



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 16, 2026

Michele Stankiewicz
Forever Young Living LLC
32968 Lyndon
Livonia, MI 48154

RE: License #: AS820390561
Investigation #: 2026A0993003
Forever Young Living LLC.

Dear Ms. Stankiewicz:

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 (313) 456-0380.

Sincerely,

A handwritten signature in cursive script that reads "DaShawnda Lindsey". The signature is written in black ink and is positioned above the printed name and address.

DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820390561
Investigation #:	2026A0993003
Complaint Receipt Date:	03/09/2026
Investigation Initiation Date:	03/10/2026
Report Due Date:	05/08/2026
Licensee Name:	Forever Young Living LLC
Licensee Address:	32968 Lyndon Livonia, MI 48154
Licensee Telephone #:	Unknown
Administrator:	Michele Stankiewicz
Licensee Designee:	Michele Stankiewicz
Name of Facility:	Forever Young Living LLC.
Facility Address:	37011 Bennett Livonia, MI 48152
Facility Telephone #:	(734) 673-7945
Original Issuance Date:	10/08/2018
License Status:	REGULAR
Effective Date:	04/08/2025
Expiration Date:	04/07/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility was dirty.	No
Licensee designee Michele Stankiewicz refused to administer Resident A's medications as prescribed. She also instructed staff to not administer Resident A's medications to her.	Yes
Resident A was dirty.	No
Licensee designee Michele Stankiewicz refused to allow Beacon Hospice to enter the facility to care for Resident A.	No
Licensee designee Michele Stankiewicz refused a hospital bed for Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/09/2026	Special Investigation Intake 2026A0993003
03/10/2026	Contact - Telephone call made Telephone call made to Resident A's daughter. Left a message.
03/10/2026	Contact - Document Sent Sent an email to Resident A's daughter
03/10/2026	Special Investigation Initiated - Telephone Telephone call received from Resident A's daughter
03/11/2026	Inspection Completed On-site Conducted an unannounced onsite investigation
03/11/2026	APS Referral Forwarded allegations to adult protective care (APS)
03/11/2026	Contact - Face to Face Observed Resident A in current residence
03/12/2026	Contact - Telephone call made Telephone call made to licensee designee Michele Stankiewicz

03/12/2026	Contact - Telephone call made Telephone call made to Beacon Hospice nurse Desiree Reitmeyer. Left a message.
03/12/2026	Contact - Telephone call made Telephone call made to home manager Christian McQuirter
03/12/2026	Contact - Telephone call made Telephone call made to Beacon Hospice nurse Jenna Conklin
03/12/2026	Contact - Telephone call made Telephone call made to staff Chrishana Jordan. Left a message.
03/12/2026	Contact - Telephone call made Telephone call made to Beacon Hospice nurse Desiree Reitmeyer
03/12/2026	Contact - Telephone call made Telephone call made to Beacon Hospice nurse Courtney Alhoms. Left a message.
03/12/2026	Contact - Telephone call made Telephone call made to Beacon Hospice administrator Jennifer Augustine. Left a message.
03/12/2026	Contact - Telephone call received Telephone call from APS specialist Regina Harris
03/13/2026	Contact - Telephone call made Telephone call made to staff Chrishana Jordan. Left a message.
03/13/2026	Contact - Telephone call made Telephone call made to Beacon Hospice administrator Jennifer Augustine
03/13/2026	Contact - Telephone call made Telephone call made to Beacon Hospice nurse Courtney Alhoms. Left a message.
03/17/2026	Contact - Telephone call made Telephone call made to staff Chrishana Jordan. Left a message.
03/17/2026	Contact - Telephone call made Telephone call to Beacon Hospice administrator Jennifer Augustine to request documentation

03/17/2026	Contact - Telephone call made Telephone call made to Beacon Hospice nurse Courtney Alhoms
03/17/2026	Contact - Document Received Received text message from Beacon Hospice nurse Courtney Alhoms
03/17/2026	Contact - Telephone call made Telephone call made to licensee designee Michele Stankiewicz
03/17/2026	Contact - Document Received Received medication of staff medication administration training
03/23/2026	Contact - Telephone call made Telephone call made to staff Chrishana Jordan. Left a message.
03/23/2026	Contact - Telephone call made Telephone call made to Beacon Hospice administrator Jennifer Augustine. Left a message.
03/25/2026	Contact - Telephone call made Telephone call made to staff Chrishana Jordan. Left a message.
03/25/2026	Contact - Telephone call made Telephone call made to Beacon Hospice administrator Jennifer Augustine. Left a message.
03/30/2026	Contact - Document Received Received documentation from Beacon Hospice
03/30/2026	Contact - Telephone call made Telephone call made to Resident A's daughter
03/30/2026	Contact - Telephone call made Telephone call made to Beacon Hospice North Detroit to request documentation
04/01/2026	Contact - Document Received Received documentation from Beacon Hospice
04/07/2026	Contact - Document Sent Emailed status update to complainant
04/09/2026	Contact - Telephone call made Telephone call made to staff Chrishana Jordan. Left a message.
04/09/2026	Contact - Telephone call made

