GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 29, 2026

Claudiu Marit
Selah Senior Living LLC
1825 Hiller Rd
West Bloomfield, MI 48324

RE: License #: AS630410571
Investigation #: 2026A0991003
Ahava of White Lake

Dear Claudiu Marit:

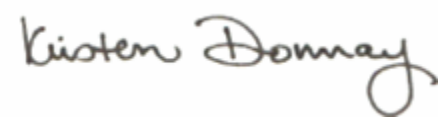
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630410571
Investigation #:	2026A0991003
Complaint Receipt Date:	11/03/2025
Investigation Initiation Date:	11/04/2025
Report Due Date:	01/02/2026
Licensee Name:	Selah Senior Living LLC
Licensee Address:	1825 Hiller Rd West Bloomfield, MI 48324
Licensee Telephone #:	(248) 860-3101
Administrator:	Daniela Marit
Licensee Designee:	Claudiu Marit
Name of Facility:	Ahava of White Lake
Facility Address:	760 Robar Circle White Lake, MI 48324
Facility Telephone #:	(248) 860-3101
Original Issuance Date:	09/23/2022
License Status:	REGULAR
Effective Date:	03/23/2025
Expiration Date:	03/22/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A is not receiving proper care at Ahava of White Lake. Staff are not moving or changing Resident A regularly, and she has multiple wounds on her coccyx, hip, legs, ankle, and toe. Resident A has lost significant weight over the past three months, and she is not being fed the appropriate diet.	Yes

III. METHODOLOGY

11/03/2025	Special Investigation Intake 2026A0991003
11/03/2025	APS Referral Received from Adult Protective Services (APS)
11/04/2025	Special Investigation Initiated - Telephone To Adult Protective Services (APS) worker, Gene Evans
11/10/2025	Inspection Completed On-site Unannounced onsite inspection- interviewed staff and observed Resident A
11/10/2025	Contact - Telephone call received From licensee designee, Claudiu Marit
11/12/2025	Contact - Document Received Documents from Ahava- assessment plan, weight records, hospice care plan and notes, incident reports, and documentation regarding wounds
11/14/2025	Contact - Telephone call made Left message for guardian
12/03/2025	Contact - Document Received Email from APS worker, Gene Evans- Resident A passed away on 11/17/25
12/03/2025	Contact - Telephone call made Left message for St. Croix Hospice
12/15/2025	Contact - Telephone call received From APS worker, Gene Evans

12/17/2025	Contact - Telephone call made Left message for guardian
12/23/2025	Contact - Telephone call made Call to St. Croix Hospice- interviewed Chris Peterson- manager of clinical services
12/23/2025	Contact - Telephone call made Interviewed Sue Harris, St. Croix Hospice nurse
12/23/2025	Contact - Telephone call made Left message for Noel Hancock- Ahava nurse
12/24/2025	Contact - Document Received Hospice records
01/07/2026	Exit Conference Via telephone with licensee designee, Claudiu Marit

ALLEGATION:

Resident A is not receiving proper care at Ahava of White Lake. Staff are not moving or changing Resident A regularly, and she has multiple wounds on her coccyx, hip, legs, ankle, and toe. Resident A has lost significant weight over the past three months, and she is not being fed the appropriate diet.

INVESTIGATION:

On 11/03/25, I received a complaint from Adult Protective Services (APS) alleging that Resident A is not receiving proper care at Ahava of White Lake. The complaint alleged that staff are not moving or changing Resident A regularly, and she has multiple wounds on her coccyx, hip, legs, ankle, and toe. The complaint noted that Resident A lost 16 pounds over the past three months, and she is not being fed the appropriate diet. I initiated my investigation on 11/04/25 by contacting the assigned APS worker, Gene Evans. Mr. Evans stated that he saw Resident A at the home on 11/04/25. Her guardian is planning to move her out of the home later in the month.

On 11/10/25, I conducted an unannounced onsite inspection at Ahava of White Lake. I interviewed the Ahava care manager, Amanda Beeler. Ms. Beeler stated that it has been a battle with Resident A's hospice team since she moved into the home on 08/15/25. When Resident A was admitted to the home, they met with the hospice nurse from St. Croix Hospice. The nurse stated that Resident A's skin was great and everything was fine. The hospice nurse reported that Resident A did not have any skin breakdowns. Later that day, Noelle Hancock, Ahava's director of nursing, completed a

