



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

May 5, 2026

Stephen Levy  
ARHC ARCLRMI01 TRS, LLC  
5900 Water Tower PL  
Clarkston, MI 48346

RE: License #: AL630365575  
Investigation #: 2026A0605015  
Addington Place of Clarkston 1

Dear Stephen Levy:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

A handwritten signature in cursive script that reads "Frodet Dawisha".

Frodet Dawisha, Licensing Consultant  
Bureau of Community and Health Systems  
3026 W. Grand Blvd., Ste 9-100  
Cadillac Place  
Detroit, MI 48202  
(248) 303-6348

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AL630365575
<b>Investigation #:</b>	2026A0605015
<b>Complaint Receipt Date:</b>	03/25/2026
<b>Investigation Initiation Date:</b>	03/25/2026
<b>Report Due Date:</b>	05/24/2026
<b>Licensee Name:</b>	ARHC ARCLRMI01 TRS, LLC
<b>Licensee Address:</b>	27th Floor 540 Madison Ave New York, NY 10022
<b>Licensee Telephone #:</b>	(248) 625-0500
<b>Administrator/Licensee Designee:</b>	Stephen Levy
<b>Name of Facility:</b>	Addington Place of Clarkston 1
<b>Facility Address:</b>	5900 Water Tower Pl Clarkston, MI 48346
<b>Facility Telephone #:</b>	(248) 625-0500
<b>Original Issuance Date:</b>	06/19/2015
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/06/2025
<b>Expiration Date:</b>	09/05/2027
<b>Capacity:</b>	20
<b>Program Type:</b>	PHYSICALLY HANDICAPPED MENTALLY ILL ALZHEIMERS/AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
<b>A 20-resident facility is allegedly experiencing neglect due to understaffing, inadequate care, and unresponsive management.</b>	Yes
<b>The residents are not being fed or hydrated with fluids.</b>	No
<b>Staff are mean to residents.</b>	No

**III. METHODOLOGY**

03/25/2026	Special Investigation Intake 2026A0605015
03/25/2026	APS Referral Adult Protective Services (APS) made referral but will not be investigating these allegations
03/25/2026	Special Investigation Initiated - Telephone Discussed allegations with medication technician Andrea Whitaker
03/25/2026	Contact - Telephone call made Left messages for direct care staff (DCS)
03/25/2026	Contact - Telephone call received Discussed allegations with DCS
03/25/2026	Contact - Document Sent Email to Bureau Fire Safety (BFS) Tom Lyon
03/26/2026	Inspection Completed On-site Conducted unannounced on-site investigation
03/26/2026	Contact - Telephone call received Discussed fire drills with BFS Tom Lyon
04/01/2026	Contact - Telephone call made Discussed allegations with Resident A's and Resident B's family. Left message for Resident C's family.
04/02/2026	Contact - Telephone call made Discussed allegations with DCS

04/08/2026	Contact - Telephone call made Interviewed medication technician
04/21/2026	Contact - Face to Face Attempted surprise fire drill with BFS
05/04/2026	Exit Conference Conducted with licensee designee Stephen Levy via telephone with my findings.

**ALLEGATION:**

**A 20-resident facility is allegedly experiencing neglect due to understaffing, inadequate care, and unresponsive management.**

**INVESTIGATION:**

On 03/25/2026, intake# 210005 was referred by Adult Protective Services (APS). APS will not be investigating these allegations.

On 03/25/2026, I initiated this special investigation by contacting medication technician Andrea Whitaker regarding the allegations. Andrea has been working for this corporation for one year. She works first shift from 6:15AM-2:30PM. She is responsible for both Addington Place of Clarkston building 1 at 5900 Water Tower Place and Addington Place of Clarkston building 2 at 5800 Water Tower Place. Both buildings are in the same parking lot across from each other. There are 12 residents at building 1 and 13 residents at building 2. As a medication technician, Andrea is responsible for administering medications for both buildings 1 and 2 and providing caregiving services to residents when she is not administering medications. There is one direct care staff (DCS) scheduled at building 1 and one direct care staff scheduled at building 2 during the three shifts. There is also a medication technician scheduled during each shift and a floater. When the medication technician is administering medications at building 1, then the floater is at building 2 to ensure that there are always two DCS per shift in each building except for the midnight shift. During the midnight shift, there is only a medication technician or a floater that runs between buildings 1 and 2. Medication technicians and floaters are counted towards staff to resident ratios if not assigned to that building/license for that entire shift. The floater is the DCS that goes between buildings 1 and 2 to assist staff with residents who are two person assists and provides direct care to residents.

Andrea stated that during her shift, all residents are checked and changed every two hours and more often if needed. Shifts begin 15 minutes before their start time because during the 15-minute shift change, staff do walk throughs and check on residents to ensure they are not soiled. Afterwards, residents are checked/changed every two hours or more often if needed. There have not been any residents left soiled in urine or feces

for long periods of time. There is no tracking sheet but there is a communication log for staff to document anything abnormal or unusual with the residents. She has not started her shift and found any resident soiled nor has she received or heard any complaints from either staff, residents, or family regarding residents who were found soiled.

On 03/25/2026, I interviewed medication technician Lisa Kirksey regarding the allegations via telephone. Lisa has been working for this corporation for about 16 years. She works second shift from 2:15PM-10:30PM about three to four days a week. She too works in both buildings 1 and 2. Lisa also helps DCS on shift when she is not administering medications. There is one DCS scheduled at buildings 1 and 2 and then one medication technician and one floater that assist at buildings 1 and 2. If Lisa is at building 1, then the floater is at building 2 and vice versa. The medication technicians and the floaters are counted towards the residents to staff ratios. There is one resident that is a two-person to assist with a Hoyer lift. There is another resident that also requires two staff when being toileted. She or the floater would assist with these residents if the DCS in building 1 needs assistance.