	Telephone call made to licensee designee Michele Stankiewicz
04/09/2026	Contact - Telephone call made Telephone call made to staff Anjeleise McKinley
04/14/2026	Contact - Telephone call made Telephone call made to Beacon Hospice nurse Desiree Reitmeyer
04/15/2026	Exit Conference Held with licensee designee Michele Stankiewicz

ALLEGATION:

The facility was dirty.

INVESTIGATION:

On 03/10/2026, I received the allegations from Licensing and Regulatory Affairs (LARA) Bureau of Community Health Systems (BCHS) Online Complaints.

On 03/10/2026, I conducted a telephone interview with Resident A's daughter. Resident A's daughter confirmed Resident A used to live in the facility. When she visited Resident A at the facility, she observed that the facility was dirty. Resident A's daughter did not provide any other details on the appearance of the facility.

On 03/11/2026, I conducted an unannounced onsite investigation. I interviewed staff Kaylea Drake. Ms. Drake denied that facility was dirty. She stated staff regularly clean the facility. Ms. Drake also showed me a logbook where staff documented the appearance of the facility. I observed several entries on different days documenting that the facility was cleaned.

During the unannounced onsite investigation, I looked in different rooms, including the residents' bedrooms, kitchen, living room, and bathroom. The facility was clean and did not have an odor. I did not observe any concerns with the appearance of the facility.

On 03/11/2026, I forwarded the allegations to Adult Protective Services (APS).

On 03/12/2026, I conducted a telephone interview with licensee designee Michele Stankiewicz. Ms. Stankiewicz denied that the facility was dirty. She stated staff regularly clean the facility.

On 03/12/2026, I conducted a telephone interview with home manager Christian McQuirter. Ms. McQuirter denied that the facility was dirty. She stated staff regularly clean the facility.

On 03/12/2026, I conducted a telephone interview with Beacon Hospice nurse Jenna Conklin. Ms. Conklin stated the facility was not “cluttery dirty,” but there was a smell in the facility. Per Ms. Conklin, the facility smelled like urine and feces.

On 03/12/2026, I conducted a telephone interview with Beacon Hospice nurse Desiree Reitmeyer. Ms. Reitmeyer denied the facility was dirty.

On 03/12/2026, I conducted a telephone interview with APS specialist Regina Harris. She stated her investigation is pending. At this point in the investigation, she did not see any concerns about the facility.

On 03/13/2026, I conducted a telephone interview with Beacon Hospice administrator Jennifer Augustine. Ms. Augustine stated the facility was dirty. She did not provide any other details on appearance of the facility.

On 03/17/2026, I conducted a telephone interview with Beacon Hospice nurse Courtney Alhomsy. Ms. Alhomsy denied the facility was dirty.

On 04/09/2026, I conducted a telephone interview with staff Anjeleise McKinley. Ms. McKinley denied the facility was dirty. She stated staff clean the facility regularly.

On 04/09/2026 as well as on five other days prior to this date, I attempted interview staff Chrishana Jordan with no success. Ms. Jordan did not return any of my phone calls.

APPLICABLE RULE	
R 400.647	Safety and maintenance of premises.
	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.
ANALYSIS:	Ms. Stankiewicz as well as Ms. Drake, Ms. McQuirter and Ms. McKinley denied the facility was dirty. They stated staff regularly clean the facility. Ms. Reitmeyer and Ms. Alhomsy also denied the facility was dirty. During an unannounced onsite investigation on 03/11/2026, I looked in different rooms, including the residents’ bedrooms, kitchen, living room, and bathroom. The facility was clean and did not have an odor. I did not observe any concerns with the appearance of the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATIONS

Licensee designee Michele Stankiewicz refused to administer Resident A's medications as prescribed. She also instructed staff to not administer Resident A's medications to her.

