



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 8, 2026

Sunil Bhattad
Campbell Personal Care Home #4 Inc
1900 Lakeville Road
Leonard, MI 48367

RE: License #: AL630015496
Investigation #: 2026A0612025
Caremore of Leonard

Dear Mr. Bhattad:

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 (248) 972-9136.

Sincerely,

A handwritten signature in cursive script that reads "Johnna Cade". The signature is written in black ink and is positioned to the left of the typed name and address.

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(248) 302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630015496
Investigation #:	2026A0612025
Complaint Receipt Date:	05/28/2026
Investigation Initiation Date:	06/01/2026
Report Due Date:	07/27/2026
Licensee Name:	Campbell Personal Care Home #4 Inc
Licensee Address:	1040 S. State Road Davison, MI 48423
Licensee Telephone #:	(248) 628-6348
Administrator:	Sunil Bhattad
Licensee Designee:	Sunil Bhattad
Name of Facility:	Caremore of Leonard
Facility Address:	1900 Lakeville Road Leonard, MI 48367
Facility Telephone #:	(248) 628-6348
Original Issuance Date:	11/12/1993
License Status:	REGULAR
Effective Date:	03/14/2025
Expiration Date:	03/13/2027
Capacity:	16
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff are repeatedly observed administering medications late, and completing documentation hours after care was provided.	Yes

III. METHODOLOGY

05/28/2026	Special Investigation Intake 2026A0612025
06/01/2026	Special Investigation Initiated - Telephone Telephone interview with Licensing Consultant Sara Shaughnessy and licensee designee Sunil Bhattad.
06/03/2026	Inspection Completed On-site I completed an unscheduled onsite inspection I interviewed direct care staff Evangeline Adchao, homeowner Ruby Princesa, Resident B, Resident D, and Resident E.
06/03/2026	Exit Conference Telephone call with licensee designee Sunil Bhattad to conduct an exit conference.

ALLEGATION:

Staff are repeatedly observed administering medications late, and completing documentation hours after care was provided.

INVESTIGATION:

On 05/28/26, I received an anonymous referral that in summary indicates the reporting source observed repeated medication delays and late charting. Medications scheduled for morning administration were often given hours late on multiple occasions during the day and night shifts. Charting/documentation was frequently completed at the end of shifts rather than at the time care was provided. The referral further alleged that staffing levels appeared insufficient at times.

On 06/01/26, I initiated my investigation with a telephone interview with AFC Licensing Consultant Sara Shaughnessy. Ms. Shaughnessy confirmed that SIR # 2026A0626020 addressed an allegation of insufficient staffing at this facility. The report cited no rule violations. The investigation was closed on 05/25/26. As such, the allegation regarding insufficient staffing is not addressed in this report. Additionally, on 06/01/26, I placed a telephone call to licensee designee Sunil Bhattad. Mr. Bhattad stated homeowner Ruby Princesa and home manager, Barbara Hulsey, are responsible for the oversight of medication administration and would be able best able to speak about this allegation.

On 06/03/26, I completed an unscheduled onsite inspection I interviewed direct care staff Evangeline Adchao, homeowner Ruby Princesa, Resident B, Resident D, and Resident E. While onsite I reviewed the resident's physical medications on hand and the corresponding June 2026 Medication Administration Records (MAR). I observed the following relevant information:

- Resident A, Resident B, Resident F, and Resident G's, MAR's were not signed on 06/03/26 at 7:00 am. However, the medications were administered to the residents as they were gone/popped out of the bubble packs. Direct care staff Evangeline Adchao was responsible for administering 7:00 am medications on 06/03/26.
- Resident A is prescribed Levothyroxine 112 mcg – take one tablet by mouth every day (30 minutes before first meal/meds of the day). The medication was not administered on 06/03/26, at 7:00 am. The medication remained in the bubble pack. Direct care staff Evangeline Adchao was responsible for administering 7:00 am medications on 06/03/26.
- Resident C is prescribed Ferrous Gluc tab 324 mg – take one tablet by mouth every other day. The medication was not administered on 06/03/26, at 7:00 am. The medication remained in the bubble pack. Direct care staff Evangeline Adchao was responsible for administering 7:00 am medications on 06/03/26.
- Resident B's June 2026 MAR lists that he is prescribed Doxycycline Hyclate 100 mg – take one tablet by mouth twice daily. The medication has not been signed for as administered on any date in June 2026, and there is no physical medication/ bubble pack on hand in the home.

On 06/03/26, I interviewed direct care staff Evangeline Adchao. Ms. Adchao stated she has been working at this home for one year. She is trained to administer medications. I reviewed the allegation and the findings of the onsite medication audit with Ms. Adchao. Ms. Adchao stated that when she passes medications sometimes, she forgets to sign the MAR at the time she administers the medication to the resident. Ms. Adchao admitted that when she passed medications today, 06/03/26, at 7:00 am she did not sign the resident's MAR. Ms. Adchao remarked sometimes when she gets busy, she forgets to complete the documentation. Today she was cleaning and she forgot. I

inquired why Resident B's June 2026 MAR lists that he is prescribed Doxycycline Hyclate 100 mg however this medication is not onsite or available in the home. Ms. Adchao did not know why this medication was not onsite and suggested it must not have been delivered by the pharmacy.

