GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 29, 2026

Kimberly Singer
Welcome Home Assisted Living - Owosso
1605 Vandekarr Rd
Owosso, MI 48867

RE: License #: AS780402781
Investigation #: 2026A0466038
Welcome Home Honey

Dear Ms. Singer:

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

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

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

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

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS780402781
Investigation #:	2026A0466038
Complaint Receipt Date:	05/07/2026
Investigation Initiation Date:	05/08/2026
Report Due Date:	07/06/2026
Licensee Name:	Welcome Home Assisted Living - Owosso
Licensee Address:	1605 Vandekarr Rd Owosso, MI 48867
Licensee Telephone #:	(989) 723-3807
Administrator:	Brooke Bowen
Licensee Designee:	Kimberly Singer
Name of Facility:	Welcome Home Honey
Facility Address:	1605 Vandekarr Rd Owosso, MI 48867
Facility Telephone #:	(989) 723-3802
Original Issuance Date:	02/06/2020
License Status:	REGULAR
Effective Date:	08/06/2024
Expiration Date:	08/05/2026
Capacity:	6
Program Type:	AGED

II. ALLEGATIONS:

	Violation Established?
Resident A did not receive proper care and supervision.	No
Resident A was not administered prescribed pain medications as prescribed.	No
Assisted devices were not used as ordered by Resident A's physician.	Yes
Resident B did not receive proper care and supervision.	No
Additional Findings	Yes

III. METHODOLOGY

05/07/2026	Special Investigation Intake 2026A0466038.
05/08/2026	Special Investigation Initiated – Letter to Complainant.
05/08/2026	Contact - Document Received from Complainant.
05/08/2026	APS Referral Rebbeca Schalow assigned.
05/11/2026	Contact - Document Sent to/from APS Rebbeca Schalow.
05/12/2026	Contact - Telephone call made to APS Rebbeca Schalow interviewed.
05/28/2026	Inspection Completed On-site.
05/29/2026	Contact- Telephone call recevied from DCW Tanya Dunham.
06/16/2026	Contact - Telephone call made to APS Rebbeca Schalow, message left.
06/17/2026	Contact - Telephone call made to DCW Tonya Dunham interviewed.
06/17/2026	Contact - Telephone call received from DCW Gabriela Lindsay interviewed.
06/21/2026	Contact - Telephone call made to APS Rebbeca Schalow interviewed.
06/23/2026	Contact- email sent to/from licensee designee Kimberly Singer.

06/23/2026	Contact- telephone call made to licensee designee Kimberly Singer, message left.
06/24/2026	Contact- email sent to/from licensee designee Kimberly Singer specifying needed documents.
06/25/2026	Contact- email from licensee designee Kimberly Singer specifying needed documents.
06/29/2026	Exit Conference with licensee designee Kimberly Singer.

ALLEGATION: Resident A did not receive proper care and supervision.

INVESTIGATION:
On 05/07/2026, APS Centralized Intake Referral was transferred to the department of licensing and regulatory affairs (LARA) for investigation. Complainant reported that Resident A is 72 years old and resides at Welcome Home Honey Assisted Living Facility. The complaint also stated that Resident A was admitted to hospice. Complainant reported that Resident A is diagnosed with Alzheimer's dementia, chronic respiratory failure, rib fractures, and anemia. Complainant reported that Guardian A1 was advised by a hospice social worker to bring Resident A to the emergency room due to an unsafe environment at the facility. Complainant reported that the environment was unsafe due to multiple, reoccurring falls. Complainant reported that Resident A has a splint on her right arm due to a fall and a broken hip from another fall. Complainant reported that Resident A requires full care for all actives of daily living (ADL)s. Complainant reported that Resident A has frequent falls from her bed. Complainant reported that on 04/24/26, Resident A fell from her bed and a nurse evaluated her at the facility with no visible bruises at that time. Complainant reported that on 04/30/26, Resident A was taken to the emergency room since her wrist looked worse. Complainant reported that Resident A's wrist was fractured in two places and she also had a fractured rib. Complainant reported that Resident A got her arm caught in the bedrail while trying to get up from bed and the direct care worker (DCW) on duty did not notice. Complainant reported that Resident A is not being supervised in the facility by DCWs despite Guardian A1 paying extra to have someone supervise Resident A so that she won't fall again. Complainant reported that rent went up for the facility.

On 05/08/2026, a second APS Centralized Intake Referral was transferred to LARA for investigation, Complainant reported that Resident A is currently unable to ambulate and requires extensive assistance from the facility staff. Complainant reported that on 04/10/2026, Resident A fell at the facility and had to go to the hospital. Complainant reported that Resident A was diagnosed with a hip fracture and required surgery. Complainant reported that Resident A returned to the facility following her hospital stay because the family was advised that she would receive physical and occupational therapy there, but this did not happen. Complainant

reported that Resident A returned to the facility on 04/19/2026. Complainant reported that on 05/01/2026, Resident A's right wrist was observed to be swollen and disfigured. Complainant reported that the facility denied Resident A had an injury or fall however she was sent to the hospital, where she was diagnosed with a wrist fracture and broken rib. Complainant reported that Resident A returned to the facility later that evening. Complainant reported that Resident A has experienced repeated falls and sustained injuries. Complainant reported that the owner/licensee Kimberly Singer has been observed attempting to sleep instead of supervising the residents.

On 05/08/2026, Adult Protective Services (APS) supervisor Cheryl Hunt reported that Resident A is currently at Owosso Memorial Hospital while a new placement is located. APS worker Rebbeca Schalow is assigned to this investigation.