skin assessment. She noted that Resident A had a wound on her bottom. She took pictures to document the wound and sent them to the hospice nurse, who acted very surprised. Ms. Beeler stated that Noelle Hancock was trying to be on top of wound care for Resident A. Usually hospice provides the orders for wound care, and they follow those orders. However, Ms. Hancock did not feel that the hospice nurse was providing appropriate orders or care. The original hospice orders stated to clean with soap and water, layer antifungal cream, and leave open to air. The orders stated not to cover the wounds; however, Resident A is incontinent and wears briefs. Ms. Hancock made several attempts to get additional clarification and to change the orders. Ms. Beeler stated that the hospice nurse did not look at Resident A's wounds every time she came to the home. On 10/09/25, the hospice nurse came to the home, but Resident A was at the table eating, so the nurse did not look at Resident A's wounds or change the dressing. They expressed concerns about this to the hospice agency. There was also conflicting information regarding how often the hospice nurse was changing the dressings. It was initially stated that she would change the dressings twice a week; however, it was later stated that she would only do it once a week. The staff at Ahava would change the dressings daily. Ms. Beeler stated that staff reposition Resident A every two hours or more often if needed. She did not have any concerns about Resident A not being repositioned.

Ms. Beeler stated that the hospice nurse, Sue, raised concerns that Resident A was soaked in urine. This was brought up to Ahava management. Ms. Beeler stated that since this concern was raised, she and Ms. Hancock have been on a rotation conducting visits to the home. They have not observed anyone sitting in soiled briefs for an extended period of time. Ms. Beeler stated that the hospice agency never appointed a wound care nurse, so the regular hospice nurse, Sue, was responsible for assessing and treating Resident A's wounds. She stated that a new nurse was recently assigned to Resident A after they expressed concerns to hospice.

Ms. Beeler stated that Resident A did not lose 16 pounds in three months. Her weight has declined, but she had ten teeth extracted on 09/23/25. Resident A weighed 95.2 pounds at the time of her admission on 08/15/25, 93.3 pounds in September, and 89 pounds in October following the dental procedure. Ms. Beeler stated that Resident A is having some difficulty eating. They began pureeing her food after her teeth were extracted. Ms. Beeler stated that Resident A was sent to the hospital due to a choking incident on 08/28/25. She was on a mechanical soft diet at that time. Her food was bite sized, but she had a hard time with it. Ms. Beeler stated that staff put her food into a food processor and puree it now. Ms. Beeler stated that staff do provide Resident A with three meals a day. Resident A typically eats well, but she takes a lot of time to eat.

On 11/10/25, I interviewed direct care worker, Rachel Hubbard. Ms. Hubbard stated that she has worked for Ahava for eight years. She typically works Monday-Thursday from 7:00am-7:00pm. Ms. Hubbard stated that when she arrives for her shift, Resident A has

typically just been changed by the midnight shift. She checks on her and then an hour later gets her up for breakfast. She checks and changes her at that time. Resident A eats breakfast at the table. After breakfast, she will usually lay down or sit in her chair. Ms. Hubbard stated that Resident A has wedge pillows that they use to relieve pressure, and they will put a pillow between her legs or on her sides. Ms. Hubbard stated that Resident A is rotated back and forth at least every two hours. She tends to end up back on her right side. Ms. Hubbard stated that staff change Resident A at least every two hours. Ms. Hubbard stated that Resident A is a heavy wetter, but she is never left unchanged. Staff always change her when she is wet or soiled. Sometimes Resident A soils herself right after staff have changed her. She stated that Resident A had some wounds when she moved into the home. They have gotten worse since she has been living in the home. She stated that staff are following the wound care instructions the best they can. She then stated that the previous nurse said to let the wound air dry; however, she put a dressing on it and did not leave it open to air. Ms. Hubbard stated that the orders state to cover the wound now, and they recently got a new order for Flagyl, which they crush and put in the wound before putting a dressing on it. Ms. Hubbard stated that Resident A is provided a soft diet. Resident A did choke and went to the hospital at the end of August. She was not on a soft diet at that time. Ms. Hubbard stated that she was not sure when Resident A was switched to a soft diet, but she thought it was after the second time she choked. She stated that Resident A sees other people eating and wants regular food.

During the onsite inspection on 11/10/25, I observed Resident A laying in her bed. She was unable to participate in an interview due to limited verbal and cognitive abilities. Resident A had on heel protectors and her wounds were covered. During the onsite inspection, I noted that there was a foul odor in the facility.