Lisa stated that during shift changes, staff conduct walk throughs and check residents to see if they are soiled and/or need changing. Afterwards, residents are checked and/or changed every two hours and often if needed. Lisa stated it is usually the DCS responsibility to make sure residents are changed if soiled and to conduct the checks; however, medication technicians will assist when they are not administering medications. She has never received any complaints from staff and or family members stating that a resident was found soiled.

On 03/26/2026, I conducted an unannounced on-site investigation at Addington Place of Clarkston 1 regarding the allegations. I met with registered nurse (RN), Brittany Goodling, regarding the allegations. Brittany is one of the RNs for both buildings 1 and 2. There are 12 residents at building 1 and 13 residents at building 2. There are two DCS during the first shift, two DCS during the second shift and one DCS during the midnight shift. During the first shift and second shift there are always a DCS scheduled at each building and one medication technician and one floater that go to both buildings during opposite times. If the medication technician is administering medications at building 1, then the floater is at building 2 and vice versa. The medication technician and the floater are counted towards resident to staff ratios. There are times when there is only one DCS at each building plus either a medication technician or a floater. Brittany stated that the goal ratio staff to residents is one-to-eight and the max ratio is one-to-12, but that does not occur always due to staff calling in. At building 1, Resident A is sometimes a two-person assist due to a Hoyer lift when this resident is weak or is too tired to assist staff with transferring.

Brittany stated DCS are required to check residents every two-four hour; however, there are residents who require checking/changing more frequently than other residents. Residents C, D, and E are those residents who require checking more frequently than other residents. There are also some residents who ask to be toileted and can tell staff they need to either be changed or go to the bathroom. If Brittany receives reports from staff regarding residents found soiled, Brittany and management investigate these

allegations to determine which residents and which staff were working during those shifts and once it has been determined which staff, then those DCS are either in-serviced or receive disciplinary action. Brittany has not received current complaints from staff or family members regarding residents found soiled. Checking and/or changing residents is not recorded; however, DCS are required to check/change or toilet residents when residents first wake up, then after breakfast, prior to lunch if a resident needs to be toileted or is soiled, during shift change at 2:15PM, then dinner time, shift change again at 10:15PM, then must be checked four hours later during the night. I recommended to Brittany that tracking/documenting checking and changing residents may be beneficial to ensure DCS are doing these checks for accountability and so residents are not left soiled if it is occurring. She acknowledged.

On 03/26/2026, I interviewed Memory Care Director Kara Fraser regarding the allegations. Kara is responsible for both buildings 1 & 2. There are three shifts, first shift from 6:15AM-2:30PM, second shift from 2:15PM-10:30PM and third shift from 10:15PM-6:30AM. There is one DCS scheduled at buildings 1 and 2. There is also a medication technician and a floater that are scheduled, but they go between buildings 1 and 2. If the medication technician is at building 1, then the floater is at building 2 and vice versa. The medication technician and the floater are counted towards resident to staff ratios. In building 2, Resident A and Resident B are two-person assist during transfers, and Resident C is a two-person assist during showers which occurs twice weekly. The medication technician and the floater are counted during fire drills even though they are floating between buildings 1 & 2.

Kara reported there have been a couple of incidents with staff during shift change that found residents wet. When this happens, staff are reeducated on checking/changing policy every two hours and if it continues with the same DCS, then they receive disciplinary action. Family have complained about residents being soiled, but Kara must remind family that they need to wait until DCS can get to the residents after DCS are finished with other residents. Residents sometimes must wait about five-10 minutes before DCS can get to them to change them. Kara does not believe that residents are left wet/soiled because there is not sufficient DCS in each building. DCS have walkies to communicate with each other and when they need either the floater or the medication technician to come to the building for assistance.

On 03/26/2026, I interviewed medication technician Alicia Adams regarding the allegations. Alicia has been working on/off for this corporation for about three years. She quit for two years and recently returned. She works first and second shifts as she works doubles two-three days a week. There is one DCS scheduled per shift plus a medication technician and a floater that run to both buildings 1 & 2 to help. If the medication technician is at building 1 then the floater is at building 2 and vice versa. Alicia stated, "the issues are the call-ins which happen frequently especially during the weekends." When there is a call-in which are usually the floaters, then there is only the medication technician that is working both buildings 1 & 2, so the DCS at each of the buildings must wait until the medication technician finishes at one building before going

to the next building. When a call-in happens, then the RN and manager are contacted and either the RN or manager will pick up the shift and work.

Alicia stated during her shift, she always checks each resident during shift change and every two hours and changes them if needed. She also makes sure residents who can toilet themselves are asked if they need to go to the bathroom. She has never left any resident soiled nor has she started her shift and found a resident soiled. There have not been any complaints made to her by other staff or families about residents found wet/soiled. There is no documentation or tracking sheet used to document when residents are checked/changed.

On 03/26/2026, I interviewed DCS Cyonah Pruitt regarding the allegations. Cyonah has worked one year for this corporation. She mainly works first shift from 6:15AM-2:30PM, but sometimes also works afternoon shifts from 2:15PM-10:30PM. Today she is assigned to building 1 and has a medication technician, Kimberly Conigliaro, who is also scheduled to work only at this building. However, other days, there is one DCS scheduled at each building 1 & 2, plus a medication technician and floater that go between each building. If the medication technician is at building 1, then the floater is at building 2 and vice versa. Cyonah reported that it is rare, but it does happen frequently during the weekends when the floater calls in. Management is notified and will try to send another floater to work, but that is not always possible so the DCS is left working alone in the building with a medication technician that must work both buildings 1 & 2. In this building 1, there are two residents who are a two-person assist with transfers, Residents A and B. Cyonah has participated in fire drills and a couple of times they evacuated during the fire drills, but other times maintenance will do walk throughs and test staff on what to do.

