GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 28, 2026

Kimberly Wozniak
Norton Shores Care Operations, LLC
940 Monroe Ave. NW
Grand Rapids, MI 49503

RE: License #:	AL610418574
Investigation #:	2026A0356025
	Harbor Homes Assisted Living 1

Dear Ms. Wozniak:

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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL610418574
Investigation #:	2026A0356025
Complaint Receipt Date:	03/05/2026
Investigation Initiation Date:	03/05/2026
Report Due Date:	05/04/2026
Licensee Name:	Norton Shores Care Operations, LLC
Licensee Address:	940 Monroe Ave. NW GRAND RAPIDS, MI 49503
Licensee Telephone #:	(231) 600-7188
Administrator:	Daniyel Baer, Administrator
Licensee Designee:	Kimberly Wozniak, Designee
Name of Facility:	Harbor Homes Assisted Living 1
Facility Address:	2649-A Vulcan St. Norton Shores, MI 49444
Facility Telephone #:	(231) 600-7188
Original Issuance Date:	08/14/2024
License Status:	REGULAR
Effective Date:	02/14/2025
Expiration Date:	02/13/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Direct Care Worker (DCW) Will Huiet's inappropriately touched Resident's A & B.	No
DCW Will Huiet's interaction with Resident A was inappropriate.	No
There was no food in the facility to make meals for residents.	No
Additional Findings	Yes

III. METHODOLOGY

03/05/2026	Special Investigation Intake 2026A0356025
03/05/2026	Special Investigation Initiated - Telephone Marci Fuel, 3rd Coast Elder Initiative, legal guardianship.
03/05/2026	Contact - Telephone call received DCW Morgan Groesser. re: concerns.
03/05/2026	APS Referral Ken Beckman, Muskegon County DHHS, APS.
03/12/2026	Contact - Telephone call made Interview with Ken Beckman, APS, Kim Wozniak, LD, Daniyel Baer, Administrator, Felicity Gring, DCW.
03/13/2026	Contact - Telephone call received Kim Wozniak, LD
03/19/2026	Contact - Telephone call received Ken Beckman, APS.
03/20/2026	Contact - Telephone call received Ken Beckman, APS worker after Norton Shores Police department interview of Will Heustel.
03/24/2026	Inspection Completed On-site
03/24/2026	Contact - Face to Face w/Natasha Grew, Licensing Consultant, Kim Arnold, DCW, Sequoia Armstrong, DCW, Resident A, Shelby Vanderstelt, DCW.

03/26/2026	Contact - Telephone call received Casey Olson, Health West, ORR.
04/02/2026	Contact - Face to Face Casey Olson, HW ORR, Kim Wozniak, LD, Michelle Lyons, HW ORR, DCW's LaShonte Ware, Felicity Gring, Crystal Gil-Hall, Jasmine Cooper.
04/03/2026	Contact-Face to Face Resident C with support from Jamie Romanowsky, MOKA.
04/03/2026	Contact - Telephone call made DCW Will Huiet
04/27/2026	Exit conference Kim Wozniak, Licensee Designee.

ALLEGATION: Direct Care Worker (DCW) Will Huiet inappropriately touched Resident's A&B.

INVESTIGATION: On 03/05/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported Direct Care Worker William Huiet checked Resident A & B's briefs, he had no gloves on, he also checked Resident A & B's vagina and then smelled his hand.

On 03/12/2026, I conducted an interview with Ken Beckman, Muskegon County, DHHS (Department of Health and Human Services), APS (Adult Protective Services) worker, Kim Wozniak, Licensee Designee, Daniyel Baer, Administrator of DCW Felicity Gring, 3rd shift worker. Ms. Gring reported that on 02/24/2026, it was her first night working at the facility and she was conducting rounds with DCW Will Huiet, they went into Resident A's room to check her brief. Ms. Gring stated Mr. Huiet did not have a glove on, he turned Resident A on her side, slid his hand inside the back of Resident A's brief from her left leg side, mid-buttock area using the back of his hand across Resident A's buttock. Ms. Gring stated Mr. Huiet pulled his hand out and sniffed his hand and stated that she was sweaty but not wet with urine. Ms. Gring stated they did not change Resident A's brief, and she was "shocked" at the way Mr. Huiet checked Resident A's brief. Ms. Gring stated she was observing Mr. Huiet as he worked because this was her first night working, but she knew this was not an appropriate way to check a resident's brief. Ms. Gring stated then, Mr. Huiet changed Resident B's brief with no gloves on but did not put his hand into her brief to check for urine as he did with Resident A. Ms. Gring stated in addition, Mr. Huiet was wiping Resident B from back to front with no gloves on. Another DCW who was working on the night of 02/24/2026-02/25/2026, Jasmine Cooper, told Mr. Huiet to wipe Resident B from front to back and to put gloves on as it was unsanitary.

