GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 4, 2026

Nichole VanNiman
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AS230404895
Investigation #: 2026A0007020
Beacon Home at Arlene

Dear Nichole VanNiman:

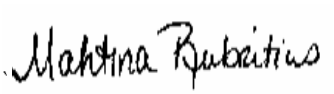
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS230404895
Investigation #:	2026A0007020
Complaint Receipt Date:	03/10/2026
Investigation Initiation Date:	03/13/2026
Report Due Date:	05/09/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Arlene
Facility Address:	4219 Arlene Drive Lansing, MI 48917
Facility Telephone #:	(517) 253-7112
Original Issuance Date:	10/02/2020
License Status:	REGULAR
Effective Date:	03/29/2025
Expiration Date:	03/28/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
There are serious concerns about Resident A's medication management, including unauthorized dosage increases, lack of monitoring, poor communication with providers, and worsening side effects.	Yes

III. METHODOLOGY

03/10/2026	Special Investigation Intake - 2026A0007020
03/13/2026	Special Investigation Initiated – Telephone Interview with Guardian A1.
03/13/2026	Contact - Document Received - Documentation.
03/26/2026	Inspection Completed On-site - Unannounced- Face-to-face contact with Aurora Cimmerer, DCW, Sheresse Farr, DCW, and Michele Hitsman, who has the role of home manager, and Resident A.
03/26/2026	Contact - Document Received - Email from Michele Hitsman. Request for documenting sleep data.
03/30/2026	Contact - Document Received - Email from Michele Hitsman. Resident A's labs have been completed, and his next PCP appointment is 4/27.
03/31/2026	Contact - Document Sent - Email to Michele Hitsman.
04/01/2026	Contact - Document Received - Email from Michele Hitsman. Does licensing need a copy? The lab results have been received and sent to the guardian.
04/30/2026	APS Referral made.
04/30/2026	Contact - Telephone call made - Michele Hitsman. Message left.
04/30/2026	Contact - Telephone call made to Brook Landis, Program Manager. Discussion. Correct contact information provided for Michele Hitsman.

04/30/2026	Contact - Document Received - Medication Narratives and discontinued medications.
04/30/2026	Contact - Telephone call made to Brook Landis, Program Manager. Discussion.
04/30/2026	Contact - Document Received - Medication Logs.
04/30/2026	Contact - Document Sent to Guardian A1.
04/30/2026	Contact - Document Received - Email from Guardian A1.
05/01/2026	Contact – Document Sent – Email to Nichole VanNiman, Licensee Designee. I requested a phone call to conduct the exit conference.
05/04/2026	Contact – Document Sent – Email to Nichole VanNiman, Licensee Designee, regarding the conclusion of the investigation, a request for a written corrective action plan, and a copy of the report sent.

ALLEGATION: There are serious concerns about Resident A's medication management, including unauthorized dosage increases, lack of monitoring, poor communication with providers, and worsening side effects.

INVESTIGATION:

On April 13, 2026, I interviewed Guardian A1. Guardian A1 informed me that her parents, Relative A1 and Relative A2, were Resident A's guardians and that changed in December of 2025, due to health issues. Guardian A1 is Resident A's sibling. We discussed the situation regarding Resident A and Guardian A1 provided written documentation. It was noted that Resident A has been diagnosed with Autism and Cognitive Impairment. Resident A is non-verbal and he has limited communication skills. Resident A depends on others to advocate for him. We discussed Resident A's medications.

Regarding the medication, Trazodone, Michele Hitsman provided paperwork (around Thanksgiving) to the guardian, and it was noted that Resident A was receiving 150 mg (total) of Trazodone. I reviewed a document, *Release of Responsibility for Medications*, documenting Resident A's medications, dated November 27, 2025, which was consistent with the information provided (Resident A was receiving 150 mg (total) of Trazodone). It was noted that the start date was February 26, 2025. It was also noted that the medication counts at the time of LOA only listed 100 mg of Trazodone as the 50mg of Trazodone was not listed. According to Guardian A1, Michele Hitsman stated there were no medication changes in the last year. So, Guardian A1 was of the impression that Resident A was receiving 150mg of Trazodone the whole time.

