



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 15, 2025

Brian Nitz
Baruch SLS, Inc.
Suite 203
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL410375718
Investigation #: 2026A1029008
Fountain View of Lowell South

Dear Mr. Nitz:

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 licensee designee 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 (231) 922-5309.

Sincerely,

A handwritten signature in black ink that reads "Jennifer Browning". The signature is written in a cursive, flowing style.

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410375718
Investigation #:	2026A1029008
Complaint Receipt Date:	08/27/2025
Investigation Initiation Date:	08/27/2025
Report Due Date:	10/26/2025
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	3196 Kraft Avenue SE, Suite 203 Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Robyn Risdon
Licensee Designee:	(pending) Brian Nitz
Name of Facility:	Fountain View of Lowell South
Facility Address:	11537 E. Fulton, Lowell, MI 49331
Facility Telephone #:	(616) 897-8413
Original Issuance Date:	02/06/2019
License Status:	REGULAR
Effective Date:	08/06/2025
Expiration Date:	08/05/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A suffered a femur fracture during the weekend of 08/16/2025 and there is no explanation for how the injury occurred.	Yes
Resident A suffered a femur fracture on 08/16/2025 or 08/17/2025 and she did receive medical care until 08/19/2025.	Yes
There was no <i>AFC Incident / Accident Report</i> completed regarding Resident A suffering from a femur fracture as required.	Yes

III. METHODOLOGY

08/27/2025	Special Investigation Intake 2026A1029008
08/27/2025	Special Investigation Initiated – Telephone call made by AFC licensing consultant Arlene Smith.
10/31/2025	Contact – Document sent to APS Ms. Wassenaar
11/04/2025	Inspection Completed On-site – face to face with administrator Robyn Risdon, Bobbi Sedelmaier, and Resident A at Fountain View of Lowell South
11/07/2025	Contact - Document Sent Email to Ms. Risdon
11/11/2025	Contact - Document Received Ms. Risdon
11/18/2025	Contact - Document Received - Documents from Ms. Risdon
11/21/2025	Contact - Document Sent- Email to Ms. Risdon
11/24/2025	Contact – Telephone call to APS Ms. Wassenaar, Alyssa Knowlton, Relative A1, Connie Clauson, Left message, Team Health, Ms. Kinyon, and Mr. Farrell
12/02/2025	Contact – Telephone call to licensee designee Connie Clauson (left message and sent email), email to Ashleigh Wassenaar, Caitlyn Woodward (Left message)
12/04/2025	Contact – Telephone call made to Caitlyn Woodward, Left message, Relative A2, Connie Clauson (left message).
12/09/2025	Exit conference with licensee designee Connie Clauson by email.

12/10/2025	Contact – Telephone call made to complete exit conference with pending licensee designee Brian Nitz.
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ALLEGATION: Resident A suffered a femur fracture during the weekend of 08/16/2025 and there is no explanation for how the injury occurred.

INVESTIGATION:

On 08/27/2025 a complaint was received via Bureau of Community and Health Systems online complaint system alleging that direct care staff members did not transfer Resident A properly because a Hoyer lift was used without two direct care staff members leading to Resident A suffering a femur fracture at Fountain View of Lowell South. I was assigned to investigate these concerns on 10/30/2025 due to a workload reassignment. These concerns were also investigated by Kent County Adult Protective Services (APS) Specialist Ashleigh Wassenaar.

On 10/31/2025 I received an email response from APS Specialist Ms. Wassenaar who confirmed she substantiated an unknown direct care staff member for neglect after Resident A sustained a femur fracture which required surgery while at Fountain View of Lowell South and direct care staff members and/or administration did not know the cause of the injury. Ms. Wassenaar stated the injury occurred on or around 8/17/2025 and hospital staff informed Relative A1 that it's likely this type of fracture occurred from not using the Hoyer lift properly as the injury was not consistent with a fall.

On 11/04/2025 I completed an unannounced on site investigation at Fountain View of Lowell South and interviewed administrator Robyn Risdon. Ms. Risdon stated Resident A requires the assistance of two direct care staff members anytime she needs to be transferred using her Hoyer lift, which has always been a requirement since Resident A moved into Fountain View of Lowell South. Ms. Risdon stated she had no information that any direct care staff members did not transfer Resident A as required. Ms. Risdon stated Relative A1 visited the weekend Resident A sustained this injury and it was initially believed Resident A had a urinary tract infection, not a fractured femur, since she has a history of these.

