



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 17, 2026

Sarah Novak-Schwalm
The Bells Assisted Living, LLC
401 Church St.
Almont, MI 48003

RE: License #: AL440397767
Investigation #: 2026A0623041
The Bells Assisted Living, LLC

Dear Sarah Novak-Schwalm:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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) 643-7960.

Sincerely,

A handwritten signature in cursive script that reads "Cynthia Badour". The ink is dark and the signature is fluid, with a large loop on the "B" and a distinct "D".

Cynthia Badour, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa St.
P.O. Box 30664
Lansing, MI 48909
(517) 648-8877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL440397767
Investigation #:	2026A0623041
Complaint Receipt Date:	06/30/2026
Investigation Initiation Date:	06/30/2026
Report Due Date:	08/29/2026
Licensee Name:	The Bells Assisted Living, LLC
Licensee Address:	401 Church St. Almont, MI 48003
Licensee Telephone #:	(810) 798-2355
Administrator:	Sarah Novak-Schwalm
Licensee Designee:	Sarah Novak-Schwalm
Name of Facility:	The Bells Assisted Living, LLC
Facility Address:	401 Church St. Almont, MI 48003
Facility Telephone #:	(810) 798-2355
Original Issuance Date:	07/25/2022
License Status:	REGULAR
Effective Date:	01/25/2025
Expiration Date:	01/24/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's narcotic medication was found to be missing on 06/26/26.	Yes
Additional Findings	No

III. METHODOLOGY

06/30/2026	Special Investigation Intake 2026A0623041
06/30/2026	APS Referral An APS referral was completed.
06/30/2026	Special Investigation Initiated - Telephone I contacted APS worker Rose Koss.
07/09/2026	Inspection Completed On-site Observation and interviews.
07/09/2026	Contact - Document Received I received AFC documents.
07/16/2026	Contact - Telephone call made I contacted staff Jill Podeski
07/16/2026	Contact - Document Sent I emailed a request for a copy of the police report.
07/17/2026	Contact - Document Received I received a copy of the police report.
07/22/2026	Contact - Telephone call made I contacted APS worker Rose Koss.
08/10/2026	Contact - Telephone call made I contacted staff Jill Podeski.
08/10/2026	Contact - Telephone call made I contacted APS worker Rose Koss.
08/11/2026	Contact - Telephone call made I contacted staff Mark Kenney.

08/11/2026	Contact - Telephone call made I contacted hospice nurse Julie Uplinger.
08/11/2026	Contact - Telephone call made I contacted staff Alexandra "Lexi" Wilding.
08/14/2026	Contact - Document Received MiCourt case search online. State of Michigan vs. Podeski.
08/14/2026	Contact - Telephone call made I contacted staff Jill Podeski.
08/14/2026	Inspection Completed-BCAL Sub. Compliance
08/14/2026	Exit Conference I contacted Licensee Designee Sarah Novak-Schwalm.

ALLEGATION:

Resident A's narcotic medication was found to be missing on 06/26/2026.

INVESTIGATION:

On 06/30/2026, An Adult Protective Service referral was completed. I shared information with APS.

On 06/30/2026, I contacted APS worker Rose Koss. APS Koss stated that staff Jill Podeski was identified as the staff person responsible for the missing medication. APS is following up with the detective and other related parties to this investigation.

On 07/09/2026, I conducted an unannounced onsite inspection of the facility. I interviewed Resident A, Relative A, Director Shannon Moriarity and Licensee Designee Sarah Novak-Schwalm.

On 07/09/2026, I interviewed Resident A in her bedroom alone. Resident A appeared frail and hard of hearing. Resident A was able to recall staff Jill Podeski telling her she didn't need to take one of her pain medications. Resident A stated that she knows what she is supposed to take. Resident A stated that she did not refuse her pain medication. Resident A stated that she likes the home and staff are good to her. Resident A stated that she doesn't remember things sometimes.