Cyonah has arrived at her shift and found residents soiled because the midnight shift DCS have not changed them. This occurs about 80% of the time and it is always the same DCS, Dajahnique Nelson-McClellan and DCS Tamyra Faulkner. Cyonah has observed the residents wet/soiled and has heard other DCS complain about these two specific DCS not changing residents during the midnight shifts when they are working. The policy is to check/change every two hours and more often if needed. She has not received any complaints from residents' families regarding residents being found soiled, just from her observations and other staff.

On 03/26/2026, I interviewed medication technician Kimberly Conigliaro regarding the allegations. Kimberly has been working for this corporation for about three-in- half years. She works first shift from 6:15AM-2:30PM full time, five days a week. Kimberly usually works both buildings 1 & 2, but today she is assigned to building 1 because there are two medication technicians working today, one in each building. When Kimberly is the only medication technician scheduled to pass medications, then she is responsible for both buildings; therefore, a floater staff is also scheduled. If Kimberly is at building 1, then the floater staff is at building 2 and vice versa. This process works unless someone calls in which is usually the floater. When the floater calls in, then there is only the medication technician responsible for both administering medications and

helping DCS with caregiving duties between both buildings. When this happens, the DCS scheduled at each building is working alone until the medication technician can get to that building to assist. There are two residents at building 1 who are a two-person assist, Resident A and Resident B. Resident C is also a two-person assist but with toileting only. Kimberly has participated in a fire drill, and the maintenance personnel goes through the evacuation process with staff too.

Residents get checked/changed if wet/soiled when they first wake up, then checked/changed before and/or after lunch, then again during shift change. She has heard that during second and third shifts, residents have been found wet/soiled. She has observed residents soiled when she started her shift because the midnight shift staff did not change them. These concerns were reported to management.

I followed up with Memory Care Director Kara Fraser and RN Brittany Goodling regarding my interviews with DCS/medication technicians reported that residents have been found wet/soiled during first shift because midnight DCS Dajahnique Nelson-McClellan and DCS Tamyra Faulkner are not checking/changing them. Kara stated she is aware and is currently investigating these concerns. She is looking into disciplinary action towards these staff members. I also expressed concerns with insufficient staffing based on how many residents are a two-person assist at each buildings 1 & 2 as medication technicians and floaters that are not scheduled at each building cannot be counted towards resident to staff ratio. Brittany stated she will be discussing these concerns with the licensee designee Stephen Levy.

I was provided with Resident A's, Resident B's and Resident C's assessment plans, January-March 2026 staff schedule and 12 residents' face sheets along with staff contact information.

On 03/26/2026, I reviewed Resident A's, Resident B's, and Resident C's assessment plans.

- Resident A's assessment plan was completed on 10/08/2025
  - Occasional disorientation; current and history of wandering with the facility
  - Requires two-person assist for transfers
  - Dependent on DCS for grooming/dressing/toileting
  - Requires physical assistance to evacuate
- Resident B's assessment plan was completed on 12/02/2025
  - Occasional disorientation, current/history of hallucinations/delusions
  - Requires two-person assist for transfers
  - Dependent on DCS for grooming/dressing/toileting
  - Requires physical assistance to evacuate
- Resident C's assessment plan was completed on 12/02/2025
  - Cannot follow instructions and difficulty in receiving information
  - Current or history of wandering within the facility
  - Requires hands-on assistance with transfers and or changes in position
  - Requires hands-on assistance with all bathing tasks
  - Requires physical assistance with all tasks related to toileting

- Monitor resident for elopement behavior
- Staff must assist residents to evacuate

**Note:** I reviewed January 2026-March 2026 staff schedules for first, second and third shifts at building 1 regarding resident to staff ratio and according to the schedules, there is only one DCS scheduled at building 1 plus a medication technician and sometimes a floater that are scheduled at both buildings 1 & 2. However, during the midnight shifts, there is no floater and the medication technician is scheduled at buildings 1 & 2 plus the HFA building. There is insufficient staffing at building 1 to meet the needs of 12 residents especially Residents A, B, and C who are a two-person assist.

**Note:** I reviewed 2026 first quarter fire drills for building 2 and according to the fire drill records, Mike the maintenance personnel conducted and pulled the fire alarm during each drill. Also, Mike included himself as “staff,” participating in the fire drill. On 01/30/2026, during first shift two staff members plus Mike’s names are under team member participation, on 02/25/2026, during second shift there are three staff members plus Mike under team member participation, and on 03/26/2026, there is one staff member plus Mike under team member participation. All three drills have an evacuation time of exactly six minutes. It is unclear if the residents were evacuated out of the building or if these were mock drills. Based on this home typically only having one DCS scheduled per shift, the maintenance personnel assisting with the drills and residents seemingly not evacuating during drills, these evacuation times are not accurate in determining if all 12 residents can safely evacuate out of the building with one DCS working per shift.

On 03/26/2026, I received a call from Bureau Fire Safety (BFS) Fire Marshal Inspector Tom Lyon. Mr. Lyon recently was assigned to Addington Place of Clarkston 1 and Addington Place of Clarkston 2. He is not too familiar with these buildings but did complete the inspections which both passed. He was unaware that these buildings were using floater staff including medication technicians towards their staff to resident ratios while conducting fire drills. He agreed to a surprise fire drill to be conducted on 04/21/2026.

