



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 9, 2026

Katie Edwards
Wood Care VIII, Inc.
910 S Washington Ave
Royal Oak, MI 48067

RE: License #: AL090281508
Investigation #: 2026A0572044
Monet House Inn

Dear Katie Edwards:

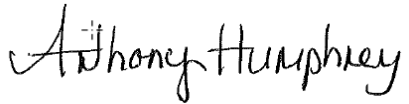
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL090281508
Investigation #:	2026A0572044
Complaint Receipt Date:	07/17/2026
Investigation Initiation Date:	07/22/2026
Report Due Date:	09/15/2026
Licensee Name:	Wood Care VIII, Inc.
Licensee Address:	910 S Washington Ave Royal Oak, MI 48067
Licensee Telephone #:	(810) 299-1320
Administrator:	Katie Edwards
Licensee Designee:	Katie Edwards
Name of Facility:	Monet House Inn
Facility Address:	6700 Westside Saginaw Rd Bay City, MI 48706
Facility Telephone #:	(810) 299-1320
Original Issuance Date:	12/05/2007
License Status:	REGULAR
Effective Date:	12/15/2025
Expiration Date:	12/14/2027
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There is inadequate staffing.	Yes
Staff appear to be lacking in training.	No
Staff are neglecting to disperse medications to Resident A.	No
There is poor frequency of bathing for Resident A	No
Resident A is put in bed with the same clothes she wore all day and leaving her in soiled diapers	Yes
The soiled diapers caused Resident A to have soiled linens on the bed that weren't changed.	Yes
Staff are leaving Resident A parked in the hallway.	No

III. METHODOLOGY

07/17/2026	Special Investigation Intake 2026A0572044
07/22/2026	Special Investigation Initiated - Letter Complainant
07/28/2026	Inspection Completed On-site Administrator for Turner, Abbie Card; Staff, Brittany Beck; and Staff, Jessica Spegal.
08/27/2026	Contact - Telephone call made Staff, Stella Payne.
09/08/2026	Exit Conference Director, Hannah Beagle
09/08/2026	Exit Conference Katie Edwards.
09/09/2026	Contact - Telephone call made Resident A's Family Member #1.
09/09/2026	APS referral An APS referral was made.

ALLEGATION:

There is inadequate staffing.

INVESTIGATION:

On 07/17/2026, the local licensing office received a complaint for investigation. Contact will be made with the Complainant for further information.

On 07/22/2026, contact was made with the Complainant regarding which licensed facility was Resident A located, as the physical location has 3 separate licenses. Monet House Inn is the location, and Resident A is no longer residing in the home.

On 07/28/2026, I made an unannounced onsite at Monet House Inn, located in Bay County Michigan. I was able to speak with the Administrator of Turner Inn, Abbie Cord; and she set up interviews with Staff, Brittany Beck; Staff, Jessica Spegal; and Staff, Stella Payne.

On 07/28/2026, I spoke briefly with the Administrator of Turner Inn, Abbie Cord. Abbie Cord informed that Resident A moved out of the home on 07/17/2026. Resident A only resided in Monet House Inn for a short period of time. Resident A moved into the home because her home was damaged during a major storm. State Farm paid for Resident A's stay at the Monet House Inn until she moved back into her own home.

On 07/28/2026, I interviewed Staff, Brittany Beck regarding the allegation. Brittany Beck informed that Resident A was in the home for a few months and moved out once her home was repaired. Brittany Beck stated that there is not enough staffing at Monet House Inn to provide quality of care. They currently have 14 residents with 2 staff. 5 of those residents are on Hoyer Lifts and one sit-to-stand. Staff are often left by themselves when one staff has to go help out in Leighton House Inn. It has become difficult to respond to call lights due to lack of staffing.

On 07/28/2026, I interviewed Staff, Jessica Spegal regarding the allegation. Jessica Spegal informed that there is not enough staffing. She believes that they have 5 residents who use a Hoyer Lift and a resident who is a sit-to-stand. It is difficult because they will take away a staff to assist in Leighton House Inn, leaving the other staff alone with residents who constantly attempt to elope or get up when they are not able to ambulate on their own. It's hard to care for residents and complete all the other responsibilities when left alone. Jessica Spegal stated that Resident A was there for a few months as her home was going through some renovations.

