cleaned, dry and dressed appropriately for the day. No concerns were noted.

On 09/02/2025, I interviewed DCS Palma Lucas regarding the allegations. Residents A, B, C, D, and E get checked every two hours and change if needed. However, when Resident F was at this home, she checked every hour and changed as needed. During the midnight shifts, Ms. Lucas checks on the residents for signs of life and if they are wet. She has never left residents soiled and if residents are found soiled by the next shift, it does not mean that they were not changed. Ms. Lucas explained that some of the residents may have been wet themselves after being checked/changed at the two-hour window.

On 09/02/2025, I interviewed DCS Tiffany Mauldin regarding the allegations. All the ladies are checked every two hours to make sure they are dry and if they are not, then they are changed. When Ms. Mauldin worked the midnight shift, she would check all the

residents every two hours for signs of life and if they were wet. If wet, then she would change them. Resident A, Resident C, and Resident E get checked/changed in their beds while Resident B usually wakes up to go to the bathroom. Ms. Mauldin wakes Resident B up and asks her if she needs to go to the bathroom and if yes, then Ms. Mauldin assists Resident B in the bathroom. Staff are given a directive by the manager that Resident D's guardian/mother does not want Resident D woken up at night; therefore, she is not to be checked for being wet. Staff only check for sign of life for Resident D. However, staff must document if Resident D is wet or dry when she wakes up in the morning on the tracking sheet. She has not found a resident soiled during her shift or when she began her shift.

On 09/02/2025, I interviewed the assistant manager Ebony Knott regarding the allegations. One day, date unknown when Ms. Knott began her shift and found Resident B and Resident C soiled. She is unsure who was working during the shift. All the residents have a two-hour check and if wet it needs to be changed. Resident A and Resident C are changed in their beds and Resident B walks to the bathroom. Resident D is also checked and if wet, she can stand up and take off her briefs to be changed. Resident E takes sleeping pills, so she is checked and changed into bed.

On 09/04/2025, I observed Resident B at Lopez Family Home, and she appeared to be dry and clean. There were no concerns noted.

On 09/04/2025, I interviewed DCS Carmen Ozuna at Lopez Family Home regarding the allegations. She is usually working with Resident F who is at the nursing home but does assist other staff with the residents. She has never found any of the residents soiled when she began her shift.

On 09/04/2025, I followed up with DCS Mary Green at Lopez Family Home regarding the allegations. Ms. Green received a telephone call from DCS Iesha Hall while Ms. Green was on vacation. Ms. Green cannot recall the exact date but was during 07/24/2025-08/02/2025 as that is when she was on vacation. Ms. Hall told Ms. Green that when Ms. Hall began her day shift, Ms. Hall found Resident D "soaking wet." Ms. Green has never observed any residents being wet/soiled when she began her shifts.

On 09/11/2025, I interviewed DCS Kenyanna Riley regarding the allegations. All the residents are checked for wetness/soiled every two hours. If they are wet, then they are changed. Resident B gets toileted, so she is asked every two hours if she needs to go to the bathroom. One time when Ms. Riley arrived at her shift at 3PM, Resident C was soiled because, "the previous shift did not change her." The assistant manager Ebony Knott noticed Resident C was wet and reported this to the manager Ashley Gist. This happened during the summer.

On 09/11/2025, I followed up with ORR Amber Oliver. Ms. Oliver interviewed DCS Kiara Brown-Ford regarding these allegations. Ms. Brown-Ford reported to Ms. Oliver that on 07/29/2025, DCS Iesha Hall called Ashley Gist informing Ms. Gist that Resident D was found soiled. Ms. Brown-Ford changed Resident D prior to leaving her shift, but

Resident D, who is extremely active, went back into her bedroom, got undressed, and must have wet herself again because Ms. Hall found Resident D's brief on the floor wet. Ms. Brown-Ford told Ms. Oliver that she always checks/changes every two hours but that sometimes the residents urinate afterwards before the next two hours check.

Ms. Oliver also interviewed DCS Hotyi Bambara regarding these allegations. Ms. Bambara told Ms. Oliver that she always checks all the residents every two hours and changes as needed. She has not found any residents soiled.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on my investigation and information gathered, DCS at Lopez Family Home are providing the personal care required to Residents A, B, C, D, and E. All DCS stated that they check the residents every two hours and if soiled, they are changed. However, the residents may urinate after the two-hour check and possibly soil themselves again before their next check. Therefore, I am unable to determine if the residents found soiled are due to DCS not checking and/or changing them or if they have soiled themselves again after the initial check/change.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff do not follow the discontinued script.