On 04/01/2026, I contacted Resident A’s family (Family A) regarding the allegations. Family A visits regularly and prior to two weeks ago, Resident A had been found soiled numerous times. There have been times when Resident A is soiled and there is no staff to be found. Family A had been told that there are two DCS in the building, but when Family A is at the building and is looking for staff, they initially think staff is with another resident, but after waiting long periods of time, they learn that there is only one DCS present. This occurs usually during the weekends and during evening hours. Resident A is sometimes a two-person assist only when DCS are new and unable to have Resident A assist them with transfers.

On 04/01/2026, I contacted Resident B’s family (Family B) regarding the allegations. Family B visits every other week. About six months ago to a year, Resident B was found soiled, but Family B stated it was not due to negligence, but that Resident B had to wait a little longer. Family B went to a staff member and that staff member changed Resident

B immediately. There are at least two to three DCS working in this building and all have been helpful. Family B had no concerns to report.

On 04/01/2026, I received a return call from Resident C's family. Family C last visited Resident C in 12/2024. Resident C's dementia worsened and Family C's visits were agitating Resident C as Resident C no longer knew and/or recognized Family C. However, when Family C visited, Resident C was never observed to be soiled. There seemed to be enough staff as the facility had recently been licensed and there were not many residents residing at the facility. Family C is unaware if there is sufficient staff now at the facility.

On 04/02/2026, I interviewed DCS Zamaria McClendon via telephone regarding the allegations. Zamaria has been with this corporation for about two months. She works first shift from 6:15AM-2:30PM about one to two times a week at both buildings 1 & 2 as DCS. Zamaria is on the schedule with either a floater DCS or a medication technician. The floater and the medication technician work between buildings 1 & 2. She believes that two DCS are enough staff to provide for the care of all 13 residents, even the residents who are two-person assists. Zamaria has never conducted nor participated in a fire drill since employment at either building.

Zamaria checks/changes residents every two hours as that is their policy. There have not been a time that a resident had been left soiled nor have there been any complaints made by other staff or family members that residents were found soiled.

On 04/02/2026, I interviewed DCS Tamyra Faulkner via telephone regarding the allegations. She began employment at this corporation in 12/2025 but stated she is currently suspended for her "behavior." She worked second shift from 2:15PM-10:30PM full time and worked at both buildings 1 & 2. She is the only DCS scheduled during her shift plus a floater staff and a medication technician staff that go between buildings 1 & 2. Tamyra stated that most of the time she worked alone but then when she needed assistance with a two-person assist resident, she would call either the floater or the medication technician to assist her in transferring them. In building 1 there are two residents who are two-person assists and in building 2 there are three residents who are a two-person assist. When the floater or medication technician come to either building to help Tamyra with the two-person assist residents, they leave the building afterwards. Tamyra has not participated in a fire drill but stated that maintenance has shown staff where the fire alarms are and how to turn them off. She informed me that the fire alarm went off sometime on 02/2026, the doors closed but the residents did not evacuate. She stated, "I saw higher ups, managers and RN's running around, but we never evacuated." She does not believe there is enough staff at either building to safely evacuate all the residents during an emergency.

Residents are to be checked/changed every two hours or more frequently if needed. Tamyra stated this was not policy but that she is a certified nursing assistant (CNA) and learned this during her education, but that she was informed by managers to "go off the call lights." Tamyra stated she resident's bedroom has a call light and when the resident

needs to go to the bathroom or needs to be changed, they will use their light; however, she checks each resident two hours during her shift. Tamyra had begun her shift before and found residents soiled. When this happens, she documents it in the communication log and then informs management. She is unsure what management does after concerns are reported.

On 04/02/2026, I interviewed DCS Dajahnique Nelson-McClellan regarding the allegations. Dajahnique has been working for this corporation since 11/2025. She works the midnight shift from 10:15PM-6:30AM in both buildings 1 & 2. She is the only DCS scheduled plus a floater and a medication technician that go between each building; however, since she began working at either building, there has not been a floater during the midnight shift. She must rely on the medication technician who works in both buildings to assist her with any of the two-person residents if they need changing in either building. There is one resident that is a two-person assist in building 1 and three residents that are two-person assist in building 2. Dajahnique has not participated in a fire drill since working at either building. A couple months ago, the maintenance person went over the fire alarm, how to reset the alarm and where the fire extinguishers were only. She stated, "it would be impossible for me to evacuate all the residents at either building by myself safely."

Dajahnique checks/changes the residents every two hours per policy. Some residents require frequent checks/changes if the resident is heavy wetter. She has never left nor has she found a resident soiled. All staff check residents at the beginning of their shifts, and then every two hours after that or more often if needed. If she finds any residents that are soiled at the beginning of her shift, she reports this to that staff and then to management.

On 04/08/2026, I interviewed medication technician Jennifer Moore regarding the allegations. Jennifer has been working at this corporation for about three years. She works third shift from 10:15PM-6:30AM. She began working at the HFA building as both a medication technician and a DCS; however, as of six months ago, during third shift, she is now responsible for medication administration in all three buildings, HFA, 1 & 2, but only provides caregiving duties to HFA. Jennifer stated she rarely administers any medications to buildings 1 & 2 but sometimes does pass an as needed medication. DCS at either building 1 or 2 call her, but rarely to assist a resident who is a two-person assist. She is also responsible for giving both DCS in buildings 1 & 2 their 30-minute breaks around 2AM-3AM. Jennifer stated that in 2025, there was a temp agency used when DCS called in during third shift, but in 2026, that temp agency was no longer used; therefore, whenever someone calls in during third shift, there is no coverage because there is no floater assigned during that shift, so Jennifer is then responsible to provide care in all three buildings. Since working in buildings 1 & 2, Jennifer has never conducted nor participated in a fire drill where she and other DCS evacuated residents out of the buildings. Every two-months, the maintenance personnel Mike does "walk throughs," with staff showing them how to turn off the fire alarm and what the evacuation procedures are. Jennifer stated, "it's pushing it," when asked if she can

safely evacuate all the residents from each building with another DCS in less than eight minutes.