On 03/13/2026, I interviewed Ms. Wozniak via telephone. Ms. Wozniak stated Mr. Huiet was trained to wear gloves and reported that Mr. Huiet was fully trained and background checked.
On 03/20/2026, I interviewed Mr. Beckman via telephone. Mr. Beckman stated he met with Detective Sarah Trombley, Norton Shores Police Department and they interviewed Mr. Huiet. Mr. Beckman reported that Mr. Huiet acknowledged checking Resident A with no gloves and in the manner described by Ms. Gring but emphatically denied that he did anything nefarious or sexually abusive to Resident A. Mr. Beckman stated Mr. Huiet admitted to smelling his hand after checking Resident A's brief, and Mr. Huiet reported that he never wore gloves when checking residents briefs for wetness but if Resident A had been wet, he would put gloves on to change her briefs. Mr. Beckman stated Mr. Huiet may have been poorly trained and was practicing poor procedures but there was no indication that it was anything other than that.

On 03/24/2026, I conducted an unannounced inspection at the facility and interviewed DCW Sequoia Armstrong. Ms. Armstrong stated she worked with Mr. Huiet 3-4 times on 3rd shift. Ms. Armstrong stated one side of the hall in this building has male resident rooms and the other side of the building has female resident rooms. Ms. Armstrong stated she and Mr. Huiet performed personal care together and she never saw him doing anything inappropriate with any of the residents during personal care.

On 04/02/2026, I conducted an interview at the facility along with Casey Olson, Health West, (Community Mental Health), Office of Recipient Rights (ORR) Officer, Ms. Wozniak, Licensee Designee and Michelle Lyons, Health West, ORR advisor. Ms. Olson, Ms. Wozniak, Ms. Lyons and I interviewed DCW LaShontae Ware. Ms. Ware confirmed that she has worked with Mr. Huiet. Ms. Ware stated that she was not present when this allegation occurred, but she heard from Ms. Gring that Mr. Huiet "reached inside Resident B's, (not Resident A's) briefs but she (Ms. Ware) did not see it firsthand. Ms. Ware stated when she worked with Mr. Huiet, he interacted well with the residents. He cleaned; he was a "good worker". Ms. Ware stated she did not see Mr. Huiet do anything "weird or wrong."

Ms. Wozniak clarified the complaint allegations that she received occurred on 3rd shift, 02/24/2026-02/25/2026. Ms. Gring, Mr. Huiet, and Jasmine Cooper were working that shift and reported that around 12:00p.m./midnight on 02/25/2026, Mr. Huiet placed an ungloved hand in both Resident A and Resident B's briefs and then smelled his ungloved hand.

On 04/02/2026, I did not conduct interviews with Resident A or B. Resident A & B are non-verbal and unable to provide information pertinent to this investigation.

On 04/02/2026, Ms. Olson, Ms. Wozniak, Ms. Lyons and I interviewed Ms. Gring at the facility. Ms. Gring reported the same information as she reported in the interview conducted on 03/12/2026. Ms. Gring stated Mr. Huiet only checked Resident A in

the manner reported in the allegation at 12:00p.m. on 02/25/2026 and after that he did not check Resident A's briefs again but did conduct every 2-hour wellness check. Ms. Gring stated later that same night, 02/25/2026, she and Ms. Cooper saw Mr. Huiet change Resident B's brief with no gloves on and he wiped Resident B from back to front, which is unsanitary. Ms. Gring stated once these allegations were made known to Mr. Huiet, he would not go into the women's hall to provide care. He performed other duties such as mopping and cleaning.

On 04/02/2026, Ms. Olson, Ms. Wozniak, Ms. Lyons and I interviewed DCW Crystal Gil-Hall at the facility. Ms. Gil-Hall stated she mainly works 2nd shift but covers all shifts as needed. Ms. Gil-Hall stated she was informed about the allegations by Ms. Gring, but she was not a witness to it. Ms. Gil-Hall stated when she has worked with Mr. Huiet, she never had a problem with him. He cleaned and did not do anything inappropriate.

