



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 11, 2026

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

RE: License #: AL630365576
Investigation #: 2026A0605016
Addington Place of Clarkston 2

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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
3044 W. Grand Blvd.
2nd Floor Annex, Ste 2-730
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

License #:	AL630365576
Investigation #:	2026A0605016
Complaint Receipt Date:	03/23/2026
Investigation Initiation Date:	03/23/2026
Report Due Date:	05/22/2026
Licensee Name:	ARHC ARCLRMI01 TRS, LLC
Licensee Address:	27th Floor 540 Madison Ave New York, NY 10022
Licensee Telephone #:	(248) 625-0500
Administrator:	Margaret Canny
Licensee Designee:	Stephen Levy
Name of Facility:	Addington Place of Clarkston 2
Facility Address:	5800 Water Tower Pl Clarkston, MI 48346
Facility Telephone #:	(248) 625-0500
Original Issuance Date:	06/19/2015
License Status:	REGULAR
Effective Date:	01/22/2025
Expiration Date:	01/21/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL AGED/ALZHEIMERS

II. ALLEGATION(S)

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

III. METHODOLOGY

03/23/2026	Special Investigation Intake 2026A0605016
03/23/2026	APS Referral Adult Protective Services (APS) referral made but it was denied
03/23/2026	Special Investigation Initiated - Letter Email sent to APS
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 made Discussed allegations with BFS Tom Lyon
04/01/2026	Contact - Telephone call made Left messages for Resident A's public guardian, Resident B's family (Family B), Resident C's family (Family C), Resident E's family (Family E), and Resident F's family (Family F). Attempted to discuss allegations with Resident D's family, but they stated they did not have any information to provide.
04/02/2026	Contact - Telephone call made Discussed allegations with DCS
04/02/2026	Contact - Telephone call made Left messages for DCS

04/03/2026	Contact - Telephone call received Family E left message returning my call
04/06/2026	Contact - Telephone call made Discussed allegations with Residents A, G, and H's public guardian
04/07/2026	Contact - Document Sent Email to RN
04/08/2026	Contact - Telephone call received Discussed allegations with Resident B's family (Family B)
04/08/2026	Contact - Telephone call made Left messages for DCS
04/08/2026	Contact - Telephone call made Discussed allegations with DCS
04/09/2026	Contact - Document Received Email from RN
04/13/2026	Contact - Document Sent Email to RN
04/22/2026	Contact - Telephone call made Attempted to call RN Brittany Goodling, but unable to leave message. Mailbox full. Left message for Kara Fraser requesting a return call.
04/22/2026	Contact - Document Received Email from RN
04/22/2026	Contact - Telephone call received Follow-up with RN
05/11/2026	Exit Conference Left message for licensee designee and conducted exit conference with the administrator Maggie Canny with my findings.

ALLEGATION:

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

INVESTIGATION:

On 03/23/2026, intake #209978 was made regarding Addington Place of Clarkston 2 located at 5800 Water Tower Place in Clarkston.

Note: This investigation was initially assigned to another licensing consultant but then reassigned to me on 03/25/2026 since I was assigned a complaint regarding Addington Place of Clarkston 1 at 5900 Water Tower Place in Clarkston regarding these same allegations.

On 03/23/2026, this complaint was referred to Adult Protective Services (APS). APS will not be investigating these allegations.

On 03/26/2026, I conducted an unannounced on-site investigation at Addington Place of Clarkston 2 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 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 2, then the floater is at building 1 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 2, 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 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. At building 2, Residents A, B, and D are a two-person assist for transfers and Resident C is a two-person assist for showers and changing. Alicia has participated in a fire drill that is usually conducted by maintenance. All the residents are evacuated outside the facility in the courtyard.

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 Alexandria Davis regarding the allegations. She has been working for this corporation for one year. She works first shift from 6:15AM-2:30PM. Depending on the day, like today she is the DCS scheduled to work at building 2 along with the medication technician Alicia because there are two medication technicians scheduled today, one at each building. When there is only one medication technician for each building, then a floater is scheduled. If the medication technician is at building 1, then the floater is at building 2 and vice versa. There are times when Alexandria is working alone if the medication technician is on break or someone calls in. Alexandria must wait until the medication technician returns from break or the floater can come to the building to assist her especially with residents who require two-person assist with transfers or changing. Resident A and Resident B are two-person assistants with transfers and changing and Resident C is a two-person assist for showers. Alexandria has never conducted nor participated in fire drills since working for this corporation. The maintenance personnel, Mike gets all DCS together and walks them throughout the facility showing them where the alarm panels are and how to shut them off and where to evacuate but she has never participated in the evacuation process. Alexandria does not believe she can safely evacuate all 13 residents by herself during her shift in less than eight minutes.