Jennifer has observed residents soiled, but this occurred months ago when a DCS who is no longer employed was working at buildings 1 & 2. Since that staff was terminated, she has not observed any resident soiled.

On 04/21/2026, I, along with Tom Lyon with BFS conducted a surprise on-site visit at building 1 to conduct a fire drill. We arrived at 10AM and met with DCS Alexandra Davis who was working alone with 12 residents present. I advised Alexandra she needed to conduct a fire drill and follow her emergency evacuation procedures and evacuate all the residents. Alexandra stated, "I've never done a fire drill here. We have people in Hoyer lifts, still in bed, and in wheelchairs. I don't know how to do a drill." I advised Alexandra to contact management. Alexandra made several attempts to call management, but no one was available. After 15 minutes, staff began showing up to building 1 including Memory Care Director Kara Fraser and Executive Director Maggy Canny. I explained to Kara and Maggy the purpose of our visit and the need to observe a fire drill with only one DCS, Alexandra, to conduct the drill to determine evacuation time. Alexandra pulled the fire alarm but then all staff began to assist in the evacuation process. I intervened and advised that Alexandra was the only person to conduct this evacuation process. Alexandra asked, "if I take the residents out, who will stay outside with them when I come back and get the other residents." I advised Alexandra that was a good question. Maggy stated it was impossible for Alexandra to evacuate all the residents by herself because "this was a team effort." Mr. Lyon explained that roaming staff from other buildings cannot be counted because each building was licensed separately as an AFC facility. Maggy stated, "that's impossible because we would fail." The fire drill was not conducted. Maggy continued to state that "this was a team effort," and that "the team always assists during the evacuation process." Even though it was evident that Alexandra tried calling the "team," at 10AM and no one showed up until 15 minutes later. Maggy asked, "when did the rules change that we can't use other staff from other buildings." I advised Maggy that roaming staff from other buildings are not counted towards resident to staff ratio because again each building is licensed separately as an AFC. I also advised Maggy that during my initial on-site investigation on 03/26/2026, I expressed concerns about insufficient staffing due to three residents at this building are a two-person assist and that Kara stated that they were going to address the concerns about insufficient staffing. Kara stated, "I was waiting for you to tell us how many staff we must have in each building." I advised Kara that I provided RN Brittany Goodling with a staffing to resident ratio checklist to assist them in identifying the needs of the residents and based on those needs to determine staffing to resident ratios. Kara then stated, "we don't have additional staffing for each building plus we need approval from corporate for additional staffing." I again expressed concerns pertaining to three residents who are two-persons assist and there are two residents that have been assessed as wanders; therefore, there should be at least three DCS on shift for this building that are not floaters or medication technicians who are going between both buildings 1 & 2. Maggy continued to state that she was unaware that they cannot utilize staff from other buildings for fire drills. Again, Mr. Lyon reminded her that

we arrived at 10AM and Alexandria attempted to get the team over to this building, but no one showed up until 15 minutes later. I expressed serious concerns about the safety and protection of the 12 residents and staff, if there was an emergency with only one DCS on shift and all needed to evacuate. I advised Maggy that I may recommend modification of the license to a six-month provisional license due to significant concerns regarding insufficient staffing; staffing are not competent with the facilities evacuation process and the safety and protection of the residents. Maggy advised that she wants an opportunity to address these concerns and would submit a corrective action plan. Maggy also advised that building 2 would fail the evacuation process if the evacuation was only conducted with one DCS.

Mike, the maintenance personnel spoke briefly with us outside stating that he was unaware that he could not participate in the fire drills and that there is only one DCS during third shift when he conducts the evacuation process. Mike implied that residents are not evacuated out of the building during these drills.

<b>APPLICABLE RULE</b>	
<b>R 400.619</b>	<b>Emergency preparedness plan.</b>
	<b>(8) A licensee shall practice the emergency preparedness plan, including the fire safety plan, at least once a quarter per calendar year during each shift, 7 a.m. to 3 p.m., 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. A record of the practices must be maintained for 2 years.</b>
<b>ANALYSIS:</b>	Based on my investigation, interviews and review of the 2026 first quarter fire drills DCS are not evacuating residents out of the building during the evacuation process. Several DCS reported to me that Mike, the maintenance personnel, conducts the fire drills but that he only does a walk through showing them how to pull the fire alarm and what the evacuation process is.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.629</b>	<b>Direct care staff; qualifications and training.</b>
	<b>(4) Direct care staff shall possess all of the following qualifications before working independently: (b) Be capable of appropriately handling emergency situations.</b>

