



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 10, 2026

Jasween Jagjit-Webb
Auburn Heights Senior Care, Inc.
110 Auburn Road
Auburn, MI 48611

RE: License #: AL090260028
Investigation #: 2026A0572045
Auburn Heights Senior Care, Inc.

Dear Jasween Jagjit-Webb:

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) 643-7960.

Sincerely,

A handwritten signature in black ink that reads "Anthony Humphrey". The signature is written in a cursive style with a large, stylized "A" and "H".

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL090260028
Investigation #:	2026A0572045
Complaint Receipt Date:	07/21/2026
Investigation Initiation Date:	07/24/2026
Report Due Date:	09/19/2026
Licensee Name:	Auburn Heights Senior Care, Inc.
Licensee Address:	110 Auburn Road Auburn, MI 48611
Licensee Telephone #:	(989) 662-2099
Administrator:	Johanna Rueda
Licensee Designee:	Jasween Jagjit-Webb
Name of Facility:	Auburn Heights Senior Care, Inc.
Facility Address:	110 Auburn Road Auburn, MI 48611
Facility Telephone #:	(989) 545-9462
Original Issuance Date:	01/27/2004
License Status:	REGULAR
Effective Date:	06/13/2026
Expiration Date:	06/12/2028
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was served lunch. It is unknown if he receives breakfast and dinner. The lunch was not adequate, and it was left out for hours.	No
Resident A's bed sheets are soiled with urine; he does not have Chux pads or incontinence pads.	No
The caretakers empty Resident A's urinal then come back and put it on the floor so there is no way for him to use the bathroom.	No
The caregivers are not getting Resident A out of the bed; he is being left in the bed all day.	No
Resident A has stage 2 pressure to his left buttock from a fall which caused him to get a wound. When the wound opened, they did not take him to the hospital immediately.	No
Resident A's blood pressure or blood sugar is not being checked. He is being provided blood pressure medication without his blood pressure being taken.	No
Resident A needs full assistance with transfers and positioning, when the caretakers boost him up, they are not using a sheet or transfer materials. The caretakers are hiking Resident A up under his arm pits causing discomfort.	Yes

III. METHODOLOGY

07/21/2026	Special Investigation Intake 2026A0572045
07/21/2026	APS Referral Referral came from APS.
07/24/2026	Special Investigation Initiated - Letter
07/29/2026	Inspection Completed On-site
07/29/2026	Contact - Face to Face Home Manager, Johanna Greko; Staff, MaKenna Korte; and Staff, Haylee Lewis.
08/06/2026	Contact - Document Sent APS, Bethany Hornbacher.
08/07/2026	Contact - Document Received APS, Bethany Hornbacher.

08/11/2026	Contact – Telephone call made Dr. Kahn's Office.
09/09/2026	Contact - Telephone call made Resident A's Family Member 1
09/09/2026	Contact - Telephone call made Resident A.
09/10/2026	Exit Conference Jasween Jagjit-Webb

ALLEGATION:

Resident A was served lunch. It is unknown if he receives breakfast and dinner. The lunch was not adequate, and it was left out for hours.

INVESTIGATION:

On 07/21/2026, the local licensing office received a complaint for investigation. Adult Protective Services (APS) made the referral to licensing.

On 07/29/2026, I made an unannounced onsite at Auburn Heights Senior Care, located in Bay County Michigan. Interviewed were Home Manager, Johanna Greko; Staff, MaKenna Korte; and Staff, Haylee Lewis.

On 07/29/2026, I interviewed Home Manager, Johanna Greko regarding the allegation. Johanna Greko informed that Resident A was a very picky eater and would only eat about half of his food. He only really likes to eat the chips that his family would bring him, as opposed to what he was served at the home. Johanna Greko denied that his food was ever left out for hours.

On 07/29/2026, I interviewed Staff, MaKenna Korte regarding the allegation. MaKenna Korte informed that Resident A did not like the food so he would refuse. If food was left in his room, it's because he refused it. MaKenna Korte denied that his food was left out for hours.