On 11/10/25, I received a phone call from the licensee designee, Claudiu Marit. Mr. Marit stated that there have been ongoing communication issues with the St. Croix Hospice team since Resident A moved into the home. He stated that when Resident A moved into the home, they were provided with her hospice plan from July 2025. They asked for an updated plan at the time of her admission, but it was never provided by hospice. Mr. Marit stated that there were discrepancies regarding Resident A’s diet and wound care. The health care appraisal stated regular diet and thin liquids. At some point, the hospice nurse left a note in the communication log that she would like to change the diet, but there was no physician order regarding the diet change. Mr. Marit stated that Resident A did not have a significant weight loss in the home. She was prescribed Furosemide, which is a diuretic that caused her to lose some weight. Mr. Marit stated that the hospice team was very bad at communicating. Resident A’s guardian is planning to move her from the home on 11/17/25.

On 12/03/25, I received an email from the assigned APS worker, Gene Evans, indicating that Resident A passed away on hospice at the home on 11/17/25.

I interviewed Chris Peterson, the manager of clinical services, at St. Croix Hospice. Mr. Peterson stated that the hospice team informed him of concerns regarding Resident A's care while she was residing at Ahava of White Lake. He stated that the main concern was that Resident A would frequently still be in bed when the nurse or aide came to the home. She was often found to be in a brief that was saturated in urine, and the bedding would often be saturated as well. This happened on multiple occasions. They would also find that Resident A was still in bed at noon and had not been given breakfast yet. Mr. Peterson stated that Resident A had an air mattress to help alleviate the pressure for her wounds. On one occasion, the air mattress was found to be deflated. Staff at the home told the hospice team that the bed had not been working for a few days, but they did not call to report the issue. Mr. Peterson stated that he began going to the home due to some of the issues they were having regarding Resident A's care and tensions between the hospice team and Ahava. He stated that he observed firsthand that Resident A was in saturated briefs and that staff at the home were not getting her out of bed until hospice arrived. He stated that the home's staff, Rachel, refused to cooperate with hospice and would not assist with getting Resident A in or out of bed and changing her clothes. He stated that Rachel also told the hospice nurse that she did not have time to puree Resident A's food.

On 12/23/25, I interviewed Sue Harris, a registered nurse with St. Croix Hospice. Ms. Harris stated that she was initially assigned as Resident A's hospice nurse when Resident A moved into Ahava of White Lake. She stated that on the day of admission, everything seemed great and the staff were very polite and nice. The following day, she informed staff at the home, Rachel, that Resident A could not eat hard food and required a pureed diet. Ms. Harris stated that Rachel had an attitude and asked her, "Are you going to come and prepare her food?" stating that she did not have the time to puree Resident A's food. Ms. Harris stated that Resident A would pocket food. She observed staff, Rachel, giving Resident A soup that had chunks of vegetables in it. She told Rachel that Resident A was pocketing carrots. Rachel responded by saying, "Oh, well she can chew." Ms. Harris stated that she put the diet order in writing and gave it to the caregivers at the home. She typically observed staff giving Resident A soft foods such as yogurt or oatmeal, but the soup was not the proper consistency. She stated that Resident A was a very slow eater, and staff would allow Resident A to sit for over an hour and a half eating. She never observed staff feeding Resident A. Ms. Harris stated that this was concerning, as Resident A should not be sitting in one position for that long due to her wounds. She stated that she had ongoing concerns about Resident A's care while she was in the home. Resident A had a wound on her coccyx when she moved into the home, but she developed additional wounds while living in the home, including a wound on her ankle and hip. She stated that staff were not consistently putting a pillow under Resident A to ease the pressure on her wounds. Resident A had heel protector boots for the wound on her ankle. Staff did not consistently put the boots on Resident A, as they would sometimes be on Resident A and sometimes not when hospice came to the home.

Ms. Harris stated that Resident A was often wet. On more than one occasion, when the hospice aide went to the home, they observed that Resident A was in the same clothes as the day before, and there would be dried urine on her clothing. Ms. Harris stated that Resident A was not being changed often enough and was not being kept clean. The hospice team frequently had to change Resident A. Ms. Harris stated that Resident A was often left in bed until hospice came to the home. She had concerns that Resident A was not getting all of her meals, as staff would say she ate 100% of her breakfast, but she was still in bed and had not been up yet. Resident A took her meals at the table and did not eat in bed. There were also times that staff told the hospice team Resident A had not eaten yet, when they arrived for their visit at noon. Ms. Harris stated that the caregiver, Rachel, often refused to assist hospice with getting Resident A in and out of bed. She stated that one person could transfer Resident A, but Ms. Harris did not feel comfortable transferring Resident A on her own. Ms. Harris stated that she began going to the home at the same time as the hospice aide, so that they could transfer Resident A together. She stated that she felt some of Resident A's bruises and abrasions were caused from staff transferring her. Ms. Harris stated that there was an occasion when the hospice aide went to the home and found Resident A's air mattress was deflated and she was laying directly on the bedframe. She stated that they reported this to the home's management team and it was repaired right away. However, when she expressed concerns about the home's caregiver, Rachel, she felt management at Ahava ignored her concerns. Ms. Harris stated that she felt Resident A's wounds and health got worse due to the lack of care she received while at Ahava of White Lake.

