GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 8, 2026

Jordan Walch
Spectrum Community Services
Suite 700
185 E. Main St
Benton Harbor, MI 49022

RE: License #: AS410360517
Investigation #: 2026A0469027
Parkview Home

Dear Ms. Walch:

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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Natasha Grew, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410360517
Investigation #:	2026A0469027
Complaint Receipt Date:	08/27/2026
Investigation Initiation Date:	08/31/2026
Report Due Date:	10/26/2026
Licensee Name:	Spectrum Community Services
Licensee Address:	Suite 700 185 E. Main St Benton Harbor, MI 49022
Licensee Telephone #:	(734) 458-8729
Administrator:	Jordan Walch
Licensee Designee:	Jordan Walch
Name of Facility:	Parkview Home
Facility Address:	2165 Bayham Dr. SE Kentwood, MI 49508
Facility Telephone #:	(616) 551-3129
Original Issuance Date:	04/28/2014
License Status:	REGULAR
Effective Date:	10/28/2024
Expiration Date:	10/27/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The facility does not follow the physician's recommendations to manage Resident A's diabetes when he has low blood sugar episodes.	Yes
Facility staff do not follow the menu.	Yes
Staff are not assisting with Resident A's hygiene or personal care needs.	No
The facility is not adequately staffed.	No
Additional Findings	Yes

III. METHODOLOGY

08/27/2026	Special Investigation Intake 2026A0469027
08/27/2026	APS Referral Complaint received from Adult Protective Services (APS)
08/31/2026	Special Investigation Initiated - Telephone APS- Meg Moorhead
09/11/2026	Inspection Completed On-site
09/14/2026	Contact - Document Sent Email sent to Crystal Cunningham
09/16/2026	Contact - Telephone call made Guardian 1A and Guardian 2A
09/17/2026	Contact - Document Received Email received from Crystal Cunningham
09/22/2026	Contact - Document Received Email received from Crystal Cunningham
09/30/2026	Contact - Telephone call made Medication Lead Staff- Melinda Mann
09/30/2026	Contact - Telephone call made Network 180 Case Manager- Angela Fisher
09/30/2026	Contact - Telephone call made Corewell Health Diabetes and Endocrinology

09/30/2026	Contact - Telephone call made Harmony Cares
10/06/2026	Contact - Telephone call received Harmony Cares- Chiahui Neilly DNP
10/07/2026	Exit Conference Licensee Designee- Jordan Walch

ALLEGATION: The facility does not follow the physician's recommendations to manage Resident A's diabetes when he has low blood sugar episodes.

INVESTIGATION: On 08/27/2026 I received a complaint from Adult Protective Services that stated: *'(Resident A) has diabetes, down syndrome, swelling of his kidneys, skin condition, and bipolar. (Resident A) has a guardian. (Resident A) is insulin dependent and has a continuous glucose monitoring (CGM) device. In the last two weeks (Resident A) has had 8 low blood sugar episodes. The home has not been noting the alarms and is not following the proper procedures for when the alarm goes off. The monitor will tell when (Resident A's) blood sugar starts to go down and staff should be treating (Resident A). (Resident A) should be getting a snack if his blood sugar goes down to 80 and a blood sugar test strip be used if his blood sugar goes down to 70. There are conflicting statements of whether the test strips have been given or not as there is another resident in the home that also has diabetes and uses test strips. (Resident A) should be getting juice if his blood sugar is low and the home does not have juice. The home does not follow the menu and (Resident A's) blood sugar dropped while he was in the community as he did not have enough to eat as it was reported Resident A had soup for a meal. The home does not take care of (Resident A's) personal care needs. The home does not have adequate staffing.'*

On 08/31/2026, I interviewed APS worker Meg Moorhead. Ms. Moorhead confirmed she has an active investigation with concerns relating to Resident A's diabetes not being managed. Ms. Moorhead stated she interviewed staff during her visit to the facility and was told they rely only on the Dexcom device for Resident A's blood sugar levels when there is an alarm for a low blood sugar episode. Ms. Moorhead stated if Resident A has a low blood sugar level and Resident A's Dexcom device makes an alarm sound, staff are supposed to be doing a manual blood sugar test with a lancet and Resident A's meter to confirm the low blood sugar level. Ms. Moorhead stated staff are not documenting when Resident A has low blood sugar.