On 05/11/2026, APS Rebbeca Schalow reported that she observed Resident A at the hospital and spoke with Guardian A1 as Resident A did not want to talk due to being in pain and trying to sleep. APS Schalow reported that Guardian A1 advised that the allegations were true and advised that Resident A will not be returning to the facility. APS Schalow reported that she has not spoken with anyone at the facility yet.

On 05/12/2026, APS Schalow reported that Resident A fractured her hip on 4/10/2026. APS Schalow reported that on 4/24/2026, Resident A fell from her bed, the hospice nurse evaluated Resident A and reported no injury. APS Schalow reported on 4/30/2026, Resident A was in the emergency room for a fractured wrist that got worse after she caught her wrist in the bedrail trying to get out of bed.

On 05/28/2026, I conducted an unannounced investigation and reviewed Resident A's record which documented that she was admitted to the facility on 12/15/2025 and had a do not resuscitate order (DNR) in her record. Resident A's written *Assessment Plan for Adult Foster Care Residents (AFC*) was completed on 4/28/2026 and signed by Guardian A1. The written *Assessment Plan for AFC Residents* documented that Resident A is forgetful, requires simple instructions, and requires the assistance of one DCW for all actives of daily living including toileting, grooming, dressing, personal hygiene and walking. The "walking/mobility" section of the report documented "one staff member full assist." The written assessment plan documented that Resident A uses a hospital bed, wheelchair, walker, gait belt and oxygen as assistive devices.

Resident A's *Resident Care Card* dated admission 12/16/2025 documented for "transfer" that Resident A is a "2 assist, sit to stand." Under "weight bearing" it documented, "partial on occasion," but non-weight bearing was also checked. Under nutrition, "dependent feed, mostly in room." Under "fall risk" it stated, "fell x 2 December 2025, lt wrist fx, lt humerous fx." Resident A is incontinent of bladder and bowel, wears pads and briefs but also toilets. Resident A requires total care for personal grooming, bathing and dressing. On 06/24/2026, licensee designee Singer

reported the documentation that Resident A required two direct care staff members for transfer was, “That was my error. I corrected it. [Resident A] was never a two-person assist. She was initially a transfer into a wheelchair then transfer onto BSC then transfer to recliner. She was always a one person assist even after she fell and fractured her hip. We received orders for a Geri Chair not a Sit to Stand. I personally made an error and put Sit to Stand when it was a Geri Chair with one assist. If you look below on her care plan, it does show she is a one-assist.”

Resident A’s record which documented the following orders by Heartland Hospice:

- 4/19/2026, “use standard walker and gait belt for ambulation and transfers.”
- 4/20/2026, “Stand by assist with ambulation until rolling walker arrives at Welcome Home Facility.” In “bed mobility” it stated, “1 assist, frequent repositioning rt arm lt arm. Splint lt arm.”

At the time of the unannounced investigation Resident A’s record did not contain any additional written physician orders for assistive device or therapeutic supports that were specified in the resident's assessment plan and agreed on by the resident's designated representative. The orders that are in the resident record and listed above did not contain the reason for use and/or the term of the authorization.

Resident A’s *Health Care Appraisal* documented that Resident A is 72 years old and diagnosed with chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, obstructive sleep apnea (OSA), anxiety and heart disease. In the “other health related information or concerns” it stated, “LA broken-in sling, lump diminished BLE bruise on shins, right, hand bruised, confusion, slurred speech, weakness.”

I reviewed Fall*/Accident Documentation*:

- On 2/24/2026 at 2:31pm and it documented Jessica Schimbery witnessed the fall. In the “narrative” section of the report, “found resident on floor sitting upon left side no injury, resident said she had to get up.”
- On 10/10/2026 [sic] at 11:15pm and completed by Tonya Dunham. It documented in the “narrative” section of the report, “11:15 staff heard thud, resident had gotten out of chair to bed and fell no injury noticed at this time. 1215, resident in pain on side hip.” Resident sent to hospital. On 6/24/2026, licensee designee reported that DCW Dunham came in and corrected that date of 10/10/2026 to 4/10/2026. Licensee designee Singer reported that DCW Dunham admitted to being tired and said, “I have no idea why on earth I dated that Fall form for 10-10 when 10-10-26 hasn’t even happened.”

I reviewed three *AFC Licensing Division Incident/Accident Reports* which were not signed by licensee designee Kimberly Singer.

- Dated 4/10/2026 and completed by Tonya Dunham who documented that the incident occurred at 11:15pm. In the “explain what happened” section of the report it stated, “Was in the kitchen getting breakfast prepared for the next day. I heard a thud. Resident got out of chair without using call light. No

injuries noticed at this time." In the "action taken by staff" section of the report it stated, "Checked vitals, call placed to home manager Jaclyn Papenfuss. Home manager called daughter. 12:30 am resident complained of pain. Home manager called. Hospice called at 2:10am and stated be here in 45 minutes. Was transported to Sparrow." In the Corrective measures" section of the report it stated, "Reminded resident to use her call light at all times."

- Dated 4/24/2026 and completed by Jessica Schimberg who documented that the incident occurred at 2:31pm. In the "explain what happened" section of the report it stated, "Staff performing routine safety check and observed resident on the floor next to bed. Bed rail was up, floor mat in place call light was in reach and bed lowered to floor in correct position at time of safety check, Hospice LPN on scene." In the "action taken by staff" section of the report it stated, "Checked for visible injuries, none, denied new pain when vitals taken. Hospice nurse arrived. Nurse performed assessment. Hospice nurse called for ambulance assistance. Staff member notified on call house manager." In the Corrective measures" section of the report it stated, "House manager increased routine safety checks to every 15 minutes. Bed alarm placed under her."