On 07/29/2026, I interviewed Staff, Haylee Lewis regarding the allegation. Haylee Lewis informed that Resident A would not allow them to feed him, so he would feed himself. When they insisted on feeding him, he would become upset and then demonstrate that he had no problems feeding himself. He refused his meals all the time. He was served breakfast, lunch, dinner and snacks. Resident A kept snacks in his room. Haylee Lewis denied that Resident A's food was left out for hours.

On 07/29/2026, I interviewed Staff, Becky Brown regarding the allegation. Becky Brown informed that Resident A was offered 3 meals per day and it was taken to him. Resident A did not always want to eat lunch on time, so they would keep it stored until he was ready for it. Resident A would usually only eat maybe half of his food. Resident A really liked chips, so he would eat those if given to him. Becky Brown denied that staff left food out for hours.

On 09/09/2026, I contacted Resident A's Family Member #1 regarding the allegation. She informed that the food there was not very appetizing to Resident A, so he didn't eat much of the food. She is unsure if food was left out for hours but was informed by a nurse that it was.

On 09/09/2026, I interviewed Resident A regarding the allegation. Resident A informed that the allegation is not true. It is true that he did not like the food as it was horrible and says that it made him pass out because his blood pressure dropped to 40. He says that he was offered meals 3 times per day, but it was left out because he wouldn't eat it.

APPLICABLE RULE	
R 400.663	Nutrition; adoption by reference.
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	Based on my interviews with Staff, Resident A and Family Member #1, there is not enough evidence to establish a licensing rules violation. All staff and Resident A denied the allegation. Family Member #1 had not witnessed this but was informed by a nurse that it was.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A's bed sheets are soiled with urine; he does not have Chux pads or incontinence pads.

INVESTIGATION:

On 07/29/2026, I interviewed Home Manager, Johanna Greko regarding the allegation. Johanna Greko was not aware of any issues regarding Resident A having soiled bed sheets. If his sheets were ever soiled, staff would change them immediately.

On 07/29/2026, I interviewed Staff, MaKenna Korte regarding the allegation. MaKenna Korte informed that Resident A never had soiled sheets. He had accidents, but he was cleaned immediately as Resident A had no problems letting them know that he had an accident.

On 07/29/2026, I interviewed Staff, Haylee Lewis regarding the allegation. Haylee Lewis informed that staff would change his sheets every time they became soiled. Resident A would let them know that he had an accident.

On 07/29/2026, I interviewed Staff, Becky Brown regarding the allegation. Becky Brown informed that Resident A refused to wear briefs, so if his bedding got wet, it would be changed immediately. Resident A had no problems letting staff know that he needed his bedding to be changed.

On 09/09/2026, I interviewed Resident A regarding the allegation. Resident A denied ever having soiled sheets. He informed that he had a urinal and that he uses it and staff empties it. He informed that if he did have soiled sheets, he was capable of calling staff to change him and his bedding, but this was never an issue.

APPLICABLE RULE	
R 400.669	Linens.
	(1) A licensee shall provide all of the following: (a) Clean bedding in good condition that includes a minimum of a fitted sheet, top sheet, pillowcase, and blanket or comforter for each bed.
ANALYSIS:	Based on the interviews conducted with staff and Resident A, there was not enough evidence to establish a licensing rules violation. Both staff and Resident A denied that this ever occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **The caretakers empty Resident A's urinal then come back and put it on the floor so there is no way for him to use the bathroom.**
- **The caregivers are not getting Resident A out of the bed; he is being left in the bed all day.**

INVESTIGATION:

On 07/29/2026, I interviewed Home Manager, Johanna Greko regarding the allegation. Johanna Greko informed that Resident A had a urinal that he would use, push the call button and then staff would empty it. She denies that the urinal was out of reach for Resident A, but informed that they had wrote incident reports due to Resident A consuming his own urine. In regard to being left in bed all day, Johanna Greko informed that Resident A was always encouraged to get out of bed so that he does not develop bedsores, since he was bedridden, but he always refused. She printed out communication that she had with the family explaining that Resident A refuses to get out of bed.

