GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 16, 2026

Nirmal Kesavan
Legacy at Orchard Grove
71301 Orchard Crossing Ln
Romeo, MI 48065

RE: License #: AH500367780
Investigation #: 2026A0628008
Legacy at Orchard Grove

Dear Licensee:

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 authorized representative 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 (517) 335-5985.

Sincerely,

Rebekah Looney and Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500367780
Investigation #:	2026A0628008
Complaint Receipt Date:	10/31/2025
Investigation Initiation Date:	11/06/2025
Report Due Date:	12/30/2025
Licensee Name:	Trilogy Healthcare of Romeo, LLC
Licensee Address:	#200 303 N. Hurstbourne Pkwy. Louisville, KY 40222
Licensee Telephone #:	(502) 412-5847
Authorized Representative:	Nirmal Kesavan
Administrator:	Dana Best
Name of Facility:	Legacy at Orchard Grove
Facility Address:	71301 Orchard Crossing Ln Romeo, MI 48065
Facility Telephone #:	(586) 372-4899
Original Issuance Date:	03/14/2017
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	35
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is restrained in recliner chair. (KH)	No
The home did not deliver prescription eyeglasses to Resident A timely. (RL)	No
Caregivers were emotionally abusive to Resident A. (RL)	No
Employees are not appropriate with Resident A. (KH)	No
The home does not follow infection control practices. (RL)	No
The home did not report a fall to Resident A's DPOA. (RL)	No
Resident A was not properly supervised at night. (KH)	No
Resident A was transferred incorrectly. (KH)	Yes
Resident A had unsafe supervision. (KH)	No
Resident A was forced out of bed. (KH)	Yes
Resident A was left unattended in the bathroom. (RL)	No
Resident A was not given medications as prescribed. (RL)	Yes
Mechanical lifts are kept in hallways. (KH)	No
Additional Findings (RL)	Yes

III. METHODOLOGY

10/31/2025	Special Investigation Intake 2026A0628008
11/06/2025	Special Investigation Initiated - Letter email sent to complainant acknowledging complaint
11/10/2025	Inspection Completed On-site
11/18/2025	Contact - Document Received received additional documents on Resident A
12/04/2025	Contact – Document Received

	received additional information from complainant
12/08/2025	Contact-Media Received Received Ring Footage
02/17/2026	Exit Conference conducted with Nirmal Kesavan

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Resident A is restrained in recliner chair.

INVESTIGATION:

The complainant alleged that Resident A has been observed left in recliner chair with footrest extended and wheelchair placed under footrest.

Staff Person 1 (SP1) reported that he has not observed for this to have occurred. SP1 reported that Resident A does spend time in the common area, but a wheelchair is not placed under the footrest. SP1 reported that Resident A is to be physically taken to her room to be checked and changed every two hours. SP1 reported that Resident A will often refuse, and caregivers cannot force Resident A to complete tasks. SP1 reported that when a resident refuses care, caregivers are to attempt three times before a refusal is documented.

SP2 reported that she had not observed this to happen. SP2 reported that Resident A would not be left for extended period in the chair as Resident A is to be physically taken to her room every two hours to be checked and changed. SP2 reported that if this did occur Resident A would be able to make her needs known that she would want to get out of the chair.

SP3 statements were consistent with those made by SP1 and SP2.

While onsite, I observed many residents in recliner chairs in the common area. I did not observe any wheelchairs to be placed under the footrest. The residents I did observe were not left for extended time in the chair. In addition, caregivers were engaged and interacted with each of the residents.

I reviewed Resident A's MAR for October 16th, 2025. The MAR revealed that Resident A did in fact refuse to do toiletries at 12:00pm, 2:00pm, and 4:00pm. The

caregivers documented that they attempted three times. It was noted that at 2:00pm Resident A did not want to get out of the chair.

I reviewed Resident A's progress notes for 10/16/2025. The progress notes revealed that in the morning hours of 10/16/2025, Resident A was awake most of the night which could have resulted in Resident A wanting to sleep most of the day on 10/16/2025.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician, by a physician's assistant with whom the physician has a practice agreement, or by an advanced practice registered nurse, for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician, physician's assistant, or advanced practice registered nurse who authorized the restraint. In case of a chemical restraint, the physician, or the advanced practice registered nurse who authorized the restraint, shall be consulted within 24 hours after the commencement of the chemical restraint.**
ANALYSIS:	Interviews conducted, observations made, and review of documentation revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The home did not deliver prescription eyeglasses to Resident A timely.

