GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 12, 2026

Teresita Sandoval Barrera
Hidden Harbors Center, LLC
11800 E. Nine Mile Road
Warren, MI 48089

RE: License #: AL500415483
Investigation #: 2026A0465009
Hidden Harbors Center

Dear Ms. Sandoval Barrera:

Attached is the Special Investigation Report for the above-referenced facility. No substantial violations were found.

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,

Stephanie Gonzalez

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500415483
Investigation #:	2026A0465009
Complaint Receipt Date:	12/29/2025
Investigation Initiation Date:	12/29/2025
Report Due Date:	02/27/2026
LicenseeName:	Hidden Harbors Center, LLC
LicenseeAddress:	11800 E. Nine Mile Road Warren, MI 48089
LicenseeTelephone #:	(248) 289-0803
Administrator:	Teresita Sandoval Barrera
Licensee Designee:	Teresita Sandoval Barrera
Name of Facility:	Hidden Harbors Center
Facility Address:	31601 Harper Avenue Saint Clair Shores, MI 48082
Facility Telephone #:	(586) 859-7556
Original Issuance Date:	03/11/2024
License Status:	REGULAR
Effective Date:	09/11/2024
Expiration Date:	09/10/2026
Capacity:	18
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 1/23/2025, Resident A wandered away from the facility due to insufficient staff supervision.	No
Direct care staff are mistreating residents.	No
There is not sufficient food in the home.	No
Bed linens are not in good condition.	No
Medication bottles do not match prescription orders.	No
Resident B was not provided with bathing assistance during the seven days that he resided at the facility.	No

III. METHODOLOGY

12/29/2025	Special Investigation Intake 2026A0465009
12/29/2025	Special Investigation Initiated - Telephone AFC Licensing Consultant, Sara Shaughnessey, spoke to Complainant via telephone
01/16/2026	Inspection Completed On-site I conducted an onsite investigation. I completed a walk-through of the facility, reviewed resident files, observed residents and interviewed direct care staff, Brennan Cooper
01/20/2026	Contact - Document Received Facility documents received via email
02/04/2026	Contact - Telephone call made I spoke to direct care staff, Sade Gibbs via telephone
02/04/2026	Contact – Telephone call made I spoke to Guardian A1 via telephone
02/04/2026	Contact - Telephone call made I spoke to Guardian B1 via telephone
02/10/2026	Contact - Document Received Facility documents received via email
02/11/2026	Contact - Document Received Facility documents received via email

02/12/2026	Contact - Document Received Facility documents received via email
02/18/2026	Contact - Telephone call made I spoke to direct care staff Alexus Green, via telephone
02/18/2026	Contact - Telephone call made I spoke to direct care staff, Yvonne Martin, via telephone
02/18/2026	Contact - Telephone call made I spoke to direct care staff, Sahara Harris, via telephone
02/18/2026	Contact - Telephone call made I spoke to direct care staff, Monae Roberts, via telephone
02/18/2026	Contact - Telephone call made I spooke to Guardian C1 via telephone
02/18/2026	Contact - Telephone call made I spoke to Guardian D1 via telephone
02/18/2026	Contact - Telephone call made I spoke to direct care staff, Alayna Ratcliff, via telephone
02/18/2026	Exit Conference Exit Conference with licensee designee and administrator, Teresita Sandoval, via telephone

ALLEGATION:

Resident A wandered away from the facility due to insufficient staff supervision.

INVESTIGATION:

On 12/29/2025, a complaint was received, alleging that, on 1/23/2025, Resident A wandered away from the facility due to insufficient staff supervision. The complaint stated that Resident B wandered outside, completely unsupervised. The complaint stated that direct care staff were unaware that Resident A had eloped from the home.

On 12/29/2026, AFC Licensing Consultant, Sara Shaughnessey, spoke to Complainant via telephone. Complainant confirmed the information contained in this complaint is accurate.

On 1/16/2026, I conducted an onsite investigation at the facility. The home specializes in caring for the Aged/Alzheimer's population. At the time of my onsite investigation, there were nine residents residing at the facility. Due to the cognitive and memory deficits of the residents, I was unable to conduct resident interviews for this investigation. I completed a walk-through of the facility, reviewed resident files, observed residents and interviewed direct care staff, Brennan Cooper. I observed the home to be clean and in good condition. I observed all residents to be properly dressed and with adequate hygiene. I reviewed the *Staff Schedule*, which documented the staff to resident ratio as 2:9.

