GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 22, 2025

Susan Mckiddy
10892 Abbey Drive
Brighton, MI 48114

RE: License #: AS630407256
Investigation #: 2026A0612003
Victor Manor

Dear Ms. Mckiddy:

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,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(248) 302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630407256
Investigation #:	2026A0612003
Complaint Receipt Date:	10/30/2025
Investigation Initiation Date:	10/31/2025
Report Due Date:	12/29/2025
Licensee Name:	Susan Mckiddy
Licensee Address:	10892 Abbey Drive Brighton, MI 48114
Licensee Telephone #:	(810) 923-6550
Administrator:	Susan Mckiddy
Licensee Designee:	Susan Mckiddy
Name of Facility:	Victor Manor
Facility Address:	1305 Ford Rd White Lake, MI 48383
Facility Telephone #:	(810) 923-6550
Original Issuance Date:	06/09/2021
License Status:	REGULAR
Effective Date:	12/09/2023
Expiration Date:	12/08/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's bedsore worsened due to neglect.	Yes
Victor Manor has staff who are illegally working in the United States. The staff do not have a Background check on file in the LARA Workforce Background Check system.	Yes
Victor Manor is operating over their maximum capacity of 6 residents.	Yes
Resident A did not receive a receipt for her monthly cost of care payments.	Yes
A resident threw up at the dinner table.	No
Resident A lost 15 lbs. while living at Victor Manor.	No
Additional Findings	Yes

III. METHODOLOGY

10/30/2025	Special Investigation Intake 2026A0612003
10/30/2025	APS Referral Referral received from Adult Protective Services (APS). APS denied the referral for investigation.
10/31/2025	Special Investigation Initiated - Telephone Telephone interview with Resident A's daughter.
11/03/2025	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed licensee designee Susan (Sue) Mckiddy, direct care staff Gloria Heywood, Resident B, Resident C, Resident D, Resident E, and Resident F. While onsite Ms. Mckiddy sent me a photo via text message of Resident A's bedsore take on 10/27/25.
11/03/2025	Contact - Document Received I conducted a search on the LARA Workforce Background Check website.

11/05/2025	Contact - Telephone call made Telephone interview completed with Dr. Cutting and Care Bridge administrator Ahmed Malik.
11/05/2025	Contact - Document Received Facility documentation received via email from licensee designee Susan (Sue) Mckiddy.
11/10/2025	Contact - Document Received Resident Register received via text message from home manager Mary Henderson.
11/20/2025	Contact - Telephone call made Telephone call to Care Bridge administrator Ahmed Malik to request Care Bridge nursing notes.
12/01/2025	Contact - Telephone call made Telephone interview with home manager Mary Henderson and Resident A's husband.
12/05/2025	Contact - Document Received Received Care Bridge nursing notes sent via email from Care Bridge administrator Ahmed Malik.
12/12/2025	Exit Conference I completed an exit conference with licensee designee Susan (Sue) Mckiddy via telephone.

ALLEGATION:

Resident A's bedsore worsened due to neglect.

INVESTIGATION:

On 10/30/25, I received a referral from Adult Protective Services (APS). APS denied the referral for investigation. The referral indicated Resident A has Multiple Sclerosis (MS) and is wheelchair bound. She was residing with her husband and her daughter. Resident A received in home physical therapy (PT) and occupational therapy (OT) through Care Bridge. Resident A's health declined. She was psychiatrically hospitalized for a week. Resident A's mobility got worse. It was recommended that she move into Victor Manor. Resident A's husband wrote Victor Manor checks while she was there for 2 months, he never received a receipt. Resident A had a bedsore on her coccyx from sitting in her wheelchair, it got worse when she went to Victor Manor. Resident A is currently in the hospital for her second procedure due to her bedsore being neglected. Resident A was ripped from her wheelchair at Victor Manor. The bedsore reopened due

to the way they were handling her. On Sunday, a staff member told Resident A's husband that her bedsore was black and that she should go to the hospital. There are concerns about the care that the facility provides. There are 6 other residents there. A couple of women last week were observed vomiting at the dinner table.

On 10/31/25, I initiated my investigation with a call to Resident A's daughter. Resident A's daughter stated previously Resident A was residing with her family. Resident A received physical therapy (PT) and occupational therapy (OT) through a company called Care Bridge. Then, she had a mental health hospitalization. Care Bridge recommended that Resident A move to Victor Manor. Upon discharge from the hospital, Resident A was admitted to Victor Manor. Resident A lived at Victor Manor for 2 months. Resident A's daughter later discovered that Resident A's Care Bridge RN, Susan (Sue) Mckiddy is the owner and licensee designee of Victor Manor and Sue's sister, Mary, is the home manager. Resident A and her family were unaware that Sue was affiliated with Victor Manor prior to Resident A moving into the home.