On 08/27/2026, I interviewed Staff, Stella Payne regarding the allegation. Stella Payne informed that there is not enough staffing. There was a time in which they had 3 staff per shift. They currently have 5 Hoyer Lift residents as well as residents who attempt to elope. They will take staff from Monet House Inn and have them assist at Leighton House Inn. Staff are by themselves when the other staff leave to help out in the other licensed area or when they take their breaks and lunches.

On 09/08/2026, phone contact was made with Staff, Stella Payne on any updates regarding staffing. She informed that management is still taking staff from Monet House Inn to assist in Leighton House Inn. They currently have 20 residents. 1st shift has 2 staff from 6am to 6pm. There's a staff person who comes in from 6pm to 10pm and then another staff person comes in from 10pm to 6am. Both of those shifts may have either 1 or 2 staff. There are still 5 Hoyer Lift residents and there are still residents who will try to elope. When one staff comes in from 6pm to 10pm or the night staff is working by themselves, they are severely understaffed because they have to do the Hoyer Lifts by themselves.

On 09/08/2026, I held an exit conference with the Director, Hannah Beagle. Hannah Beagle informed that she agreed that staff needs to be mindful of what's in the Resident Assessment Plan when caring for residents and the staffing concerns is something that they are actively working on. Hannah Beagle informed that Katie Edwards is the Licensee Designee and will be the person responsible for the corrective action plan.

On 09/08/2026, I conducted an exit interview with Licensee Designee, Katie Edwards regarding the allegation. Katie Edwards informed that they are currently working on hiring more staff so there's a minimum of two staff on each shift, and more staff if necessary.

On 09/09/2026, I spoke with Resident A's Family Member #1 regarding the allegation. Family Member #1 informed that there is not enough staff as when they would try to get some assistance, there was never any staff around. Family Member #1 was told by management that the State of Michigan ratio is 1-15, so that's the ratio that they were going by. Family Member #1 also was concerned that when they did find a staff member to express their concerns to, they were always on their cellphones.

APPLICABLE RULE	
R 400.633	Staffing requirements.
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: (a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities. (b) 12 residents for small group and family homes.

ANALYSIS:	Based on the interviews conducted with staff, there are not enough staff in the home, therefore a licensing rules violation has been established. There are 5 Hoyer Lift and a sit-to-stand residents in Monet House Inn. If there is only one staff scheduled or if one staff leave to assist another licensed area, then Monet House Inn is understaffed.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Staff appear to be lacking in training.

INVESTIGATION:

On 07/28/2026, I interviewed Staff, Brittany Beck regarding the allegation. Brittany Beck informed that all staff are trained. They are all trained in med passing, Hoyer Lift as well as other trainings.

On 07/28/2026, I interviewed Staff, Jessica Spegel regarding the allegation. Jessica Spegel informed that all staff are fully trained, but they can always use some more training.

On 07/28/2026, I interviewed Staff, Stella Payne and she informed that all staff are trained, but could always use some additional training.

On 07/28/2026, I reviewed all the employee files and according to their training logs, all staff are fully trained.

On 09/09/2026, I interviewed Resident A's Family #1, and she informed that she believes that staff are not trained sufficiently because many of the issues in the home comes down to training.

APPLICABLE RULE	
R 400.707	Staff training.
	(1) Staff who work with residents shall have successfully completed training that provides basic concepts required in providing specialized dependent care before working independently. Staff shall show the ability to comprehend and be competent to deliver each resident's individual plan

	of service as written. Training must include all of the following before working independently: (a) An introduction to community residential services and the role of direct care staff. (b) Understanding and carrying out individual plans of service for residents. (c) An introduction to the special needs of residents that have developmental disabilities or have been diagnosed as having a mental illness and is specific to the needs of residents to be served by the facility. (d) Protecting and respecting the rights of residents in accordance with chapter 7 of the mental health code, 1974 PA 258, MCL 330.1700 to 330.1758, including providing resident orientation to written facility policies and procedures. (e) Non-aversive techniques for prevention and treatment of challenging behavior of residents in accordance with an individual plan of service.
ANALYSIS:	Based on my interviews with staff, and my review of Resident A's file, the staff are appropriately trained to work in an AFC Home, therefore there is not enough evidence to establish a listening rules violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff are neglecting to disperse medications to Resident A.