I reviewed Resident A's file. The *Face Sheet* stated that Resident A resided at the facility from 12/27/2024 through 9/2/2025, and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Dementia. The *Assessment Plan for AFC Residents* stated that Resident A required supervision in the community, needed assistance with personal care tasks and used a cane and walker for mobility assistance. The *Incident/Accident Report*, dated 1/23/2025, stated the following:

1/23/2025 at 6:45am; Completed by Monae Roberts: Staff were assisting resident in room. Staff heard door alarm in hallway. Staff immediately went to door. Staff observed Resident A attempting to exit the building. Assisted resident back into the building. Resident A stated was looking for someone. POA and director contacted.

I spoke to direct care staff, Brennan Cooper, who stated that she has worked at the facility for two years. Ms. Cooper stated, "There is always a sufficient number of staff on duty to care for residents. We always have at least two staff on duty. This can change when we have residents that require more care and supervision. We do have residents that will wander throughout the home and become confused. We have alarms on all the exit doors so that we know if a resident tries to leave the home. There have been times when residents have tried to leave the house, but the alarm alerts us and we immediately redirect them back inside. I know there have been times when residents have opened the door, but I am not aware of anyone actually leaving the property or wandering away from the home. Resident A did not wander away from the home. The door alarm went off, and staff intervened when Resident A was still at the doorway with the door open." Ms. Cooper denied knowledge of this complaint being true.

On 2/4/2026, I spoke to direct care staff, Sade Gibbs via telephone. Ms. Gibbs stated that she has worked at the facility for several years. Ms. Gibbs stated, "We provide supervision and monitoring to all residents in the home. There are staff on duty at all times. I have never had a resident elope from home when I am working. I heard rumors a while ago about Resident A possibly trying to elope from the home, but I do not know any other details. We have alarms on the doors to let us know if a resident is trying to leave the facility so we can intervene. I haven't had any issues on my shifts." Ms. Gibbs denied knowledge of this complaint being true.

On 2/4/2026, I spoke to Guardian A1, via telephone. Guardian A1 stated, “Resident A was somewhat mobile when he was living at the facility but was unable to walk for extended periods of time. He spent most of time in his room or common area. He would occasionally try to walk towards the exit doors, but I am not aware of a time that he actually exited the facility and made it outside. The home had alarms on the doors and staff were always present. I did not have any concerns with the supervision provided by staff during the time that Resident A was living there. Guardian A1 denied any concerns related to this complaint.

On 2/18/2026, I spoke to direct care staff Alexus Green, via telephone. Ms. Green stated that she has worked at the facility for two years. Ms. Green stated, “We have sufficient staff in the home. We monitor the residents and make sure they are taken care of. I heard that Resident A eloped from the facility, but I was not working that day and do not know any details. I just know it was during the wintertime. I have not had any resident elope from the home when I am working. I have not had any issues with this.”

On 2/18/2026, I spoke to direct care staff, Yvonne Martin, via telephone. Ms. Martin stated that she has worked at the facility for two years. Ms. Martin stated, “I feel we have sufficient staff working in the home. We have two staff working at all times. We monitor all of the residents and provide care and supervision. I have not heard of any recent elopements, and no resident has eloped when I have been working. I heard that Resident A tried to elope, but he was quickly brought back inside by staff. I do not know anything more about it.”

On 2/18/2026, I spoke to direct care staff, Sahara Harris, via telephone. Ms. Harris stated that she has worked at the facility for one year. Ms. Harris stated, “I am not aware of residents eloping from the home. I have not had this happen when I am working. We have alarms on the doors and ensure that residents are checked on continuously throughout the day. No one has eloped when I was at work.”