On 04/02/2029, Ms. Olson, Ms. Wozniak, Ms. Lyons and I interviewed DCW Jasmine Cooper at the facility. Ms. Cooper stated she was not present when Mr. Huiet checked Resident A's briefs with Ms. Gring however, she witnessed Mr. Huiet wiping Resident B from back to front and asked him if he knew how to wipe a female so she asked Mr. Huiet to step aside and she and Ms. Gring completed Resident B's clean up and brief change.

On 04/03/2026, I interviewed Resident C at her day program. Resident C was accompanied by Jamie Romanowsky, supervisor of community supports. Resident C is not verbal but is able to answer questions with the use of a "bliss board." Ms. Romanowsky worked with Resident C regularly at the day program and assisted me with communicating with Resident C. Resident C stated Mr. Huiet provided care for her including personal care. Resident C stated Mr. Huiet did a "good job," and reported no issues with the care provided by Mr. Huiet.

04/03/2026, I interviewed DCW Will Huiet via telephone. Mr. Huiet stated during 3rd shift on 02/24/2026-02/25/2026, he checked to see if Resident B's (not Resident A) brief was wet or soiled by pulling the brief out to look and feel, to see if there was feces or urine. Mr. Huiet stated he could not feel moisture with gloves on, so he did not use gloves to check Resident B. Mr. Huiet acknowledged that he smelled his hand to see if it smelled like urine or feces. Mr. Huiet stated he may have wiped Resident B from back to front at some point while he was cleaning her. Mr. Huiet stated he was just trying to get Resident B cleaned up thoroughly in all areas that had fecal material in and on it. Mr. Huiet stated that he was trained in all areas. A lot of training was on the job training, and he did not receive individual training on the care needs of each resident. Mr. Huiet stated this was not his first direct care job and that he knows how to provide personal care to residents. Mr. Huiet stated he never touched Resident A or B's vagina but put his hand in the back of Resident B's brief to check if she was wet or dry.

On 04/03/2026, I reviewed Mr. Huiet's Workforce Background Check document

dated 02/03/2026. The Workforce Background Check documented that Mr. Huiet is eligible to work in an AFC facility.

On 04/03/2026, I reviewed Mr. Huiet's training through Flex Training and the facility, in-house training was signed as completed by Ms. Gil-Hall and Mr. Huiet on 02/13/2026.

On 04/03/2026, I reviewed Mr. Huiet's Health West Recipient Rights Check dated 02/04/2026 and there are no recorded recipient rights violations for Mr. Huiet.

On 04/27/2026, I conducted an exit conference with Licensee Designee, Kim Wozniak via telephone. Ms. Wozniak stated she agreed with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	The complainant reported that DCW William Huiet checked Resident A & B's briefs with no gloves on. He also checked Resident A & B's vagina and then smelled his hand. Based on investigative findings that included interviews with staff, Resident C, and a review of training documents, there was conflicting information of which resident(s) Mr. Huiet allegedly performed questionable care on. There is no evidence to support that during third shift on 02/24/2026- 02/25/2026 DCW Will Huiet inappropriately touched Resident's A&B.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: DCW Will Huiet's interaction with Resident A was inappropriate.

INVESTIGATION: On 03/05/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported that Resident A asked for a hug and Mr. Huiet jumped in to give Resident A a hug and then held Resident A from 4:00a.m. to 6:00a.m. The complainant reported that Mr. Huiet was rolling his eyes and seemed way to "into it."

On 03/19/2026, I interviewed Mr. Beckman via telephone. Mr. Beckman stated he received an allegation that Mr. Huiet wrapped Resident A in a blanket and wanted to cuddle with her. Mr. Beckman stated his report alleged that Mr. Huiet called the

female residents “his girls.” Mr. Beckman stated Resident B (not reported as Resident A) is a “hugger” and according to his allegations, Resident B (not Resident A) would not look at Mr. Huiet but would “look down” and (Resident B) did not “seem to like” Mr. Huiet.

On 03/24/2026, I conducted an unannounced inspection at the facility and interviewed DCW Sequoia Armstrong. Ms. Armstrong stated on or about Thursday, 03/16/2026, (03/16/2026 was a Monday) at 6:00a.m., Mr. Huiet sat close to Resident A in the sunroom with the lights down low. Ms. Armstrong stated she did not witness any hugging, physical touching or interaction between Mr. Huiet or Resident A.