On 10/27/25, Resident A was taken to Trinity Brighton Hospital via EMS from Victor Manor due to a bedsore on her buttock that had worsened. Resident A's daughter stated Resident A lost 15 lbs. while living in this home. Resident A's daughter remarked, the bedsore was a point of contention. Victor Manor staff did not properly rotate Resident A. They did not use the proper medical equipment to dress the wound, and they did not clean the wound 3 x a day as prescribed. Resident A's doctor, Dr. Cutting prescribed specific medical pads to cover the wound, however, the home was using regular band-aids. The home was using soap which contained menthol to clean the wound. Resident A's daughter stated Care Bridge staff Betsy ripped Resident A out of her wheelchair and that reopened the wound. Resident A's daughter stated on 10/20/25, she attended a meeting at Victor Manor with Dr. Cutting and licensee designee Ms. Mckiddy. Ms. Mckiddy picked Resident A out of her wheelchair aggressively for Dr. Cutting to observe the bedsore. Resident A's daughter stated she did not look at the wound during this visit. However, Dr. Cutting said that it looked good. On 10/26/25, Resident A's husband went to visit her, and Victor Manor staff informed him that the bedsore looked very bad and said that they think she should go to the hospital. Dr. Cutting was contacted, and he called in an antibiotic for Resident A. The following day, Dr. Cutting advised that Resident A be sent to the hospital. Resident A's daughter stated Resident A remains in the hospital at this time and upon discharge she will be returning to her family home.

On 11/03/25, I completed an unscheduled onsite investigation. I interviewed licensee designee Susan Mckiddy, direct care staff Gloria Heywood, Resident B, Resident C, Resident D, Resident E, and Resident F. While onsite Ms. Mckiddy sent me a photo via text message of Resident A's bedsore take on 10/27/25. The wound is located on her buttock; it appears to be infected.

On 11/03/25, I observed Resident B sitting in a recliner chair in the front room. Resident B was well groomed. Resident B appeared confused, she did not respond to open-

ended questions with appropriate statements. Resident B repeated, “I don’t know why I am here.”

On 11/03/25, I observed Resident C sleeping in a recliner chair in front room. She did not respond to my attempts to interview her.

On 11/03/25, I interviewed Resident D. Resident D stated he has no issues or concerns with the care that he is receiving, he is happy living in the home.

On 11/03/25, I interviewed Resident E. Resident E appeared confused and she was unable to answer open-ended interview questions. Resident E consistently repeated she does not know how long she has been in this home or why she was living here.

On 11/03/25, I interviewed Resident F. Resident F’s daughter was visiting at the time of this interview and participated in the interview. Resident F and his daughter reported no issues or concerns with the care that he receives. They consistently reported Resident F is well cared for, he has no wounds and he receives proper nutrition.

On 11/03/25, I interviewed direct care staff Gloria Heywood. Ms. Heywood was guarded initially unwilling to be interviewed and requested that I obtain any needed documentation including resident names from the licensee designee Ms. Mckiddy. With further prompts Ms. Heywood stated she works morning and afternoon shifts at Victor Manor she was unable/unwilling to state the time at which the shifts start and stop. Ms. Heywood stated Resident A had a bedsore upon moving in. Ms. Heywood stated she did not treat Resident A’s bedsore. However, she did observe it and remarked it was red. When asked to describe how the wound looked, Ms. Heywood stated “it was not big.”

On 11/03/25, I interviewed licensee designee Susan (Sue) Mckiddy. Ms. Mckiddy stated Resident A lived at Victor Manor for 2 months. Prior to moving into Victor Manor, Resident A developed a bedsore, she was receiving treatment from Dr. Cutting and Care Bridge at her family home. Ms. Mckiddy was Resident A’s Care Bridge nurse. After Resident A’s hospitalization her family was looking for an adult foster care home. Victor Manor was recommended to them by the Care Bridge Marketer. Ms. Mckiddy stated the family was unaware that she owned and operated Victor Manor. Ms. Mckiddy stated upon moving into Victor Manor she continued to provide Resident A with nursing services through Care Bridge. Ms. Mckiddy clarifies she does not work shifts at Victor Manor so while she was treating Resident A’s wound it was as the Care Bridge RN. Ms. Mckiddy stated one week before Resident A was taken to the hospital, she had an appointment with Dr. Cutting. Resident A’s daughter was present for the appointment. During the appointment Dr. Cutting explained that Resident A had to get out of her wheelchair more often to help the wound heal. Ms. Mckiddy stated Dr. Cutting ordered Medihoney for the wound and advised that it should be covered with a patch; the patch should be changed 3 x week. Ms. Mckiddy stated Resident A also received OT, and PT services from Care Bridge. Care Bridge staff and Victor Manor staff were both responsible for the treatment of the bedsore. Care Bridge came to the home 1 – 2 x