On 2/18/2026, I spoke to direct care staff, Monae Roberts, via telephone. Ms. Robers stated that she has worked at the facility for almost two years. Ms. Roberts stated, “I do remember Resident A and I was working the day he tried to elope from the home. That day, I was helping another resident when I heard the door alarm go off. I immediately when to the exit door area and I observed Resident A attempting to walk out the door to go outside. He was barely out of the door, and the door was still open. I redirected him back into the house and he came inside with me. He never actually left the house, and he never got all the way out the door. He never really actually eloped from the home. And this was the only time something like this happened.” Ms. Roberts denied that this allegation is true.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.** **(b) 12 residents for small group and family homes.**
ANALYSIS:	According to the *Staff Schedule*, the staff to resident ratio is two staff for nine residents. According to the *Incident/Accident Report,* dated 1/23/2025 and Ms. Roberts, on this date, Resident A opened the door in an attempt to go outside, at which time Ms. Roberts immediately went to the doorway and brought Resident A back into the facility. According to Ms. Roberts, Resident A never exited the home and did not elope. According to Ms. Cooper, Ms. Gibbs, Ms. Green, Ms. Martin, Ms. Harris, the current staffing ratio is sufficient to meet the needs of the residents. Ms. Cooper, Ms. Gibbs, Ms. Green, Ms. Martin, Ms. Harris and Ms. Roberts denied knowledge of any resident eloping from the facility. Based on the information above, there is not sufficient information to confirm that Resident A, nor any other resident, has eloped from the home and wandered outside unsupervised.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Direct care staff are mistreating residents.

INVESTIGATION:

On 12/29/2025, a complaint was received, alleging that direct care staff are mistreating residents. The complaint stated that direct care staff spoke inappropriately to residents, including making comments such as, “Shut up,” and

verbal threats to residents that they would not allow them to see their family members. The complaint did not provide dates or specific names of staff related to this allegation.

I reviewed *Incident/Accident Reports and Employee Files* for the last year and was unable to locate any documentation related to staff mistreatment towards residents or resident complaints related to staff care.

During my onsite investigation on 1/16/2026, I spoke to Ms. Cooper. Ms. Cooper stated, “I have never mistreated or hurt a resident. I have never threatened a resident or denied any resident visits with their family. I have never heard any other staff do anything harmful to a resident either.” Ms. Cooper denied knowledge of this complaint being true.

On 2/4/2026, I spoke to Ms. Gibbs via telephone. Ms. Gibbs stated, “We treat all residents with respect. I have never mistreated or yelled at any resident. Residents have the right to visit with their loved ones, and we have visitors at the facility daily. I have never threatened anyone with refusal of visits. I have not personally heard any other staff say or do these things.” Ms. Gibbs denied knowledge of this complaint being true.

On 2/4/2026, I spoke to Guardian A1, via telephone. Guardian A1 stated, “Resident A received good care when he lived at the facility. I did not have any concerns with how staff treated and cared for him.” Guardian A1 denied any concerns related to this complaint.

On 2/18/2026, I spoke to Ms. Green, via telephone. Ms. Green stated, “I have never yelled at a resident or been verbally abusive to a resident. I have never threatened or mistreated anyone. I have not seen any other staff do anything like this.” Ms. Green denied knowledge of this complaint being true.

On 2/18/2026, I spoke to Ms. Martin, via telephone. Ms. Martin stated, “I have never heard a staff threaten a resident. I have not mistreated a resident either.” Ms. Martin denied knowledge of this complaint being true.

On 2/18/2026, I spoke to Ms. Harris, via telephone. Ms. Harris stated, “I have not mistreated any resident, and I have not threatened anyone. I have never done this, and I have never seen anyone else do this to a resident either.” Ms. Harris denied knowledge of this complaint being true.

On 2/18/2026, I spoke to Ms. Roberts, via telephone. Ms. Roberts stated, “I have never harmed a resident. I have never heard of any other staff harming a resident.” Ms. Roberts denied knowledge of this complaint being true.

On 2/18/2026, I spoke to Guardian C1 via telephone. Guardian C1 stated, “I have no concerns regarding the care being provided to Resident C. I am at the facility every

day, for an average of three hours per day. I have good insight into how the facility is run and I have not observed any issues related to verbal abuse or mistreatment." Guardian C1 denied concerns related to this complaint.

On 2/18/2026, I spoke to Guardian D1 via telephone. Guardian D1 stated, "The staff are great. I go to the facility two to three times per week, and I have not observed any form of mistreatment. The staff are attentive to the residents." Guardian D1 denied any concerns related to this complaint.

On 2/18/2026, I spoke to Guardian E1 via telephone. Guardian E1 stated, "I do not have any concerns. I am at the facility three days per week, and my adult children visit the facility on the weekends as well. We have not observed any concerns. I feel the staff are doing the best that they can, and this is hard work." Guardian E1 denied any concerns related to this complaint.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	According to Ms. Cooper, Ms. Gibbs, Ms. Green, Ms. Martin and Ms. Harris, they have never mistreated or caused physical or emotional harm to a resident. Ms. Cooper, Ms. Gibbs, Ms. Green, Ms. Martin, Ms. Harris and Ms. Roberts denied knowledge of this complaint being true. Based on the information above, there is not sufficient information to confirm that direct care staff have mistreated or exposed a resident to emotional or physical harm.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

There is not sufficient food in the home.