Alexandrea checks/changes residents every two hours during her shift. When she arrives at 6:15AM, that is the time she makes her rounds and checks resident. She stated, "as soon as I smell urine on a resident, I change them immediately." There has never been a complaint made by other staff or family members about a resident found wet/soiled.

Note: All 13 residents were eating lunch during this visit and did not want to talk; therefore, I only observed them. There were no concerns noted.

I was provided with Resident A's Resident B's, and Resident C's assessment plans, January 2026-March 2026 staff schedules and 13 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 10/23/2025
 - Requires two-person assist for transferring
 - Requires two-person assistance with bathing
 - Dependent on DCS for grooming/personal hygiene/toileting

- Requires physical assistance with evacuating
- Resident B's assessment plan was completed on 01/30/2026
 - Requires two-person assist for transferring
 - Requires two-person assistance with bathing
 - Dependent on DCS for grooming/personal hygiene/toileting
 - Requires physical assistance with evacuating
- Resident C's assessment plan was completed on 03/16/2026
 - Requires two-person assistance with bathing- resists care
 - Dependent on DCA for grooming/dressing/toileting
 - Requires physical assistance with evacuating

Note: I reviewed January 2026-March 2026 staff schedules for first, second and third shifts at building 2 regarding resident to staff ratio and according to the schedules, there is only one DCS scheduled at building 2 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 2 to meet the needs of 13 residents especially Residents A, B, and C who are a two-person assist.

Note: I reviewed 2026 first quarters 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; however, based on the residents' needs and there is only one DCS per shift, these evacuation times are not accurate in determining if all 13 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 left messages for Resident A's public guardian, Resident B's family (Family B), Resident C's family (Family C), Resident E's family (Family E), and Resident F's family (Family F).

On 04/01/2026, I contacted Resident C's family (Family C) to discuss the allegations but was informed to call another family member, which I did but the number was no longer in service.

On 04/01/2026, I received a return call from Resident C's family. Family C visits Resident C daily. Resident C is usually taking a nap around dinner time so Resident C is sometimes soiled. Family C calls staff and they immediately change Resident C. Generally, there is a pad on the bed, but because of the way Resident C sleeps, the pad moves so the sheets get soiled. Whenever this happens, staff change and launder Resident C's sheets. When Family C visits, there are about two-three staff; however, one of the staff is usually administration or the activities personnel. The only time Family C sees that there can be an issue of no staff is when both staff members give a resident a shower or take a resident to the bathroom, which happens a lot then that leaves no staff around.

On 04/01/2026, I received a return call from Resident F's family. Family F visits daily. Family F has found Resident F soiled when Resident F is sleeping. Once Family F mentions this to staff, Resident F is immediately changed. Family F stated that they have never had any issues locating staff at this facility when Family F visits.

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 in less than eight minutes with one DCS on shift.

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 they are heavy wetters. 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 04/06/2026, I interviewed a representative Jamerson McCarthy with public guardian Jennifer Kerney’s Advocates for Independence and Self-Reliance office regarding the allegations. Jennifer Kerney’s office has three residents that reside at building 2. Two of those three residents, Resident G and Resident H, are on Ms. McCarthy’s caseload and Resident A is on Jennifer Burnett’s caseload. I briefly spoke with Ms. Burnett who advised me that she has never visited Resident A; however, to speak with Ms. McCarthy who has visited this facility. Ms. McCarthy has been at this facility a couple of times and reported staff greeting her at the door and observing staff in the management’s office.