On 04/02/2026, I conducted an interview at the facility along with Ms. Olson, Ms. Wozniak, and Michelle Lyons. Ms. Olson, Ms. Wozniak, Ms. Lyons and I interviewed DCW LaShontae Ware. Ms. Ware stated she had seen Mr. Huiet sit on the couch in the sunroom with Resident A and Resident A put her head on his shoulder while watching a movie and he did paperwork. Ms. Ware stated this was not unusual as Resident A did that with any staff that sat in the room with her. Ms. Ware stated she did not witness Mr. Huiet doing anything wrong or inappropriate. Ms. Ware stated Mr. Huiet also sat with male residents, ate with them and hung out with them. Again, Ms. Ware stated there was nothing inappropriate with his interactions with residents.

On 04/02/2026, Ms. Olson, Ms. Wozniak, Ms. Lyons and I interviewed DCW Crystal Gil-Hall at the facility. Ms. Gil-Hall stated she had seen Mr. Huiet in the sunroom sitting next to Resident A when it was dark in the room, but Resident A liked to have staff in the room with her, sitting next to her on the couch. Ms. Gil-Hall stated she never saw Mr. Huiet do anything inappropriate with Resident A.

04/03/2026, I interviewed DCW Will Huiet via telephone. Mr. Huiet stated when he charted in the sunroom, he would put cartoons on and Resident A would sit next to him on the couch. Mr. Huiet acknowledged that Resident A put her head on his shoulder while she watched cartoons. Mr. Huiet stated Resident A would have done the same thing with any staff that was sitting next to her while she was watching TV.

On 04/27/2026, I conducted an exit conference with Licensee Designee, Kim Wozniak via telephone. Ms. Wozniak stated she agreed with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	The complainant reported that Resident A asked for a hug and Mr. Huiet jumped in to give Resident A a hug and then held

	Resident B from 4:00a.m. to 6:00a.m. The complainant reported that Mr. Huiet was rolling his eyes and seemed way to “into it.” Based on investigative findings, there is no evidence to show that Mr. Huiet’s interactions with Resident A were inappropriate. A violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: There was no food in the facility to feed the residents.

INVESTIGATION: On 03/05/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported the following narrative; ‘*The failure to provide food to residents in a licensed assisted living facility in the State of Michigan is not a minor oversight, it is an egregious violation of basic human dignity, resident rights, and stated regulatory standards. Under Michigan licensing requirements for Adult Foster Care, facilities are mandated to provide adequate, nutritious meals that meet residents daily dietary needs. Depriving vulnerable residents of food places them at immediate risk of malnutrition, dehydration, medical decline, and emotional distress. Many residents in assisted living settings rely entirely on the facility for sustenance due to age, disability, or medical condition. The absence of food is not merely noncompliance it constitutes neglect and a direct threat to residents’ health and safety. This level of disregard demonstrates a systemic failure in oversight and care planning.’* The complainant added there is no food for residents and employees are buying food.

On 03/05/2026, I interviewed Marcie Feustel, guardian for various residents in the facility, via telephone. Ms. Feustel stated she received a call from staff who reported there is no food in the facility, and nothing to serve meals to the residents. Ms. Feustel stated staff reported that they pooled their money and bought pizza on Sunday, 03/01/2026. Ms. Feustel stated on 03/02/2026, she went to the facility and observed residents eating Lee’s Famous Recipe Chicken bought by staff. Ms. Feustel stated she talked to Daniyel Baer, Administrator, who assured her there was food at the facility and explained that staff had been stealing food, so they put the food in another building on the campus. Ms. Baer sent pictures of food to Ms. Feustel but staff claim Ms. Baer got the food to make it appear there was food at the facility. Ms. Feustel stated staff claim their food deliveries have been cancelled and the food issue at this facility is not new, but it has been worse the last two weeks.

On 03/03/2026, I interviewed Anonymous DCW via telephone. Anonymous DCW stated she will not provide her name for fear of losing her job. She stated since Ms. Baer has been the administrator at the facility there has not been enough food to make the meals on the menus. Anonymous DCW stated staff had to buy pizza for the residents on Saturday 02/28/2026 or Sunday 03/01/2026. She was not working

on the days staff bought pizza but on 03/02/2026 when she was working, there was hardly anything for breakfast. There were no eggs, brown sugar, meat, fresh fruit and staff cannot operate and make adequate meals for the residents with the food available at the facility. Anonymous DCW stated on 03/02/2026, the marketing director, Jennifer Carter bought Lee's Famous Recipe chicken for lunch because they could not make the meal that was on the menu. Anonymous DCW stated Gordon's food service used to deliver to the facility but there has not been a delivery for approximately a month.