week to complete OT, PT, and nursing services. Ms. Mckiddy stated on 10/27/25, she called Dr. Cutting and sent him a photo of Resident A's wound as it appeared to be worsening. Dr. Cutting advised that Resident A be sent to the hospital, she was sent via EMS.

On 11/05/25, I interviewed Dr. Cutting via telephone. Dr. Cutting stated his first visit with Resident A was in August 2025, she was living in her family home. Resident A's bedsore was stage 2. Dr. Cutting stated he had an appointment with Resident A on Wednesday (date unknown) and the wound appeared to be healing, there was no odor. Dr. Cutting prescribed Medihoney. On Friday or Saturday (date unknown) Dr. Cutting stated he was contacted by Ms. Mckiddy who expressed concern about how the wound looked. Dr. Cutting prescribed an antibiotic. Dr. Cutting was later informed that Resident A had an allergy to the medication that he prescribed so he sent in another prescription. Dr. Cutting stated on Monday (date unknown) he received a photo of Resident A's wound; he was also advised that it had an odor. Dr. Cutting recommended that Resident A be sent to the hospital. Dr. Cutting stated the wound is in a bad location. Resident A wears adult briefs; staff assists her with changing her brief but if she sits in stool the stool can get into the wound causing it to worsen. Dr. Cutting stated Resident A was advised many times that she needed to get up and move every hour. Resident A uses a wheelchair; however, she can reposition and transfer herself independently. Dr. Cutting remarked, Resident A is stubborn, and she did not want to get up. Dr. Cutting stated Victor Manor staff reported that they would encourage Resident A to get up and she refused. Dr. Cutting prescribed Medihoney and aqua gel pads to cover the wound, the pads were to be provided by the family and could be purchased over the counter. Dr. Cutting stated he did not prescribe any specific soap to clean the wound. Dr. Cutting stated it is hard to determine if any staff were negligent causing the wound to worsen due to the location of the wound, the resident not moving, and the family not encouraging movement.

On 11/05/25, I interviewed Care Bridge administrator Ahmed Malik. Mr. Malik stated Resident A began services with Care Bridge in August 2025 while she was living in her family home. Sue Mckiddy was her assigned Care Bridge nurse. Resident A received RN, OT, and PT services in the home two times a week. These services continued when Resident A moved into Victor Manor. During the time that Resident A was living at Victor Manor her wound worsened ultimately leading to her being hospitalized. Mr. Malik stated Care Bridge was not aware that Ms. Mckiddy owned and operated Victor Manor however, this has now been brought to their attention.

On 12/01/25, I interviewed home manager Mary Henderson. Ms. Henderson stated Resident A moved into the home with a bedsore. The family was seeking an AFC home as Resident A was not compliant with treatment orders. Ms. Henderson stated Resident A uses a wheelchair, she is unable to transfer independently. She also wears adult brief. Every 2 hours staff would prompt Resident A to get out of her wheelchair, rotate in bed, or sit in the recliner chair in her bedroom to elevate pressure on the wound. Resident A refused. She preferred to sit in her wheelchair and stay in the bedroom. Ms. Henderson stated Dr. Cutting explained to Resident A the harm she was causing herself

by being non-compliant and not getting off the wound. Ms. Henderson stated Dr. Cuttings RN's would come to change the bandage every 2 – 3 days. However, if the bandage became soiled in between appointments the AFC staff would clean the wound and change the bandage. The doctor provided bandages, and wound spray was used to clean the area. Ms. Henderson stated Resident A's wound began to worsen in less than 48 hours when staff observed the change, they notified licensee designee Ms. Mckiddy and she called Dr. Cutting. Resident A was transferred to the hospital.