INVESTIGATION:

On 12/29/2025, a complaint was received, alleging that there is not sufficient food in the home. The complaint stated that, during an unknown time period, the facility served pizza three days in a row due to not having food in the home.

On 1/16/2026, I conducted an onsite investigation at the facility. I conducted a walk-through of the facility, including the kitchen area. I observed an ample amount of food in the refrigerator, freezer and cabinets. I reviewed the *Meal Menus* for the last 90 days and observed the daily meals to include three meals per day, including snacks and beverages. I did not observe any concerns related to the food supply and quality of food items contained within the home. I spoke to Ms. Cooper, who stated, “We always have ample food in the home, and we serve three meals daily to residents. We do, on occasion, have pizza but that is on rare occasions. About a year ago, we served pizza during the holiday season on two occasions. But we haven’t served pizza since that time.” Ms. Cooper denied this complaint is true.

On 2/4/2026, I spoke to Ms. Gibbs via telephone. Ms. Gibbs stated, “We always serve three meals per day, plus snacks. We have a scheduling system for groceries to be delivered each week. There are times that we will order pizza for the residents, but this is not every day. It is on occasion. We provide a variety of food items and meals to the residents.” Ms. Gibbs denied knowledge of this complaint being true.

On 2/4/2026, I spoke to Guardian A1, via telephone. Guardian A1 stated, “Resident A was well-cared for when he lived at the facility. I did not have any concerns with the meals and food provided by the staff.” Guardian A1 denied any concerns related to this complaint.

On 2/18/2026, I spoke to Ms. Green, via telephone. Ms. Green stated that she has worked at the facility for two years. Ms. Green stated, “I am one of the cooks for the facility. There is always a good supply of food in the home all the time. And I always cook good and nutritious meals every day. We follow a meal plan and menu that we serve food from. We do have pizza parties on special occasions, such as birthday parties or around the holidays. But we do not serve pizza every day. This is not true.”

On 2/18/2026, I spoke to Ms. Martin, via telephone. Ms. Martin stated, “This is not true. We always have food in the home and always provide meals to every resident daily. We served pizza last year, during the holiday season. We served pizza one day for residents, and then the next day, a family member of one of the residents surprised residents and brought pizza. This doesn’t happen all the time and we always offer alternative meals items for residents as well. We cook different meals for breakfast, lunch and dinner every day. I think the last time the residents were given pizza was during the holidays last year. We have not served pizza since then.” Ms. Martin denied knowledge of this complaint being true.

On 2/18/2026, I spoke to direct care staff, Sahara Harris, via telephone. Ms. Harris stated, “There is always food in the house for meals every day. When I am working, I also assist with cooking meals for residents. So, I know there is food in the home all the time. I cook meals that are nutritious and include meats and vegetables.” Ms. Harris denied knowledge of this complaint being true.

On 2/18/2026, I spoke to Ms. Roberts, via telephone. Ms. Roberts stated, “I work in the kitchen a lot, so I know what meals are being served and the meals are nutritious. And there is always food in the home. Sometimes we do run short on the day that we are awaiting the new grocery delivery, but we still have sufficient food in the home needed to cook the meals for that day.” Ms. Roberts denied knowledge of this complaint being true.

On 2/18/2026, I spoke to Guardian C1 via telephone. Guardian C1 stated, “I have no concerns regarding the food being provided to Resident C. I am at the facility every day, for an average of three hours per day. I have good insight into how the facility is run and I have not observed any issues.” Guardian C1 denied concerns related to this complaint.

On 2/18/2026, I spoke to Guardian D1 via telephone. Guardian D1 stated, “The staff are great. I go to the facility two to three times per week, and meals are being provided every day to the residents. The staff are attentive to the residents.” Guardian D1 denied any concerns related to this complaint.