INVESTIGATION:

The complainant alleged that Resident A's eyeglasses were delivered to the home on 07/28/2025 but not delivered to Resident A until 08/21/2025. While interviewing SP1, he reported he was aware of this incident, and it was addressed. He reported that steps have been put in place to avoid this happening in the future. SP1 reported that occasionally, resident mail/packages get delivered to the wrong building on the health campus. When SP1 was made aware that Resident A's glasses had been delivered to the campus, but could not be found in the Legacy building, SP1 searched the other buildings and found the glasses were delivered to a different building on the campus. Since this incident, SP1 goes to each building on the campus, every morning when he reports to work, sorts through the mail at each building and ensures it is delivered to the correct building and subsequently the correct resident.

APPLICABLE RULE	
333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2)k A patient or resident is entitled to associate and have private communications and consultations with his or her physician or a physician's assistant with whom the physician has a practice agreement, with his or her advanced practice registered nurse, with his or her attorney, or with any other individual of his or her choice and to send and receive personal mail unopened on the same day it is received at the health facility or agency, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.

ANALYSIS:	The alleged incident did occur; however, the home now has a system in place to ensure that mail is delivered to residents in a timely manner. Therefore, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Caregivers were emotionally abusive to Resident A.

INVESTIGATION:

The complainant alleged that on 08/28/2025 and 09/02/2025 the home did not respect Resident A's rights and staff were emotionally abusive to Resident A. The complainant alleged the staff used harsh tones and forced Resident A to get up when she didn't want to. Video footage on both dates reveal that Resident A yells and swears at the caregivers. Throughout the video footage, the caregivers use kind voices, tell Resident A what they are doing and why they are doing it and encourage Resident A to help, as she is able and willing. The caregivers continue to use a calm tone with Resident A throughout the encounters. Resident A does tell the caregivers "no" at times but continues to allow them to assist her with dressing and transferring to her wheelchair.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(a) Assume full legal responsibility for the overall conduct and operation of the home.** **supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Review of ring camera footage from 08/28/2025 and 09/02/2025 reveal the caregivers used calm voices when talking with Resident A and encouraged her to get up and go to breakfast. Therefore, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Employees are not appropriate with Resident A.

INVESTIGATION:

The complainant alleged staff members are inappropriate with Resident A. The complainant alleged staff members do not reassure Resident A nor attempt to ensure Resident A is safe.

The administrator reported that all employees are trained in dementia care upon hire and have refresher courses. The administrator reported that if a concern is brought to her attention, it is addressed. The administrator reported that there have been no recent concerns on resident and employee interactions.

SP1 reported that he observes employees interact with residents. SP1 reported that residents are treated with respect and dignity.

I reviewed SP2 and SP3's training records. The records revealed each employee was trained in dementia care.

While onsite, I observed many staff members interactions with residents. There were residents that were confused and required re-direction. Each employee was appropriate and took time with the resident to ensure the resident was comfortable and redirected.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(a) Assume full legal responsibility for the overall conduct and operation of the home.** **supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Interviews conducted and observations made revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The home does not follow infection control practices.

INVESTIGATION:

The complainant alleged that on numerous occasions the home does not follow proper infection control policies and procedures. Additional information was received

by the department on 12/04/2025, that included concerns on how the home addressed possible c. diff cases in the home.

While onsite, I interviewed SP1 who reported that staff are to wear gloves when there is a potential that they are handling potentially infections matter. SP1 reported that gloves are available in the private bathrooms of each resident apartment.

While onsite, I interviewed SP2 and SP3. SP2 reported that they wear gloves all the time when giving care. They also reported that gloves are to be disposed of after a "check and change" even if the resident is dry. Additionally, they reported that gloves are located in the resident bathrooms and gloves aren't supposed to be worn in the hallway. SP3 reported that gloves can be found in each resident bathroom. SP3 reported that gloves are used when giving care within the room and generally are not used in the hallway. Additionally, SP3 reported that gloves are to be discarded when soiled, even when assisting the same resident and gloves should always be changed between residents.

Policies provided by the home included standard precautions and contact precautions. Additionally, in-service documents regarding hand hygiene education for staff were provided by the home. Per the contact precautions policy provided, *"Upon verification that a resident has an infection that requires contact precautions, the nurse will implement the precautions and inform the attending physician, appropriate department heads, nursing staff, the infection control practitioner, the resident and the resident's family".* In addition, the policy stated, *"The application of Standard Precautions during patient care is determined by the nature of the staff-resident interaction and the extend of anticipated blood, body fluid, or pathogen exposure.*"

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(2) The admission policy shall specify all of the following: (d) That the home has developed and implemented a communicable disease policy governing the assessment and baseline screening of residents
ANALYSIS:	Documents provided reveal the home has a program in place to educate staff on infectious disease and standard precautions. Additionally, the home was within the scope of their policy when they did not report possible c. diff in the facility to the complainant, as Resident A was not identified as having c. diff. Therefore, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The home did not report a fall to Resident A's DPOA.