Ms. McCarthy has never observed her residents to be soiled. There is a visitor, Beth Geladin, who works for Ms. Kerney's office that visits the residents regularly who would have direct knowledge of any concerns if there were concerns regarding the residents. On 04/06/2026, I interviewed Beth Geladin who works at Jennifer Kerney's office. Ms. Geladin visits Resident A, Resident G, and Resident H quarterly. Ms. Geladin is familiar with Resident A, Resident G, and Resident H. She last visited with them on 03/12/2026 soon after lunch time, around 1PM-2PM. When she arrived, she observed bruising on Resident A's face and legs. She wanted to bring this to staff's attention and found both staff members who identified themselves as Tiera and Alicia, who were medication technician aides sitting each on a chair next to the front door away from the residents and on their phones. There were no other staff in the building. Ms. Geladin asked them what happened to Resident A, and both stated, "Resident A falls frequently out of bed." Ms. Geladin inquired about bed alarms and bed rails for Resident A as a protective measure to alert staff when Resident A is attempting to get out of bed, but Ms. Geladin was informed that, "bed alarms and bed rails are not allowed." Ms. Geladin observed a mat near Resident A's bed on the floor. Resident A is a two-person transfer, so it is unclear if her falls are due to insufficient staffing or just due to no protective measures in place. Ms. Geladin has never observed Residents A, G, or H soiled during any of her visits.

Note: According to Resident A's assessment plan dated 10/23/2025 regarding falls, "monitor resident for falls and report to appropriate team members. Observe Resident A is embracing safety measures to decrease fall potential (there are no safety measures documented on plan); encourage residents to use assistive devices, such as canes, walkers, or handrails as needed to improve mobility and prevent falls. Resident A is wheelchair bound; therefore, she is non-ambulatory and these assistive devices are not appropriate protective measures to prevent Resident A from falling out of bed.

On 04/07/2026, I emailed RN Brittany Goodling requesting to know their policy on bed alarms and bed rails.

On 04/08/2026, I received a return call from Resident B's family (Family B) regarding the allegations. Family B visits regularly during the week. Whenever they visit, they observe at least two DCS working; however, there have been times when Family B had a question or needed something for Resident B and was unable to locate staff. The staff were assisting residents who require at least two-person assist. Family B stated, "I feel they can benefit from having an additional staff so when two staff are with a resident, the third staff can assist other residents when needed." Family B found Resident B soiled once and told staff and staff changed Resident B.

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 by herself or 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 04/09/2026, I received an email from RN Brittany with their policy on bedrails. The policy stated that "Senior Lifestyle (Company) prohibits the use of Bed and/or Side Rails in Assisted Living, Personal Care, Memory Care, or Skilled Nursing communities. Any device attached to a resident bed must be certified non-entrapment (e.g. Halo Safety Ring, Direct Supply Zero Opening Assist, trapeze)."

On 04/13/2026, I emailed RN Brittany the following: I received concerns regarding Resident A falling out of bed, observed with multiple bruises on her face and body. If your corporation does not allow bedrails, then what protective measures are put in place to ensure her safety? Also, please send me the incident reports pertaining to her falls for my review. I received no incident reports and no response from Brittany.

Note: On 04/21/2026, I attempted to conduct a surprise fire drill with Tom Lyon, BFS but was informed by Executive Director Maggy Canny while we were in building 1, that a fire drill conducted with only one DCS would be a fail as the DCS would be unable to evacuate all residents outside the building by themselves. Therefore, a fire drill was not conducted at building 2. However, while at building 1, I spoke with Mike, the maintenance personnel who implied that when he conducted the fire drills, residents never evacuated either building. Mike does not believe that one DCS can safely evacuate all the residents.

On 04/22/2026, I attempted to call RN Brittany regarding Resident A falling out of bed, but her mailbox was full.

On 04/22/2026, I left a message for Kara Fraser requesting a return call regarding Resident A and that I've been trying to get a hold of RN Brittany.

On 04/22/2026, I received a return call from RN Brittany. Resident A can assist staff with transfers. Resident A was in the hallway in her wheelchair when Resident A attempted to get up from her wheelchair and fell. RN is working with Care Team Hospice regarding protective measures for Resident A. She will email me incident reports (IR) regarding Resident A's falls.

On 04/22/2026, I received the following email from RN Brittany regarding Resident A. "We currently are encouraging engagement during waking hours, fall mat to pad and appropriate footwear. We switched out her wheelchair cushion. Keeping her bed lowest to the ground position. The bed is also positioned so that one side is against the wall in her room. Keeping her floor area free of any trip hazards when she sits up out of bed and frequent checking." Also included was an incident report dated 03/08/2026 regarding Resident A's fall. Resident A was observed on the floor in the hallway, no injuries observed at this time. Staff interviewed on shift. Resident Attempted to self-transfer without assistance. The actions taken were, "Verbal education to resident and staff. New wheelchair cushion required."