I received and reviewed Resident A's Patient Information Report from St. Croix Hospice, which includes nursing notes from each hospice visit. The following relevant information was noted.

On 08/28/25, the hospice notes indicate that Resident A is on a 2000 calorie mechanical soft diet with thin liquids. She continues pocketing food. She takes an extended amount of time to eat (1 hour), eating less than 50%, two meals daily. The notes indicate that the new facility was non-compliant with mechanical soft diet and Resident A is taking two hours to eat. The notes indicate that Resident A used to be a one-person assist for transfers, but she is unable to bear weight and now sometimes requires a two-person assist with transfers. The notes state that Resident A went to the hospital on 08/28/25 due to choking on soup. She has a stage two wound on her coccyx and a stage two wound on her right ankle. Both wounds are being treated by the hospice nurse and facility staff.

On 08/31/25, the hospice notes indicate that they received a call from Amanda at the group home. Resident A was sitting up at the table and then slouched over and was unresponsive. She is a full code and was sent out to the hospital.

On 09/03/25, the hospice notes indicate that Resident A was sitting up in her wheelchair, having just gotten up for the day. The facility caregiver, Rachel, indicated that she provided wound care to the coccyx and right ankle prior to getting Resident A up. The caregiver refused to assist the hospice nurse in placing Resident A back in bed to assess the wounds, but she stated “wounds are about the same.” Rachel reported that Resident A is eating 25-50% of three small meals a day. She is only tolerating soups or a full liquid type food since her last choking incident. Rachel stated that it takes Resident A one to two hours to consume a half bowl of soup.

On 09/11/25, the hospice notes indicate that Resident A has edema in her right hand. Wound care was completed on her coccyx and right ankle. The hospice nurse applied heel protectors. Resident A is on a pureed diet.

On 09/15/25, the hospice notes indicate that there is edema in Resident A’s right hand and face. Resident A’s left leg has a new abrasion present that is covered with foam dressings and tape wrapped all around the leg. The hospice nurse educated the caregiver, Rachel, to leave it open to air. There is a new onset skin tear on Resident A’s left forearm with bruising. The caregiver denied any falls. Wound care was completed on Resident A’s coccyx and right ankle. The hospice nurse applied heel protectors and reinforced to the caregiver that the bandages on the ankle and coccyx need to be changed twice a week unless soiled. The caregiver, Rachel, verbalized that the new facility nurse wrapped Resident A in all the tape.

On 09/22/25, the hospice notes indicate that Resident A has a bruise on her left wrist.

On 09/29/25, the hospice notes indicate that Resident A has a new stage one wound on her right hip. Wound care orders were given to Rachel and the facility team.

On 10/16/25, the hospice notes indicate that Resident A was in her room with the caregiver, Rachel. Rachel was in the process of putting Resident A in bed. The hospice aid was present with the nurse to assist with wound care. The caregiver, Rachel, was verbally upset with the hospice aid and nurse. Resident A was in the same clothes that the hospice aid put on her at yesterday’s visit. Her shirt smelled like urine. Her brief was saturated with urine and bm (bowel movement). Resident A’s brief was changed, and she was dressed in a new shirt. She has new onset redness around the right eye and a new onset wound on the second toe of her right foot. The toe is scabbed. A new mattress is in place after it was losing air since Monday. The hospice aid told the caregiver, Rachel, on Wednesday’s visit that the bed was still not working and the middle of the air mattress was sunken in. The hospice aid informed the facility’s manager, Amanda. All wound care was completed. The nurse put heel protectors on and placed a blanket between Resident A’s legs and floated her hips with pillows on each side.

On 10/17/25, during the hospice interdisciplinary group (IDG) meeting, concerns were voiced by the hospice nurse case manager (RNCM) and the hospice chaplain related to Resident A's care at the Ahava facility. The concerns that were voiced included:

- The RNCM and aides noted that Resident A's clothing, bedding, and brief are often wet and saturated with urine.
- Resident A was noted to be on a bed with a deflated mattress upon arrival
- Resident A has an increasing number of wounds.
- Resident A's clothing is not being changed between visits and it appears soiled.
- The caregiver, Rachel, has been refusing to put Resident A in bed for bathing and/or dressing changes.
- The dressing on Resident A's bottom has been "saturated in urine and feces".
- The Chaplain noted that after another patient's family members left the facility, the caregiver was noted rolling her eyes at another resident and slamming doors.