On 11/04/2025 I interviewed direct care staff member, whose role is second shift lead, Bobbi Sedelmaier. Ms. Sedelmaier stated she was working the weekend Resident A sustained this injury and was upset because all direct care staff members know Resident A requires the assistance of two direct care staff members for transferring. Ms. Sedelmaier confirmed that Relative A1 visited Resident A because Relative A1 thought Resident A had a urinary tract infection again because she was running a fever, vomiting, and not wanting to eat. Ms. Sedelmaier stated neither she nor Relative A1 realized anything was wrong with her leg. Ms. Sedelmaier stated she didn't notice any swelling on Resident A's right leg. Ms. Sedelmaier stated that on 08/19/2025 Relative A2 came to visit Resident A and stated Resident A should be sent to the hospital by EMS. Ms. Sedelmaier stated Resident A was sent to Trinity Health. Ms. Sedelmaier

stated Relative A1 later updated facility staff that Resident A had a fractured femur on her right leg and did not have a urinary tract infection. Ms. Sedelmaier stated she had discharge paperwork from Resident A's hospital stay but could not locate it at the time of the onsite investigation. Ms. Sedelmaier stated the document would be forwarded to me via email or I could get it from Relative A1. Ms. Sedelmaier stated she has never transferred Resident A without having another person with her as required. Ms. Sedelmaier stated before this incident she reported concerns to the former administration at Fountain View of Lowell that direct care staff members were not completing Hoyer transfers as required and nothing was done about it until this incident occurred. Ms. Sedelmaier stated she believes direct care staff members were transferring Resident A using three direct care staff instead of the Hoyer lift. Ms. Sedelmaier stated this process would not have been any safer than using the Hoyer lift with two direct care staff. Ms. Sedelmaier stated she was present when Resident A received a shower on 08/18/2025 and Resident A did not appear to be in pain at that time.

I attempted to interview Resident A however; due to her dementia diagnosis she was unable to answer questions about this incident and only smiled during the interview process. During the on-site Resident A was observed to have a black eye and scab over her right eye. Ms. Sedelmaier stated Resident A recently had a fall from her bed causing this injury.

During the on-site investigation, I observed a white board in the main office with resident notes which stated "[Resident A] must use hoyer lift." I toured Resident A's bedroom and there was a sign stating:

"Attention: Please follow these instructions as [Resident A] heals from her surgery.

- *Place a pillow between her knees while in bed to prevent pressure on her joints.*
 - *She should be at the table for all meals.*
 - *While in bed, rotate her every two hours and note it in the chart.*
- *Use her Hoyer lift only (2 people) whenever she is transitioning from the bed to chair and vice versa. Training will be offered by Trinity Health PT if needed."*

I also reviewed the following documents in Resident A's resident record:

1. Resident A's *Assessment Plan for AFC Residents* which included documentation under mobility and transferring which stated, "2 person assistance, Toileting – 2-3 person assistance."
2. Resident A's *Health Care Appraisal* which states she utilizes a wheelchair as an assistive device.

Ms. Risdon sent me the additional documents I requested on 11/18/2025 to review:

1. Progress notes for the weekend Resident A received her injury with the following timeline of events.
 - 08/16/2025 – Resident given PRN Tylenol for pain at 2:45 pm.
 - 08/17/2025 – 11 AM Resident A started throwing up when staff got her up. Resident A refused breakfast and morning medications.