On 12/01/25, I interviewed Resident A's husband via telephone. Resident A's husband stated when Resident A moved into Victor Manor the skin on her buttock was not broken. A week later a wound appeared, Dr. Cutting prescribed a cream, and Ms. Mckiddy stated it would be taken care of. Ms. Mckiddy confirmed that she had the prescribed cream at the home. One week later, Victor Manor staff informed Resident A's husband that Resident A should be taken to the hospital because the wound had an odor. Resident A's husband called her family doctor and he also advised that she be taken to the hospital. Resident A's husband stated when Resident A was in the hospital the wound was black around the edges, he remarked "it was unbelievable how big it was." Resident A stayed in the hospital in Ann Arbor, MI then after two wound debridement's she was transferred to Medi Lodge in Milford, MI. Resident A's husband stated "I don't think the home was doing anything. She did not receive the proper medical care that was prescribed for the wound." Resident A's husband explained that Resident A was not turned or rotated. He stated Resident A would allow staff to assist her in repositioning; she did not refuse. Resident A's husband stated Resident A is doing well now and the wound is healing.

I reviewed the following Victor Manor direct care staff notes:

10/22/25 - 12a - 8a - Resident A's wound was cleaned and changed.
10/19/25 - 12a - 8a – Cleaned wound on the bottom.
10/25/25 - 8a - 12a – Resident A's wound has a smell; the area is swollen. Doctor was contacted.

I reviewed a handwritten note on loose leaf piece of paper titled Wound Care Order for Resident A. The note is dated 10/17/25, and in summary indicates, clean wound with wound cleanser. Apply Medihoney and cover with Meplex 3 x weekly and as needed if dressing gets soiled or dislodged.

I reviewed Care Bridge nursing notes dated 09/05/25 – 10/22/25 sent via email from Care Bridge administrator Ahmed Malik. The following is relevant information:

- In summary nursing note dated 09/05/25, indicates Resident A is living with spouse and daughter. Resident A is at risk for pressure ulcer development. Risk factors include Multiple sclerosis (MS) with limited mobility, inability to stand independently, urinary incontinence, and bilateral lower extremity edema. Resident A failed the Time up and Go (tug) test and cannot use her walker due to left shoulder brace following fracture and surgery. Resident A has patchy dry skin on buttocks treated with cream. Resident A requires assistance with all activities

of daily living (ADL) and Instrumental activities of daily living (IADL). The report indicates that Resident A has no pressure ulcers/injuries and no stageable pressure ulcers/injuries.

- In summary, nursing note dated 09/10/25, indicates Resident A's skin assessment indicates "Turgor: Decreased." There is no further mention of a wound and/or patchy dry skin on Resident A's buttocks in this nursing note.
- In summary, nursing note dated 09/16/25, indicates that Resident A's skin assessment documents good turgor no issues noted. There is no further mention of a wound and/or patchy dry skin on Resident A's buttocks in this nursing note.
- In summary nursing Discharge Summary dated 09/25/25, indicates Resident A's skin assessment documents Turgor: Good / Elastic. All maximum goals met during this home health episode. Resident A was discharged from home health services with successful completion of treatment plan.
- In summary, nursing note dated 10/20/25, indicates Dr. Cutting was at this skilled nursing visit with Resident A's daughter to discuss wound appearance and plan of care. Dr. Cutting explained the importance of changing position often. The report indicates the open wound (unstageable pressure injury) is located on the buttocks. The wound is 4cm in length, 3cm wide and 0cm deep. The report includes the following comment from the nurse, "Wound Care **-** Skilled wound care was completed to the unstageable pressure injury on the buttocks per physician orders. The wound was cleansed with wound cleanser, Medihoney applied, and covered with an ABD pad secured with paper tape. Wound care is ordered three times weekly and PRN for dressing dislodgement or soiling—twice weekly by home health nursing and once weekly by facility staff and more as needed when soiled. Surrounding skin remains fragile, and ongoing monitoring for further skin breakdown continues. Patient and caregiver received education regarding the purpose of wound care, infection prevention, early signs and symptoms to report, and the availability of home health services 24 hours for urgent concerns. Medication review was completed; no medication changes or discrepancies noted. The patient was observed seated in the wheelchair, Dr. Cutting is at this skilled nursing visit with Patient's daughter present during the visit. The nurse explained the importance of frequent position changes to reduce the risk of pressure injuries and maintain skin integrity, including repositioning at least every 2 hours while in bed and hourly while seated in a chair. The caregiver reported that the patient was unwilling to change positions and attempted to remain seated in the wheelchair rather than transfer to another chair or bed to off load pressure on wound. Education was provided to both patient and caregiver regarding safe mobility, pressure relief techniques, risks of sustained pressure on bony prominences, and the medical necessity of routine repositioning to prevent worsening of the buttocks wound."
- In summary, nursing note dated 10/22/25, indicates "the patient refused to get out of the wheelchair or lie in bed for rest. Upon arrival at the patient's residence, the patient was observed seated in her wheelchair, appearing comfortable but refusing to transfer or reposition. Skilled wound care was performed on the patient's unstageable buttock wound per physician orders. The wound was cleansed, appropriate dressing applied, and surrounding skin assessed for