INVESTIGATION:

On 08/27/2025, I interviewed DCS Mary Green regarding the allegations. Ms. Green stated that whenever a medication is discontinued, a discontinued script is either received, or it is documented in the health care chronological (HCC) which prescribing doctor discontinued the script. There are times that the home does not receive the discontinued script immediately from the medical provider; however, it is always documented in HCC. There has not been a time that medication had been discontinued but then administered by staff.

On 08/27/2025, I interviewed DCS Mirta Van Etten regarding the allegations. Ms. Van Etten stated that whenever a medication is discontinued, it is removed from the residents' medication basket to assure that the medication is no longer given. She has never seen medication in the resident's basket after it has been discontinued. When the

prescribing physician discontinues a medication, it is written in the HCC and then a discontinued script is received.

On 08/27/2025, I interviewed DCS Iesha Hall regarding the allegations. Ms. Hall stated that whenever a prescribing physician discontinues a medication or prescribes an antibiotic, the staff is supposed to write in the HCC and then receive the discontinued script from the prescribing doctor. Sometimes the prescribing doctor does not send the script immediately, but the medication is removed from the resident's medication basket. Ms. Hall has never administered a medication that had been discontinued, nor has she found medication in the residents' medication basket after it had been discontinued. Resident A was taken to urgent care by the assistant manager Ebony Knott for a urinary tract infection (UTI). Resident A was prescribed with antibiotic cream for a specific number of days; however, Ms. Knott did not have the discharge papers or the script showing that this medication was only used for a specific number of days. Ms. Hall was unable to locate the script; however, the script was emailed to me by Shelly Phenix with Angel's Place on 09/03/2025.

On 08/27/2025, I reviewed Resident A's, B's, C's, D's, and E's medications and medication logs to verify if scripts were received/documented after the prescribing physician discontinued a medication. All discontinued scripts were received and the medications that were discontinued were not in the residents' medication baskets.

- Resident A's Nitrofurantoin Mono was discontinued on 08/08/2025 and script was verified to have been received via email on 09/03/2025.
- Resident B had no discontinued medications for 08/2025.
- Resident C's Clotrimazole-BET was discontinued, and script was verified in the file.
- Resident D had no discontinued medications for 08/2025.
- Resident E Nitrofurantoin Mono-MCR was completed on 08/22/2025 and script was verified.

On 09/02/2025, I interviewed DCS Palma Lucas regarding the allegations. Ms. Lucas worked midnight shifts so the only medication she administered was to Resident C in the AM before breakfast. She never found discontinued medication in the residents' medication basket and believes all the scripts were received for discontinued medication.

On 09/02/2025, I interviewed DCS Tiffany Mauldin regarding the allegations. Ms. Mauldin stated there were a couple of times that medications were discontinued but the medication was still in the basket. She cannot recall which resident it was or which medication but that it was there. Ms. Mauldin cannot recall if a discontinued script had been received for that unknown medication. She was unable to provide any details.

On 09/02/2025, I interviewed the assistant manager Ebony Knott regarding the allegations. The process is that whenever a medication is discontinued, the staff member writes it in the HCC and then a discontinued script is received from the prescribing physician. Ms. Knott stated she took Resident A to urgent care and when she returned, she filed the discharge papers and script; therefore, she was unclear why DCS Iesha Hall could not locate these documents during my visit to the home. Ms. Knott also documented the visit in the HCC. Ms. Knott was informed that the documents were emailed to my attention and reviewed. She acknowledged.

On 09/04/2025, I interviewed DCS Carmen Ozuna regarding the allegations. Ms. Ozuna administers medications. The process for discontinued medications is that it is documented in the HCC, that medication is removed from the medication basket and then a discontinued script is received from the prescribing physician. When Ms. Ozuna sees that medication was discontinued and cannot locate the documents, she contacts the assistant manager Ebony Knott who usually locates the scripts. She has not found any discontinued medication in the residents' basket.

On 09/22/2025, I conducted the exit conference with licensee designee Shannon White-Schellenberger with my findings. Ms. White-Schellenberger agreed to submit a corrective action plan. She did not have any questions.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	Based on my investigation and review of Residents A, B, C, D, and E all medications that were discontinued were followed by instructions from the prescribing physician and a discontinued script had been received.
CONCLUSION:	VIOLATION NOT ESTABLISHED

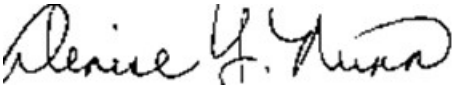
IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.

09/29/2025

Frodet Dawisha — Date
Licensing Consultant

Approved By:



10/02/2025

Denise Y. Nunn — Date
Area Manager