INVESTIGATION:

On 03/10/2026, I conducted a telephone interview with Resident A's daughter. Resident A's daughter stated Beacon Hospice prescribed pain medications to Resident A to address pain, but staff did not administer the medications as prescribed. While visiting Resident A at the facility one day (date not recalled), Resident A's daughter stated she heard Resident A screaming. Licensee designee Michele Stankiewicz told staff to give Resident A pain medication. Resident A's daughter asked Ms. Stankiewicz what medications Resident A was taking. Ms. Stankiewicz informed her she was taking 1000mg Tylenol and a pain pill as needed. Resident A's daughter could not recall how often Resident A was administered the Tylenol. She also did not recall the name of the pain pill. About 15-20 minutes later, Resident A was no longer screaming and talking normally. Resident A's daughter stated she contacted Beacon Hospice and told them Resident A needed her pain medications adjusted. Per Resident A's daughter, initially, Beacon Hospice prescribed pain medication every six hours, but no difference was observed in Resident A's pain level. Resident A's daughter did not recall the name of the pain medication. Beacon Hospice changed it and prescribed pain medication every four hours. Still, no difference was observed in Resident A's pain level. Beacon Hospice prescribed Norco and Morphine every six hours, where staff were instructed to alternate each medication every three hours (e.g. Norco administered, then Morphine administered three hours later, then Norco administered three hours later, and so on). Per Resident A's daughter, staff stated they were not administering the medications as prescribed. Staff only administered Norco every six hours. Resident A's daughter stated Ms. Stankiewicz refused to administer the medications as prescribed as she felt it was too much medication being administered to Resident A. Resident A's daughter stated Beacon Hospice later realized staff were not administering the medications to Resident A as prescribed.

On 03/11/2026, I conducted an unannounced onsite investigation. I interviewed staff Kaylea Drake. Ms. Drake stated staff administered all Resident A's medications as prescribed. Per Ms. Drake, Ms. Stankiewicz stated the number of medications prescribed to Resident A was an "overkill." However, she denied that Ms. Stankiewicz instructed staff not to administer Resident A's medications as prescribed. Ms. Drake confirmed she completed medication administration training. She also confirmed that all staff who administered medications completed medication administration training.

On 03/12/2026, I conducted a telephone interview with licensee designee Michele Stankiewicz. Ms. Stankiewicz denied instructing staff not to administer Resident A's medications to her as prescribed. She stated she only said it was an "overkill." Ms. Stankiewicz stated all staff who administered medications have completed medication

administration training. I asked Ms. Stankiewicz to forward me Resident A's medication administration records (MAR). She stated she may have shredded Resident A's MARs. If she did not shred them, she agreed to forward them to me.

On 03/12/2026, I conducted a telephone interview with home manager Christian McQuirter. Ms. McQuirter stated staff administered all Resident A's medications as prescribed. Per Ms. McQuirter, Ms. Stankiewicz stated the number of medications prescribed to Resident A was an "overkill." However, she denied that Ms. Stankiewicz instructed staff not to administer Resident A's medications as prescribed. Ms. McQuirter confirmed she completed medication administration training. She also confirmed that all staff who administered medications completed medication administration training.

On 03/12/2026, I conducted a telephone interview with Beacon Hospice nurse Jenna Conklin. Ms. Conklin stated staff were not administering medications to Resident A as prescribed. Per Ms. Conklin, staff were not medicating Resident A appropriately, and there were times when Resident A did not receive her pain medications at all. Ms. Conklin did not provide specific dates or times when staff did not administer Resident A's medications to her as prescribed. Ms. Conklin stated one day Beacon Hospice held an interdisciplinary team (IDT) meeting to discuss how to manage a resident when the provider is not cooperating. After the IDT meeting, Ms. Conklin went to the facility with Beacon Hospice nurse Courtney Alhomsy to review Resident A's medications and MARs. Resident A's medications and MARs were unorganized. In addition, Ms. Stankiewicz did not know where some of Resident A's medications were at.

On 03/12/2026, I conducted a telephone interview with Beacon Hospice nurse Desiree Reitmeyer. Ms. Reitmeyer stated staff were not administering Resident A's medications as prescribed. Staff were instructed to administer Norco and Morphine every six hours; however, they were instructed to alternate those medications every three hours to allow medication to always be in Resident A's system. Staff did not administer the medications to her that way. Staff stated Resident A was not in pain, so they did not always administer the medications to Resident A.

On 03/13/2026, I conducted a telephone interview with Beacon Hospice administrator Jennifer Augustine. Ms. Augustine stated staff did not administer Resident A's medications to her as prescribed. Resident A was in so much pain. Beacon Hospice changed her pain medications. Per Ms. Augustine, Ms. Drake argued with her about the change. Initially, Ms. Drake informed Ms. Augustine that they were not going to start the new pain management regiment until the following month. Ms. Drake contacted Ms. Stankiewicz and later brought out the medication to administer it to Resident A. Ms. Augustine did not provide the date of this incident.