Following the IDG meeting, a call was placed to the facility owner, Claudiu Marit, to discuss the concerns. He stated that he knows Rachel and that she is not like that. He stated that they wash clothing every night, so Resident A could be wearing the same clothes every day and they would be clean. He does not believe that Resident A would be in the same clothing. He stated that he was going to fire St. Croix for bad care and that he wants his manager to speak to hospice. They attempted a conference call, which was unsuccessful. The manager, Amanda, called and spoke to the hospice team. They discussed the concerns and developed a plan where the nurse and aide will visit together to help with turning and repositioning. They will call prior to visiting so the staff will have time to put Resident A in bed.

On 10/20/25, the hospice notes indicate that Rachel was in the process of putting Resident A in bed. Resident A's brief was dry at the visit.

On 10/23/25, the hospice notes indicate that Resident A's brief was dry during the visit. Resident A did not have a pillow between her legs or under her right hip, as she was lying on her right side upon arrival. Resident A has redness on her right hip area.
On 11/06/25, the hospice notes indicate that Resident A was laying in bed on her left side with a pillow between her knees. The notes indicate that wound care was provided and her soiled/wet brief was changed. The wound to Resident A's coccyx has started to open up and appears to be tunneling now. New wound care supplies were ordered. The caregiver, Rachel, stated that Resident A ate 25% of her breakfast, but Resident A was noted to not have been out of bed yet today. Resident A was transferred out of bed and placed in her wheelchair. She was taken to the dining room for lunch and was observed to be feeding herself soup and yogurt.

The hospice notes include an addendum to the narrative note from 10/27/25, which states that upon arrival, Resident A was found to be laying on her right side, curled in the fetal position. Resident A was in a fully saturated and soiled brief with a heavy odor to it. Soiling was dried in the brief and on Resident A. The home health aide notes that Resident A was wearing the same socks she applied to Resident A the previous week. Resident A had no heel protectors on or pillows supporting her body. Resident A was still in bed from the night before, although the caregiver, Rachel, stated that Resident A refused breakfast.

The hospice notes include an addendum to the narrative note from 11/03/25, which indicates that upon arrival, Resident A was found to be in a soiled brief, which was doubled up. Resident A was laying without pillows between her knees. Per the facility caregiver, Rachel, Resident A had eaten breakfast; however, she was still in bed from the night before.

On 11/12/25, the hospice notes indicate that Resident A presented curled in a fetal position in bed, on her left side. The hospice nurse changed all dressings to her four skin care wounds. The coccyx dressing was saturated with a foul-smelling purulent drainage, and her diaper was saturated with urine. Her pajama pants were removed due to wetness. The caregiver reported that Resident A ate three bites of scrambled eggs for breakfast and drank one glass of fruit punch. The nurse educated the facility caregiver, Rachel, about the importance of paying attention to only feeding or giving drink if Resident A wants it. The risk for aspiration is high at this stage of life. Rachel verbalized understanding. The nurse encouraged all dressings to be changed when Resident A's brief is changed so the dressing on the coccyx does not become saturated with drainage, providing comfort and dignity to Resident A. The hospice nurse also encouraged premedication before transfers for comfort measures.

On 11/13/25, the hospice notes indicate that Resident A was sitting in her recliner in her room resting. Resident A was transferred back to bed to provide wound care. All dressings were changed. The dressing to the coccyx was saturated and the wound was actively draining purulent drainage. Resident A's brief was changed. Transferring Resident A and providing wound care caused Resident A to yell out. Resident A had not received PRN morphine since the visit yesterday, despite the caregiver, Rachel, verbalizing an understanding to medicate Resident A. Resident A was prescribed Morphine 5mg PO every eight hours around the clock and every two hours PRN to be given prior to transferring or providing wound care ordered.

I received and reviewed a copy of Resident A's health care appraisal dated 08/15/25 completed by the hospice nurse, Sue Harris, which notes that she is on a regular diet with thin liquids.

I received and reviewed a copy of Resident A's licensing assessment plan dated 08/15/25, which notes that she requires assistance with eating/feeding, toileting, bathing, grooming, dressing, and personal hygiene. The assessment plan states,

“caregiver will provide assist with feeding when needed,” and “caregiver will provide total assist,” for the other needs. No additional information is noted regarding the type of assistance needed. The assessment plan notes that Resident A is not on a special diet. A note was added to the assessment plan that states, “On 9/5 a note was found stating (Resident A) is put on puree diet. No order received or faxed.”