- Dated 5/01/2026 and completed by Jennifer Naylor who documented that the incident occurred at 12:26 pm. In the "explain what happened" section of the report it stated, "Rachel nurse from Heartland (hospice) assessing resident appears to have broken wrist. [Guardian A1] on scene." In the "action taken by staff" section of the report it stated, "Rachel called emergency services. Transferred to hospital." In the Corrective measures" N/A."

I reviewed *Patient Visit Information* from Memorial Hospital that was dated 5/1/2026 and documented that "[Resident A] was found to have a right radial fracture, placed a splint on her right wrist with recommendation to wear this 4 to 6 weeks. Decision has been made to not pursue any operative intervention. We provided orthopedic surgery follow-up in which patient can be seen in the next week for monitoring of fracture and healing process. [Resident A] was also found to have a potential fracture in her right hip. As there is no wish to pursue any additional intervention, we did not obtain any CT imaging for further clarification/ confirmation of this fracture. Chest x-ray imaging [Resident A] was found to have evidence of potential pneumonia. Patient was given dose of IV antibiotic here in emergency department and was prescribed doxycycline to take twice daily for 7 days."

I interviewed licensee designee Singer who reported that Resident A had been admitted to the facility on 12/15/2025 after she had fallen and she was diagnosed with a double fracture on her arm and she was admitted to the facility wearing a sling. Licensee designee Singer reported that Resident A was a one person assist for walking/mobility, but she would often not use the call light and ambulate independently. Licensee designee Singer reported that on 4/10/2026, Resident A fell, hospice sent her to the hospital, and she was diagnosed with a fractured hip and

sent back to the facility without any rehabilitation services. Licensee designee Singer reported that on 4/24/2026, Resident A fell from bed even though the bed was against the wall on one side and the other side of the bed had a bed rail. Licensee designee Singer reported that Resident A had her wrist caught in the bedrail on 4/27/2026 and the hospice nurse was out on 4/28/2026 to assess Resident A's wrist and did not send her to the hospital. Licensee designee Singer reported that DCW Tanya Dunham was icing the wrist. Licensee designee Singer reported that on 5/01/2026 a different hospice nurse came out and sent Resident A to the hospital and she was admitted. Licensee designee Singer reported that Resident A will not be returning to the facility as her family members picked up all her belongings including all her medications.

Licensee designee Singer reported that there is one direct care worker per shift at this facility. Licensee designee Singer reported that the staff are awake during all shifts. Licensee designee Singer reported that when she covers shifts, she does not sleep in lieu of providing supervision and care to residents. Licensing designee Singer reported that there were no falls or any incidents that occurred the few times she laid down during third shift.

On 06/17/2026, I interviewed DCW Tonya Dunham and DCW Gabriela Lindsay who reported that Resident A was a one person assist for walking/mobility, but she would often not use the call light and ambulate independently which would result in a fall. DCW Dunham and DCW Lindsay both reported that Resident A never required two direct care staff to assist with personal care or transfers. DCW Dunham and DCW Lindsay both reported that DCWs that worked the midnight shift were awake.

On 06/21/2026 I spoke with APS Schalow who reported that she has not talked to any facility staff about the allegations. APS Schalow reported that she was concerned about the number of falls and injuries that resulted and reported that she was contemplating substantiating neglect.

On 6/24/2026, licensee designee Singer provided a *Physician Verbal/Phone Order* dated 3/24/2026 which documented "V/O from Rachel LPN- In contact with Dr. Vanwingen. Bed alarm and chair alarm used for safety while in recliner and /or in bed. Hospital bed with 2 full sized bed rails full mat to be placed under recliner/bed for safety. Bedside commode to be used as needed. Gait belt and walker used for transferring. Use wheelchair as needed. V/O given to Gabriela Lindsay."

On 06/25/2026, licensee designee Singer provided a *Hospice Certification and Plan of Care* dated 4/19/2026 which documented "dme-bed alarm; dme-bed full rails; dme-bedside commode; dme-chair alarm; dme-fall mat; dme-hospital bed; dme-nebulizer; dme-over the bed table; dme-oxygen concentrator; dme-oxygen cylinder; dme-oxygen supplies; dme-walker; gait belt; incontinence; respiratory supplies."

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: **(a) The amount of personal care, supervision, and protection required by the resident that is available at the facility.**
ANALYSIS:	Resident A's written *Assessment Plan for Adult Foster Care Residents (AFC*) was completed at admission on 4/28/2026 and documented that Resident A is forgetful, requires simple instructions, the assistance of one DCW for all activities of daily living including toileting, grooming, dressing, personal hygiene and walking. The written assessment plan documented specifically for "walking/mobility" that Resident A was a "one-person full assist." Licensee designee Singer, DCW Dunham and DCW Lindsay all reported that Resident A was a one person assist for walking/mobility however Resident A would often not use the call light and ambulate independently which would result in a fall. For additional safety measures the written assessment plan documented that Resident A utilized a hospital bed, wheelchair, walker, gait belt and oxygen as assistive devices. Resident A's written assessment plan did not document that she required additional supervision measures. Licensing designee Singer reported that Resident A had previous falls and sustained injuries prior to admission into the facility. Complainant, licensee designee Singer, administrator Bowen and DCW Dunham all reported that Resident A had falls while living at the facility and the falls did result in some additional injuries. Licensee designee Singer and administrator Bowen reported that while Resident A was living in the facility there were only four residents admitted to the facility therefore there was a four to one staffing ratio. The amount of personal care, supervision, and protection required by the resident as documented in the written assessment plan and as agreed to by Guardian A1 was available and provided to Resident A while she resided at the facility therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.673	**Use of assistive devices, therapeutic support.**
	(1) An assistive device or therapeutic support intended to achieve or maintain a resident's proper position to enhance mobility, physical comfort, safety, and well-being must be specified in the resident's assessment plan and agreed on by the resident or resident's designated representative. **(2) An assistive device or therapeutic support must be authorized in writing by an appropriately licensed health care professional and the authorization must state the reason for and the term of the authorization.**