INVESTIGATION:

On 07/28/2026, I interviewed Staff, Brittany Beck regarding the allegation. Brittany Beck informed that Resident A was always administered her medications.

On 07/28/2026, Staff, Jessica Spegel informed that Resident A always received her medications. Resident A would sit herself in the doorway at a little nook and never had an issue with medications.

On 07/28/2026, I reviewed Resident A's Medication Administration Record, and it appears that it was accurate and medications were administered at the appropriate days and times.

On 08/27/2026, Staff, Stella Payne informed that Resident A was always administered her medications timely. There were never any issues with regards to administering her medications.

On 09/09/2027, I was unable to interview Resident A as she is 93 years of age and has dementia. I interviewed Resident A's Family Member #1 regarding the allegation. She informed that a staff member had not administered Resident A's medication by 1pm and believed that the staff member had gotten into trouble.

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:	Based on my interview of staff and review of Resident A's record, there is not enough evidence to establish a licensing rules violation as it appears that Resident A was administered her medications as prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

There is poor frequency of bathing for Resident A.

INVESTIGATION:

On 07/28/2026, I interviewed Staff, Brittany Beck regarding the allegation. Brittany Beck informed that she is not aware of how often Resident A received a shower, but informed that they do have a shower log that keeps track of resident showers. It's possible that some showers could have been missed.

On 07/28/2026, I interviewed Staff, Jessica Spiegel regarding the allegation. Jessica Spiegel informed that everyone has shower days. To her understanding, Resident A would get showered on her two days during the week and receive an additional shower on the weekend if needed. There were times in which she would refuse a shower, so she would say to her, "Hey, I see you didn't get a shower, would you like to take one today?" Resident A could have as many showers as she wanted.

On 07/28/2026, I reviewed Resident A's Assessment Plan, and it indicates that Resident A needs a 1-person assist for bathing.

On 07/28/2026, I reviewed Resident A's Shower Log, and it appears that she received a shower at least twice per week and sometimes 3 times within a week.

On 08/27/2026, I interviewed Staff, Stella Payne regarding the allegation. Stella Payne informed that Resident A always got her showers and was able to shower herself but received assistance.

On 09/09/2026, I interviewed Resident A's Family Member #1, and she informed that bathing was very infrequent. She informed that in her observations, Resident A's hair would be greasy and matted, which tells her that Resident A was going a period of at least a week without bathing.

APPLICABLE RULE	
R 400.677	Resident hygiene, clothing.
	(2) A licensee shall ensure the resident receives or has access to all of the following: (a) Bathing at least weekly.
ANALYSIS:	Based on my interviews with staff, and review of the shower logs, there is not enough evidence to establish a licensing rules violation. Resident A was scheduled for two showers per week and according to the shower log, she always received a minimum of two showers within a week and sometimes would receive a 3 rd shower during the week.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Resident A is put in bed with the same clothes she wore all day and leaving her in soiled diapers**
- **The soiled diapers caused Resident A to have soiled linens on the bed that weren't changed.**

INVESTIGATION:

On 07/22/2026, I interviewed Staff, Brittany Beck regarding the allegation. Brittany Beck informed that Resident A would dress herself and appeared to be very independent. Resident A would change her own briefs and bra, and the family never complained about it. Staff Beck is not sure if Resident A wore the same clothes two days in a row, because one day Brittany Beck may be scheduled to work in Monet House Inn, and then the next day she may be scheduled to work in Leighton House Inn. Brittany Beck denied that staff would ever leave soiled linens on a bed and if it did happen, this would not have been intentional. They didn't have housekeeping for a couple of weeks, around that time the family had complained about having to make Resident A's bed.

On 07/22/2026, I interviewed Staff, Jessica Spigel regarding the allegation. Staff Spigel informed that there were times when Resident A would go to bed and then wake up the next morning in the same clothes as she wore the day before. Staff Spigel does not recall Resident A being left in soiled briefs as she would change herself. Staff would still have to check to make sure she was clean because she may not wipe herself the best, so the staff had to make sure that they checked. Resident

A wanted to feel independent, so she did things on her own. Staff Spegel never witnessed soiled linen being placed back on the bed as clean linens go hand-in-hand with shower days. Showers and changed linens are on the same days.