I received and reviewed Resident A’s Hospice Certification and Plan of Care. Ahava noted that the only Plan of Care received from hospice was dated 07/27/25, which covered the certification period ending 09/24/25. This plan was established prior to Resident A’s move into the home. St. Croix Hospice did not provide an updated Plan of Care upon admission or at any time thereafter. They noted that following the expiration of the certification period on 09/24/25, St. Croix Hospice refused to issue a new Plan of Care for the subsequent certification period. The plan notes that Resident A’s nutritional requirements are a mechanical soft diet.

The hospice plan includes a Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated 09/02/25. The update report notes wound care orders dated 08/21/25 which state to cleanse the coccyx wound with warm water and soap, pat dry with gauze, apply thin layer of barrier cream topically BID (twice a day) and PRN (as needed) with incontinence by facility staff. Hospice nurse to assess weekly and PRN. There are also wound care orders dated 08/28/25, which note to cleanse the right ankle with wound cleanser and pat dry with gauze. Apply 1cm honey and cover with island dressing. Hospice nurse to change twice a week unless soiled. The update notes that declines/symptom management and med changes since the last IDG meeting include choking on food, and that education was provided regarding food safety.

I reviewed Resident A’s weight record. It notes that she weighed 98 pounds at admission. On 08/18/25, she weighed 95.2 pounds. On 09/13/25, she weighed 93.3 pounds. On 10/20/25, she weighed 89 pounds. The weight record notes that Resident A had ten teeth extracted on 09/23/25 and hospice was notified. On 11/11/25, Resident A weighed 87.3 pounds.

I reviewed the documentation provided by Ahava regarding Resident A’s wound care orders and instructions. They noted that the wound care orders were generated, printed, and faxed from St. Croix Hospice to Ahava on 10/22/25. No other formal wound care instructions were provided. The wound care documentation includes the following orders:

- Order Date: 09/25/25- Cleanse the lower left leg wound with wound cleanser and pat dry with gauze dressing. Apply medihoney and cover with island dressing. Hospice nurse to assess and change twice a week. Caregiver to perform PRN.
- Order Date: 09/29/25- Cleanse right hip stage 1 with warm water and soap. Pat dry with gauze. Caregiver to apply thin layer of barrier cream at brief changes. Keep open to air. Caregiver to perform. Hospice nurse to assess weekly and PRN.

- Order Date: 10/16/25- Cleanse left iliac crest area with wound cleanser and pat dry with gauze. Apply thin layer of barrier cream and cover with a foam dressing. Hospice nurse to change twice a week.
- Order Date: 10/20/25- Cleanse second right toe with wound cleanser and pat dry with gauze. Leave open to air. Caregiver to apply A&D daily and nurse to apply at each visit.

A recommended plan of treatment from hospice dated 10/21/25 notes that the sacrococcygeal wound has evolved to an eschar covered, full thickness pressure injury. The periwound has abraded epidermis and rash with irregular borders consistent with moisture and yeast, current wound care is barrier cream BID but coordination notes state a dressing has been in use. The plan of treatment also notes that there is a slough filled wound to the right, lateral ankle region. Current wound care is barrier cream covered with bordered foam, changed twice a week. The right second toe has dry, crusted blood, possible blood blister presumably from trauma. The area is stable without erythema, induration, or drainage.

The plan provides the following recommendations:

- Buttocks: Cleanse with soap and water, thin layer of antifungal ointment around wound, gluteal cleft, rash to vulva region, then cover all with zinc oxide based barrier cream BID/prn incontinence.
    - If patient is sitting in wheelchair/recliner, obtain a gel seat cushion and caregiver to help patient shift weight/release pressure every 30 minutes when in chair.
- Right lateral ankle: Cleanse with wound cleanser, pat dry, zinc oxide to periwound skin, honey gel inside wound, cover with island dressing. Change twice a week unless soiled.
    - Continue to use protective booties or pillows under the knee and calf to remove pressure
- Left iliac crest: Cover with bordered foam and change twice a week
- Right second toe: stable, no dressing required

Regarding safety concerns, the hospice plan notes that per the coordination notes, Resident A has been found many times sitting in soiled and saturated briefs and clothing, and the sacral dressing saturated in urine and feces.