On 03/13/2026, I interviewed Kim Wozniak, Licensee Designee via telephone. Ms. Wozniak stated she was notified that staff were buying food such as pizza and chicken because there was not enough food at the facility to make meals on the menu. Ms. Wozniak stated she spoke to the administrator, Daniyel Baer, and Ms. Baer reported that there was food at the facility and the residents wanted pizza, so staff got pizza for the residents. Ms. Wozniak stated Ms. Baer reported smothered chicken was on the menu one day, but staff forgot to take chicken out of the freezer, so they did not have the ingredients to make smothered chicken and improvised and bought pizza and chicken on two different occasions.

Ms. Wozniak stated Ms. Baer sent pictures of food available at the facility and Ms. Wozniak stated according to the pictures there was adequate food available. Ms. Wozniak stated she went to the facility on Tuesday, 03/03/2026 and observed adequate food. Ms. Wozniak stated staff told her that Ms. Baer went to Walmart and got food to make it appear as if there was adequate food at the facility but prior to this, there was not enough food to make meals on the menu. Ms. Wozniak stated she reviewed receipts from food purchases made by Ms. Baer and the purchases were made after she requested pictures of food at the facility from Ms. Baer which led her to believe that staff's accounts of not enough food at the facility was accurate. Ms. Wozniak stated she has re-stocked the facility with food. She had appointed DCW Kim Arnold as the main full-time cook immediately and Ms. Arnold will make all the main meals. Ms. Wozniak stated she has provided the facility with a la carte pantry items such as ingredients to make sandwiches and snacks for in-between meal foods. Ms. Wozniak stated she followed-up with Gordon Food Service and discovered that no food order had been place since 02/06/2026 when the former administrator Trenecia La Fear was there. Ms. Wozniak stated Ms. Baer is no longer working at the facility.

On 03/24/2026, I conducted an unannounced inspection at the facility with Licensing Consultant, Natasha Grew. Ms. Grew and I interviewed Ms. Arnold. Ms. Arnold stated she is now the facility full-time cook and there is enough food to make the meals on the menus as well as snacks and alternative meals. Ms. Arnold confirmed there were issues with food availability earlier in the month and there were issues with having ingredients to make full meals that were on the menu. Ms. Arnold stated now she cooks the main meals, resident snacks and alternative meal option ingredients are always available for staff to make for the residents for in between meals or meal alternatives.

On 03/24/2026, Ms. Grew and I reviewed facility menus. The food available in the facility matched ingredients available in the facility for meal preparation.
On 03/24/2026, I interviewed DCW Sequoia Armstrong at the facility. Ms. Armstrong stated she had worked at the facility since January 2026 on 1st shift. Ms. Armstrong stated the food available at the facility and the menus coincide. There is food available at the facility to make the meals and if the residents do not want what is on the menu, staff make the residents sandwiches as an alternative to the menu item. Ms. Armstrong stated in mid-January 2026, she bought Lee's Famous Recipe Chicken meals for all the residents in this building because there was not food in the facility to make the meals that were on the menu. Ms. Armstrong stated they did not have all the ingredients to make a full meal, they did not have jelly to go with peanut butter for example, just to make a sandwich. Ms. Armstrong stated that since they have had a designated cook making all the main meals for the facility, mealtimes have been much better.

On 03/24/2026, I interviewed DCW Shelby Vanderstelt at the facility. Ms. Vanderstelt stated she has worked at this facility for 7 months, since August 2025 on 1st shift. Ms. Vanderstelt stated this facility has never run out of food, she has never had to buy food, and they have always had food to make what was on the menu.

On 03/24/2026, I interviewed Resident A at the facility. I observed Resident A eating broccoli, rice and glazed pork loin. The serving was plenty and Resident A stated the food was good. Resident A stated the meals at the facility are good and she has never been without a meal.