- 08/17/2025 – 9 PM – Resident did not eat any meals today and had a temp ranging from 99.5-101.5 all day and only had one output of urine over a long span. Resident spent most of the day in bed sleeping. PRN Hydrocodone was given at 5:30 for pain.
 - 08/18/2025 6 AM – Resident has had a temp during the night. 1 wet brief on third shift.
 - 08/18/2025 – Residents family would like urinalysis done.
 - 08/18/2025 2 PM – Resident did not eat breakfast or lunch and kept falling asleep at the table. She did not have a bowel movement and had a little urine in the brief.
 - 08/18/2025 5 PM – Resident family came and got her to eat pudding and a few bites of apple sauce but resident did not eat dinner and started to spike a fever at 100.4 at 5:30 PM. Resident has been taking fluids.
 - 08/18/2025 5 PM – No urine output all day.
 - 08/19/2025 6 AM – 1 wet brief on third shift.
 - 08/19/2025 10 AM – Resident's right knee looks and feels dislocated. Resident in extreme pain. Family was called and wanted resident sent to Trinity Hospital. Resident leg also very swollen.
 - 08/19/2025 12 pm – Resident's son called with an update. Resident has a broken femur and a broken knee cap. Resident will have to have pins put in her leg.
 - Resident A was hospitalized after this and there are no other entries related to this event or for Resident A until 08/22/2025.
2. *Home Health Communication Form* dated 08/23/2025 with documentation that Resident A was starting services with Trinity Health at Home and she required Hoyer transfer to chair with two person assistance and was non weight bearing on her right leg.
 3. *Discharge Summary from hospital stay generated on 08/21/2025 with the following Assessment / Plan:*
 - *Closed fracture of the distal end of femur. Pre-op femur fracture.*
 - *On 08/19/2025 radiographs of right femur. Findings: A displaced and comminuted fracture of the distal right femur is again noted. There is a posterolateral displacement of the dominant distal fracture fragment of up to 2.8 cm with retraction of approximately 2 cm. Mild to moderate degenerative changes at the right knee with joint space narrowing and marginal osteophytosis. A right arthroplasty is noted. Mild surrounding heterotopic ossification is noted.*
 - *Resident A had surgery on 08/20/2025 for Open Reduction internal fixation right distal femur by Dr. Fras.*
 4. Fountain View of Lowell training manual showing the appropriate steps for a hoyer transfer.
 5. Two person transfer and hoyer lift quizzes completed in 2025 showing verification Ms. Sedelmaier was appropriately trained on how to safely transfer Resident A.

On 11/24/2025 I interviewed direct care staff member Cassie Kinyon. Ms. Kinyon stated she was working, but did not know what occurred, however observed Ms. Sedelmeier in the room alone with Resident A on 08/16/2025 and heard Resident A yell out in pain which was not common for her. Ms. Kinyon stated after she heard this she went into the room and Resident A said, "she hurt my leg" and Ms. Sedelmeier said, "she's just being dramatic." Ms. Kinyon stated Resident A can make some short statements but she will not have a full conversation or be able to relay details of what occurred. Ms. Kinyon stated she did not think much of it at the time because Resident A was out of her hydrocodone medication at that time so she thought she could have been in pain due to not having the medication. Ms. Kinyon stated direct care staff members Andrea Porter and Alyssa Misner worked the following day and reported to her that Resident A had thrown up and was not feeling well and that's when she started to realize something was wrong. Ms. Kinyon stated they all thought something was wrong but thought it was an urinary tract infection. Ms. Kinyon stated there were no signs of leg pain at that time and Resident A went back to sleep. Ms. Kinyon stated Resident A was sent to the hospital on 08/19/2025.

On 11/24/2025 I interviewed direct care staff member Mark Farrell. Mr. Farrell stated he returned to work on 08/19/2025 after being off work for the previous three days and upon seeing Resident A realized Resident A had an injury to her leg. Mr. Farrell stated since he was off work he didn't know what happened but he could tell anytime he tried to interact with Resident A she was immediately in pain. Mr. Farrell stated he was trained when he started that Resident A always required the assistance of two direct care staff members to use her Hoyer lift. Mr. Farrell stated he has never observed any direct care staff using the Hoyer lift with three staff, not using the hoyer correctly, or trying to transfer Resident A independently. Mr. Farrell stated he does not understand how this occurred because the Hoyer lift should always be done safely.