ANALYSIS:	Resident A's record documented the following order by Heartland Hospice: • 4/19/2026, "use standard walker and gait belt for ambulation and transfers • 4/20/2026, "Stand by assist with ambulation until rolling walker arrives at Welcome Home Facility." In "bed mobility" it stated, "1 assist, frequent repositioning rt arm lt arm. Split lt arm." The written assessment plan documented that Resident A uses a hospital bed, wheelchair, walker, gait belt and oxygen as assistive devices. On 06/24/2026, licensee designee Singer provided a *Physician Verbal/Phone Order* dated 3/24/2026 which documented "VO from Rachel LPN- In contact with Dr. Vanwingen. Bed alarm and chair alarm used for safety while in recliner and /or in bed. Hospital bed with 2 full sized bed rails full mat to be placed under recliner/bed for safety. Bedside commode to be used as needed. Gait belt and walker used for transferring. Use wheelchair as needed. V/O given to Gabriela Lindsay." On 06/25/2026, licensee designee Singer provided *Hospice Certification and Plan of Care* which documented oxygen as being prescribed. Resident A did get her wrist caught in the bed rail on 4/27/2026 which resulted in an injury however Resident A's assessment plan did not specify any additional supervision requirements for bed rail use therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was not administered prescribed pain medications as prescribed.

INVESTIGATION:
On 05/07/2026, APS Centralized Intake Referral was transferred to LARA for investigation. Complainant reported that licenses designee Singer and administrator Bowen will not provide Resident A pain medication as prescribed by her doctor even though Resident A is in extreme pain. Complainant reported that DCWs refused to give Resident A the pain medication that hospice ordered. Complainant reported that Resident A was only provided with Tylenol even though she is in a lot of pain due to her injuries.

On 05/08/2026, a second APS Centralized Intake Referral was transferred to the LARA for investigation. Complainant reported that on 04/10/2026, Resident A fell at the facility and had to go to the hospital. Complainant reported that Resident A was diagnosed with a hip fracture and requires surgery. Complainant reported that on 04/28/2026, Resident A was restless and in a lot of pain but her PRN comfort medications were not being administered. Complainant reported that hospice was notified of Resident A's discomfort and medication changes were made by hospice. Complainant reported that on 05/01/2026, Resident A's right wrist was observed to be swollen and disfigured. Complainant reported that the facility denied her having an injury or fall however she was sent to the hospital, where she was diagnosed with a wrist fracture and broken rib. Complainant reported that Resident A returned to the facility later that evening. Complainant reported that on 05/04/2026, Resident A was restless and in pain. Complainant reported that again, the staff were not administering her comfort medications. Complainant reported that staff have been directed by owner/licensee designee Singer not to administer these medications because she does not want Resident A to be too sedated. Complainant reported that on 05/06/2026, instead of giving Resident A the comfort medications she is prescribed, Resident A was given Tylenol and another medication for pain. Complainant reported that the PRN morphine medication was requested multiple times and declined. Complainant reported that Resident A's comfort medications are being requested multiple times and denied.

On 05/12/2026 APS Schalow reported that Resident A fractured her hip on 4/10/2026 and was refused PRN medications on 4/19/2026 even though they were prescribed. APS Schalow reported that Resident A was again refused pain medications on 5/4/2026 and 5/6/2026 although she was in pain and uncomfortable from her wrist injury.

On 05/28/2026, I conducted an unannounced investigation and reviewed Resident A's record which documented the following prescribed pain medications ordered by Heartland Hospice:

- 4/27/2026, "Meloxicam 15 mg tablet daily for pain."
- 5/5/2026, "Morphine concentrate .25 100mg/5ml oral solution, take .25ml by mouth every hour for pain or shortness of breath."
- 5/6/2026 "Morphine conc 20mg/1mltake .25 ML twice daily scheduled.

I reviewed Resident A's May 2025 medication administration record (MAR) which documented that she was prescribed following pain medications:

- Morphine Sul Sol 100/5 ML, Take .25 ML (5MG) by mouth every hour as needed for pain and shortness of breath (prefilled syringe). This was ordered on 12/16/2025 and discontinued on 5/4/2026. This medication was administered once on 5/1/2026, three times on 5/2/2026, twice on 5/3/2026 and five times on 5/4/2026.
- Morphine Sul Sol 100/5 ML, give .25 ML (5MG) by mouth every hour as needed for pain and shortness of breath (prefilled syringe). This was ordered

on 5/4/2026 and discontinued on 5/6/2026. This medication was administered three times on 5/5/2026 and twice on 5/6/2026.