<b>ANALYSIS:</b>	Based on my investigation and information gathered, DCS lack the qualifications and are not capable of appropriately handling emergency situations. On 04/21/2026, during an unannounced visit to building 1 with BFS, DCS Alexandria Davis was working alone with 12 residents present. Alexandria was asked to conduct a fire drill and to evacuate all 12 residents out of the building. Alexandria's response was, "I've never conducted a fire drill here. We have people in Hoyer lifts, some still in bed, and others in wheelchairs. I don't know how." Therefore, Alexandria would not be capable of appropriately evacuating all 12 residents in an emergency.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.629</b>	<b>Direct care staff; qualifications and training.</b>
	<b>(5) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be trained and competent in all of the following areas before performing assigned tasks independently: (f) Safety and fire prevention.</b>
<b>ANALYSIS:</b>	On 04/21/2026, during an unannounced visit, DCS Alexandria Davis stated, "I do not know how," when asked to conduct a fire drill and evacuate the residents out of the building. In addition, several DCS also reported that they have never conducted a fire drill since their employment at this building; therefore, DCS are not competent in all areas of performing safety and fire prevention when they are working independently during their shifts.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.671</b>	<b>Resident care.</b>
	<b>(1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.</b>

<b>ANALYSIS:</b>	Based on my investigation and review of Resident's A, B, and C assessment plans and the staff schedules from January 2026-March 2026, there is insufficient staff according to their assessment plans. There are a total of 12 residents at this building. Residents A, B, and C are two-persons assist according to their assessment plans; with transferring and with their personnel hygiene needs and Resident A and C have been assessed as wanders; however, there is only one DCS working per shift. I was informed by Memory Care Director Kara Fraser that there is a floater plus a medication technician scheduled at both buildings 1 & 2 who are counted in the staff to resident ratio; however, there are shifts according to the staffing schedule, specifically third shift when there is no floater and the medication technician is responsible for buildings 1, 2, and HFA. Kara was informed that floating staff, floater and the medication technician cannot be counted towards the staff to resident ratio if they are not specifically assigned to this home for that shift.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.677</b>	<b>Resident hygiene, clothing.</b>
	<b>(2) A licensee shall ensure the resident receives or has access to all of the following:</b> <b>(c) Assistance with resident hygiene as needed.</b>
<b>ANALYSIS:</b>	Based on my investigation and information gathered, Family A reported that there have been recent concerns of Resident A found soiled due to waiting long periods of time for staff to change Resident A.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.</b>

<b>ANALYSIS:</b>	Based on the unannounced on-site visit on 04/21/2026, all 12 residents would not be protected and safe during an emergency. DCS Alexandra Davis did not know how to evacuate the residents, and it took 15 minutes for Alexandra to get other staff members and management to building 1. Residents cannot self-evacuate and there are residents in wheelchairs and Hoyer lifts that require staff to assist in the evacuation process. In addition, building 1 is not equipped due to insufficient staffing to ensure the protection and safety of these residents.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**The residents are not being fed or hydrated with fluids.**

**INVESTIGATION:**

On 03/25/2026, medication technician Andrea Whitaker was interviewed regarding these allegations. Residents receive three meals, breakfast, lunch and dinner plus snacks in between. Breakfast is served around 8AM, then a snack at 10AM, lunch at 12PM, snack at 2PM, and dinner between 4PM-5PM plus another snack at 7PM. With each meal, residents get either water or juice or coffee. There is also a water dispenser sitting in the dining room available 24 hours a day, seven days a week for residents to drink with plastic cups next to the dispenser. There has never been a time when staff refused a meal to a resident or refused a resident from drinking water, juice or anything else. Residents have the right to refuse a meal, but when that happens, we set the meal aside and eventually the residents eat their meals. There have never been a complaint from the residents, the staff or family members about residents not eating meals.

On 03/25/2026, I interviewed medication technician Lisa Kirksey regarding the allegations. Lisa stated that residents receive three nutritional meals daily plus snacks. During her shift, dinner is served and if a resident refuses to eat, then their plate is set aside for a later time. There are snacks that residents receive and if they request it, they are given snacks. Water and/or juice is provided with dinner and there is a water dispenser in the dining room that is accessible 24/7. She has observed residents using the dispenser. There have not been any residents who were dehydrated.

On 03/26/2026, I interviewed RN Brittany Goodling regarding the allegations. Residents are being fed and receive three nutritious meals daily plus snacks in between and snacks when residents ask for it. Breakfast is served around 8:30AM, lunch is from 12-12:30PM and dinner at 5PM. Snacks are provided between the meals. Water and/or juice or coffee is provided during meals. They have pudding, fruit, and other snacks available throughout the day and have a water dispenser at each building for residents to access 24/7. The only time a resident is dehydrated is if they are declining medically

and/or are diuretic which attributes to dehydration. There have not been any complaints made by staff, residents, or family that residents are not being fed or are dehydrated.

On 03/26/2026, I interviewed Memory Care Director Kara Fraser regarding the allegations. Residents are always fed three nutritious meals daily plus snacks in between. Breakfast is offered around 8AM-9:30AM, then a snack with hydration, then lunch around 11:30AM, then snack plus hydration, then dinner around 4:30PM and again snack and hydration. Residents also receive drinks during meals. There is a water dispenser in the dining room available for residents to help themselves 24/7 with plastic cups next to it. Residents are observed using the water dispenser. DCS assist the residents who cannot feed themselves, but sometimes residents refuse to eat. If a resident refuses to eat, their plate of food is set aside and offered to them later, which then they accept and eat. However, sometimes when a resident is in hospice and/or end of life, they cannot eat, but families feel that staff should “push,” the residents to eat even if the resident is refusing to eat or cannot eat. There have not been any complaints that residents are not getting fed or dehydrated.

On 03/26/2026, I interviewed medication technician Alicia Adams regarding the allegations. During Alicia’s shifts, meals are always provided for the residents. During meals, residents are given water, juice or coffee. There is also a water dispenser in the dining room available 24/7 for residents. She has not seen food being withheld by residents and when residents are still hungry after their meal, they are either given seconds or a snack. Snacks are always available throughout the day and between meals. There have not been any complaints made by residents or family members at this building regarding being fed or dehydrated.