integrity. No changes in the patient's medications were noted during this visit. The skilled nurse immediately encouraged the patient to change positions frequently to promote circulation to the buttocks, reduce the risk of pressure injury progression, and maintain skin integrity. Despite repeated encouragement and explanation, the patient refused to get out of the wheelchair or lie in bed for rest periods. The caregiver reported that the patient spends most of the day seated in her room, is unwilling to transfer to a bed or another chair, and will not reposition independently, placing her at high risk for worsening skin breakdown and delayed wound healing. The nurse provided comprehensive skilled education to both the patient and caregiver, including: The medical necessity of regular repositioning to prevent tissue ischemia, maintain circulation, and support wound healing. Pressure relief techniques including turning schedules, safe use of the wheelchair, and timed bed rest to offload bony prominences. The clinical consequences of prolonged pressure, emphasizing that failure to reposition can lead to wound deterioration, infection, or development of new pressure injuries. Reinforcement of wound care importance, including observation for redness, drainage, odor, or other early warning signs of skin compromise. Physician Dr. Cutting was involved again and communicated with the patient and her daughter, emphasizing that the unhealed buttocks wound will worsen without adequate circulation and pressure relief, and that noncompliance with repositioning puts the patient at risk for complications. Skilled wound care was performed on the patient's unstageable buttocks wound per physician orders."

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based upon the information gathered during this investigation there is sufficient information to conclude Resident A did not receive personal care as prescribed. Resident A moved into Victor Manor on 09/05/25, she was receiving skilled nursing services from Care Bridge. Her assigned nurse was Susan (Sue) Mckiddy who is also the licensee designee/administrator of Victor Manor. Upon moving into the home Ms. Mckiddy's Care Bridge nursing notes document that Resident A had patchy dry skin on her buttock. Then, on 09/25/25, Resident A was discharged from Care Bridge nursing services indicating all

	her goals were met and she successfully completed her treatment plan. Although it is well documented that Resident A is at risk for pressure ulcer development due to risk factors including Multiple sclerosis (MS), limited mobility, inability to stand independently, urinary incontinence, and bilateral lower extremity edema Victor Manor provided no documentation outlining their efforts to reposition and/or transfer Resident A to reduce the development of pressure ulcers from the time that she was discharged from Care Bridge nursing services on 09/25/25 until a wound was identified and documented on/around 10/20/25. After the wound progressed and Victor Manor received wound care orders, they failed to produce sufficient documentation demonstrating that these orders were properly carried out. This includes a lack of evidence that the wound was cleansed with the prescribed cleanser, that Medihoney was applied, or that the wound was covered with Meplex 3 x weekly or as needed when the dressing became soiled or dislodged.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Victor Manor has staff who are illegally working in the United States. The staff do not have a background check on file in the LARA Workforce Background Check system.

INVESTIGATION:

Upon initiation of this investigation the complainant alleged that Victor Manor has staff who are illegally working in the United States.

On 10/31/25, I interviewed Resident A's daughter via telephone. Resident A's daughter stated the direct care staff from Victor Manor were "absolutely fabulous" however, they are from Jamaica, and she is not sure if they can legally work in the United States.

On 11/03/25, I completed an unscheduled onsite investigation. I interviewed licensee designee Susan Mckiddy and direct care staff Gloria Heywood. Ms. Heywood stated she is authorized to work in the United States. Licensee designee Susan (Sue) Mckiddy stated she has two direct care staff, Gloria Heywood and Reyanna Gomez who have work permits to work in the United States. Ms. Mckiddy provided proof of Ms. Heywood's Jamaican passport both Ms. Gomez's and Ms. Heywood's tax ID numbers.

On 11/03/25, I conducted a search on the LARA Workforce Background Check website. There is no background checks affiliated with Victor Manor for direct care staff Gloria Heywood and Reyanna Gomez.

On 12/01/25, I interviewed home manager Mary Henderson via telephone. Ms. Henderson stated there are two direct care staff, Gloria Heywood and Reyanna Gomez who have work permits to work in the United States. Ms. Heywood has been employed at the home for approximately 30 days. Ms. Gomez has been employed less than 30 days. Ms. Henderson stated both staff work alone and have not been fingerprinted.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under

	subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Based upon the LARA Workforce Background Check website, there are no background checks affiliated with Victor Manor for direct care staff Gloria Heywood and Reyanna Gomez.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Victor Manor is operating over their maximum capacity of 6 residents.

INVESTIGATION:

Upon initiation of this investigation the complainant alleged that Victor Manor is operating over their maximum capacity of 6 residents.