On 07/29/2026, I interviewed Staff, MaKenna Korte regarding the allegation. MaKenna Korte denied that Resident A's urinal was left out of his reach. If he needed to use it, it was right within his grasps. He would then push his call button, and staff would be there to empty it. In regard to Resident A being left in bed all day, MaKenna Korte informed that Resident A always would refuse to get out of bed.

On 07/29/2026, I interviewed Staff, Haylee Lewis regarding the allegation. Haylee Lewis informed that Resident A would urinate in the urinal and defecate in a tray. Resident A would push the call button to have them both emptied. In regard to Resident A being left in bed all day, Haylee Lewis says that they were only able to encourage Resident A to get out of bed. Resident A only wanted to get up for showers, which were on Wednesdays and Saturdays. Most times he would just want to lay in bed. They would use the Hoya Lift so they could put him in his wheelchair, but he would just stay in his room and not leave.

On 07/29/2026, I interviewed Staff, Becky Brown regarding the allegation. Becky Brown informed that staff would empty Resident A's urinal, clean it and sit right next to him or he would ask them to hook it to his bedrail. In regard to Resident A being left in bed all day, Becky Brown informed that is where he wanted to be. They tried to get him out of bed by encouraging him or even going as far as bribing him with ice cream or trying to get him to meet some of the other residents by encouraging him to come out for some activities, but he didn't want to. He would only get up for showers or to use his computer. He just wanted to lay in bed. In the rare occasions that he would get out of bed, staff would use the Hoyer Lift to sit him in his wheelchair so he can use his computer, but he wouldn't come out for activities.

On 09/09/2026, I contacted Resident A's Family Member #1 regarding the allegation. Resident A's Family Member #1 had informed that I could speak with Resident A as he has a phone and has the capacity to speak and answer questions. He just has some physical health issues. She did share that she heard from a nurse that Resident A's food was being left on a table next to his bed for hours, but it's not something that she witnessed.

On 09/09/2026, I interviewed Resident A regarding the allegation. Resident A informed that he does not have accidents. He is able to urinate in the urinal, and the staff keeps the urinal near him for him to use it. He informed that it was easier for him to empty it into a Styrofoam cup, but it caused staff to think that he was drinking his own urine. In regard to being left in bed all day, Resident A informed that they would have to use a Hoyer Lift in order to get him out of bed and it would be used so he can get in the shower. He informed that when staff would ask if he wanted to get up for anything else, the answer would usually be, "No."

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 interviews with staff, Resident A and Family member #1, there is not enough evidence to establish a licensing rules violation. Both staff and Resident A all denied both allegations. Resident A had a urinal nearby and he was left in bed all day because that's where he preferred to be.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Resident A has stage 2 pressure to his left buttock from a fall which caused him to get a wound. When the wound opened, they did not take him to the hospital immediately.**
- **Resident A's blood pressure or blood sugar is not being checked. He is being provided blood pressure medication without his blood pressure being taken.**
- **Resident A needs full assistance with transfers and positioning, when the caretakers boost him up, they are not using a sheet or transfer materials. The caretakers are hiking Resident A up under his arm pits causing discomfort.**

INVESTIGATION:

On 07/29/2026, I interviewed Home Manager, Johanna Greko regarding the allegation. Informed that it was true that Resident A had developed a pressure sore on his buttocks, but it began to open due to him refusing to get up. Resident A had a Wound Care Specialist. Cream was prescribed to Resident A, and it was being applied on the wound. Staff were always encouraging him to get out of bed, so he doesn't develop sores. Resident A's Son-In-Law is a Dermatologist and demanded that he be transported to the ER, where he was diagnosed with cellulitis. In regard to the transfers and repositioning, he was transferred with a Hoyer Lift. One staff could assist with repositioning in bed, but Resident A could also reposition himself. With regards to the blood sugar and blood pressure not being checked, there were no orders to check blood pressure. When the Home Care Nurse came to see Resident A on 07/21/2026, they were given a verbal order to check blood pressure everyday for a period of 7 days due to low blood pressure.