On 2/18/2026, I spoke to Guardian E1 via telephone. Guardian E1 stated, “I do not have any concerns. I am at the facility three days per week, and my adult children visit the facility on the weekends as well. We have not observed any concerns.” Guardian E1 denied any concerns related to this complaint.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	On 1/16/2026, I observed there to be sufficient food in the home. The *Meal Menus* documented three nutritious meals per day, in addition to snacks and beverages. According to Ms. Cooper, Ms. Gibbs, Ms. Green, Ms. Martin, Ms. Roberts and Ms. Harris, there is always sufficient food in the home to provide three nutritious meals daily. Ms. Cooper, Ms. Gibbs, Ms. Green, Ms. Martin, Ms. Harris and Ms. Roberts denied knowledge of this complaint being true. Based on the information above, there is not sufficient information to confirm the facility does not have adequate food in the home to provide three nutritious meals to residents on a daily basis.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Bed linens are not in good condition.

INVESTIGATION:

On 12/29/2025, a complaint was received, alleging that bed linens are not in good condition. The complaint stated that the bed linens in the home are worn and no longer usable.

During my onsite investigation on 1/16/2026, I conducted a walk-through of the facility. I observed all of the bed linens in each resident's bedroom to be in good condition and clean. I observed all the linens in the linen closet to be clean and in good condition. I did not observe any concerns related to bed linens. I spoke to Ms. Cooper, who stated, "There are always clean be linens in the home for resident use. I have never observed dirty or torn linens being used in the home." Ms. Cooper denied knowledge of this complaint being true.

On 2/4/2026, I spoke to Ms. Gibbs via telephone. Ms. Gibbs stated, "We change bed sheets frequently throughout the week and more often if needed. We do laundry daily and ensure linens are clean. I have never seen be sheets in the home that are ruined or have holes in them." Ms. Gibbs denied knowledge of this complaint being true.

On 2/4/2026, I spoke to Guardian A1, via telephone. Guardian A1 stated, "I did not have any concerns related to the condition of Resident A's bedroom and bed sheets. I did not see anything that worried me." Guardian A1 denied any concerns related to this complaint.

On 2/18/2026, I spoke to Ms. Green, via telephone. Ms. Green stated, "We change bed linens frequently because we have a lot of residents that are incontinent. I have not observed any bed sheets that are in bad condition." Ms. Green denied knowledge of this complaint being true.

On 2/18/2026, I spoke to Ms. Martin, via telephone. Ms. Martin stated, "We change bed sheets daily. We have some residents that are incontinent, so we change sheets often. We also check on every resident throughout the day to see if they need their sheets changed." Ms. Martin denied knowledge of this complaint being true.

On 2/18/2026, I spoke to Ms. Roberts, via telephone. Ms. Roberts stated, "The bed sheets in the home are always being cleaned and changed for residents. The bed sheets are always clean, but they are not necessarily brand-new sheets. The sheets are in good condition and don't have holes or anything." Ms. Roberts denied knowledge of this allegation being true.

On 2/18/2026, I spoke to Guardian C1 via telephone. Guardian C1 stated, "I have no concerns regarding the care being provided to Resident C. I am at the facility every

day, for an average of three hours per day. I have good insight into how the facility is run and I have not observed any issues related to this." Guardian C1 denied concerns related to this complaint.

On 2/18/2026, I spoke to Guardian D1 via telephone. Guardian D1 stated, "The staff are great. I go to the facility two to three times per week, and I have not observed any issues. The staff are attentive to the residents." Guardian D1 denied any concerns related to this complaint.

On 2/18/2026, I spoke to Guardian E1 via telephone. Guardian E1 stated, "I do not have any concerns. I am at the facility three days per week, and my adult children visit the facility on the weekends as well. We have not observed any concerns. I feel the staff are doing the best that they can, and this is hard work." Guardian E1 denied any concerns related to this complaint.

APPLICABLE RULE	
R 400.669	**Linens.**
	(1) A licensee shall provide all of the following: **(a) Clean bedding in good condition that includes a minimum of a fitted sheet, top sheet, pillowcase, and blanket or comforter for each bed.**
ANALYSIS:	According to Ms. Cooper, Ms. Gibbs, Ms. Green, Ms. Martin and Ms. Roberts, there are always clean be linens, in good condition, accessible to residents at all times. Ms. Cooper, Ms. Gibbs, Ms. Green, Ms. Martin and Ms. Roberts denied knowledge of this complaint being true. Based on the information above, there is not sufficient information to confirm that the facility is using bed linens that are not in good condition.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Medication bottles do not match prescription orders.