APPLICABLE RULE	
R 400.619	Emergency preparedness plan.
	(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.
ANALYSIS:	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.
CONCLUSION:	VIOLATION ESTABLISHED

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

ANALYSIS:	Based on my investigation and information gathered, DCS lack the qualifications and are not capable of appropriately handling emergency situations. During my interviews with DCS and medication technicians, the following staff Tamyra Faulkner, Alexandra Davis, Zamaria McClendon, and Dajahnique Nelson-McClellan stated that they have never conducted fire drills while being employed at building 2. All reported that they would not be capable of appropriately evacuating all 13 residents working alone during their shifts in an emergency.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.629	Direct care staff; qualifications and training.
	(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.
ANALYSIS:	Based on my investigation and information gathered, staff members I interviewed reported that they have never conducted nor participated in a fire drill where the staff evacuated residents outside the building. Therefore, DCS/medication technicians are not properly trained nor competent in all areas performing safety and fire prevention when they are working independently during their shifts.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.671	Resident care.
	(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.

ANALYSIS:	Based on my investigation and review of Resident's A, B, C, and D 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 13 residents at this building. Residents A, B, C, and D, are two-person assist according to their assessment plans; with transferring and with their personnel hygiene needs and Resident A is a fall risk; 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.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.677	Resident hygiene, clothing.
	(2) A licensee shall ensure the resident receives or has access to all of the following: (c) Assistance with resident hygiene as needed.
ANALYSIS:	Based on my investigation and information gathered, Family C and Family F reported that there have been concerns of Residents C and F who were found soiled. Both family members had to locate staff to inform them that Residents C and F were soiled and had to be changed.
CONCLUSION:	VIOLATION ESTABLISHED

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

ANALYSIS:	Based on my interviews with DCS/medication technicians, all 13 residents would not be protected and safe during an emergency. DCS Tamyra Faulkner, Alexandria Davis, Zamaria McClendon, and Dajahnique Nelson-McClellan have never conducted nor participated in fire drills where they evacuated the residents outside building 2. 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 2 is not equipped due to insufficient staffing to ensure the protection and safety of these residents.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.685	Resident admission; resident assessment plan; resident care agreement; health care appraisal.
	(2) A licensee shall not accept or care for a resident until a written assessment has been completed. A written assessment plan must include all of the following: (b) The services, skills, and physical accommodations required by the resident that are available at the facility.
ANALYSIS:	I reviewed Resident A's assessment plan dated 10/23/2025 and IR dated 03/08/2026, regarding her fall. Resident A was observed by the legal guardian's visitor Beth Geladin on 03/12/2026 with bruising on Resident A's face and legs. Ms. Geladin was informed by DCS Tiera and Alicia that "Resident A frequently falls out of bed," and that "bed alarms and bed rails are not allowed," at this facility. The IR stated that "Resident A fell out of her wheelchair," and was "found by staff on the floor." According to the assessment plan, Resident A needs to be "monitored," for falls, but due to insufficient staff available per shift, the services, skills, and physical accommodations required by Resident A are not available at building 2.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

The residents are not being fed or hydrated with fluids.

INVESTIGATION:

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. Alicia stated the other day, the family member of Resident F told her that Resident F did not get a meal, but when Alicia asked the DCS working (she could not recall which staff) the DCS stated that “Resident F ate his meal.” Resident F told his family member that he did not eat, so Resident F was given another plate of dinner.

On 03/26/2026, I interviewed DCS Alexandria Davis regarding the allegations. Residents are all brought out to the dining room for breakfast and lunch that are served during her shift. Breakfast is around 8-8:30AM and lunch is around 11:30-12PM. If a resident is on hospice, they do not come to the dining room for meals. Also, some residents refuse food and when that happens their plate of food is set aside and they are offered again and eventually eat. Residents gets drinks during each meal and when snacks are served between meals. Alexandria stated, “residents are not dehydrated because they are always getting changed because they drink lots of fluids.” There has not been any complaints reported to her by anyone regarding residents not being fed or given drinks.

Note: During this on-site investigation, I observed all 13 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.

On 04/01/2026, I interviewed Family C regarding the allegations. Family C feeds Resident C dinner every evening. The staff is very accommodating to Family C and because Resident C likes drinking diet coke, staff have it ready for Family C. In the dining room, Family C observes all the residents sitting and having a meal. There is staff walking around with pitchers of water and/or cranberry juice for the residents. Family C has no concerns about Resident C not getting fed or not getting enough fluids.