On 03/17/2026, I conducted a telephone interview with Beacon Hospice nurse Courtney Alhomsy. Ms. Alhomsy stated staff were not administering medications to Resident A as prescribed. One day while at the facility, she asked to review Resident A's MARs. She noticed it had almost been four days, and Resident A had not been administered her pain medications. Ms. Alhomsy could not recall the date of this visit.

On 03/17/2026, I received a text message from Ms. Alhoms. The text message consisted of two pictures of Resident A's medication log. In the first picture, I observed a record showing that Resident A was prescribed Hydrocodone-Acetaminophen 5-3.25Mg every 4 hours for moderate pain. The record started on 02/12/2026 at 3pm, and the last entry was on 02/23/2026 at 2pm. I observed the following:

- On 02/12/2026, Resident A received medication at 3:00 p.m. and 8:00 p.m.
- On 02/13/2026, Resident A received medication every 4 hours starting at midnight.
- On 02/14/2026, Resident A received medication every 4 hours starting at midnight until 8:00 p.m. Resident A did not receive medication after 8:00 p.m. that day.
- On 02/15/2026, Resident A received medication at 8:00 a.m., 1:00 p.m., 5:45 (unsure if it was "am" or "pm" as it was not listed) and 9:45 p.m.
- On 02/16/2026, Resident A received medication at 1:45 a.m., 4:45 a.m., 8:45 a.m. and 12:45 p.m.
- On 02/17/2026, Resident A received medication at 12:45 (unsure if it was "am" or "pm" as it was not listed).
- On 02/18/2026, Resident A received medication at 9:30 (unsure if it was "am" or pm as it was not listed).
- On 02/19/2026, Resident A did not receive medication.
- On 02/20/2026, Resident A received medication at 11:30 (unsure if it was "am" or "pm" as it was not listed), 5:00 p.m., and 11:00 p.m.
- On 02/21/2026, Resident A received medication at 4:00 a.m., 9:00 a.m. and 7:00 p.m.
- On 02/22/2026, Resident A received medication at 7:00 a.m., 12:00 p.m. and 7:00 p.m.
- On 02/23/2026, Resident A received medication at 4:00 a.m., 10:00 a.m. and 2:00 p.m.

In the second picture, I observed a record showing Resident A was prescribed Morphine Sulf 100MG/5MI Conc. 0.25ML every 6 hours (3:00 a.m., 9:00 a.m., 3:00 p.m., 9:00 p.m.) for pain. The record started on 02/20/2026 at 11:00 a.m., and the last entry was on 02/20/2026 at 8:00 p.m. Those were the only entries documented on the record.

On 03/17/2026, I followed up Ms. Stankiewicz to request Resident A's MARs. Ms. Stankiewicz stated she did not have Resident A's MARs. She stated she tossed Resident A's records as she did not realize she had to keep them for two years.

On 03/17/2026, I received verification Ms. Stankiewicz, Ms. Drake, Ms. McQuirter, and Ms. McKinley completed medication administration training.

On 03/30/2026, I received notes from Beacon Hospice. The notes included the following:

- Per a note published on 03/30/2026 by Ms. Conklin, Ms. Conklin and Ms. Alhoms. Alhoms visited the facility on 02/24/2026 "to address ongoing concerns

regarding patient care, medication administration, and adequacy of symptom/pain management.” Concerns about the medication schedule was not being followed as ordered were discussed. “Discrepancies included medications not being administered on certain days and incorrect times of doses.”

- Per a note published on 03/30/2026 by Ms. Augustine, Ms. Augustine visited the facility on 02/25/2026 due to Resident A’s daughter stating Resident A appeared to be in pain. Ms. Augustine documented Resident A’s body “was tense, her mouth was clenched, and she appeared to be in excruciating pain.” Ms. Augustine questioned staff about Resident A’s medications, and staff stated Resident A did not require any that day. Ms. Augustine inquired about Resident A’s fentanyl patch, and staff stated it was not necessary to start it until 03/01/2026. Ms. Augustine spoke with Ms. Stankiewicz via telephone to inquire about Resident A’s medications. Ms. Stankiewicz yelled Resident A was not in pain, and Beacon Hospice had just come to murder her. Ms. Augustine told Ms. Stankiewicz that Resident A’s daughter approved all prescribed medications. Ms. Augustine asked staff for the medications. Staff obtained the medications, slammed them on the table, and walked away. Ms. Augustine attempted to discuss Resident A’s medications with staff. Staff told Ms. Augustine that “they would do what they wanted to do.”