Regarding patient education, the plan notes instruction not to soak the wound. It is okay to take a shower and let soap and water run over the wound, but no soaking the wound in tubs, lakes, pools, etc. The plan instructs for repositioning every two hours, including time in a chair. If using a wheelchair for long periods, shift weigh or recline every 15-20 minutes to relieve pressure. Avoid direct pressure on the wound, as it can worsen without proper relief. Offloading pressure to heel is needed for wound prevention and

wound healing. Utilize heel suspension boots or float heels by placing pillows under calves.

I reviewed the St. Croix Hospice Residential Communication Form, which includes notes from the hospice nurse that were provided to the facility following visits. On 08/28/25, the notes indicate “would like to change diet to mech soft.” On 09/05/25, the notes indicate Resident A is on pureed diet due to choking and pocketing food.

I reviewed a complaint form from Ahava Care Manager, Amanda Beeler, dated 08/15/25, which notes that the hospice nurse, Sue, indicated that all skin was intact, and there was no breakdown, other than Resident A’s ankle at the time she moved in. The complaint form notes that Ms. Beeler and staff assessed Resident A’s skin and discovered a major breakdown on her bottom. The hospice team was informed and pictures of the skin breakdown were provided.

I received and reviewed the Ahava Nursing Assessment notes, which indicate that the nursing staff from Ahava were regularly monitoring and treating Resident A’s wounds. Text message exchanges between the Ahava nursing staff and St. Croix hospice nurse were also received and reviewed, showing that the Ahava nursing staff reached out to hospice on several occasions regarding Resident A’s wounds getting worse and making suggestions for wound care treatment including recommendations for dressings and heel protectors. Nursing assessment notes dated 9/26/25 and 10/03/25, completed by Breonna Robinson, note that the caregiver was educated on the importance of frequently repositioning Resident A and keeping wounds clean and dry, and reporting any changes to nursing. Nursing notes completed by Noel Hancock dated 08/20/25 and 09/02/25 note that she discussed the importance of offloading and frequent position changes with the caregiver and reviewed pressure points.

On 10/09/25, a complaint form was completed by the Ahava Care Manager, Amanda Beeler, which notes that there have been multiple nurse visits where the hospice nurse has not put eyes on Resident A’s wounds. The complaint notes that they have expressed concern many times regarding Resident A’s wound on her bottom getting worse and needing attention. A text message exchange between the hospice nurse, Sue, and the Ahava nurse, Noel, on 10/09/25 shows that Noel expressed concern regarding the status of Resident A’s wounds. The hospice nurse stated that Resident A was at the table eating breakfast when she arrived. The caregiver, Rachel, said she changed her bandages. Sue asked Rachel to leave Resident A in bed on Monday so she could see the wounds then.

On 10/29/25, an incident was noted by the caregiver, Rachel Hubbard, and care manager, Amanda Beeler, indicating that the St. Croix Hospice nurse stated that she came to the door and called the home, but received no response. Ms. Beeler and Ms. Hubbard indicated that they were at the home all morning and did not hear anyone at the door or calling the home.

On 11/04/25, the care manager, Amanda Beeler, documented that she received a call from a manager at St. Croix hospice on 10/16/25 regarding concerns that the Ahava caregiver has an attitude, does not change Resident A in a timely manner, and does not always assist with transferring Resident A in and out of bed. Ms. Beeler indicated that they agreed hospice would notify her prior to their arrival so Resident A could be prepared and in bed, preventing delays if staff was helping another resident. Since the discussion, she only received one call or text from the hospice nurse on 10/29/25. Ms. Beeler noted that since the conversation with hospice, she and the Ahava nurses have been conducting frequent, unannounced “pop-ins” at various times of the day, including meal times. They observed repositioning, brief changes, hygiene, meal preparation and food consistency, and medication administration. They felt the residents were all well cared for. Ms. Beeler documented that staff continue to express concerns about Resident A’s wound care. They have discussed their concerns with hospice, and the Ahava nurse made recommendations regarding the wound care plan. Hospice stated that they would discuss the recommendations and get back to Ahava staff, but they never received any follow-up contact from St. Croix Hospice.

I received and reviewed an incident report dated 08/28/25, which notes that Resident A was eating while sitting up at the dining table. She began to choke on a piece of food. She was able to move air with some difficulty. Heimlich was not attempted. Staff called 911 and Resident A was transported to the hospital. The incident report notes that the corrective measures to prevent recurrence include speaking with the hospice team regarding any diet changes. I reviewed a second incident report dated 08/31/25, which notes that Resident A was eating at the dining table and began breathing hard and coughing. When asked if she was okay, Resident A shook her head no. Staff called 911 and Resident A was transported to the hospital.