On 04/01/2026, I interviewed Family F regarding the allegations. Family F visits around lunch or dinner time between 1PM-5PM. All the residents, including Resident F, sit at the dining room table and get meals and drinks with their meals. The food appears to be nutritious and good as Resident F “eats it all.” There was one time when another resident’s family member informed Family F that Resident F did not come to the dining room two nights in a row for dinner. Family F went to staff and advised them that Resident F did not eat dinner, but staff told Family F that Resident F did eat dinner, but the other resident’s family insisted that Resident F did not. The staff on shift brought a dinner plate for Resident F and he ate his dinner. Staff mentioned that Resident F was sleeping during dinner time and they did not want to wake him. Family F brought this to Kara Fraser’s attention and advised Kara to have staff wake Resident F up for all his meals. Kara acknowledged and since then there has been no issues with Resident F not eating meals.

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 04/06/2026, I interviewed Jamerson McCarthy with Jennifer Kerney's office regarding the allegations. Ms. McCarthy never visited during meal times; therefore, she has no information to report. She has never received any complaints from Ms. Geladin regarding residents not getting their meals or getting enough fluids to drink.

On 04/06/2026, I interviewed Beth Geladin regarding the allegations. Ms. Geladin had never visited during meal times, but there was a time she arrived and observed Resident A sitting at the dining room table eating finger food. It was long after lunch was over and there were no staff around assisting her with her meal. Resident A can feed herself but does require staff to remind her to eat. Resident A will take a bite, then stare out and then look down and sees her food and then remembers to eat. Ms. Geladin observed water in Resident G's bedroom and stated that Resident H's son reported that Resident H is gluten-free, but this facility does not offer her a gluten-free diet. When Resident H eats gluten food, she constantly burps, which Ms. Geladin has observed, which indicates that this facility is not offering her gluten-free food.

On 04/08/2026, I interviewed Resident B's family (Family B) regarding the allegations. Family B visited Resident B during meals, and they observed Resident B eating and drinking fluids during meals. Family B also brings snacks for Resident B and staff inform Family B that Resident B eats the snacks. No concerns were raised by Family B.

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.

APPLICABLE RULE	
R 400.663	Nutrition; adoption by reference.
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents. (3) Not more than 14 hours must elapse between the evening and morning meal.
ANALYSIS:	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.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff are mean to residents.

INVESTIGATION:

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 homes for the aged/assisted living 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 Alexandria Davis regarding the allegations. Alexandria denied being mean to residents. She has never yelled or been disrespectful to any resident. There have not been any complaints that she heard or was told by other staff or the residents' families about a DCS being mean to a resident. She would report it immediately.

On 04/01/2026, I interviewed Family C regarding the allegations. When Family C is there, staff have not been observed to be mean or disrespectful to Resident C nor has Family C witnessed staff being mean to other residents. Resident C's father and son visit on the weekends and have never seen staff treat anyone badly. Family C has observed staff on their phones, but Family C can only assume and believes that the staff is on their break, which they are entitled to.

On 04/01/2026, I interviewed Family F regarding the allegations. Family F stated that staff are not mean to Resident F, but Family F wanted Resident F to wear a bib during meals, but staff stated it was "degrading to Resident F," so instead, the staff put an apron on Resident F during meals. Family F stated, "I question them (staff) putting an

apron on him that's uglier than a bib, so I don't understand this logic." Family F did not provide any further details. Family F has observed staff sitting in the front room with residents when residents are watching TV, but stated that "staff are on their phones," but "still watching them (residents)."

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 04/06/2026, I interviewed Jamerson McCarthy regarding the allegations. When she visited, she never observed any staff being mean or mistreating a resident at this building.

On 04/06/2026, I interviewed Beth Geladin regarding the allegations. Ms. Geladin has never observed or heard staff speaking in a mean way to Residents A, G, and H or any other resident. However, she has observed staff sitting down on their phones as she did during her visit on 03/12/2026.

On 04/08/2026, I interviewed Resident B's family (Family B) regarding the allegations. Whenever Family B visited, they have never observed staff mean to Resident B or any other resident. Family B observed during the evening hours after 6:30PM when they have visited, staff sitting on their cellphones.

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 05/11/2026, I left message for licensee designee and conducted exit conference with the administrator Maggie Canny with my findings. I explained to Ms. Canny what a provisional license entails and she acknowledged.

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: (p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.
ANALYSIS:	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.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

Frodet Dawisha

05/11/2026

Frodet Dawisha
Licensing Consultant

Date

Approved By:

Jay Calwerts

For

05/11/2026

Denise Y. Nunn
Area Manager

Date