On 04/01/2026, I received notes from Beacon Hospice. The notes included the following:

- Per a note published on 02/23/2023 by Ms. Conklin, Ms. Conklin visited the facility on 02/20/2026 and learned staff had been administering Norco to Resident A once at lunch time and once prior to bed. Staff administered Morphine prior to wound care only. Both medications were prescribed every six hours, with alternating times so that Resident A received pain relief every three hours.
- Per a note published on 03/31/2026 by Beacon Hospice nurse Courtney Olson (referred to as Courtney Alhomsy throughout this report), Ms. Alhomsy visited the facility on 02/24/2026 and reviewed Resident A’s medications. She observed that the “prescribed morphine had not been administered as ordered” and the “prescribed Norco was also not being administered according to prescribed time/schedule.”

On 04/09/2026, I conducted a telephone interview with staff Anjeleise McKinley. Ms. McKinley stated staff administered all Resident A’s medications as prescribed. She denied that Ms. Stankiewicz instructed staff not to administer Resident A’s medications as prescribed. Ms. Kinley confirmed she completed medication administration training. She also confirmed that all staff who administer medication completed medication administration training.

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:	Resident A's daughter, Ms. Conklin, Reitmeyer, Ms. Augustine, and Ms. Alhomsy stated staff did not administer Resident A's medications to her as prescribed. Resident A's MARs were not available for review. However, I reviewed two records for Hydrocodone-Acetaminophen 5-3.25Mg and Morphine Sulf 100MG/5MI Conc. 0.25ML. I also reviewed notes written by Ms. Conklin, Ms. Augustine, and Ms. Alhomsy. Based on the records and notes, staff did not administer at least some of Resident A's medications to her as prescribed.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATIONS:

Resident A was dirty.

INVESTIGATION:

On 03/10/2026, I conducted a telephone interview with Resident A's daughter. Resident A's daughter stated Resident A was dirty when she lived at the facility. Resident A's daughter did not provide any other details on Resident A's hygiene while living in the facility.

On 03/11/2026, I conducted an unannounced onsite investigation. I interviewed staff Kaylea Drake. Ms. Drake denied Resident A was dirty when she was at the facility. Per Ms. Drake, staff checked and/or changed Resident A every 2 hours. Beacon Hospice staff bathed Resident A twice per week. Resident A's clothes were changed every other day, or more if needed.

On 03/11/2026, I visited Resident A at her residence. I was unable to interview Resident A due to her limited cognitive abilities. I did not observe any abuse or neglect concerns.

On 03/12/2026, I conducted a telephone interview with licensee designee Michele Stankiewicz. Ms. Stankiewicz denied Resident A was dirty when she was at the facility. Resident A received a bath from Beacon Hospice twice per week. In addition, staff wiped her down and changed her clothes.

On 03/12/2026, I conducted a telephone interview with home manager Christian McQuirter. Ms. McQuirter denied Resident A was dirty. She stated that Beacon Hospice bathed Resident A twice per week.

On 03/12/2026, I conducted a telephone interview with Beacon Hospice nurse Jenna Conklin. Ms. Conklin stated Resident A was not changed regularly. There was a hospice aid that visited the facility to bathe Resident A. Resident A had dry stool on her. Her clothes were dirty. Her hair was greasy. Overall, she looked disheveled.

On 03/12/2026, I conducted a telephone interview with Beacon Hospice nurse Desiree Reitmeyer. Ms. Reitmeyer stated that Resident A was dirty when she was in the facility. Resident A had dried poop on her as well as her catheter. Her brief was also saturated. Per Ms. Reitmeyer, it did not seem like the residents were properly cared for at the facility.

On 03/13/2026, I conducted a telephone interview with Beacon Hospice administrator Jennifer Augustine. Ms. Augustine stated Resident A was dirty when she lived in the facility. She did not provide any other details on Resident A's hygiene while living in the facility.

On 03/17/2026, I conducted a telephone interview with Beacon Hospice nurse Courtney Alhomsy. Ms. Alhomsy stated Resident A was dirty when she lived in the facility. Her clothes were dirty. Her nails were caked with stools.