INVESTIGATION:

On 12/29/2025, a complaint was received, alleging that the medication bottles in the facility do not match the current physician orders on file.

I reviewed *Incident/Accident Reports* for the last year and was unable to locate any documentation related to any medication errors.

During my onsite investigation on 1/16/2026, I reviewed the medication bottles/bubble packs, *Medication Administration Records,* and the prescription orders. I observed all of the physical medications to match the MAR and active physician orders. I did not observe any discrepancies. I spoke to Ms. Cooper, who stated, “I am not aware of any medication issues. We document all medication in the system, and we document every time we pass the medication to a resident. All of the medication comes directly from the pharmacy and is based on current active physician orders.” Ms. Cooper denied knowledge of this complaint being true.

On 2/4/2026, I spoke to Ms. Gibbs via telephone. Ms. Gibbs stated, “I am trained to pass medication and am aware of the protocol to ensure it is done correctly. I am not aware of a time when incorrect medications were administered to a resident.” Ms. Gibbs denied knowledge of this complaint being true.

On 2/4/2026, I spoke to Guardian A1, via telephone. Guardian A1 stated, “The staff provided good care to Resident A. I did not have any problems with staff or medication.” Guardian A1 denied any concerns related to this complaint.

On 2/18/2026, I spoke to Ms. Green, via telephone. Ms. Green stated that she has worked at the facility for two years. Ms. Green stated, “This is not true. I am not aware of any medication errors. Every medication is properly labeled and tracked by us to ensure it is correct. We review medications daily.” Ms. Green denied knowledge of this complaint being true.

On 2/18/2026, I spoke to Ms. Martin, via telephone. Ms. Martin stated, “I am not aware of any medication issues or mistakes. All of the residents’ medications are on the computer system and monitored for accuracy. We match this information with the medication labels to ensure the medication is correct.” Ms. Martin denied knowledge of this complaint being true.

On 2/18/2026, I spoke to Ms. Harris, via telephone. Ms. Harris stated, “I am not trained to administer medications; however, I am not aware of any medication errors or medication issues. We have an electronic system used to monitor medications and staff reviews as well.” Ms. Harris denied knowledge of this complaint being true.

On 2/18/2026, I spoke to Ms. Roberts, via telephone. Ms. Roberts stated, “There are no medication issues that I am aware of. We are on top of medications and we use an EMAR system to monitor and track all medications. Our medication administration system and process is very good.” Ms. Roberts denied knowledge of this complaint being true.

On 2/18/2026, I spoke to Guardian C1 via telephone. Guardian C1 stated, “I have no concerns regarding the care being provided to Resident C. I am at the facility every day, for an average of three hours per day. I have good insight into how the facility is run and I have not observed any issues.” Guardian C1 denied concerns related to this complaint.

On 2/18/2026, I spoke to Guardian D1 via telephone. Guardian D1 stated, “The staff are great. I go to the facility two to three times per week, and I have not observed any issues.” Guardian D1 denied any concerns related to this complaint.

On 2/18/2026, I spoke to Guardian E1 via telephone. Guardian E1 stated, “I do not have any concerns. I am at the facility three days per week, and my adult children visit the facility on the weekends as well. We have not observed any concerns. I feel the staff are doing the best that they can, and this is hard work.” Guardian E1 denied any concerns related to this complaint.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	According to Ms. Cooper, Ms. Gibbs, Ms. Green, Ms. Martin, Ms. Harris and Ms. Roberts, they are unaware of any medication discrepancies or errors. Ms. Cooper, Ms. Gibbs, Ms. Green, Ms. Martin, Ms. Harris and Ms. Roberts denied knowledge of this complaint being true. Based on the information above, there is not sufficient information to confirm that direct care staff are improperly administering residents’ medication.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident B was not provided with bathing assistance during the eight days that he resided at the facility.

INVESTIGATION:

On 12/29/2025, a complaint was received, alleging that Resident B was not provided with bathing assistance during the seven days that he resided at the facility. The complaint stated that Resident B was left in soiled briefs for long periods of time.

On 1/12/2026, Ms. Shaughnessey spoke to Guardian B1 via telephone. Guardian B1 stated, “No one was assisting Resident B with hygiene. Resident B had sores on his genitals because staff were not changing his brief as often as they should have.” Guardian B1 stated that he believes this allegation is true.

During my onsite investigation on 1/16/2026, I reviewed Resident B’s file and interviewed Ms. Cooper.