On 03/26/2026, I interviewed DCS Cyonah Pruitt regarding the allegations. Residents are fed very well and receive three meals a day plus a snack between each meal. Residents also get water, juice, coffee or tea with meals and there is a water dispenser in the dining room that residents have access to 24/7. Residents have refused to eat because they are either sick or just do not feel hungry, but their plate of food is put aside and they eventually eat. There have not been any complaints of residents being hungry or dehydrated. Snacks and drinks are always available for residents at each building.

On 03/26/2026, I interviewed medication technician Kimberly Conigliaro regarding the allegations. Residents are always fed three meals a day. There are residents who cannot feed themselves, so DCS feed them. The only time residents do not eat is when they refuse and even then, their plate of food is set aside and then the resident is offered the meal again. Residents also get seconds if they want plus snacks between meals. Drinks are always provided during meals and during snacks. Residents have a water dispenser they can access 24/7 in the dining room. There have not been any concerns of residents not being fed or are dehydrated.

**Note:** During this on-site investigation, I observed all 12 residents sitting at the dining room tables having lunch. The residents were eating goulash with a biscuit and each resident had either a cup of water or juice with their meal.

I attempted to interview Resident D and Resident E after they finished eating their lunch, but I was unsuccessful as both were asking me to “get them out of here.” Resident D said, “I want to live with my family. Can you get me out of here.” Resident E said, “I was in Florida and when I got back, I’m being held here against my will.” Both appeared to have good hygiene and no concerns were noted.

On 04/01/2026, I interviewed Family A regarding the allegations. Generally, Resident A gets his meals, but there are times when Resident A is sleeping, staff do not wake him up and he misses a meal. After Resident A wakes up, Family A asks for the meal, but staff say it is close to dinner time, so staff wait until dinner time to give Resident A his meal. Family A has observed numerous times at the dinner table other residents who have meals in front of them but are not eating and just stare off. Family A believes that because there are not enough staff, those residents who cannot feed themselves have to wait long periods time to eat.

On 04/01/2026, I interviewed Family B regarding the allegations. Resident B is in hospice and must be fed, which staff are doing. Family B usually visits after work, around Resident B’s dinner time and always sees other residents sitting in the dining room eating dinner. Resident B has never had any issues with dehydration as she drinks plenty of fluids.

On 04/02/2026, I interviewed Family C regarding the allegations. When Family C visited, Resident C always had enough food to eat. Family C would visit around or after lunch time and Resident C would be observed eating. There were no concerns about Resident C being dehydrated.

On 04/02/2026, I interviewed DCS Zamaria McClendon regarding the allegations. Whenever she is working her shift, she observes all residents eating breakfast, snacks, and lunch. Residents get a drink with every meal. There have not been any concerns of residents being dehydrated. Zamaria does not recall that there had been any resident asleep and they did not get a meal after they woke up. She stated, “the only time a resident would not eat is when they are going through end of life.” There have not been any complaints received from family members stating that a resident did not get a meal or fluids.

On 04/02/2026, I interviewed DCS Tamyra Faulkner regarding the allegations. During her shifts, everyone gets a meal and eats. There are a couple of residents at either buildings 1 or 2 that cannot feed themselves, so Tamyra assists them with their meals. However, there are times when a resident is sleeping so whenever this happens, their meal is set aside, and they offer it to the resident multiple times after they wake up, but there have been times that the resident still refused their meals. With each meal and

snack, residents get fluids to drink. There have not been any complaints received from family members that a resident did not eat or is dehydrated.

On 04/02/2026, I interviewed DCS Dajahnique Nelson-McClellan regarding the allegations. During her shift, there are no meals provided, just snacks, juices, and water if residents are hungry. Some residents ask for sandwiches during her shift, but the kitchen is closed so she offers them snacks instead. Some of the residents accept the snack but others do not. DCS have requested sandwiches to be left in the kitchen during the midnight shift, but that idea was rejected. She does not know why.

On 04/08/2026, I interviewed medication technician Jennifer Moore regarding the allegations. During third shift, snacks and drinks are provided, no meals. She reported no concerns with residents not getting fed or getting enough fluids.

<b>APPLICABLE RULE</b>	
<b>R 400.663</b>	<b>Nutrition; adoption by reference.</b>
	<b>(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.</b> <b>(3) Not more than 14 hours must elapse between the evening and morning meal.</b>
<b>ANALYSIS:</b>	Based on my investigation and information gathered, residents are receiving meals and fluids during their meals. There have not been any concerns reported by DCS nor by family members that residents are not being fed or dehydrated.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**Staff are mean to residents.**

**INVESTIGATION:**

On 03/25/2026, I interviewed medication technician Andrea Whitaker regarding the allegations. Andrea denied being mean or disrespectful towards a resident. Nor has she heard or seen other DCS be mean or disrespectful towards a resident. A resident nor their family have reported to her about a staff member being mean. She would report any staff that she observed being mean or abusing a resident in any way. Andrea said there are some staff that are sometimes lazy but that happens at every job. She stated if she sees staff not doing their jobs, she will address it immediately with management.

On 03/25/2026, I interviewed medication technician Lisa Kirksey regarding the allegations. Lisa denied being mean to a resident nor has she been disrespectful towards them. Lisa stated, "if I heard or seen another staff member being mean or disrespectful towards a resident, I would report it." She has not received any complaints from other staff members or family members regarding a member of staff being mean to a resident. She has not seen any staff being lazy or sitting too long. If Lisa saw a staff member sitting too long or not doing what they were supposed to do during their shifts, then she would advise them to get up and go check on the residents She would also report this to management.