On 07/29/2026, I interviewed Staff, MaKenna Korte regarding the allegation. MaKenna Korte informed that Resident A had a wound and he had cream for it. She

indicated that it may have developed because he would refuse to get out of bed. In regard to transferring and repositioning, Resident A would prefer to be left alone and says that he could do it himself. She was present when a Home Health Nurse was there and the nurse asked how they do transfers. She informed that they usually have bed pads under the bed, but they were being washed. MaKenna Korte left out the room to get a clean bed pad and when she came back, the nurse told her that staff were picking Resident A up by his armpits. She assumed that Resident A told the nurse this but was not aware of any staff doing this.

On 07/29/2026, I interviewed Staff, Haylee Lewis regarding the allegation. Haylee Lewis informed that she had worked with Resident A and knew that he had developed a wound. Resident A had a wound care specialist that would come to see him, and he was prescribed a cream, which was being used. In regard to transfers and repositioning, Haylee Lewis says that Resident A wouldn't allow staff to reposition him and would tell them that he can do it himself, then he would show them that he could do it. There was a time when Resident A requested that they get him up by the arms because he did not want to use the Hoyer Lift, so she got another staff to assist her with sitting him up. The nurse told them not to transfer him like this, so they never did it again. In regard to blood sugar and blood pressure, Haylee Lewis informed that it's not an automatic that they have to check blood pressure or blood sugar if the resident is on the medications. They initially had no orders to check them. When an order was made to check blood pressure, they began checking blood pressure.

On 07/29/2026, I interviewed Staff, Becky Brown regarding the allegation. Becky Brown informed that Resident A had developed a small wound on his tailbone and he was prescribed some cream for it. Becky Brown informed that Resident A was transferred with Hoya Lift and staff would reposition him if he allowed them to. In regard to blood sugar and blood pressure not being checked, they did not have an order to check them. Becky Brown informed that if they had an order, they would have checked them as they have other residents who they are ordered to check several times per day.

On 07/29/2026, I reviewed a 07/11/2026 communications between Home Manager, Johanna Greko and Resident A's Family member #1. Family Member #1 was concerned that there was evidence that Resident A could be developing some early skin breakdown because he is frequently lying on one side. Family Member #1 informed that she had spoken to a Nursing Assistant and there was no current plan to roll Resident A on a frequent basis and wanted to see if the physician can make the appropriate orders. Johanna Greko responded and informed that she will ensure that staff will assist Resident A by repositioning every two hours. She explained that Resident A is able to reposition himself independently and has been doing so, but staff will provide additional assistance and reminders to help reduce the risk of skin breakdown. She further informed that the biggest concern with this is that Resident A has been encouraged to get out of bed throughout the day, as prolonged periods

in bed can contribute to skin breakdown regardless of how frequently he is repositioned.

On 07/29/2026, I reviewed an Incident Report, dated for 07/11/2026, indicating receipt of an email from Family Member #1 requesting that Resident A be repositioned. Action Taken was to ensure that staff rotate/reposition Resident A every two hours and apply barrier cream on wound. Resident A was placed on a rotating schedule to ensure Resident A was appropriately being rotated and document refusals.

On 07/29/2026, I reviewed Resident A's Assessment Plan, and it indicates that Resident A has a Hoyer Lift. In regard to repositioning assistance, it states, "1 person assist to reposition in bed, also can independently reposition as well."

On 07/29/2026, I reviewed Resident A's repositioning schedule, and it appears that this was implemented on 07/15/2026 at 10am and it was completed every two hours.

On 07/29/2026, I reviewed a Physician Order from Dr. Khan dated 07/17/2026. It states to keep the wound clean and dry. There will be a follow up and an attempt to get Resident A an air mattress.

On 07/29/2026, I reviewed a Physician's Order from Dr. Khan, dated for 07/01/2026 to lower the dosage of blood pressure medication Metoprolol from 50mg to 25mg due to low blood pressure concerns. Staff are to monitor blood pressure every day for 7 days and notify the office if blood pressure is more than 140/90 or less than 100/60.