On 11/24/2025 I interviewed former direct care staff member, whose role was Resident Care Manager, Alyssa Knowlton. Ms. Knowlton stated she recently left Fountain View of Lowell after she's been there for 10 years because of this incident. Ms. Knowlton stated she does not believe this incident should have occurred because they are all trained to use two direct care staff with the Hoyer lift to assist Resident A with transferring and Resident A should have never been in a situation where her leg was broken as a result of not using the Hoyer lift correctly because all direct care staff members were trained in how to do this correctly. Ms. Knowlton stated there was an *AFC Incident / Accident Report* for this incident stating Ms. Sedelmeier transferred Resident A on her own and caused this injury. Ms. Knowlton stated she did not work during the weekend but when she arrived at work on 08/18/2025 or 08/19/2025, she could tell her leg was injured, she contacted Relative A2 to notify her of these concerns, and let her know Resident A needed to be sent to the hospital.

On 11/24/2025 I interviewed Relative A1. Relative A1 stated he was not there when the incident occurred so he can only relay what physician Dr. Fras at the hospital told him. Relative A1 stated that because it was fracture from her knee to hip lengthwise, she likely did not fall. Relative A1 stated Resident A does not have a history of falling.

Relative A1 stated he was informed by Dr. Fras she was either lifted or twisted incorrectly, which caused that type of fracture, and she would have screamed and yelled in pain. Relative A1 stated at first direct care staff members all thought Resident A had a urinary tract infection because she has a history of these but on 08/19/2025 they realized her leg was swollen so Resident A was sent to Trinity Health. Relative A1 stated the hospital did a catheter and there was no urinary tract infection but she had a broken femur which shocked him. Relative A1 stated Resident A is not able to communicate what happened but stated he was upset that Resident A was not sent to the hospital earlier. Relative A1 stated he believes one of the direct care staff members inappropriately transferred her causing her leg to break requiring surgery. Relative A1 stated Resident A has a brand new Hoyer lift which requires two direct care staff members to use safely. Relative A1 stated most of the time when direct care staff are transferring Resident A, he is not in the room. Relative A1 stated he hasn't observed the direct care staff members transfer her inappropriately and this is the first time in nine years that she's had an incident other than a urinary tract infection. Relative A1 stated Relative A2 put up signs in Resident A's room informing direct care staff members how they need to care for Resident A. Relative A1 stated there was a care conference recently about Resident A's care which included a physician from Team Health. Relative A1 stated the family is in the facility each day because Resident A cannot advocate for herself and to monitor what is taking place.

On 12/02/2025 I interviewed Relative A2 who stated nothing has been explained about this incident and there was no acknowledgement about what occurred or expressions of remorse about Resident A's injury. Relative A2 stated she sees Ms. Risdon frequently and she has never discussed the concerns with her. Relative A2 stated when she took Resident A to the emergency room, she asked the orthopedic surgeon what the conditions might look like for a fracture like Resident A's to occur and the surgeon provided two different scenarios that could have led to this injury. Relative A2 stated these scenarios were improper use of the Hoyer lift or an improper transfer but this injury did not happen because of a fall. Relative A2 stated Resident A's leg had a slice at an angle where the upper part of the bone was resting on her knee. Relative A2 stated she believes this occurred on 08/16/2025 in the evening after Relative A1 ended his visit and direct care staff were getting her ready for bed. Relative A2 stated direct care staff members Ms. Kinyon and Ms. Sedelmeier were working at this time. Relative A2 stated she visited with Resident A on 08/17/2025 and noticed she had vomited, had a temperature, and her eyes were bloodshot. Relative A2 stated she had not seen Resident A experience that level of pain before so she instructed staff to take her back to the room so they could give her something for her fever. Relative A2 stated direct care staff tried to get Resident A's physician services to call in some pain medications for her and she seemed to be comfortable for the rest of the day. Relative A2 stated when she laid Resident A down she didn't want to straighten her legs which is not uncommon for Resident A so Relative A2 stated she did not think of there being a leg injury. Relative A2 stated at this point they were thinking it was a urinary tract infection, so they were concentrating on giving fluids to Resident A. Relative A2 stated she was visiting on 08/18/2025 around 5 PM and informed direct care staff members that if Resident A's fever was worse, then Resident A should go to the hospital. Relative A2