- Morphine Sul Sol 100/5 ML, give .25 ML (5MG) by mouth every hour as needed for pain and shortness of breath (prefilled syringe). This was ordered on 5/6/2026. This medication was administered twice on 5/6/2026 and twice on 5/7/2026.
- Morphine Sul Sol 100/5 ML, give .25 ML (5 MG) by mouth twice daily (prefilled syringe). This was ordered on 5/6/2026 and administered at 8pm on 5/6/2026 and on 5/7/2026 at 8am.
- Acetaminophen Tab 325 take 2 tablets by mouth every 8 hours as needed for pain. This was ordered on 4/19/2026 and discontinued on 5/4/2026.This medication was administered three times on 5/3/2026 and once on 5/4/2026.
- Acetaminophen Tab 325 take 2 tablets by mouth every 8 hours as needed for pain or fever." This was ordered on 5/2/2026. This medication was administered once on 5/4/2026, three times on 5/5/2026 and once on 5/6/2026.
- Acetaminophen Tab 500 take 1 tablet by mouth every 6 hours as needed for pain. This medication was ordered on 2/23/2026 and was discontinued on 5/2/2026. This medication was administered twice on 5/1/2026 and twice on 5/2/2026 prior to it being discontinued. This medication was not administered for the rest of May 2025 after it was discontinued.
- Lorazepam, tab 1 mg, take 1 tablet every hour as needed for anxiety or restlessness. This was ordered on 4/30/2026 and was administered once on 5/1/2026, three times on 5/2/2026, once on 5/3/2026, four times on 5/4/2026, once on 5/5/2026, five times on 5/5/2026 and two times on 5/7/2026.

I reviewed Resident A's April 2025 medication administration record (MAR) which documented that she was prescribed following pain medications:

- Morphine Sul Sol 100/5 ML, give .25 ML (5MG) by mouth every hour as needed for pain and shortness of breath (prefilled syringe). This was ordered on 12/16/2025. This medication was administered twice on 4/11/2026, twice on 4/19/2026, four times on 4/20/2026, three times on 4/21/2026, three times on 4/22/2026, twice on 4/23/2026, three times on 4/24/2026, twice on 4/25/2026, twice on 4/26/2026, once on 4/27/2026, once on 4/28/2026 and four times on 4/30/2026. Additionally the MAR documented, "It should be noted that Resident A was out of the facility 4/10/2026-4/19/2026." On 6/24/2026, licensee designee reported that Resident A fell on 4/10/2026 at 11:15pm. Medications were given twice after midnight reflecting the correct date of 4/11/2026. She was sent out via ambulance at 4am per hospice.
  - Meloxicam TAB 15mg, take 1 tablet by mouth daily for pain. "This medication was ordered on 4/27/2026 and administered on 4/28/2026, 4/29/2026 and 4/30/2026 as prescribed.
  - Acetaminophen Tab 500mg, Take 1 tablet by mouth every 6 hours as needed for pain."

Complainant reported that Resident A was “restless and in pain” on 4/28/2026 and 5/4/2026. According to Resident A’s MAR, she was administered Morphine once and acetaminophen tab 500 on 4/28/2026. On 5/4/2026, MAR documented that Resident A was administered Morphine, five doses and Lorazepam, five doses on 5/4/2026.

Resident A was hospitalized on 5/7/2026 and never returned to the facility, so I was not able to interview her and her medications were not available to be compared against the MAR. Resident A’s May 2025 MAR which included 5/1/2026-5/7/2026 documented that Resident A was administered 44 pro re nata (PRN)s for restlessness/pain. Resident A’s April 2025 MAR which excluded 4/10/2026-4/19/2026 as Resident A was “out of facility” documented that Resident A was administered 56 PRNs for restlessness/pain in April 2026. Resident A’s May 2026 and April 2026 MARs both documented that all medications were administered as prescribed.

I interviewed licensee designee Singer who reported that she does administer Resident A with all medication as prescribed by her doctor and that they did administer Resident A PRN pain medication due to her being in pain. License designee Singer denied that she nor other DCWs refused to give Resident A pain medication. Licensee designee Singer reported that Morphine was requested by Guardian A1 when Resident A was sleeping and in such a deep sleep that she was snoring. Licensee designee Singer reported that she did not see the need to wake Resident A up to administer Morphine to a sleeping resident who did not show any sign of pain when it was being requested by Guardian A1.

I interviewed administrator Brooke Bowen who reported that she did administer Resident A medication as prescribed by her doctor. Administrator Bowen reported that PRNs were administered to Resident A for pain as needed. Administrator Bowen denied that she nor other DCWs refused to give Resident A pain medication.

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:	Complainant reported that Resident A was “restless and in pain” on 4/28/2026 and 5/4/2026. According to Resident A’s MAR, she was administered Morphine once and acetaminophen tab 500 on 4/28/2026. Resident A’s MAR documented on 5/4/2026, Resident A was administered Morphine, five doses and Lorazepam, five doses. Additionally, Resident A’s May 2025 MAR which included 5/1/2026-5/7/2026, 7 days documented that Resident A was administered 44 PRNs for restlessness/pain. Resident A’s April 2025 MAR which excluded 4/10/2026-4/19/2026 (9 days) as Resident A was “out of facility” on the MAR and the MAR documented that Resident A was administered 56 PRNs for restlessness/pain. License designee Singer and administrator Bowen reported that Resident A was provided with all medications as prescribed by her doctor. License designee Singer and administrator Bowen both denied that they directed other DCWs to not administer Resident A pain medication therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Assisted devices were not used as order by Resident A’s physician.