Guardian A1 informed me, in writing, that on January 23, 2026, an *Individual Plan of Service* meeting was held, and Michele Hitsman said there were no med changes last year. Michele Hitsman "also commented on how [Resident A] was on a low dose of Trazodone and she would like it increased to see if it'll help with his sleep. It is stated that his Trazodone is at 150mg. Katie Rutkowski (stand in support coordinator) looked up and confirmed there was a med increase this past year. Michele [Hitsman] mentioned that [Resident A] has not been aggressive and only needed one PRN of Haldol last year in August. Michele [Hitsman] mentioned his med review will be on 1/29/26." Guardian A1 told Michele Hitsman that she would like to attend (the medication review), and Michele Hitsman stated that she could not give her the time of the meeting until the morning of.

On January 27, 2026, Michele Hitsman contacted Guardian A1 at 12:00 p.m. to inform her that the medication review was that day (instead of January 29, 2026) at 3:45 p.m. Guardian A1 informed her that she could not attend, as she had another appointment at that time. According to Guardian A1, Michele Hitsman requested an increase in Trazadone. Note: Guardian A1 had someone look over the prescribed medications for Resident A, and using Trazodone for sleep was no longer recommended; the dosage he's prescribed are not following sleep guidelines (as noted in the American Sleep Guidelines). Guardian A1 informed Michele Hitsman that the Trazadone dosage was already at a level that could cause agitation and sleep disruption. The psychiatrist suggested ordering 0.5 Klonopin at bedtime. Guardian A1 requested the medication list for Resident A. Guardian A1 also reached out to a consulting pharmacist (Consulting Pharmacy #1) to review Resident A's medications. On January 28, 2026, Guardian A1 received a list of Resident A's medications, which were different from the list she received in November, and the information documented on Resident A's MyChart. According to Guardian A1, on February 6, 2026, Michele Hitsman sent a reminder to her (Guardian A1) about the paperwork, including consent forms for medications. She also inquired about adding Klonopin; which Guardian A1 advised against after discussion with Consulting Pharmacy #1. Guardian A1 requested the contact information for the psychiatrist, and Michele Hitsman informed her that she could not be personally contacted, as she was contracted for Beacon. In addition, Michele Hitsman told Guardian A1 that's why it was critical to attend medication reviews. Guardian A1 advised Michele Hitsman that the medication review had been changed at the last minute so Guardian A1 had been unable to attend. Michele Hitsman informed her that she would follow up regarding the matter, but that it might be a three-month wait. Guardian A1 reached out to Katie Rutkowski (support coordinator), who was covering for Alicia Herrington, Support Coordinator, Network 180. On February 8, 2026, Guardian A1 emailed Michele Hitsman, informing her that she dropped off the paperwork, with the exception of the consent forms. This was because she had not received the resident medication instructions, and she had not spoken to the psychiatrist about the medications. Michele Hitsman sent a follow-up email stating that those were the medications Resident A was already on, and it was yearly paperwork. Guardian A1informed Michele Hitsman that she was new to guardianship, and the forms specifically stated that she was acknowledging receipt