On 07/09/2026, I interviewed Relative A in the bedroom of Resident A with her present. Relative A stated that she and other relatives visit Resident A on an almost daily basis as they live nearby. Relative A stated that she was notified of the missing pain medication. Relative A stated that Resident A receives hospice services and are very

involved in her care. Relative A stated that she is satisfied that the facility acted quickly in notifying her, police and hospice so any medication needed was replaced.

On 07/09/2026, I interviewed Director Shannon Moriarity. Director Moriarity stated that she received a call from staff Mark Kenney regarding the narcotic count being off for Resident A. Director Moriarity stated that she requested the medication room be locked down until she arrived and completed a medication audit. Upon completion of the audit an incident report was completed, law enforcement, Relative A, hospice, licensing and APS were notified. I observed the medication training and quiz worksheet completed by staff Jill Podeski which showed a passing grade. Director Shannon Moriarity stated that staff Jill Podeski's employment was terminated on 06/30/2026.

On 07/09/2026, I interviewed Licensee Designee (LD) Sarah Novak-Schwalm. LD Novak-Schwalm stated that no other medications were found to be missing. LD Novak-Schwalm stated that staff Jill Podeski was eligible to work and had passed the medication training.

On 07/09/2026, I received and reviewed AFC documents. I reviewed the Incident Report dated 6/26/2026 at 6:45 am. Staff Mark Kenney stated the narcotic count was off on one of the narcotics in med room 1 and Director Shannon Moriarity was contacted. Shannon Moriarity came in and re-audited the narcotic, and it was off. Medication room was locked down. Staff did not proceed until after audit. Performed overall audit, reviewed security tapes, made police report (Almont Police Department), contacted resident family, pharmacy and hospice company (Heart to Heart). Staff Jill Podeski identified as the staff responsible. I reviewed the Workforce Background Check Eligibility letter for staff Jill Podeski dated 06/02/2026. I reviewed Resident A's health care appraisal form indicating she is receiving hospice services due to CHF (Chronic Health Failure), oxygen dependent, forgetful, with chronic back pain controlled with current medications. I reviewed the June 2026 MAR (Medication Administration Record) for Resident A which showed a discrepancy regarding the pain medication Acetaminophen/Hydrocodone 325MG/10MG PO Tablet, and no exception noted in the record.

On 07/16/2026, I contacted staff Jill Podeski. I left a voice mail message.

On 07/16/2026, I emailed a request for a copy of the police report to Detective Scott Isaacson. On 07/17/2026, I received a copy of the police report, complaint #26-2354 from Detective Scott Isaacson. A summary of the police report shows that on June 26, 2026, Almont Police responded to a report of stolen controlled medication from The Bells Assisted Living. Staff discovered that one blister sheet containing 30 Norco (Hydrocodone-Acetaminophen 10-325 mg) pills prescribed to Resident A was missing. The medication is normally secured in a locked controlled-substance drawer accessible only to the on-duty Med Tech. Review of surveillance footage identified Med Tech Jill Podeski, the sole employee with access during the relevant timeframe, engaging in suspicious behavior on June 25, 2026. Video showed her lingering in front of the drawer, obstructing the camera's view, manipulating the workstation, and appearing to

conceal an item in her waistband before leaving the room. A subsequent medication audit revealed the blister sheet was missing, and video confirmed that no other staff accessed the drawer after Jill Podeski's departure. Interviews were conducted with staff and Resident A. Jill Podeski denied theft and stated she is personally prescribed Norco; however, inconsistencies were found in her explanation and the handling of her personal medication. The administrator and other employees confirmed surveillance observations and medication count discrepancies. Resident A reported that Jill Podeski initially withheld her prescribed Norco and had no permission to take any of her medication. Evidence collected included surveillance video, medication audit sheets, employment documents, and prescription verification. The investigation was forwarded to the Detective Bureau, and prosecutors authorized the following charges against Jill Podeski: Controlled Substance Possession (Schedule II), 4-year felony and Larceny in a Building, 4-year felony. Jill Podeski was advised to turn herself in following warrant authorization.