INVESTIGATION:

The complainant alleged that on 08/01/2025, the home didn't properly respond and failed to notify the family when Resident A fell. Review of ring video footage from 08/01/2025 reveal that staff entered the room of Resident A, inquired about the fall and assisted Resident A into her wheelchair. Review of chart notes for Resident A dated 08/01/2025 at 10:24am reveal that the Hospice nurse was notified of Resident A's fall and came to the home to assess Resident A and also notified Resident A's daughter (DPOA) of the incident.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	Review of nursing notes from 08/01/2025 reveal that the home responded appropriately in notifying the Hospice nurse, and in turn the Hospice nurse notified Resident A's DPOA of the incident. Therefore, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was not properly supervised at night.

INVESTIGATION:

The complainant alleged on 09/19/2025, Resident A fell and was not checked on for approximately 40 minutes.

The complainant alleged on 10/03/2025, Resident A was not checked on between 10:00pm and 5:17am. The complainant alleged Resident A's wheelchair was left centered in front of her bed which obstructed the pathway to her bathroom.

SP1 reported that Resident A is to be checked on every two hours. SP1 reported that caregivers will peek into the room to ensure Resident A is sleeping. SP1 reported that if there are no safety concerns with Resident A, caregivers will not enter the room because they do not want to wake Resident A. SP1 reported that at times Resident A will not sleep and therefore if Resident A is sleeping caregivers do not want to wake Resident A.

I reviewed Resident A's service plan. The service plan read,
"High fall risk resident now subject to hourly rounding. Keep wheelchair within reach. 1 hour checks began 10/9/25."

I reviewed Resident A's MAR for 10/03/2025. The MAR revealed caregivers were to check and change Resident A, if Resident A was awake. The MAR revealed caregivers documented at 12:00am, 2:00am, 4:00am, and 6:00am that Resident A was sleeping.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Interviews conducted and review of documentation revealed Resident A is to be checked and changed every two hours, if Resident A is awake. Review of Resident A's MAR, revealed caregivers appropriately checked on Resident A during the nighttime hours on 10/03/2025. Therefore, there is lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was transferred incorrectly.

INVESTIGATION:

The complainant alleged that on 10/08/2025, Resident A was transferred out of bed to her wheelchair without physical assist from the caregivers. The complainant

alleged Resident A's service plan requires one-person physical assistance for transfers, however, Resident A transferred herself on this date.

SP1 reported no knowledge of concerns with Resident A's transfers and staff members not assisting Resident A.

I reviewed Ring Camera footage from 10/08/2025. The camera footage revealed two staff members entering Resident A's room. The two staff members assisted Resident A with changing clothes and bedding. The footage revealed that Resident A was hesitant to sit up in bed and transfer to the wheelchair. The caregivers did provide Resident A with some time sitting up in bed. The footage revealed the wheelchair was placed next to the bed but was at an odd angle for Resident A to transfer. The footage revealed that a caregiver did tell Resident A, "it's a weird angle, I know", however, no caregiver attempted to move the wheelchair or assist with the transfer. The footage revealed that eventually Resident A did transfer to the wheelchair, but no caregivers provided any physical assistance.

I reviewed Resident A's service plan. The service plan read,
"Requires physical assist of one person to transfer."

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Review of Ring Camera Footage revealed that on 10/08/2025, Resident A was transferred incorrectly.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A had unsafe supervision.

INVESTIGATION:

The complainant alleged that Resident A had unsafe supervision for an extended period. The complainant alleged it was observed on multiple instances Resident A's wheelchair was positioned directly in front of Resident A while Resident A was seated in the bed.

I reviewed Resident A's service plan. The service plan read,

“Fall Risk. Provide wheelchair. Frequently used items within reach. Room without throw rugs. Keep wheelchair within reach. 1 hour checks at night.”

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Review of Resident A’s service plan revealed Resident A’s wheelchair was to be kept within reach to decrease fall risk.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was forced out of bed.

INVESTIGATION:

The complainant alleged that on 10/17/2025, Resident A was forced out of bed. The complainant alleged it took two staff members to physically assist Resident A out of bed.

SP1 reported that at times Resident A will be placed in bed at 7:00pm, therefore, by the morning hours Resident A should be up for the day. SP1 reported that Resident A does have the right to refuse care and transfers. SP1 reported that if Resident A refuses, caregivers should change the person attempting assistance and try three different times before a refusal is documented.