On 10/31/25, I interviewed Resident A's daughter via telephone. Resident A's daughter stated Victor Manor is operating over their maximum capacity of 6 residents. Resident A's daughter stated she witnessed 7 or 8 residents living in the home.

On 11/03/25, I completed an unscheduled onsite investigation. I interviewed licensee designee Susan Mckiddy and direct care staff Gloria Heywood.

On 11/03/25, I interviewed licensee designee Susan (Sue) Mckiddy. Ms. Mckiddy stated Resident G, a respite client, lived at Victor Manor for 10 days. Resident G was admitted from 10/13/25 – 10/23/25. Ms. Mckiddy stated at the time of Resident G's admission the home had 6 AFC residents and 1 respite client (Resident G). Therefore, they were over their capacity of 6. Ms. Mckiddy stated she did not know that the maximum capacity included respite clients.

On 11/03/25, I interviewed direct care staff Gloria Heywood. Ms. Heywood stated Resident G lived in the home for 10 days as a respite client. Ms. Heywood confirmed that while Resident G was living in the home, the home also had 6 AFC residents.

On 12/01/25, I interviewed home manager Mary Henderson via telephone. Ms. Henderson the home admitted a respite client, Resident G for 10 days resulting in the home having 6 AFC residents and 1 respite client (Resident G). Ms. Henderson explained that when Resident A moved into the home she was only going to stay for 30 days. However, her husband indicated that the family was not ready/able to take her back home which is why she ended up staying for another month resulting in the overlap with the respite client leaving the home over their maximum capacity.

I reviewed Victor Manor's Resident Register that indicates Resident G was admitted for respite care from 10/20/25 – 10/30/25. Additionally, Resident G completed a Resident Care Agreement indicating that she was receiving respite care from 10/20/25 – 10/30/25 for the cost of $200 per day, $2,000 total. The Resident Care Agreement was signed by Resident G's son and licensee designee Ms. Mckiddy.

I reviewed the Bureau of Information Tracking System which indicates Victor Manor is licensed for 6 residents.

APPLICABLE RULE	
R 400.613	**Licensed capacity, occupants.**
	(1) The number of residents and number of resident beds must not be greater than the capacity authorized on the license.
ANALYSIS:	Based on the information gathered during this investigation there is sufficient information to conclude that the number of residents at Victor Manor was greater than the capacity authorized on the license. Licensee designee Susan (Sue) Mckiddy stated Resident G was admitted to the home as a respite client for 10 days. During Resident G's admission, the home had 6 AFC residents and 1 respite client (Resident G). Therefore, Victor Manor was over their licensed capacity of 6.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive a receipt for her monthly cost of care payments.

INVESTIGATION:

The APS referral received indicated that Resident A did not receive a receipt for her monthly cost of care payments.

On 10/31/25, I interviewed Resident A's daughter via telephone. Resident A's daughter stated prior to moving into Victor Manor she was informed that the monthly payment would be $5,000. Resident A's daughter stated this was a verbal agreement and she does not have any written documentation to reflect this agreed upon price. Resident A's daughter stated Resident A was charged $5,800 per month and she did not

On 11/03/25, I interviewed licensee designee Susan (Sue) Mckiddy. Ms. Mckiddy stated home manager, Mary Henderson, completed the admission paperwork with Resident A

and her family. The facility has never provided receipts for cost of care payments. Ms. Mckiddy provided a copy of Resident A's Resident Care Agreement and the Funds Part II form.

On 12/01/25, I interviewed Resident A's husband via telephone. Resident A's husband stated prior to moving into Victor Manor he was informed by home manager Mary Henderson that the monthly payment would be $5,000. Resident A's husband stated this was a verbal agreement and he does not have any written documentation to reflect this agreed upon price. Upon moving Resident A into the home, he was informed that the cost of care was $5,800 per month. Resident A's husband stated he does not recall signing the Resident Care Agreement agreeing to this rate however, upon review of the document he agrees that it is his signature. Resident A's husband stated he asked Ms. Henderson for a receipt for the monthly cost of care payments and she instructed him that the facility does not provide receipts, that his check stub serves at his receipt for payment.