On 07/22/2026, I contacted APS worker Rose Koss. APS Koss stated that she was able to speak to staff Jill Podeski briefly on the phone. APS Koss stated that staff Jill Podeski told her she quit the facility because they were not giving her enough hours. APS Koss stated that when she asked about the missing pain medication staff Jill Podeski hung up on her and did not answer the phone afterwards.

On 08/10/2026, I contacted staff Jill Podeski. The message stated that the subscriber is not accepting calls at this time.

On 08/10/2026, I contacted APS worker Rose Koss. APS Koss stated that she did substantiate her case.

On 08/11/2026, I contacted staff Mark Kenney. Staff Kenney stated that he got called to the medication room to confirm the medication count was off and it was off by a whole blister pack of Resident A's medication. Staff Kenney stated that after he recounted, he called Director Shannon Moriarity who advised him to lock the room up and when she got to the facility she would do an audit. Staff Kenney stated that no other medications were missing.

On 08/11/2026, I contacted hospice nurse Julie Uplinger. Nurse Uplinger stated that she has worked with Residents at the home for 2 years and Resident A is one of her patients. Nurse Uplinger stated that she was notified of the missing medication and she did speak to Resident A about it and was told about staff Jill Podeski telling her she didn't need it. Nurse Uplinger stated that she ordered replacement medication to cover what was missing. Nurse Uplinger stated that she believes the facility acted quickly once the count was off and she was notified and replaced the medication.

On 08/11/2026, I contacted staff Alexandra "Lexi" Wilding. Staff Wilding stated that she was present when the narcotics count for Resident A was found to be off. Staff Wilding stated that staff Mark Kenney was contacted to review the count and once he did everything got shut down until Director Shannon Moriarity came in to audit.

On 08/14/2026, MiCourt case search online. State of Michigan vs. Podeski. 71A District Court Lapeer filed on 08/04/2026. Date of offense 06/25/2026. Warrant signed and issued for Jill Podeski 2 felony counts larceny in a building and controlled substance possession (narcotic/cocaine) less than 25 grams.

On 08/14/2026, I contacted staff Jill Podeski. The message stated that the subscriber is not accepting calls at this time.

On 08/14/2026, I completed an exit conference with Licensee Designee (LD) Sarah Novak-Schwalm. I explained my investigation and findings. LD Novak-Schwalm stated that she understood and that a corrective action plan would be completed to address the rule violation. LD Novak-Schwalm will contact this consultant if she has any questions.

APPLICABLE RULE	
R 400.675	Resident medications.
	(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	The allegation stated that Resident A's narcotic medication was found to be missing on 06/26/2026. Once notified by staff, facility leadership immediately initiated a medication audit, locked down the medication room, and notified law enforcement, hospice, pharmacy, the resident's family, Adult Protective Services (APS), and state licensing. A review of security video and access records identified staff Jill Podeski as the only staff member with access to the controlled substance drawer during the relevant time. Footage showed her engaging in suspicious activity, including blocking the camera and appearing to conceal an object. Resident interviews further indicated that Jill Podeski had inappropriately withheld the resident's prescribed pain medication. Multiple attempts were made by Licensing to interview staff Jill Podeski; however, they were unsuccessful. Law enforcement, APS, and licensing investigations substantiated the incident. The police report documented that an entire blister pack of 30 Norco tablets was missing, and prosecutors authorized two felony charges against Jill Podeski: Controlled Substance Possession (Schedule II) and Larceny in a Building.

	Staff Jill Podeski's employment was terminated on June 30, 2026. No additional medication discrepancies were found, and hospice replaced the missing medication promptly. I conclude there is enough evidence to substantiate a rule violation.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



08/17/2026

Cynthia Badour
Licensing Consultant

Date

Approved By:



08/17/2026

Mary E. Holton
Area Manager

Date