I reviewed a text message exchange dated 08/29/25 between the Ahava nurse, Noel, and the hospice nurse, Sue. Noel asked Sue if they should be expecting a new diet order for Resident A. Sue responded that she was supposed to be on mechanical/ground and that the on-call nurse said Ahava switched to a pureed diet.

On 01/07/26, I conducted an exit conference via telephone with the licensee designee, Claudiu Marit. Mr. Marit stated that he did not agree with the findings and felt they were providing excellent care at Ahava of White Lake. Mr. Marit stated that the caregiver, Rachel Hubbard, has worked for him for eight years and he does not have any concerns regarding the care she provides. He stated that the allegations were made by one racist individual who did not like Ms. Hubbard and he did not feel it was fair. Mr. Marit reiterated the issues that they had with the hospice provider. He stated that they did not receive the hospice plan at the time of Resident A’s admission and never received written or verbal orders regarding a special diet or wound care instructions.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A resident who has a prescribed diet by an appropriately licensed health care professional shall be provided that diet.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A was not provided with a special diet as ordered. Ahava of White Lake did not have clear documentation showing Resident A's diet. When Resident A moved into the home on 08/15/25, there was conflicting information, as her health care appraisal noted a regular diet with thin liquids, while the hospice care plan noted a mechanical soft diet. On 08/28/25, the hospice notes from Sue Harris, RN indicate that Resident A is on a 2000 calorie mechanical soft diet with thin liquids. She continues pocketing food. She takes an extended amount of time to eat, eating less than 50% of two meals daily. The notes indicate that the new facility was non-compliant with the mechanical soft diet and that Resident A takes two hours to eat. Resident A was sent to the hospital on 08/28/25 and 8/31/25 following choking incidents while eating. The hospice nurse stated that while Resident A was often observed eating yogurt or other soft foods, she also observed staff feeding Resident A soup that had chunks of vegetables in it.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 on the information gathered through my investigation, there is sufficient information to conclude that staff at Ahava of White Lake did not provide supervision, personal care, and protection, as specified in Resident A's assessment plan and hospice care plan. Resident A moved into Ahava of White Lake on 08/15/25 and resided there until her death on 11/17/2025. The hospice care plan on file was dated 07/27/25-09/24/25. An updated plan was not obtained from hospice. Resident A's

	licensing assessment plan did not provide any detailed information regarding the care she required, including repositioning her or providing wound care. While the home's caregiver, Rachel Hubbard, stated that Resident A was changed regularly and repositioned at least every two hours, the hospice nurses, chaplain, aides, and manager of clinical services noted concerns regarding Resident A's clothing, bedding, and brief being saturated in urine, her clothing not being changed between visits, her air mattress being deflated for several days, staff not getting Resident A up for breakfast, and the dressing on her bottom being saturated in urine and feces. These concerns were documented in the hospice visit notes and were also discussed during a hospice interdisciplinary group meeting. While Resident A had wounds prior to moving into Ahava of White Lake and was already receiving hospice services due to her declining health, her wounds increased in severity and number during her time at Ahava of White Lake. Notes from the hospice nurse and Ahava nursing staff indicate that the Ahava caregiver was regularly educated regarding the importance of offloading pressure and repositioning Resident A. The hospice nurse observed that staff were not consistently using the heel protector boots or putting a pillow under Resident A to ease the pressure on her wounds.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(11) A licensee shall contact a resident's health care professional for instructions as to the care of the resident if the resident requires the care of a health care professional. The licensee shall record in the resident's record any instructions for the care of the resident.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that wound care instructions for Resident A were not consistently documented or followed. Resident A moved into the home on 08/15/25. Staff documented that Resident A had a large wound on her coccyx and a wound on her ankle at the time she moved into the home. While the hospice nurse had primary responsibility for treating Resident A's wounds, the Ahava caregivers and nurses were also treating the wounds and changing dressings as needed. Ahava of White Lake did not obtain wound care orders from hospice until 10/22/25, two months after Resident A moved into the home. There was no documentation of the wound care instructions on Resident A's medication administration record. The home's caregiver, Rachel Hubbard, stated that the original wound care orders were to leave Resident A's wound open to air, but she covered it with a dressing.
CONCLUSION:	**VIOLATION ESTABLISHED**

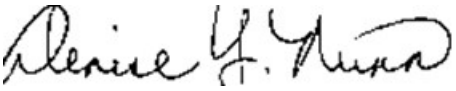
IV. RECOMMENDATION

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

01/07/2026

Kristen Donnay Date
Licensing Consultant

Approved By:



01/29/2026

Denise Y. Nunn Date
Area Manager