On 08/06/2026, I received a couple of photos from APS, Bethany Hornbacher which shows Resident A's wound on his tailbone.

On 08/07/2026, APS Bethany Hornbacher informed that her case will not be substantiated, and she will be closing her case.

On 08/11/2026, contact was made with Dr. Kahn's Office regarding the management of his diabetes. Records reveal that Resident A's diabetes have been well controlled dating back to 2024. Resident A was not required to monitor his blood glucose levels. Resident A's fasting blood glucose and A1c were both within a good range. The office monitors Resident A's diabetes through laboratory testing every six months. Although Resident A is prescribed injectable insulin, there is no medical requirement for routine blood glucose checks, as periodic laboratory monitoring is sufficient based on his stable diabetic control.

On 09/09/2026, I contacted Resident A's Family Member #1 regarding the allegation. Resident A for years had an autoimmune disease and so when he fell and broke his back, he had a red spot on his tailbone. She emailed Auburn Heights to start turning him. A few days later, she took a picture of the area, and the wound

had opened up. Her husband is a dermatologist, and he suggested that they take Resident A to the ER. Initially, Home Manager, Johanna Greko said it didn't look that bad and just put some ointment on it, but he was taken to the ER and was diagnosed with cellulitis. In regard to transfers and repositioning, Resident A's Family Member #1 informed that she was informed by a nurse that staff weren't picking up Resident A correctly. Resident A had went on Amazon to order some wedges so he could be positioned properly. She was informed by the Home Manager that they did not have any orders to use a blanket to lift or transfer Resident A.

On 09/09/2026, I interviewed Resident A regarding the allegation. Resident A informed that he had a pressure wound that had opened up after laying on it. The Home Manager said that it didn't look that bad, but it was itchy, so he had Family Member #1 take a picture of it so he could have his son-in-law look at it, who requested that he be taken to the ER. Prior to this, he was prescribed cream and it was being applied to the wound. In regard to transfers and repositioning, Resident A informed that he was kind of uncooperative in that respect because the pillows couldn't prop him up correctly, so he ordered some wedges. Staff were supposed to use a pad to lift him up, but they were lifting him by the shoulders. It was two staff that would take each arm and lift him, but someone told them that they had to use pads.

On 09/10/2026, an exit conference was held with Licensee Designee, Jasween Jagjit-Webb regarding the results of the special investigation. Jasween Jagjit-Webb appreciated the time taken to complete the investigation and informed that she will ensure that she speaks with staff in regard to following orders even if residents are not cooperating.

APPLICABLE RULE	
R 400.689	Resident health care.
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Based on my interviews with staff, Resident A, Family Member #1, the doctor's office and documents reviewed, there is enough evidence to establish a licensing rules violation. The appropriate measures appeared to be taken with regard to the wound, as Resident A had a wound care specialist, and the home was following the orders which were to keep the wound clean and dry. There was also a prescription for some cream that was being applied.

	In regard to blood sugar and blood pressure not being checked. There was no order to check either. Once there was an order to check blood pressure for a period of 7 days, the home began checking it. According to Dr. Khan's Office there were no orders to check blood glucose levels as his levels were stable.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.689	Resident health care.
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	In regard to transfers and repositioning, staff informed that Resident A was able to transfer himself and Resident A informed that he was uncooperative with transfers due to the pillows not propping him right. However; according to Resident A, a Home Care Nurse and one of the staff, Resident A was transferred at least once without the use of the Hoyer Lift.
CONCLUSION:	VIOLATION ESTABLISHED

On 09/10/2026, an exit conference was held with Licensee Designee, Jasween Jagjit-Webb. Licensee Designee, Jasween Jagjit-Webb was informed of the findings of this special investigation.

IV. RECOMMENDATION

I recommend that no changes be made to the status of this large adult foster care group home, pending the results of an acceptable corrective action plan (capacity 13-20).



09/10/2026

Anthony Humphrey
Licensing Consultant

Date

Approved By:



09/11/2026

Mary E. Holton
Area Manager

Date