On 12/01/25, I interviewed home manager Mary Henderson. Ms. Henderson stated Resident A was staying in the "big room," which is routinely leased for $5,800 per month. Resident A's family did not want her to have a roommate so although the room can accommodate two residents, Resident A was in the room alone. Ms. Henderson stated Resident A and her husband signed the AFC paperwork agreeing to the cost of care. Ms. Henderson stated she never spoke to Resident A's daughter regarding the cost of care. Ms. Henderson denied ever verbally agreeing to charge $5,000 per month. Ms. Henderson stated the facility has never given a receipt for the cost of care payment as the check they provide is proof of payment. Ms. Henderson remarked that Resident A's husband had a carbon copy of the check that he wrote. Ms. Henderson stated neither Resident A or her husband ever requested a receipt for their payment. However, when Resident A was taken to the hospital, she received a text message from Resident A's daughter demanding that she provide a written receipt for the cost of care payments within a specific amount of time. Ms. Henderson stated she did not provide the receipt as she had never delt with Resident A's daughter and Resident A's daughter is not her guardian or her representative payee.

I reviewed Resident A's Resident Care Agreement and the Funds Part II forms. Per the Funds Part II form Resident A made two payments of $5,800 on 09/04/25 and 10/08/25 which is consistent with the agreed upon rate in the Resident Care Agreement. The Resident Care Agreement was signed by Resident A's husband and the home manager, Mary Henderson, on 09/05/25.

APPLICABLE RULE	
R 400.637	**Handling of resident funds and valuables.**
	(14) A licensee shall provide a complete accounting on an annual basis and on request of all resident funds and valuables that are held in trust or that are paid to the facility, a resident, or a resident's designated

	representative. An accounting of a resident's funds and valuables that are held in trust or are paid to the facility must also be provided, on the resident's or the resident's designated representative's request, not more than 5 business days after the request and at the time of the resident's discharge from the facility.
ANALYSIS:	Based on the information gathered during this investigation there is sufficient information to conclude that Resident A and/or Resident A's husband did not receive an accounting of the funds paid to the facility upon request. Resident A's husband stated he asked home manager Mary Henderson for a receipt for the monthly cost of care payments, and she told him that the facility does not provide receipts, that his check stub serves as his receipt for payment. Although Ms. Henderson denied that Resident A and/or her husband ever requested a receipt for the cost of care payment she remarked that the facility has never given a receipt for the cost of care payment as the check they pay with serves as proof of payment. Ms. Henderson further remarked that Resident A's husband had a carbon copy of the check that he wrote. Additionally, Ms. Henderson stated that she received a text message from Resident A's daughter requesting a written receipt for the cost of care payments. Ms. Henderson said that she did not provide a receipt.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **A resident threw up at the dinner table.**
- **Resident A lost 15 lbs. while living at Victor Manor.**

INVESTIGATION:

The APS referral received indicated that on an unknown date an unknown resident threw up at the dinner table. When interviewed, the complainant further alleged that Resident A lost 15 lbs. while living at Victor Manor.

On 10/31/25, I interviewed Resident A's daughter via telephone. Resident A's daughter stated on an unknown date Resident G threw up at the dinner table during dinner then later Resident G had diarrhea. Later that day another resident (name unknown) got sick. Resident A's daughter stated none of the residents were quarantined to stop the spread of illness. Furthermore, the staff did not communicate with each other to notify one another that Resident G was ill.

On 11/03/25, I completed an unscheduled onsite investigation. I interviewed licensee designee Susan Mckiddy and direct care staff Gloria Heywood.

On 11/03/25, I interviewed direct care staff Gloria Heywood. Ms. Heywood stated she was not responsible for weighing Resident A and therefore she does not know if Resident A lost weight while living in the home. Ms. Heywood stated Resident G lived in the home for 10 days as a respite client. Ms. Heywood was on shift when Resident G vomited during dinner. Ms. Heywood stated Resident G had a cold and she was wheezing, which caused her to vomit. Ms. Heywood stated none of the other residents got ill as a result of Resident G being sick. Ms. Heywood stated she informed the other staff via the staff log that Resident G was ill.

On 11/03/25, I interviewed licensee designee Susan (Sue) Mckiddy. Ms. Mckiddy stated she does not work shifts at Victor Manor and therefore, she is not aware if Resident A lost weight while living in the home. Ms. Mckiddy stated resident weights are the responsibility of the home manager.

On 12/01/25, I interviewed home manager Mary Henderson. Ms. Henderson stated while living at the home Resident A ate well. She did not have weight loss. When Resident A moved in, she weighed 111.6 lbs. When she moved out, she weighed112.6 lbs. There were no issues or concerns regarding her weight. Ms. Henderson stated she was informed by staff that Resident G threw up at the kitchen table, however, she was not present when it occurred. Ms. Henderson stated she spoke to staff and Resident G about it. Resident G got sick to her stomach. She was removed from the table and cleaned up. The staff communicated about what occurred at shift change and in the written communication log. Ms. Henderson stated Resident G was not quarantined as she had no fever and no ongoing symptoms, she just got sick to her stomach while eating.