of Resident Medication Instructions, and the psychiatrist had clearly explained the use, risk, and side effects of the medications. In addition, that consent would be updated if a change in the guardian occurred. On February 17, 2026, Michele Hitsman informed Guardian A1about a meeting with the psychiatrist to be held on February 19, 2026, at 9:30 a.m. On February 19, 2026, Guardian A1 asked for the link to join the meeting and Michele Hitsman responded that she would call. Michele Hitsman called Guardian A1, informing that she was on speaker phone, that she was putting her phone next to the computer so she could hear. Guardian A1 had difficulty hearing the meeting. The phones and volumes were adjusted and this helped some. Medical Doctor #1 asked why they were meeting. Michele Hitsman informed that Guardian A1 declined the recommendation for starting Klonopin. Guardian A1 informed Medical Doctor #1 that she spoke with the pharmacist, who cautioned against it, as it's typically used on a short-term basis, but it appeared that they wanted to use the medication on a long-term basis. Guardian A1 stated Medical Doctor #1 discusses the opioid crisis; and how no one wants to use them anymore (but it's very common and others use much higher dosages daily). Guardian A1 informed that she would think about it. Guardian A1 informed that she wanted to speak with the doctor about the medication consent forms for Trazodone and Haldol. Guardian A1 asked questions about why Resident A was on the medications, how they were monitoring for interactions with his seizure medication and EMS symptoms. She also informed that there were no labs in over a year. Medical Doctor #1 informed that they could order labs and stated that no EMS symptoms were found. Guardian A1 voiced her concern over the changes that she noticed in Resident A since he's been prescribed and given Haldol and Trazodone. According to Guardian A1, Resident A has a dazed glassy eyed look, he's often off balance, running into things, and has gotten hurt a few times. Guardian A1 also described Resident A as showing body stiffness and that during visits at the facility, Resident A appears to wake up from a nap, seems to struggle to stay awake through the visit, and lays back down once he's back at the facility. According to Guardian A1, Michele Hitsman stated that Resident A did not nap during the day, and lying in bed is just his preferred activity. Guardian A1 requested clarification on Resident A's Trazodone dosage, as there was conflicting information between his MyChart, previous medication list, and the medication list Michele Hitsman recently sent her (Guardian A1). Medical Doctor #1 informed that Resident A's Trazodone has been at 250mg for a while. Michele Hitsman seemed to think it was 150mg as well, as she responded 150(mg) at the same time that Medical Doctor #1 said 250 (mg). Guardian A1 informed them that medication dosage was much higher than she originally thought and voiced concern over sleep guidelines. Medical Doctor #1 stated she's been doing this for 12 years and the only other option is Cognitive Behavior Therapy and Resident A can't do that. Medical Doctor #1 informed the group that the meeting would need to end soon, as she had another meeting at 10:00 a.m. Guardian A1 informed that the pharmacist suggested starting with reducing the Haldol in the daytime and adding a Magnesium supplement first. According to Guardian A1, they both got quiet for a minute and Medical Doctor #1 hesitantly informed that they can if that is what Guardian A1 really wanted. Guardian A1 restated her reasons when she thought they should. Michele Hitsman

commented on how Resident A has more behaviors during the day. Guardian A1 brings it to her attention that during the IPOS meeting, she (Michele Hitsman) said he doesn't get aggressive and he only needed one PRN last year. Michele Hitsman informed Guardian A1 that she just emailed her the records, and Resident A had the PRN medication 6 times last year. Guardian A1 stated Medical Doctor #1 agrees with Guardian A1 to reduce the Haldol during the day from 4mg to 2mg. Michele Hitsman requested that the 2mg that was being taken away be added to nighttime. Medical Doctor #1 says to them that it sounds good, she needed to wrap this up. According to Guardian A1, Medical Doctor #1 asks if she's ok with those changes. Guardian A1 did not immediately respond, so Medical Doctor #1 asks again. Guardian A1 informed that Medical Doctor #1 sounded annoyed. Guardian A1 felt rushed but stated okay. Guardian A1 noted that Medical Doctor #1's tone, throughout the call, sounded defensive. Guardian A1 informed that it was difficult to hear clearly. Guardian A1 was thrown off by inconsistent information. Guardian A1 is looking into other options.