On 04/01/2026, I received notes from Beacon Hospice. The notes included the following:

- Per a note published on 01/29/2026 by Ms. Conklin, Ms. Conklin visited the facility on 01/28/2026. Ms. Conklin documented Resident A's appearance as "well groomed, laying bed resting watching television." Ms. Conklin reminded staff of the "importance of keeping patient clean and dry as well to reduce moisture and bacteria in open wound on coccyx."
- Per a note published on 01/30/2026 by Ms. Reitmeyer, Ms. Reitmeyer documented Resident A's appearance as "well groomed, laying bed resting watching television." Ms. Reitmeyer reminded staff of the "importance of keeping patient clean and dry as well to reduce moisture and bacteria in open wound on coccyx."
- Per a note published on 02/02/2026 by Ms. Reitmeyer, Ms. Reitmeyer documented Resident A's appearance as "disheveled laying bed resting watching television."
- Per a note published on 02/23/2026 by Ms. Conklin, Ms. Conklin visited the facility on 02/20/2026. Ms. Conklin documented Resident A's appearance as "disheveled- ill-fitting clothes observed."

On 04/09/2026, I followed up with Ms. Stankiewicz to request a copy of Resident A's assessment plan. Ms. Stankiewicz stated she no longer had any of Resident A's records. She provided everything to hospice.

On 04/09/2026, I conducted a telephone interview with staff Anjeleise McKinley. Ms. McKinley denied that Resident A was dirty when she lived in the facility.

APPLICABLE RULE	
R 400.677	Resident hygiene, clothing.
	(2) A licensee shall ensure the resident receives or has access to all of the following: (a) Bathing at least weekly.
ANALYSIS:	<p>Ms. Stankiewicz as well as Ms. Drake, Ms. McQuirter and Ms. McKinley denied Resident A was dirty when she was at the facility. They stated that Beacon Hospice came out twice weekly to bathe Resident A. Ms. Drake stated Resident A was checked and changed every two hours.</p> <p>I conducted an unannounced onsite investigation on 03/11/2026; however, Resident A was no longer living in the facility. I visited Resident A at her residence. I was unable to interview Resident A's due to her limited cognitive abilities. I did not observe any abuse or neglect concerns.</p> <p>There is insufficient evidence to support that Resident A was not bathed at least weekly.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATIONS:

Licensee designee Michele Stankiewicz refused to allow Beacon Hospice to enter the facility to care for Resident A.

INVESTIGATION:

On 03/10/2026, I conducted a telephone interview with Resident A's daughter. Resident A's daughter stated licensee designee Michele Stankiewicz refused to allow Beacon Hospice nurse Desiree Reitmeyer to enter the facility to care for Resident A.

On 03/11/2026, I conducted an unannounced onsite investigation. I interviewed staff Kaylea Drake. Ms. Drake denied that Ms. Stankiewicz refused to allow Beacon Hospice to enter the facility to care for Resident A.

On 03/12/2026, I conducted a telephone interview with licensee designee Michele Stankiewicz. Ms. Stankiewicz denied she did not allow Beacon Hospice to enter the facility to care for Resident A.

On 03/12/2026, I conducted a telephone interview with home manager Christian McQuirter. Ms. McQuirter denied that Ms. Stankiewicz refused to allow Beacon Hospice to enter the facility to care for Resident A.

On 03/12/2026, I conducted a telephone interview with Beacon Hospice nurse Jenna Conklin. Ms. Conklin stated Ms. Stankiewicz refused to allow Beacon Hospice to enter the facility to care for Resident A. Specifically, she refused to allow Beacon Hospice nurse Desiree Reitmeyer to enter the facility.

On 03/13/2026, I conducted a telephone interview with Beacon Hospice administrator Jennifer Augustine. Ms. Augustine stated Ms. Stankiewicz refused to allow Beacon Hospice to enter the facility to care for Resident A.

On 03/17/2026, I conducted a telephone interview with Beacon Hospice nurse Courtney Alhoms. Ms. Alhoms denied knowledge of Ms. Stankiewicz refusing to allow Beacon Hospice to enter the facility to care for Resident A. She stated Ms. Stankiewicz was hostile towards her, but she was allowed to enter the facility to care for Resident A.

On 04/09/2026, I conducted a telephone interview with staff Anjeleise McKinley. Ms. McKinley denied that Ms. Stankiewicz refused to allow Beacon Hospice to enter the facility to care for Resident A.