INVESTIGATION:
On 05/07/2026, an APS Centralized Intake Referral was transferred to LARA for investigation and Complainant reported that DCWs do not use bed alarms to prevent falls for Resident A.

On 05/08/2026, a second APS Centralized Intake Referral was transferred to LARA for investigation. Complainant reported that the staff are also using inappropriate restraints such as a resident gate belt belted to a recliner or a dining room chair. Complainant reported that Resident A has experienced repeated falls and sustained injuries. Complainant reported that the doctor has ordered that bed alarms be used for Resident A and the facility refuses to use them because they make too much noise.

On 05/28/2026, I conducted an unannounced investigation and I reviewed Resident A’s record which contained Resident A’s written *Assessment Plan for AFC* Residents which was completed on 4/28/2026 and signed by Guardian A1 but not signed by licensee designee Kimberly Singer. The written *Assessment Plan for AFC Residents* documented Resident A uses a hospital bed, wheelchair, walker, gait belt and oxygen as assistive devices.

I reviewed Resident A's *Health Care Appraisal* that was dated 12/16/2025. In the "diagnosis" section of the report it documents, "(COPD), chronic repository failure with hypoxia, obstructive sleep apnea (OSA), anxiety, heart disease. In the "general appearance" section of the report it stated, "clean, lethargic, weak." In the "mental/physical status and limitations" section of the report it stated, "confusion, weakness. Assist with transfer."

I reviewed Resident A's record which documented the following prescribed assistive devices ordered by Heartland Hospice:

- 4/19/2026, "use standard walker and gait belt for ambulation and transfers."
- 4/20/2026, "Stand by assist with ambulation until rolling walker arrives at Welcome Home Facility."

On 6/24/2026, licensee designee Singer provided a Physician Verbal/Phone Order dated 3/24/2026 which documented "V/O from Rachel LPN- In contact with Dr. Vanwingen. Bed alarm and chair alarm used for safety while in recliner and /or in bed. Hospital bed with 2 full sized bed rails full mat to be placed under recliner/bed for safety. Bedside commode to be used as needed. Gait belt and walker used for transferring. Use wheelchair as needed. V/O given to Gabriela Lindsay."

I interviewed licensee designee Singer who reported that they used a bed alarm, floor alarm, chair alarm, full bed rails and a gait belt to ensure Resident A's safety. Licensee designee Singer reported that Resident A wears her call light around her neck so that she can call for assistance as needed. Licensee designee Singer reported that Resident A had a Gerry chair but that hospice did not want the Gerry chair used after Resident A broke her hip. Licensee designee Singer reported that once the Gerry chair could no longer be used, Resident A was in the wheelchair more and she would lean over too far and she would fall forward. Licensee designee Singer reported that she used the gait belt to wrap around her waist and the wheelchair so that Resident A would not lean over too far and fall out of the wheelchair. Licensee designee Singer denied that she ever used the gait belt to secure Resident A to a chair at the dining room table nor did she use this technique while she was sitting in a recliner. Licensee designee Singer reported that while Resident A was living in the facility there were only four residents residing at the facility and some of the shifts licensee designee Singer reported working shifts at this facility.

At the time of the unannounced investigation Resident A had already moved out therefore, I was not able to view her bedroom to assess if the bed alarms were being used nor was I able to interview her.

On 6/17/2026, I interviewed DCW Tonya Dunham who denied that she or any other staff members used a gait belt to secure Resident A to a recliner and/or dining room chair. DCW Lindsay reported that they did used bed alarms and taught Resident A how to use the call the call light so that she could notify staff when she needed something or to assist with transferring her. DCW Dunham reported

that Resident A would turn the alarms off in her room and climb out of a chair without using the call the light. DCW Dunham reported that when the alarms in the room were turned off they would not know that Resident A was up. DCW Dunham reported that Resident A thought that she could walk without assistance and she wanted to do everything herself therefore she would not use the call light.

On 06/17/2026, I interviewed DCW Gabriela Lindsay who denied that she nor any other staff members have used a gait belt to secure Resident A to a recliner and/or dining room chair. DCW Lindsay reported that they did use bed alarms and taught Resident A how to use the call the call light so that she could notify staff when she needed something so they could assist with transferring her.

On 6/24/2026, licensee designee Singer provided a *Physician Verbal/Phone Order* dated 3/24/2026 which documented "VO from Rachel LPN- In contact with Dr. Vanwingen. Bed alarm and chair alarm used for safety while in recliner and /or in bed. Hospital bed with 2 full sized bed rails full mat to be placed under recliner/bed for safety. Bedside commode to be used as needed. Gait belt and walker used for transferring. Use wheelchair as needed. V/O given to Gabriela Lindsay."

APPLICABLE RULE	
R 400.673	**Use of assistive devices, therapeutic support.**
	(1) An assistive device or therapeutic support intended to achieve or maintain a resident's proper position to enhance mobility, physical comfort, safety, and well-being must be specified in the resident's assessment plan and agreed on by the resident or resident's designated representative. **(2) An assistive device or therapeutic support must be authorized in writing by an appropriately licensed health care professional and the authorization must state the reason for and the term of the authorization.**

ANALYSIS:	Licensee designee Singer, DCW Dunham and DCW Lindsay all reported that they used bed alarms and taught Resident A how to use the call the call light so that she could notify staff when she needed something so they could assist with transferring her to prevent falls. At the time of the unannounced investigation Resident A had already moved out therefore, I was not able to view her bedroom to assess if the bed alarms were being used nor was I able to interview her. Resident A's record documented the following prescribed assistive device ordered by Heartland Hospice: On 4/19/2026, "use standard walker and gait belt for ambulation and transfers." This order did not document the term of authorization therefore a violation has been established. Licensee designee Singer reported that once the Gerry chair could no longer be used Resident A was in the wheelchair more and she would lean over too far and she would fall forward. Consequently, licensee designee Singer reported that she used the gait belt to wrap around Resident A's waist and the wheelchair so that Resident A would not lean over too far and fall out of the wheelchair which restricted her movement. This was not intended to use of a gait belt based on the physician order and therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B did not receive proper care and supervision.