On 12/01/25, I interviewed Resident A’s husband via telephone. Resident A’s husband stated Resident A lost approximately 20 lbs. while living at Victor Manor. He addressed this concern with licensee designee Ms. Mckiddy who stated it was because she was not eating nutritious food or drinking enough water. Resident A’s husband stated Resident A currently weighs 99 lbs. I requested proof of Resident A’s weight be provided. As of the date of this report no documentation has been received.

I reviewed Resident A’s Victor Manor weight record. Resident A’s weight at admission was 111.6 lbs. On 09/25/25, Resident A weighed 110.4 lbs. and on 10/20/25 Resident A weighed 112.6 lbs.

I reviewed a staff note written on 10/22/25, the note indicates that Resident G is wheezing heavily and coughing.

I reviewed Care Bridge nursing notes dated 09/05/25 – 10/22/25 sent via email from Care Bridge administrator Ahmed Malik. The following is relevant information:

- Nursing note dated 09/05/25 - Pt is on a regular diet with good appetite. History of unspecified protein-calorie malnutrition. Current weight 121 lbs. at 5'3". Note: the nursing note does not specify if this weight was self-reported or if Resident A was weighed.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe
ANALYSIS:	Based on the information gathered during this investigation there is insufficient information to conclude that any of the residents were not protected and safe due to vomiting and/or weight loss. Per Resident A's weight log while living at Victor Manor for two months she did not experience any significant changes to her weight. Although Resident A's husband stated that Resident A lost 20 lbs., proof of the weight loss was requested and as of the date of this report it was not received. Although it was reported that Resident G vomited at the table per staff interviews and written documentation, this was a one-time, isolated issue, that did not cause harm to Resident G or the other residents in the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During the course of this investigation the licensee designee provided copies of Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F's Resident Care Agreements. None of the Resident Care Agreements are signed by the licensee designee/administrator, Susan Mckiddy, instead they are signed by the home manager, Mary Henderson.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(8) A resident care agreement must be signed by all applicable parties. A copy of the signed resident care agreement along with copies of the policies listed in subrule (6) of this rule must be provided to the resident or

	the resident's designated representative and maintained in the resident's record.
ANALYSIS:	Based upon the information gathered during this investigation there is sufficient information to conclude that Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F's Resident Care Agreements do not include the licensee/ administrator's signature.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection completed on 11/03/25, I observed a smoke detector mounted on the ceiling in the dining room was not properly installed as it was hanging from the ceiling.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based upon my observation on 11/03/25, there is sufficient information to conclude that the smoke detector mounted on the ceiling in the dining room was not being maintained to provide adequately for the health and safety of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection completed on 11/03/25, I observed two boxes of medication (bubble packs) sitting on the floor, not locked in a cabinet or drawer. One box was next to the medication cart, and the other box was in the hallway. The licensee designee, Susan Mckiddy stated the medications were not used from the previous month and they will be picked up from the pharmacy to be disposed of. Ms. Mckiddy remarked that the medications should have been stored in the locked storage closet.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original

	manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	Based upon my observation on 11/03/25, Victor Manor had two boxes of prescription medication that was not being stored in a locked cabinet or drawer at the time of the unscheduled onsite inspection.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection completed on 11/03/25, I observed that the front door had a chain lock located at the top of the door. The chain lock is not non locking against egress hardware.

On 12/12/25, I completed an exit conference with licensee designee Susan Mckiddy via telephone, I reviewed the allegations and my findings. Ms. Mckiddy was advised that a corrective action plan is required, she acknowledged and agreed to submit. Ms. Mckiddy stated that she is implementing staff training on wounds, and she has already addressed several of the additional findings that were cited in this report.

APPLICABLE RULE	
R 400.725	**Means of egress.**
	(3) Doors that form a part of a required means of egress must be equipped with positive-latching, non-locking-against-egress hardware and have a width to allow for residents requiring wheelchairs or other devices to easily navigate through doorways.
ANALYSIS:	Based upon my observation on 11/03/25, the chain lock on the front door is not positive-latching, non-locking-against-egress hardware.
CONCLUSION:	**VIOLATION ESTABLISHED**

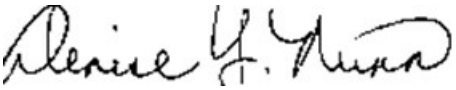
IV. RECOMMENDATION

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

12/12/2025

Johnna Cade — Date
Licensing Consultant

Approved By:



12/22/2025

Denise Y. Nunn — Date
Area Manager