On 03/24/2026, I observed the refrigerators, freezers, and pantry. I observed a standard-sized refrigerator with a bottom freezer in the kitchen and in a room off the kitchen where additional food was kept, I observed a commercial-size refrigerator, a commercial-size freezer, and shelving racks with non-perishable food. In the standard size refrigerator in the kitchen, I observed milk, juice, butter, cool whip, coleslaw, tuna salad, cheese, ketchup, mustard, salad dressings, fruit, broccoli, Jell-O, lunch meat, and salad. In the bottom freezer in the kitchen, I observed various ice cream and ice cream desserts, various styles of frozen French fries, and various frozen vegetables.

In the commercial size refrigerator, I observed eggs, milk, orange juice, grape juice, applesauce, breads, macaroni salad, Pepsi, and various vegetables. In the commercial-size freezer, I observed bread, waffles, cookie dough, various frozen vegetables, a large pan of frozen pulled pork, and tater-tots. On the shelving racks, I observed several boxes of all-purpose biscuit mix, syrup, seasonings, baking items such as flour and sugar, several cans of tuna, soups, hot chocolate mixes, various cereals, pancake mix, and banana pudding.

On 04/02/2026, I interviewed Ms. Gil-Hall at the facility. Ms. Gil-Hall stated she put in money for pizza for the facility residents because they did not have everything to

make the meals on the menu. Ms. Gil-Hall stated Ms. Baer instructed her to make noodles, cheese and sauce but they bought pizza instead. Ms. Gil-Hall stated there was food in the facility but not to make meals on the menu. Also, food went missing from the facility such as noodles and hamburger. Ms. Gil-Hall stated on one occasion, the chicken breasts were still frozen, so Ms. Carter bought Lee's Famous Recipe chicken for the residents. Ms. Gil-Hall stated things are better now and the menu is being followed, having a main cook has made a difference.

On 04/02/2026, I interviewed Ms. Cooper at the facility. Ms. Cooper stated there was a time when the food for the meal on the menu was available but still frozen. Ms. Cooper stated staff pitched in money to buy pizza for the residents at the facility once but now, the food is well stocked, Gordon Food service delivers regularly and things are better.

On 04/03/2026, I interviewed Resident C with Ms. Romanowsky. Resident C stated the food at the facility is good, she gets enough to eat, she gets snacks and she is satisfied with the food at this facility.

On 04/27/2026, I conducted an exit conference with Licensee Designee, Kim Wozniak via telephone. Ms. Wozniak stated she took steps to remedy the low food issue and put a plan in place to prevent any further menu, meal or food issues at the facility. Ms. Wozniak agreed with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	The complainant stated there is no food for residents and employees are buying food. Based on my investigative findings, there is evidence to show that there was food availability issues and on or about 03/03/2026, Ms. Wozniak took steps to replenish food in the facility, and to have meals consistently prepared by Ms. Arnold according to the menu. In addition, there is no evidence to indicate residents were not provided with meals and therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING

INVESTIGATION: On 04/02/2026, Ms. Olson, Ms. Wozniak, Ms. Lyons and I interviewed Ms. Gring at the facility. Ms. Gring stated Resident A could receive personal care from a member of the opposite sex, but Resident C could not have male caregivers. Ms. Gring stated she was not aware if Resident B could have male caregiver.

On 04/03/2026, I interviewed Resident C with Ms. Romanowsky. Resident C reported that Mr. Huiet provided personal care to her and Resident C reported that she did not want a male care giver to provide personal care to her.

On 04/03/2026, I interviewed Mr. Huiet via telephone. Mr. Huiet stated he provided personal care to Resident A, B, & C. Mr. Huiet stated he worked 1 or 2 shifts and did not know any of those residents were not supposed to be provided personal care by a member of the opposite sex. Mr. Huiet stated he was never told Resident A & C were female care only. Ms. Baer made a change to Resident B's chart, and Mr. Huiet was told he could back up female staff up but not provide personal care, and he never provided personal care to Resident A, B & C again. Mr. Huiet stated he completed other duties such as passing medications, cleaning the floors, and filling drinks. Mr. Huiet stated Ms. Baer told him he could go in the residents' rooms with a female staff and help by handing them towels, briefs and wipes but not to provide personal care and he did not once he was told. Mr. Huiet stated had he known from the beginning, he would have never provided personal care to these residents.

On 04/03/2026, I reviewed the Resident Care Agreement (RCA) for Resident A, signed by Resident A's legal guardian, Ms. Wozniak and the supports coordinator through Health West (signature is not legible) on 01/26/2026. The RCA documented that Resident A and Resident A's designated representative/legal guardian agreed to 'receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available.'