stated that on the morning of 08/18/2025 she was having breakfast and appeared to be comfortable but by 3 PM the pain was back with a fever, so direct care staff treated the pain again while Resident A was in bed. Relative A2 stated she asked the staff members if they could get a urine sample to confirm it was a urinary tract infection but she does not know if this was completed. Relative A2 stated the morning of 08/19/2025 she received a call from Ms. Knowlton who informed her she thought Resident A's leg was broken because when she tried to straighten her legs it wasn't straightening correctly and Relative A2 told her to call for an ambulance. Relative A2 stated within a couple hours of being at the hospital, it was confirmed that Resident A had a broken right femur. Relative A2 stated they never thought there would be injuries to her because she does not ambulate on her own, does not try to stand, and does not have a history of falls. Relative A2 stated Resident A's leg is healed now and she appears to be pain free. Relative A2 stated she knows that Mr. Farrell was off that weekend but Ms. Kinyon was there and would have good information because they know Resident A did not do this injury to herself. Relative A2 stated when Relative A1 was there on 08/16/2025 in the morning, there were no concerns and on 08/17/2025 when she arrived in the afternoon, two direct care staff members informed her Resident A was in pain and was screaming and upset. Relative A2 stated she does have concerns with Ms. Sedelmeier because although she physically hasn't observed her to be physically rough with residents, her tone is loud and forceful with the residents. Relative A2 stated she has given clear instructions that Resident A must be transferred by two direct care staff members when using the Hoyer lift. Relative A2 stated she observed two direct care staff using the Hoyer lift most of the time but has observed times when one direct care staff transferred Resident A using the Hoyer lift. Relative A2 stated she created the laminated signs in Resident A's bedroom but that does not mean the direct care staff members are always following the instructions.

I attempted to reach licensee designee Connie Clauson on 11/24/2025, 12/02/2025, and 12/04/2025 and left messages. I emailed her on 12/02/2025 but did not receive a response at this time. I completed the exit conference via email on 12/09/2025.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(4) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.

ANALYSIS:	Resident A was not protected from harm because she sustained an unexplained femur fracture while at Fountain View of Lowell South. Based on interviews with multiple direct care staff members and administrator Ms. Risdon, no one could provide a reasonable explanation of how this type of fracture occurred. Resident A does not have a history of falls and the treating physician told Relative A2 this fracture did not occur from a fall rather was likely due to improperly transferring Resident A. Ms. Sedelmaier stated she has observed direct care staff members not following Hoyer instructions to transfer with the assistance of two direct care staff members, reported this information to administration, and nothing occurred to remedy it until this incident occurred.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Resident A suffered a femur fracture on 08/16/2025 or 08/17/2025 and she did not receive medical care until 08/19/2025.

INVESTIGATION:

On 08/27/2025 a complaint was received via Bureau of Community and Health Systems online complaint system with concerns Resident A suffered a femur fracture on or around 08/18/2025 and she did not receive medical care until 08/20/2025. I was assigned to investigate these concerns on 10/30/2025 due to a workload reassignment. These concerns were also investigated by Kent County Adult Protective Services, Ashleigh Wassenaar.

On 10/31/2025 I received an email from APS Specialist Ms. Wassenaar who confirmed the incident occurred on 08/17/2025 or 08/18/2025 and initially it was thought Resident A had a urinary tract infection as she has a history of getting these infections. Resident A not taken to the hospital until 08/19/2025 after direct care staff member Ms. Knowlton arrived to work and noticed Resident A appeared to be in pain.

On 11/04/2025 I interviewed direct care staff member whose role is second shift lead, Bobbi Sedelmaier. Ms. Sedelmaier stated Resident A was taken to the hospital on 08/19/2025 which was a couple days after Resident A began to experience symptoms including fever, pain, vomiting and not acting like her usual self.

On 11/24/2025 I interviewed direct care staff member Cassie Kinyon. Ms. Kinyon stated she was not initially sent to the hospital because at first direct care staff members all believed she had a urinary tract infection because she was vomiting and did not want to eat, but wasn't showing signs of leg pain.

On 11/24/2025 I interviewed Relative A1. Relative A1 stated although he was upset Resident A did not get the fracture diagnosed earlier, he understands the decision not to

send Resident A to the hospital for evaluation because it was initially thought she had another urinary tract infection.

On 12/02/2025 I interviewed Relative A2 who stated neither Relative A1 nor herself told direct care staff members or Ms. Risdon not to send Resident A to the hospital. Relative A2 stated after direct care staff called Relative A2 on 08/19/2025, Resident A was transported to the hospital. Relative A2 is concerned that it would have gone on longer if Ms. Knowlton did not let her know that her knee appeared to be larger than the other and that she appeared to be in pain.