On 06/03/26, at the time of the onsite inspection, I observed Ms. Adchao completed a medication pass. Medication was administered to Resident E. Ms. Adchao did not follow the appropriate steps of medication administration. Ms. Adchao signed Resident E's MAR before administering the medication. When Ms. Adchao gave the pill to Resident E, she did not provide her with any water. The resident asked for a drink to take the medication and then one was provided to her.

On 06/03/26, I interviewed homeowner Ruby Princessa. Ms. Princessa stated Ms. Adchao is her business partner, she is trained in administering medication. Ms. Princessa stated it is her and Ms. Adchao's responsibility to review the residents medication administration records for accuracy when medications are delivered to the home from the pharmacy. I inquired why Resident B's June 2026 MAR lists that he is prescribed Doxycycline Hyclate 100 mg however this medication is not onsite or available in the home. Ms. Princessa reviewed the resident's file and current prescriptions and determined that Resident B is not prescribed this medication. This was an error made by the pharmacy; this medication should not have been listed on Resident B's MAR. Ms. Princessa was unable to provide an explanation as to why this was not noticed or addressed prior to the onsite inspection.

On 06/03/26, I interviewed Resident D. Resident D stated her medication is administered as it is prescribed, she takes medication twice a day. Resident D stated she has no complaints regarding living in the home.

On 06/03/26, I interviewed Resident E. Resident E stated her medication is administered as it is prescribed. Her medications are not given to her too early or too late. Resident E stated her and the other resident are well cared for.

On 06/03/26, I interviewed B. Resident B stated this is a good home, he has no issues or concerns regarding his medications.

On 06/03/26, I placed a telephone call to licensee designee Sunil Bhattad to conduct an exit conference and review my findings. Mr. Bhattad acknowledged and indicated that he will follow up with the home manager Barb Hulseley to ensure all staff who are passing medications are doing so appropriately. Mr. Bhattad acknowledged and agreed to complete a corrective action plan.

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:	<p>Based upon the information gathered during this investigation there is sufficient information to conclude that resident medications are not being given as they are prescribed.</p> <p>During the onsite inspection completed on 06/03/26, I observed that Resident A is prescribed Levothyroxine 112 mcg – take one tablet by mouth every day (30 minutes before first meal/meds of the day). The medication was not administered on 06/03/26, at 7:00 am.</p> <p>Additionally, Resident C is prescribed Ferrous Gluc tab 324 mg – take one tablet by mouth every other day. The medication was not administered on 06/03/26, at 7:00 am.</p> <p>Both medication errors were made by direct care staff Evangeline Adchao.</p>
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.675	Resident medications.
	<p>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:</p> <p>(a) Be trained in the proper handling and administration of medication.</p>
ANALYSIS:	<p>Based upon the information gathered during this investigation there is sufficient information to conclude that direct care staff Evangeline Adchao did not demonstrate that she is properly trained to handle and administer medication.</p> <p>During the onsite inspection completed on 06/03/26, I observed Ms. Adchao administer medication to Resident E. Ms. Adchao did not follow the appropriate steps of medication administration. Ms. Adchao signed Resident E’s MAR before administering the medication. Additionally, she did not initially provide Resident E with water to take the medication.</p>

	<p>Furthermore, homeowner Ruby Princesa and Ms. Adchao are responsible for reviewing residents' medication records for accuracy when medications are delivered to the home from the pharmacy. Resident B's June 2026 MAR lists that he is prescribed Doxycycline Hyclate 100 mg – take one tablet by mouth twice daily. The medication has not been signed for as administered and there is no physical medication on hand in the home. At the time of the onsite inspection Ms. Adchao did not know why this medication was not onsite and available for review. Upon further research Ms. Princesa determined Resident B is not prescribed this medication. This was an error made by the pharmacy, and this medication should not have been listed on Resident B's MAR. Ms. Princesa was unable to provide an explanation as to why this was not noticed or addressed prior to the onsite inspection.</p> <p>As such, Ms. Princesa and Ms. Adchao failed to demonstrate that they are proficient in the proper handling of medication documentation.</p>
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.675	Resident medications.
	<p>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:</p> <p>(b) Complete an individual medication log that contains all of the following:</p> <p>(v) Initials of the individual who administered the medication at the time given.</p>
ANALYSIS:	<p>Based upon the information gathered during this investigation there is sufficient information to conclude on 06/03/26, direct care staff Evangeline Adchao did not initial Resident A, Resident B, Resident F, and Resident G's, medication administration records at the time the medication was administered (7:00 am). The medications were administered to the residents as they were gone/popped out of the bubble packs however, at the time of the onsite inspection the resident's MAR's were not signed.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



06/08/2026

Johnna Cade
Licensing Consultant

Date

Approved By:



For

06/08/2026

Denise Y. Nunn
Area Manager

Date