INVESTIGATION:
On 05/07/2026, APS Centralized Intake Referral was transferred to the department of licensing and regulatory affairs (LARA) for investigation. Complainant reported that Resident B resides in the Welcome Home Facility in the Honey House and Resident B requires full assistance for all of her ADLs. Complainant reported that Resident B goes to the bathroom frequently due to her overactive bladder and the facilities DCWs will place the call light out of Resident B's reach. Complainant reported that on 05/04/26, Resident B fell backwards trying to get to the bathroom and this fall was not reported. Complainant reported that Resident B landed on her back and she pulled the nightstand on herself, hurting herself further. Complainant reported that Resident B had pain in her back and bruising on left side and right lower back from the fall.

On 05/08/2026, APS Hunt reported that Resident B is currently at Owosso Memorial Hospital and is looking for different placement. APS worker Rebbeca Schalow is assigned to this investigation.

On 05/11/2026, APS Schalow reported that she observed Resident B at the hospital and spoke with DPOA as Resident B was not wanting to talk due to being in pain and sleeping. APS Schalow reported that DPOA advised allegations to be true and advised that Resident B will not be returning to the facility. APS Schalow reported that she has not spoken with anyone at the facility as of yet.

On 05/12/2026, APS Schalow reported that Realtive B1 stated that licensee designee Singer deliberately placed Resident B's call light out of her reach by saying, "We keep that over here" which was the call light. APS Schalow reported that Realtive B1 asked for the call light to be handed to Resident B. APS Schalow reported that after that Realtive B1 hired a private duty staff to sit with Resident B until she was hospitalized.

On 05/28/2026, I conducted an unannounced investigation and I reviewed Resident B's record which documented that she was admitted to the facility on 2/21/2026 and had a DNR in her record. Resident B's written *Assessment Plan for Adult Foster Care Residents (AFC*) was completed on 2/21/2026 and signed by Guardian B1 and administrator Brooke Bowen. The written assessment plan documented that Resident B required one person assistance with toileting, bathing, grooming, dressing, personal hygiene and walking/mobility. Resident B utilizes bed rails, wheelchair, walker, gait belt and alarms as assistive devices.

I reviewed a *Resident Care Card* that was dated 2/24/2026 which documented that Resident B is confused at night, has impaired communication skills, unclear speech, requires the use of a wheelchair/walker and 1 person assist with gait belt as she is a fall risk. Additional notes stated, "left side weakness upon arrival. All transfers with gait belt and walker staff to walk on left side." Resident is continent both bladder and bowel and requires total assistance with bathing, dressing and grooming.

I reviewed Resident B's record which contained a *Health Care Appraisal* dated 2/21/2026 and it was signed by Guardian B2. The rest of the document was blank including the physician signature therefore additional historical medical information could not be gathered from this document.

I reviewed a *Narrative Note* dated 5/4/2026 and completed by DCW Dunham. It read:

> "I Tonya Dunham took [Resident B]to her bedside commode with walker and Gait belt held on as we walked to use the toilet at 5:30am. Pericare was done clean brief and dressed for the day. Assisted back to bed with call light in reach. Went to finish my duties and charting for my shift. 545am heard a thud went to check on resident she on the floor next to her bed. Looked her over any injuries. Noticed ½ dollar size mark on her left hip. Resident stated she was in no pan. Checked vitals BP 135/73 pulse 68 temp 97.1 02, 97%. Assisted her back into her bed. Asked her again before leaving her Room if she was in any pain stated no. Resting with call light in reach. Notified Jennifer Naylor new manager and Hospice was notified."

I reviewed a *Narrative Note* dated 5/8/2026 and completed by Jaci Helias, Heartland Hospice CNA. It read:

> "I seen [sic] [Resident B] for her shower on 5/5/26. She was able to sit on the side of her bed, denied any pain. She stood up with her walker as she normally would, pivoted into the transfer chair with ease. Showed no physical sign of pain. When we get into the shower room, she grabbed the bar and stood up with ease, turned her body to sit in the shower chair. There were no changes with [Resident B] from my last visit. I had no concerns with her."

I reviewed Resident B's MARs for May 2026 which documented:

- 05/05/2026 she was prescribed "Acetaminophen Tab 500 MG Take 1 tablet by mouth every 6 hours for pain. Acetophen is 3000 MG (3MG) per 24 hours." Resident B was administered this medication once on 5/5/2026 and once on 5/6/2026. It was not administered at all the rest of the month.
- Resident B is also prescribed "Morphine Sul SOL 100/5ML, take .25 ML by mouth every 2 hours as needed for pain or for shortness of breath. One prefilled syringe." This was ordered on 03/03/2026 and this medication was administered four times on 5/4/2026 and once on 5/5/2026. It was not administered at all for the rest of the month.