On 04/14/2026, I conducted a telephone interview with Beacon Hospice nurse Desiree Reitmeyer. Ms. Reitmeyer stated Ms. Stankiewicz did not tell her personally that she could not come into the facility to care for Resident A, but she informed Ms. Conklin that she did not want her (Ms. Reitmeyer) in the facility to care for Resident A.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: (m) Employ the services of a health care professional of choice for obtaining medical, psychiatric, or dental services.
ANALYSIS:	Ms. Stankiewicz denied refusing to allow Beacon Hospice to enter the facility to care for Resident A. Ms. Drake, Ms. McQuirter and Ms. McKinley also denied Ms. Stankiewicz refused to allow Beacon Hospice to enter the facility to care for Resident A. Ms. Alhoms stated Ms. Stankiewicz was hostile

	<p>towards her, but she was allowed to enter the facility to care for Resident A.</p> <p>There is not a preponderance of evidence to support that Ms. Stankiewicz refused to allow Beacon Hospice to enter the facility to care for Resident A. Therefore, evidence does not support that Ms. Stankiewicz violated Resident A's right to employ the services of a health care professional of choice for obtaining medical, psychiatric, or dental services.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATIONS:

Licensee designee Michele Stankiewicz refused a hospital bed for Resident A.

INVESTIGATION:

On 03/10/2026, I conducted a telephone interview with Resident A's daughter. Resident A's daughter stated Beacon Hospice wanted to order a hospital bed for Resident A. Resident A's bed was broken, and Resident A's feet were dangling. Licensee designee Michele Stankiewicz agreed to fix Resident A's bed. After two weeks, the bed was still broken. Beacon Hospice nurse Desiree Reitmeyer informed Ms. Stankiewicz that she planned to order a hospital bed for Resident A. Ms. Stankiewicz told Ms. Reitmeyer if she ordered it, she would not accept it in the facility.

On 03/11/2026, I conducted an unannounced onsite investigation. I interviewed staff Kaylea Drake. Ms. Drake denied that Ms. Stankiewicz refused a hospital bed for Resident A. Ms. Drake stated Resident A already had a hospital bed. Ms. Stankiewicz informed Beacon Hospice that she had ordered a motor for Resident A's bed and was waiting for it to arrive. In addition, Ms. Stankiewicz stated she had hospital beds in the basement. There was no need to bring another one into the facility. Per Ms. Drake, Beacon Hospice wanted to order a hospital bed to allow Resident A to prop her feet up. Resident A was able to prop her feet up with her feet, despite it needing a motor.

On 03/12/2026, I conducted a telephone interview with licensee designee Michele Stankiewicz. Ms. Stankiewicz confirmed Beacon Hospice wanted to order a hospital bed for Resident A, but she told them not to order the bed. Ms. Stankiewicz stated Resident A already had a hospital bed. She confirmed Resident A's bed needed a motor to adjust it. She ordered the motor and was waiting for it to be delivered. Ms. Stankiewicz stated she had a ton of hospital beds in the basement. There was no need for another one to be delivered to the facility. Ms. Stankiewicz stated Beacon Hospice began discussing ordering the hospital bed one week prior to Resident A moving out of the facility. She ordered the part about two weeks prior to the discussion of ordering the hospital bed. Ms. Stankiewicz that the part needed for the bed had not been delivered prior to

Resident A moving out of the facility. Beacon Hospice also never ordered the hospital bed.

On 03/12/2026, I conducted a telephone interview with home manager Christian McQuirter. Ms. McQuirter stated Resident A had her own hospital bed. Resident A's bed needed a part to adjust it. Ms. Stankiewicz ordered the piece and was waiting for it to arrive. Ms. McQuirter stated the part needed for the bed had not been delivered prior to Resident A moving out of the facility. Beacon Hospice also never ordered the hospital bed.

On 03/12/2026, I conducted a telephone interview with Beacon Hospice nurse Jenna Conklin. Ms. Conklin stated Ms. Stankiewicz refused a hospital bed for Resident A. Ms. Stankiewicz stated she had hospital beds in the facility already and did not need another one. Per Ms. Conklin, Resident A's bed was not functioning properly for months. Ms. Conklin stated Ms. Stankiewicz was informed if it was not fixed, Beacon Hospice would have no choice but to bring in one of their beds for Resident A. Ms. Stankiewicz stated if Beacon Hospice tried to bring another bed to the facility, she would refuse it.

On 03/12/2026, I conducted a telephone interview with Beacon Hospice nurse Desiree Reitmeyer. Ms. Reitmeyer stated she discussed ordering a hospital bed for Resident A due to her bed not being able to be adjusted. Ms. Stankiewicz informed her that she would turn it away if she ordered it.

On 03/13/2026, I conducted a telephone interview with Beacon Hospice administrator Jennifer Augustine. Ms. Augustine confirmed that Ms. Stankiewicz refused to allow Beacon Hospice to order a hospital bed for Resident A.