On March 1, 2026, Guardian A1 asked when Resident A's Trazodone increased from 150 mg to 250 mg, and Michele Hitsman replied at his last med review on 10/29(2025). Guardian A1 noted that was conflicting with previous communications. Guardian A1 also requested a sleep log, but Michele Hitsman informed that it had to be ordered, and she (Guardian A1) was not sure who would order it. Guardian A1 also inquired and asked Resident A's previous guardians about it, and they thought it was only increased once from 100 mg to 150 mg.

Guardian A1 contacted Pharmacy #2 and was informed that Resident A started at the pharmacy on April 28, 2025. The pharmacy staff also emailed information regarding Trazodone, which had four dosage increases on the following dates: 8/12/2025 - 50mg, 8/17/2025 - 100mg, 10/2025 - 200mg, and 1/2/2026- 250mg. Guardian A1 informed that she was the assigned guardian before 1/2/2026, and she was not informed nor gave consent to an increase. As a part of this investigation, I reviewed the forwarded email from Pharmacy #2, which documented the dates and information regarding the Trazadone being increased.

On March 26, 2026, I conducted an unannounced on-site investigation and made face to face contact with Aurora Cimmerer, DCW, Sheresse Farr, DCW, and Michelle Hitsman, who has the role of home manager, and Resident A.

They informed me there were four residents admitted into the facility. Resident A was the only resident in the home, as the other residents were at school. I observed him sleeping in his bed upon arrival. Staff informed me that Resident A is a "cat napper" and his room was a comfortable area for him. Staff informed that Resident A probably takes one nap a day. Staff informed me that Resident A did not struggle with stiffness; however, if he sits with both legs crossed, when he attempts to get up, that is when he experiences issues with stiffness. They stated that he was not unsteady on his feet. I inquired if he ran into a wall and Michele Hitsman informed me that he had. Sheresse Farr informed me that when Resident A knows it's time to

eat, he moves really quickly, as he is food aggressive. Staff informed me that when it happened, Guardian A1 was notified. According to staff, Guardian A1 said that Resident A did that at home too. Michele Hitsman agreed to send me a copy of the incident report from the incident which occurred on January 25, 2026.
Michele Hitsman stated that Resident A's father (Relative A1) was the guardian and now his sister, Guardian A1 is the guardian. Michele Hitsman reported to communicate with Guardian A1 as she (Guardian A1) will either email or send text messages. Staff informed me that Guardian A1 questions more things and then she goes to CMH. Alicia Herrington is the assigned case manager from Network 180. I inquired if there was a physician's contact log, documenting the contacts with the doctor and staff informed me it was in the medication system. Michele Hitsman agreed to send me a copy of the list. I inquired about Resident A's Trazodone being increased, and Michele Hitsman stated it increased in either October or November, but she was not exactly sure. She stated it was increased because Resident A was not sleeping at night, he has a seizure disorder, and there was a concern that he wasn't getting adequate sleep. During the day and at night, Resident A would get up and go back to bed multiple times. I inquired about labs being completed, and Michele Hitsman informed me that Resident A had not gotten the labs completed this year as his primary physician does not want the labs drawn until right before the next appointment. Michele Hitsman stated that Guardian A1 is logging into MySparrow, and the information listed there, regarding the psychiatric medications, are not lining up with the other information Guardian A1 has. Michele Hitsman stated that she cannot change the information as documented in MySparrow; however, she stated that she would be willing to ask them if they could adjust the information in the chart this summer. She informed me that Resident A's primary doctor was Primary Doctor #1, and the agency was going through some changes, and Resident A has not been assigned a new provider yet. Michele Hitsman provided me with a printed document (Active Medications for Resident A), and she stated the dates on the document were the most recent prescriptions for Resident A, from his doctor's visit in February of 2026. While I was at the facility, Resident A got up and sat in the living room for a little while, then he went back to his room and was observed snoozing in bed.

I left the facility and headed to my car, but returned, as I had follow-up questions. When I went back to the house, it was noted that Resident A was back on the couch in the living room. He appeared to be in a daze; he looked straight ahead when I spoke to him, not making eye contact. Michele Hitsman informed me that Guardian A1 requested that they track Resident A's data on his sleeping patterns, but she was not able to do that without an order.