On 03/26/2026, I interviewed RN Brittany Goodling regarding the allegations. Brittany has not received any complaints from DCS, residents or their families regarding DCS being mean to residents. She would address these complaints immediately as that is not tolerated at these facilities. Brittany has not received any regarding DCS being lazy during their shifts. Again, she would address these concerns immediately if she had concerns regarding staff.

On 03/26/2026, I interviewed Memory Care Director Kara Fraser regarding the allegations. In the past, there have been complaints about DCS being mean to residents; however, after she and the RN Brittany investigated, those DCS are no longer working for this company. When Kara sees that a DCS is burned out or shuts down because of working at either building, they are placed at their Addington of Clarkston homes for the aged (HFA) building which is not a memory care unit and the residents are less vulnerable. If Kara sees that DCS continue to mistreat residents, then again disciplinary action is taken. There have not been any current complaints regarding staff being mean or disrespectful towards residents.

On 03/26/2026, I interviewed medication technician Alicia Adams regarding the allegations. Alicia denied being mean or disrespectful towards any resident. She has never heard other DCS being mean to residents nor has she received any complaints from residents or their families regarding DCS being mean. She would report these issues to management immediately.

On 03/26/2026, I interviewed DCS Cyonah Pruitt regarding the allegations. Cyonah denied being mean to any resident at either building. She never yells at them or is disrespectful towards them. A long time ago, she heard that staff were fired because those staff members were mean towards residents. Cyonah would report any abuse she observed to management.

On 03/26/2026, I interviewed medication technician Kimberly Conigliaro regarding the allegations. Kimberly denied being mean or disrespectful towards any resident. She says sometimes she must use a "stern voice," with residents to redirect them, but never yells at them or in a demeaning manner. She never heard other DCS yelling or disrespecting residents. She has not had any complaints from family members regarding staff.

On 04/01/2026, I interviewed Family A regarding the allegations. Family A stated that the “regular staff,” are fantastic, but the staff that are not regulars do not know how to handle or provide care to Resident A. Even though staff are not mean or disrespectful, Family A observed staff just sitting at the dining room tables doing nothing or one time a staff was doing their homework. This occurred months ago during the evening hours on the weekend.

On 04/01/2026, I interviewed Family B regarding the allegations. Family B stated that staff treat Resident B very well and Resident B is very happy with this facility. Family B has never observed any staff member being mean to Resident B or any other resident. On 04/02/2026, I interviewed Family C regarding the allegations. Family C stated when they visited, Family C never saw any unkindness. The only thing Family C noticed was a high turnover of staff, so Family C is unsure if there are any concerns now.

On 04/02/2026, I interviewed DCS Zamaria McClendon regarding the allegations. Zamaria denied being mean or mistreating a resident. She has never observed another staff member mistreating a resident nor has she heard any complaints about staff mistreating a resident. Zamaria stated, “if I’m sitting down during my shift, it means I’m done with everything.” She does not know of any staff that is not doing what they are supposed to do during their shifts.

On 04/02/2026, I interviewed DCS Tamyra Faulkner regarding the allegations. She denied ever being mean to a resident or mistreated a resident in any way. She stated, “staff are nice to residents, it’s staff not being nice to each other that’s the issue.” Tamyra stated that there are staff members that are not professional towards each other and “their tone,” when speaking to each other is the issue. She stated, “this is why we have a high turnover because some staff can’t work with other staff.” Tamyra informed me that if she is sitting down at either buildings 1 or 2, it is because “she’s done with everything.” She has not seen other staff sit and not do their work.

On 04/02/2026, I interviewed DCS Dajahnique Nelson-McClellan regarding the allegations. She denied being mean or mistreating a resident nor has she received a complaint against her for being mean to a resident. Dajahnique stated that in the past, there was a DCS being mean to residents, but that staff no longer works for this corporation. All the DCS that currently work at either building are nice to the residents. During her shift, she never has time to sit because, “there’s so much to do.” She does laundry and mops and cleans the bathrooms and checks on the residents, so she stated, “there’s not much time to relax.” She had heard about DCS not doing their work during their shift, but that staff is no longer working for this corporation.

On 04/08/2026, I interviewed medication technician Jennifer Moore regarding the allegations. Jennifer denied being mean to residents and denied observing or hearing other DCS be mean to any resident. Jennifer does not have time to sit and do nothing as she is responsible for all three buildings during third shift. She has not observed any current DCS sitting at either building on their phone. Jennifer stated that there was a past DCS, no longer employed here, that was observed sitting throughout her shift and

not doing anything. She stated third shift is a “good team,” and everyone does what they should do.

On 05/04/2026, I conducted the exit conference with licensee designee Stephen Levy with my findings and my recommendation. Mr. Levy will be meeting with his team regarding this investigation and my recommendation and will reach out to me after he receives this report with questions.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(3) A licensee and staff shall respect and safeguard all of the following resident rights:</b> <b>(p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.</b>
<b>ANALYSIS:</b>	Based on my investigation and information gathered, DCS are treating all the residents with dignity and respect. DCS and family reported no concerns about observing DCS being mean to residents.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### **IV. RECOMMENDATION**

Contingent upon receiving an acceptable corrective action plan, I recommend modification of the license to a 6-month provisional license.

*Frodet Dawisha*

05/04/2026

Frodet Dawisha  
Licensing Consultant

Date

Approved By:

*Jay Calwerts*

For

05/04/2026

Denise Y. Nunn  
Area Manager

Date