On 03/17/2026, I conducted a telephone interview with Beacon Hospice nurse Courtney Alhomsy. Ms. Alhomsy confirmed that Ms. Stankiewicz refused to allow Beacon Hospice to order a hospital bed for Resident A.

On 04/01/2026, I received notes from Beacon Hospice. The notes included the following:

- Per a note published on 02/16/2026 by Ms. Reitmeyer, Ms. Reitmeyer contacted Ms. Stankiewicz regarding Resident A's hospital bed. The foot of the bed remained elevated and had been broken for weeks. Hospice staff brought up the concern on multiple occasions and were informed by staff that it would be fixed. Ms. Stankiewicz stated she would have her husband look at it that night and fix it. Ms. Reitmeyer informed Ms. Stankiewicz that if the bed was not fixed upon arrival for care in the morning, Beacon Hospice will order another bed for Resident A. Per Ms. Reitmeyer, Resident A's bed was not appropriate for care and caused more discomfort for Resident A.
- Per a note published on 02/23/2026 by Ms. Conklin, Ms. Conklin visited the facility on 02/20/2026. She documented that Ms. Stankiewicz stated the motor for Resident A's hospital bed had been ordered.

On 04/09/2026, I conducted a telephone interview with staff Anjeleise McKinley. Ms. McKinley denied Ms. Stankiewicz refused to allow Beacon Hospice to order a hospital bed for Resident A.

APPLICABLE RULE	
R 400.661	Bedroom furnishings.
	(1) Bedroom furnishings must include all of the following: (a) A bed that is not less than 36 inches wide and not less than 72 inches long with a foundation that is clean, in good condition, and provides adequate support.
ANALYSIS:	Resident A brought her own hospital bed into the facility. The bed needed a motor to adjust it. Ms. Stankiewicz ordered the part needed for the bed. When Resident A was discharged from the facility, the part had not arrived. Ms. Stankiewicz refused to allow Beacon Hospice to order a hospital bed for Resident A. Resident A's bed did not adjust appropriately and did not provide adequate support for Resident A.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 03/10/2026, I conducted a telephone interview with Resident A's daughter. She confirmed Resident A moved out of the facility on or around 02/26/2026.

On 03/12/2026, I conducted a telephone interview with licensee designee Michele Stankiewicz. I asked Ms. Stankiewicz to forward me Resident A's medication administration records (MAR). She stated she may have shredded Resident A's MARs. If she did not shred them, she agreed to forward them to me.

On 03/17/2026, I followed up with Ms. Stankiewicz to request Resident A's MARs. Ms. Stankiewicz stated she did not have Resident A's MARs. She stated she tossed Resident A's records as she did not realize she had to keep them for two years.

On 04/09/2026, I followed up with Ms. Stankiewicz to request a copy of Resident A's assessment plan. Ms. Stankiewicz stated she no longer had any of Resident A's records. She gave everything to hospice.

On 04/15/2026, I contacted licensee designee Michele Stankiewicz and conducted an exit conference. I discussed the findings as well as the department's recommendation.

Ms. Stankiewicz stated Resident A did not receive some of her medications due to being asleep during administration times. In addition, Resident A's daughter was concerned about the medications affecting Resident A's liver. Ms. Stankiewicz acknowledged the importance of administering medications as prescribed. Ms. Stankiewicz also confirmed that she is now aware that she must keep residents' records in the facility for two years after the discharge date. Ms. Stankiewicz agreed to review the report and submit a corrective action plan.

APPLICABLE RULE	
R 400.691	Resident records.
	(3) Resident records must be kept on file in the facility for 2 years after the date of resident discharge unless a shorter retention is specified elsewhere in these rules.
ANALYSIS:	<p>I asked for a copy of Resident A's MARs. On 03/12/2026, Ms. Stankiewicz stated she may have shredded Resident A's MARs. If she did not shred them, she agreed to forward them to me. On 03/17/2026, Ms. Stankiewicz stated she did not have Resident A's MARs. She stated she tossed Resident A's records as she did not realize she had to keep them for two years. On 04/09/2026, I asked for a copy of Resident A's assessment plan. Ms. Stankiewicz stated she no longer had any of Resident A's records. She gave everything to hospice.</p> <p>Resident A moved out of the facility on or around 02/26/2026. Ms. Stankiewicz did not keep Resident A's records on file in the facility for two years after she was discharged from the facility.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



04/15/2026

DaShawnda Lindsey
Licensing Consultant

Date

Approved By:



04/16/2026

Ardra Hunter
Area Manager

Date