As a part of this investigation, I reviewed the *Nextstep Note Printout* and the following information as noted:

The report was authored by Medical Doctor #1. It's a Medication Narrative, dated October 29, 2025. The date of service was also October 29, 2025. The current psychiatric medications were "HALDOL 4 MG BID PLUS 4 MG QD PRN Agitation,

Trazodone 200 HS 50MG HS." It was also noted that Resident A was a 39-year-old male with Autism and an Intellectual Disability. "He again is not sleeping well, parents [Relative A1 & Relative A2] ok with adjusting dose as per staff. He does not seem overmedicated he does have behavioral TX plan. No si/hi/sib not sleeping well." The plan included continuing medications, increasing Trazodone to 250mg hs for sleep, and get PCP – physical and will do labs. The following question was also documented on the form: Was the Individual/Guardian informed of the new medication (s) as well as any adverse medication reactions or other concerns? The documented answer was "Yes."

I reviewed the Active Medications for Resident A and the following, in relevant part, was noted:

Haloperidol Tab 2 Mg Take 1 tablet by mouth every morning **cycle**	Prescribed by Medical Doctor #1	02/20/2026 – No End Date
Haloperidol Tab 2 Mg Take 3 tablets (6 mg) by mouth every evening **cycle**	Prescribed by Medical Doctor #1	02/20/2026 – No End Date
Trazodone Tab 100 mg Take Two and One-Half Tablets (250MG) by mouth once daily (8PM) **CYCLE**	Prescribed by Medical Doctor #1	02/08/2026 – No End Date

On March 26, 2026, during the on-site investigation, I reviewed the medications for Resident A. Specifically, it was noted that the Active Medication information and medications contained within the bubble packs were consistent for the Haloperidol Tab 2 Mg (Take 1 tablet by mouth every morning) Haloperidol Tab 2 Mg (Take 3 tablets (6 mg) by mouth every evening), and Trazodone Tab 100 mg (Take Two and One-Half Tablets (250MG) by mouth once daily (8PM). No medication errors were noted.

I reviewed the *Health Care Appraisal* for Resident A, dated January 27, 2026, and it was noted that Resident A was diagnosed with Autism and a Seizure disorder. He was prescribed a regular diet.

I reviewed the *AFC Licensing Division – Incident /Accident Report*, dated January 25, 2026. Destinee Jimenez, DCW, documented that Resident A "was called for dinner when he was walking into the kitchen he walked into the wall corner hitting his face causing it to break skin and bleed. Staff provided first aid and monitored [Resident A]." Actions taken by staff included contacting on-call medical staff, and she was instructed by the nurse to provide first aid and monitor Resident A. Corrective measures included staff monitoring Resident A for safety.

On April 30, 2026, I spoke with Brook Landis, Program Manager. She informed me that according to their notes, Resident A was prescribed 250 mg (of Trazodone) on August 11, 2025, (take 2 and ½ tablets by mouth at bedtime), and that order was discontinued on April 1, 2026. She also informed me that Resident A is currently prescribed 150 mg of Trazadone (take 1 and ½ tablets by mouth at bedtime), and this started on April 3, 2026. She also agreed to submit a list of the medications discontinued notes, and physician's contact logs. Brook Landis provided me with the correct contact information for Michele Hitsman. She also stated they were having difficulty reaching her (she's removed from the schedule pending the results from a different special investigation). We discussed the documents from October 2025 and November 2025 and the inconsistencies. Brook Landis stated that Michele Hitsman was being "very secretive" and she was not sure why there was inconsistent information. I inquired about the protocol with contacting Medical Doctor #1, and she stated they don't contact her directly, as they reach out to her assistant; however, there was no reason why the assistant's contact information could not be passed along to a guardian. Brook Landis informed me that family members are notified about a week or so in advance about the upcoming meeting. Medical Doctor #1 conducts meetings on Microsoft Teams, and the link can be shared with individuals to attend the meeting. She agreed that it would be difficult to listen to a virtual meeting through staff's phone. Brook Landis stated that she had also been notified that a request had been made to change the psychiatrist for Resident A, and she was in the process of checking into that matter. During the interview, Brook Landis was cooperative and helpful.