The *Resident Registrar* and *Face Sheet* documented that Resident B resided at the facility from 3/11/2025 – 3/19/2025 and has a legal guardian, Guardian B1. The Health Care Appraisal listed Resident B's medical diagnosis as Alzheimer's Disease. The *Assessment Plan for AFC Residents* stated that Resident B required supervision in the community, was not alter to surroundings at times, required assistance with personal care tasks and used a walker for mobility assistance.

I spoke to Ms. Cooper, who stated, "I remember Resident B and the time that he was living here. He was only here for a week and then moved out. We did provide good care to Resident B, but I think his family wanted a higher level of care. We made sure he received proper care every day when he was here. We offered bathing and hygiene assistance, but his family wanted to do it when they were here. He was bathed and cleaned when he lived here. We allowed his family to assist but we were always present and able to assist as well, and we did assist Resident B with personal care during the times that his family was not here. We never left Resident B in soiled briefs. We complete consistent checks on all residents throughout the day for brief changes. This is not true." Ms. Cooper denied knowledge of this complaint being true.

On 2/4/2026, I spoke to Ms. Gibbs via telephone. Ms. Gibbs stated, "I recall Resident B. I do not remember him having any bed sores when he lives here. But he was only here for a week so that was not a long time. I remember his family was here daily for long periods of time, and they wanted to bathe Resident B. I would offer to assist or do it, but the family insisted on doing it themselves. When the family was not here, we provided bathing and personal hygiene assistance to Resident B. I never refused to assist and care for Resident B." Ms. Gibbs denied knowledge of this complaint being true.

On 2/18/2026, I spoke to Ms. Green, via telephone. Ms. Green stated, "Resident B was only here for a few days and then moved. I do not recall any concerns with his care. His family was very involved and was at the facility every day. The family wanted to do a lot of the personal hygiene care for Resident B and Resident B was provided bathes and personal hygiene after each brief change. I never observed any sores on Resident B. We change every resident's brief throughout the day and make sure they are clean and dry. Resident B's family wanted to change Resident B's brief and assist in his bathing when they were here, and we allowed it, but I always offered to help or assist as well." Ms. Green denied knowledge of this complaint being true.

On 2/18/2026, I spoke to Ms. Martin, via telephone. Ms. Martin stated, "I remember Resident B. He often refused to take a bath, so it required a lot of prompting. Resident B's family was at the facility every day and I even remember they would try to convince Resident B to bathe, and he would refuse with them too. He was only here a week, so it was not long enough for him to get acclimated and situated in the home. I did assist him with personal hygiene and brief changes when I was working,

and I never saw any bed sores." Ms. Martin denied knowledge of this complaint being true.

On 2/18/2026, I spoke to Ms. Harris, via telephone. Ms. Harris stated, "I provided care to Resident B when he lived here. I helped with brief changes and bathing. It was only for a few days. I remember I worked with him twice. I do not recall any issues, and I don't remember every seeing any bed sores on him." Ms. Harris denied knowledge of this complaint being true.

On 2/18/2026, I spoke to Ms. Roberts, via telephone. Ms. Roberts stated, "I was familiar with Resident B, but I only worked with him once. He wasn't here very long. I don't recall any specifics, but I do not remember there being any concerns or issues. We routinely check every resident on a consistent basis throughout the day to ensure they are clean and receive brief changes when needed. The majority of our residents are incontinent, so this is a normal routine that we check briefs. I am not aware of any issues when Resident B was living here." Ms. Roberts denied that this allegation is true.

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(1) A licensee shall offer a resident appropriate opportunity, access to, and instructions for the following daily: **(a) Bathing or showering, or both.**
ANALYSIS:	According to Ms. Cooper, Ms. Gibbs, Ms. Green, Ms. Martin, Ms. Harris and Ms. Roberts, they did provide bathing and personal hygiene assistance to Resident B. Ms. Cooper, Ms. Gibbs, Ms. Green, Ms. Martin, Ms. Harris and Ms. Roberts denied knowledge of this complaint being true. Based on the information above, there is not sufficient information to confirm that direct care staff failed to provide bathing and hygiene assistance to Resident B during the time that he resided at the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend that this special investigation be closed with no change to the status of the license.

2/25/2026

Stephanie Gonzalez Date
Licensing Consultant

Approved By:

For 3/12/26

Denise Y. Nunn Date
Area Manager