I reviewed the Ring Camera Footage from 10/17/2025. The footage revealed a caregiver entered the room at approximately 8:18am to assist Resident A out of bed. The footage revealed Resident A did refuse said assistance and the caregiver left. The footage revealed that at approximately 8:45am, the caregiver entered the room again. The footage revealed at first the interaction was appropriate by Resident A was changed and pleasant conversation occurred. The footage revealed when the caregiver explained to Resident A that it was time to get up in the chair and Resident A refused, the caregiver attempted to pull on Resident A to get her to a seated position. The footage revealed once Resident A was seated, she again refused to transfer to the wheelchair and the caregiver left again. The footage revealed a few minutes later, the same caregiver and another caregiver entered the room. The footage revealed once again Resident A refused to transfer to the wheelchair, however, both caregivers used more than 50% of the physical effort it took to assist Resident A to a seated position and eventually to the wheelchair. The footage revealed during this transfer, Resident A kept refusing to get out of bed.

I reviewed Resident A's service plan. The service plan read,
"*Requires physical assist of one person to transfer."*

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Review of Ring Camera Footage revealed Resident A was not treated with respect and dignity during the morning transfer on 10/17/2025. Resident A refused multiple times, and the two caregivers had to use more than 50% of the physical effort to assist Resident A to the wheelchair when Resident A does not require this level of assistance. There was no emergent need for Resident A to get out of bed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was left unattended in the bathroom.

INVESTIGATION:

The complainant alleged that on 08/19/2025, Resident A was left in her bathroom unattended for a long period of time. Review of ring video footage reveals that at 4:47 a caregiver enters the bathroom of Resident A. The caregiver then exits the bathroom at 4:48am and leaves the room of Resident A. About 30 seconds later, Resident A is seen exiting the bathroom and walking around her room. The video footage shows a caregiver returning to the room of Resident A at 5:53am. Resident A's service plan states staff are to provide assistance to toilet and that Resident A requires one person to assist her with transfers.

APPLICABLE RULE	
R 325.1931	**Resident records.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Review of ring camera footage reveals that staff left Resident A unattended in the bathroom and did not return to assist Resident

	A for over an hour. These actions are not consistent with the care needs deemed necessary in Resident A's service plan. Therefore, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was not given medications as prescribed.

INVESTIGATION:

The complainant alleged that for months Resident A was not receiving the topical medication, Voltaren, as prescribed. The complainant alleges that the home is not applying the medication to the bilateral knees of Resident A twice per day.

On 11/10/2025, while onsite, I reviewed this medication order, via Resident A's medication administration record, with the administrator and SP1. The directions for administration of Voltaren, per the medication administration record, are as follows: "*apply 4 grams (4.5inches) to bilateral knees twice daily for arthritis pain".* When asked if the 4 grams were for each knee or 4 grams was the total amount for both knees, SP1 said, "I would assume it is 4 grams for each knee, but I am not sure".

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Through review of the medication administration record for Resident A and discussion with SP1, it is apparent the medication order is not clear. Furthermore, it isn't possible to determine if the medication was administered properly since the order isn't specific. Therefore, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Mechanical lifts are kept in hallways.

INVESTIGATION:

The complainant alleged mechanical lifts are left in hallways at the facility.

SP1 reported that each resident that requires a mechanical lift has their lift placed in the bathroom. SP1 reported that when the resident needs to use the bathroom, the lift is moved to ensure the safety of the resident. SP1 reported at times there can be lifts in the hallways, especially when care is being completed, but it is not the standard. SP1 reported that Bureau of Fire Safety (BFS) has completed unannounced inspections, and no violations have occurred from their visits.

I walked and viewed the entire facility. I viewed two mechanical lifts located in the hallways. The mechanical lifts were not obstructing any resident movement within the facility.

APPLICABLE RULE	
R 325.1964	**Interiors.**
	(11) A doorway, passageway, corridor, hallway, or stairwell shall be kept free from obstructions at all times.
ANALYSIS:	Interviews conducted and observations made revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Through review of camera footage from a camera placed in Resident A's room, it was observed on more than one occasion that the camera recorded footage of Resident A changing clothes, being assisted with changing clothes, or not being fully dressed. In a discussion with the administrator, she reported that the camera was placed by Resident A's family and that per the policy of the home, staff are not to move the camera or turn it off for any reason. The home's policy regarding electronic monitoring in resident rooms states, "the campus will not intentionally obstruct, tamper with, or destroy any electronic monitoring device or any recording made by an electronic monitoring device". Additionally, the policy states, "the campus cannot assist with device set-up, updating, rebooting, maintaining, readjusting, or cleaning of any video cameras".

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.
ANALYSIS:	Upon reviewing the home's electronic monitoring policy, along with review of ring camera footage from Resident A's room, it was determined that the home did not provide a safe environment for Resident A because they failed to protect Resident A's privacy and dignity. Therefore, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

02/13/2026

Rebekah Looney Date
Licensing Staff

02/13/2026

Kimberly Horst Date
Licensing Staff

Approved By:

02/12/2026

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section