I reviewed Resident A's Assessment Plan that documents Resident A's case manager through Health West as Madison Grunow. The plan does not have any information prohibiting personal care to be completed by a member of the opposite sex.

I reviewed Resident A's IPOS (Individualized Plan of Service) dated 01/26/2026, written by Madison E. Grunow, Health West supports coordinator. There is nothing documented in the IPOS that contradicts the RCA that noted Resident A and Resident A's legal guardian agree to accept care by a staff member of the opposite sex.

On 04/03/2026, I reviewed Resident B's RCA, signed by Resident B's legal guardian and Ms. Wozniak on 02/05/2026. The RCA documented that Resident B and Resident B's designated representative/legal guardian agreed to 'receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available.'

I reviewed Resident B's Assessment Plan that documents Resident B's two legal guardians and three physicians, but no case manager. The plan does not have any information prohibiting personal care to be completed by a member of the opposite sex.

I reviewed Resident B's IPOS written by Health West, Nicole Skodack, and implemented on 07/22/2025. The IPOS documented on page 3 'while using the bathroom, 1-2 people to support her depending on her ability and willingness to support, family prefers that all personal care support be done by female staff.'

On 04/03/2026, I reviewed Resident C's RCA, signed by Resident C and Ms. Wozniak on 02/23/2026. Resident C does not have a legal guardian or a designated representative. The RCA documented that Resident C agreed to 'receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available.'

I reviewed Resident C's IPOS written by Health West, dated 02/24/2026, signed by Kara Kile, supports coordinator, Health West. The IPOS does not document any information prohibiting personal care to be completed by a member of the opposite sex.

I reviewed Resident C's Assessment Plan dated 04/06/2026, signed by Resident A and Maggie Rosser, RN (facility nurse). The plan does not have any information prohibiting personal care to be completed by a member of the opposite sex.

On 04/24/2026, I interviewed Kara Kile, Health West supports coordinator. Ms. Kile stated an in-service was conducted by Health West supports coordinator, Nicole Skodack on 02/03/2026 regarding Resident B's IPOS and the information on the IPOS should have been known by staff. Ms. Kile stated on 02/06/2026, staff were trained on Resident B's adaptive equipment also. Ms. Kile stated staff had the responsibility to make sure all corresponding paperwork matches the IPOS and services to the residents are provided according to the IPOS as well as training new staff and/or management staff that were not trained by Health West. Ms. Kile stated the staff that were trained are as follows, Felicity Gring, Trenicia La Fear, Shelby Vanderstelt, Daniyel Baer, Crystal Gil-Hall, Winter Copeland, Jeanette Lacey and De'Era Oakes.

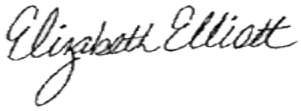
On 04/27/2026, I conducted an exit conference with Licensee Designee, Kim Wozniak via telephone. Ms. Wozniak stated she understood the IPOS, RCA and assessment plans must be consistent regarding the type of care the residents require and will review all documents and make all corrections necessary. Ms. Wozniak stated she will provide a corrective action plan and agreed with the information, analysis, and conclusion of this applicable rule.

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:	Resident A & C's assessment plans, resident care agreements and IPOS plans do not document that the residents are not to be provided personal care by a member of the opposite sex. Resident B's assessment plan and resident care agreement does not indicate that Resident B was not to receive personal care from a member of the opposite sex but Resident B's IPOS does document that she is not to receive personal care by a member of the opposite sex. Ms. Gring stated Mr. Huiet provided personal care to Resident's A, B & C. Mr. Huiet stated he provided personal care to Residents A, B & C until Ms. Baer informed him that he was not supposed to provide care to those residents. Ms. Kile stated staff at the facility were in-serviced on the residents' IPOS plans including Resident B's IPOS plan. Based on my investigative findings, Mr. Huiet provided personal care to Resident B conflicting with the information on her IPOS. It is apparent that the information on Resident B's IPOS, assessment plan and resident care agreement do not match giving conflicting information on how to care for Resident B and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

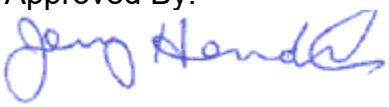
Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.



04/28/2026

Elizabeth Elliott Date
Licensing Consultant

Approved By:



04/28/2026

Jerry Hendrick Date
Area Manager