I interviewed licensee designee Singer who reported that Resident B had a baseline behavior of falls as she had fallen several times prior to admission to the facility, she fell three times while at the facility, one of which was on 5/4/2026. Licensee designee Singer reported that DCW Dunham was on duty and toileted Resident B around 5:30am. Licensee designee Singer reported that DCW Dunham heard Resident B fall just before 6am but she did not witness it. Licensee designee Singer reported that Resident B was attempting to go to the bathroom when she fell and then she pulled the night stand down on her when she was attempting to get up. Licensee designee Singer reported that both Resident B and Guardian B1 refused mobile x-rays and a trip to the hospital to be checked up. Licensee designee Singer reported that Resident B expressed that she was not in pain and she was up walking around therefore it was assumed that she was injury free from the fall. Licensee designee Singer reported that Resident B used the call light all of the time and it was always within her reach. Licensee designee Singer reported that while Resident B was living in the facility there were only four residents residing at the facility therefore there was a four to one staffing ratio.

I interviewed administrator Brooke Bowen who reported that Resident B fell on 5/4/2026 about 5:45 am when DCW Dunham was working. Administrator Bowen reported that Resident B had a quarter size bruise on her left hip and right shoulder. Administrator Bowen reported that after Resident B fell, she attempted to use the nightstand to help her up but that fell on top of her and was leaning on the right side of her body when DCW Dunham came into her bedroom. Administrator Bowen reported that the incident was reported to hospice and the nurse came out to evaluate Resident B. Administrator Bowen reported that Resident B was prescribed

morphine as a PRN and they were told to keep an eye on Resident B. Administrator Bowen reported that Resident B was up and moving around all that day, took a shower and did not show any signs of being in any pain. Administrator Bowen reported that Resident B used the call light all the time and it was always within her reach. Administrator Bowen reported that while Resident B was living in the facility there were only four residents residing at the facility, so there was a four to one staffing ratio. Administrator Bowen reported that it was not until 5/7/2026 that hospice sent Resident B to the hospital. Administrator Bowen reported that Resident B had not fallen since the fall on 5/4/2026.

At the time of the unannounced investigation Resident B had already moved out therefore, I could not view her bedroom to assess if the call button was being placed out of reach nor was I able to interview her.

On 6/17/2026, I interviewed DCW Dunham and DCW Lindsay who reported that they always made sure that Resident B's call light was within reach. DCW Dunham reported being on duty on 5/4/2026 when Resident B fell. DCW Dunham reported that she did not observe the fall, but she heard it and went to check on Resident B. DCW Dunham reported that she took Resident B's vitals and she did not report any pain. DCW Dunham reported that her shift was ending so she notified Jennifer Naylor house manager and Hospice of what had occurred.

On 06/21/2026 I spoke with APS Schalow who reported that she has not talked to any facility staff about the allegations. APS Schalow reported that she was concerned about the number of falls and injuries that resulted and reported that she was contemplating substantiating neglect.

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: **(a) The amount of personal care, supervision, and protection required by the resident that is available at the facility.**

ANALYSIS:	Resident B's written *Assessment Plan for Adult Foster Care Residents (AFC*) was completed on 2/21/2026 and signed by Guardian B1 and administrator Brooke Bowen. The written assessment plan documented that Resident B required one direct care staff assistance with toileting, bathing, grooming, dressing, personal hygiene and walking/mobility. Resident B utilizes bed rails, wheelchair, walker, gait belt and alarms as assistive devices. There was no additional supervision requirement added to the assessment plan therefore the amount of personal care, supervision, and protection required by the resident was available and provided to Resident B at the facility. Complainant, licensee designee Singer, administrator Bowen and DCW Dunham reported that on 05/04/2026, Resident B fell and she pulled the nightstand on herself trying to get up. Complainant, licensee designee Singer, administrator Bowen, DCW Dunham all reported that Resident B has a history of falls and she had bruising from the fall on 5/4/2026. Licensee designee Singer, administrator Bowen and DCW Dunham reported that hospice was notified, Resident B was moving around and denied being in any pain. The amount of personal care, supervision and protection per Resident B's assessment plan was provided.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 05/28/2026, I conducted an unannounced investigation and reviewed Resident A's and Resident B's resident records. Resident A was admitted to the facility on 12/15/2025. Resident A's written *Assessment Plan for Adult Foster Care Residents (AFC*) was completed on 4/28/2026 and signed by Guardian A1 but the document was not signed by licensee designee Kimberly Singer. Resident B's resident record documented that she was admitted to the facility on 2/21/2026. Resident B's written *Assessment Plan for Adult Foster Care Residents (AFC*) was completed on 2/21/2026 and signed by Guardian B1 and administrator Brooke Bowen, but the document was not signed by licensee designee Kimberly Singer as required.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the

	licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	Resident A and Resident B's written assessment plans were completed and signed by both residents designated representatives but not by licensee designee Singer as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 05/28/2026, I conducted an unannounced investigation and reviewed Resident B's record which contained a *Health Care Appraisal* dated 2/21/2026 and signed by Guardian B2. The rest of the document was blank including the physician signature, so no information about Resident B's health or healthcare needs could be discerned from this document.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(10) A resident or resident's designated representative shall provide a written health care appraisal or a medical discharge summary by an appropriate health care professional that is completed within the 90-day period before admission. A written health care appraisal must be completed at least annually thereafter. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be completed no later than 30 days after admission.
ANALYSIS:	Resident B's record did not contain a written health care appraisal completed within the 90 days prior to admission or 30 days after admission therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/29/2026

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Julie Elkins Date
Licensing Consultant

Approved By:

06/29/2026

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Dawn N. Timm Date
Area Manager