On 07/22/2026, I reviewed Resident A's Assessment Plan, and it indicates that she needs assistance from a staff for dressing and personal hygiene.

On 07/22/2026, during my onsite, I observed several residents in the home. They all appeared to be receiving adequate care and supervision. The residents appeared to be neat and clean in appearance.

On 08/27/2026, I interviewed Staff, Stella Payne regarding the allegation. Stella Payne informed that this may have been true as Resident A was always dressed and sitting at her doorway. Staff did not receive a lot of information for Resident A. Resident A appeared to be very independent. Resident A's daughter dropped her off at Monet House Inn due to her home being flooded, so they weren't exactly sure how much help she needed. When they would go check Resident A's diaper, Resident A would say, "I'm changed already." Stella Payne denied that Resident A was left in soiled linen and says that if the linen was soiled, they would have changed them.

On 09/08/2026, I held an exit conference with the Director, Hannah Beagle. Hannah Beagle informed that she agreed that staff needs to be mindful of what's in the Resident Assessment Plan when caring for residents and the staffing concerns is something that they are actively working on. Hannah Beagle also informed that Katie Edwards is the Licensee Designee and will be the person responsible for the corrective action plan.

On 09/08/2026, I held an exit conference with Licensee Designee, Katie Edwards. Katie Edwards informed that they are currently working on hiring more staff so that there is a minimum of two staff on each shift and they currently have 3 or 4 staff during the day.

On 09/09/2026, I interviewed Resident A's Family Member #1, and she informed that Resident A would be wearing the same clothes as the day before and when she would change her, she would not have on her diaper. Resident A is incontinent and has dementia, so there should have been someone changing her clothing and making sure she was cleaned.

APPLICABLE RULE	
R 400.677	Resident hygiene, clothing.
	(3) A licensee shall assist the resident in obtaining clothing that fits, is clean, and is seasonally appropriate.

ANALYSIS:	Based on my interviews with staff and review of Resident A's file, there is enough evidence to establish a licensing rules violation. According to staff, Resident A would change her clothing, briefs, and shower herself. According to her Assessment Plan, Resident A required assistance for these tasks.
CONCLUSION:	VIOLATION ESTABLISHED

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 my interviews with staff and review of Resident A's file, there is enough evidence to establish a licensing rules violation. Staff informed that they would not leave Resident A with soiled linen, however; one of the staff informed that they did not have housekeeping for a period of two weeks, which is the time in which the family complained about having to change the linen and make the bed for Resident A.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Staff are leaving Resident A parked in the hallway.

INVESTIGATION:

On 07/28/2026, I interviewed Staff, Brittany Beck regarding the allegation. Brittany Beck informed that Resident A used to park herself in the hallway to wait to participate in activities.

On 07/28/2026, I interviewed Staff, Jessica Spegel regarding the allegation. Jessica Spegel informed that Resident A would sit herself in the doorway at a little nook, but if the complaint is in reference to the hallway, Resident A would be waiting there for activities.

On 08/27/2026, I interviewed Staff, Stella Payne regarding the allegation. Stella Payne informed that Resident A was never left alone, parked in the hallway. If

Resident A was parked in the hallway, she was awaiting an appointment or activities.

On 09/09/2026, I interviewed Resident A's Family Member #1, and she informed that Resident A had access to her Amazon Account so she could watch her four favorite tv shows, but due to her age and dementia, she does not know how to work the remote control. Family Member #1 asked that staff assist her and turn it on one of those programs for her, but every time she comes to visit, the tv would be on, but it would only be on the Amazon Screen and not on a particular program. So out of boredom, Resident A would sit out in the doorway.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on my interview of staff, there is not enough evidence to establish a licensing rules violation. It appears that Resident A was able to ambulate on her own and would sit in the hallway, awaiting activities to participate in.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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



09/09/2026

Anthony Humphrey
Licensing Consultant

Date

Approved By:



09/09/2026

Mary E. Holton
Area Manager

Date