APPLICABLE RULE	
R 400.689	Resident health care.
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Although it is unclear if the incident occurred on 08/16/2025 or 08/17/2025 Resident A did not go to the hospital until it was noticed on 08/19/2025 by Ms. Knowlton that Resident A's right knee appeared to be dislocated and swollen. After she went to the hospital, Relative A1 contacted the facility to report that Resident A had sustained a femur fracture on her right leg Ms. Risdon and Ms. Sedelmaier both stated the delay in seeking medical treatment was because they thought she had a urinary tract infection and did not know that her leg was in pain, however it was clear that Resident A was uncomfortable and not doing well due to her vomiting and loss of appetite. There was no documentation Resident A's physician was notified of these symptoms even when it was thought to be a urinary tract infection.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: There was no *AFC Incident / Accident Report* completed regarding Resident A suffering from a femur fracture as required.

INVESTIGATION:

On 08/27/2025 a complaint was received via Bureau of Community and Health Systems online complaint system with concerns there was no *AFC Incident / Accident Report* completed after Resident A went to the hospital for a femur fracture. I was assigned to investigate these concerns on 10/30/2025 due to a workload reassignment. These concerns were also investigated by Kent County Adult Protective Services, Ashleigh Wassenaar.

On 11/04/2025 I interviewed direct care staff member whose role is second shift lead, Bobbi Sedelmaier. Ms. Sedelmaier stated she believes an *AFC Incident / Accident Report* was completed by Alyssa Knowlton after this incident but she did not have a copy of this *AFC Incident / Accident Report* and Ms. Knowlton was no longer working at Fountain View of Lowell.

On 11/24/2025 I exchanged emails with APS Specialist Ms. Wassenaar who stated she was not provided with an incident report or documentation regarding the incident.

On 11/24/2025 I interviewed direct care staff member Cassie Kinyon. Ms. Kinyon stated she discussed these concerns with Ms. Risdon after she found out Resident A's leg was broken and informed her about Resident A yelling out and throwing up. Ms. Kinyon stated she completed an *AFC Incident / Accident Report* about what she knew. Ms. Kinyon stated she does not know what happened to it after she handed it to Ms. Risdon but Ms. Kinyon stated Ms. Risdon told her to do an *AFC Incident / Accident Report* "so they had it" and she did.

On 11/24/2025 I interviewed direct care staff member Mark Farrell. Mr. Farrell stated he didn't do an *AFC Incident / Accident Report* because he received the information third hand and he just knew that something happened over the weekend. Mr. Farrell stated he believed an *AFC Incident / Accident Report* was already completed regarding this incident.

On 11/24/2025 I interviewed former direct care staff member whose role is Resident Care Manager Alyssa Knowlton. Ms. Knowlton there was an *AFC Incident / Accident Report* done which stated Ms. Sedelmeier transferred Resident A on her own and this should not have occurred. Ms. Knowlton stated she has concerns that Ms. Risdon had been "covering this up" because she does not know why the *AFC Incident / Accident Report* would not have been in Resident A's resident record.

On 12/02/2025 I interviewed Relative A2 who stated she has "Power of Attorney" but she never received an *AFC Incident / Accident Report* from this incident explaining what occurred. Relative A2 stated she believes this occurred on 08/16/2025 but it was "unsettling" because they didn't receive documentation of this incident. Relative A2 stated she does not know if the facility conducted it's own investigation into this issue because no one has spoken to her about the incident.

APPLICABLE RULE	
R 400.693	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:	Resident A was admitted to the hospital 08/19/2025-08/21/2025 with a femur fracture which required surgery and there was no <i>AFC Incident / Accident Report</i> provided by Ms. Risdon for this incident. Ms. Kinyon stated she completed an <i>AFC Incident / Accident Report</i> however she did not have a copy of this or know what happened to it after she gave it to administrator.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning

Jennifer Browning
Licensing Consultant

12/09/2025

Date

Approved By:

Dawn Timm

12/15/2025

Dawn N. Timm
Area Manager

Date