As a part of this investigation, I reviewed a screenshot of a text message sent to Michele Hitsman. It was noted on February 18, 2026, Guardian A1 inquired if she would get a link to the meeting and Michele Hitsman replied that she would call Guardian A1 on the phone. Guardian A1 replied "ok thank you."

I reviewed *Medication Narratives* authored by Medical Doctor #1. On January 27, 2026, it was noted that Resident A's current medications were Haldol 4MG BID PLUS 4MG QD PRN Agitation, Trazadone 250 hs, 50MG HS. On February 19, 2026, it was noted that Resident A's current medications were Haldol 4MG BID PLUS 4MG QD PRN Agitation, Trazadone 250 hs, 50MG HS. It was also documented that Resident A was again not sleeping well. Resident A did not appear to be over medicated, and he has a behavioral TX plan. No si/hi/sib. Resident A's sister was not comfortable with Klonopin at that time and would try MG (magnesium).

A review of the medication logs for January, February, and March of 2026, reflected that Resident A was prescribed and given 250 mg of Trazodone (take 2 and ½ tablets by mouth at bedtime). The medication log for April of 2026, documented that Resident A was prescribed 150 mg of Trazadone (take 1 and ½ tablets by mouth at bedtime), and this was administered beginning on April 3, 2026. However, there was no documentation that Resident A had received his Trazodone on April 1st and April 2nd of 2026.

On April 30, 2026, I followed up with Brook Landis who informed me that Michele Hitsman had manually changed the medication log to update and match the new order on April 3, 2026. She stated there is an issue with the system when medications are discontinued. We discussed the medication log, and there was no record that Resident A received the Trazodone. There were no staff initials documented on the medication log. We also discussed the *Medication Narratives* and how it was documented that Resident A was prescribed a total of 300 mg (Trazadone 250 hs, 50MG HS).

APPLICABLE RULE	
R 400.623	**Applicant, licensee and administrator qualifications; licensee, administrator and staff requirements; parole or probation or convicted of felony.**
	(6) A licensee, administrator, and staff shall cooperate with a resident, resident's family as appropriate, designated representative of a resident, and the responsible agency.
ANALYSIS:	Based upon my investigation, which consisted of an on-site investigation, observations, interviews with the guardian, facility staff, and review of pertinent information, it's concluded that inconsistent information was provided and facility staff did not fully cooperate with Guardian A1.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	Based upon my investigation, which consisted of an on-site investigation, observations, interviews with the guardian, facility staff, and review of pertinent information, it's concluded that while it is unclear why there was conflicting information between the *Nextstep Note Printout*, dated October 29, 2025, and the *Release of Responsibility for Medications*, documenting Resident A's medications, dated November 27, 2025, based on review of the *Active Medications* for Resident A and the medications observed in the facility (on March 26, 2026), there is not a preponderance of the evidence, at this time, to confirm that facility staff were not administering the medications as prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(b) Complete an individual medication log that contains all of the following:** **(i) Medication name.** **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) Initials of the individual who administered the medication at the time given.** **(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.**
ANALYSIS:	Based upon my investigation, which consisted of an on-site investigation, interviews with the guardian, facility staff, and review of pertinent information, it's concluded that there is a preponderance of the evidence to support the allegations, as there were no staff initials documented on the medication log for Resident A having received his Trazodone on April 1st and April 2nd of 2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.

4/30/26

_____

Mahtina Rubritius Date
Licensing Consultant

Approved By:

05/01/2026

_____

Dawn N. Timm Date
Area Manager