On 09/11/2026, I completed an unannounced on-site inspection. While on-site I interviewed direct care workers Rosine Niyigena and Joseph Gisubizo, house manager Haoyung Chien, and program administrator Crystal Cunningham.

I asked Ms. Niyigena what the protocol is for addressing a low blood sugar level for

Resident A. Ms. Niyigena stated that when Resident A's blood sugar goes below 70, his Dexcom device will make an alarm sound. Ms. Niyigena stated staff do a manual blood sugar test with the lancet and test strip to confirm the low blood sugar level. Ms. Niyigena stated if it truly is a low blood sugar episode, staff give Resident A juice or a glucose tablet and monitor his blood sugar level until it gets back to a normal. I asked Ms. Niyigena if staff documented the low blood sugar levels. Ms. Niyigena stated they had not been, however, because Guardian 2A told them to document it, they started doing this about two weeks ago. I asked Ms. Niyigena if the facility has ever been out of juice or glucose tablets for Resident A. Ms. Niyigena stated no.

I asked Mr. Gisubizo what the protocol is for addressing a low blood sugar. Mr. Gisubizo stated Resident A's Dexcom device makes a sound when Resident A's blood sugar is low, which is around 70. Mr. Gisubizo stated staff should complete a manual blood sugar test a lancet and Resident A's meter to confirm the low blood sugar level. Mr. Gisubizo stated Resident A gets a juice or a glucose tablet for a low blood sugar episode. Mr. Gisubizo stated that manual blood sugar tests are completed every 15 minutes or so while monitoring Resident A's blood sugar level until it comes back up. I asked Mr. Gisubizo if the facility has ever been out of juice or glucose tablets for Resident A. Mr. Gisubizo stated no. I asked Mr. Gisubizo if staff were documenting when Resident A has a low blood sugar episode. Mr. Gisubizo stated no. Mr. Gisubizo stated staff have started documenting low blood sugar episodes recently though.

I asked Mr. Chien and Ms. Cunningham about the protocol for Resident A's low blood sugar episodes. Mr. Chien stated that Resident A's Dexcom device makes a noise when Resident A's blood sugar is low. Mr. Chien stated staff do a manual blood test with Resident A to confirm the low blood sugar. Mr. Chien stated staff then give Resident A juice or a glucose tablet and monitor Resident A's blood sugar until it comes back up. I asked Mr. Chien and Ms. Cunningham when blood sugar levels are supposed to be documented. Ms. Cunningham stated the physician's instructions for documenting the blood sugar levels are on Resident A's Medication Administration Record (MAR). I asked Mr. Chien and Ms. Cunningham if the facility has ever been without juice or glucose tablets for Resident A. Mr. Chien and Ms. Cunningham stated no.

While on-site at the facility, I observed juice in the refrigerator. I also observed Resident A's glucose tablets in the medications.

While on-site, I was unable to interview Resident A due to his diagnoses.

On 09/15/2026, I reviewed Resident A's MAR from August 2026 and September 2026. The MAR's document for both months that Lancets Ultr Mis Thin 30G as a PRN with directions that these are used to manually check blood sugars. There are no initials in the blanks that these were administered in August or September 2026.

On 09/16/2026, I interviewed Guardian 1A and Guardian 2A. I asked Guardian 1A

and 2A what the endocrinologist's recommendations were for Resident A when Resident A has a low blood sugar episode. Guardian 1A stated a low blood sugar episode is when Resident A's blood sugar level is in the 70's. Guardian 1A and 2A stated staff are to give Resident A juice, a glucose tablet, or something else to eat to help bring his blood sugar back up. Resident 1A and 2A stated staff are to monitor Resident A's blood sugar and do manual blood sugar tests every 15 minutes until the blood sugar level comes back up.

Guardian 1A and Guardian 2A stated they do not believe the facility is following the protocol for when Resident A has a low blood sugar episode. Guardian 1A and 2A stated Resident A had eight severe low episodes in August 2026. Guardian 1A stated they monitor Resident A's Dexcom device readings. Guardian 1A stated there was a time when she was picking up Resident A and he had a low blood sugar episode before they left the driveway. Guardian 1A could not recall when this occurred. Guardian 1A stated she went into the home for juice to give Resident A and the home did not have juice to give him.

On 09/30/2026, I called Corewell Health Diabetes and Endocrinology to request the physician's instructions regarding Resident A's diabetes management, and when the blood sugar levels should be documented. I was told that no information could be verified or provided.

On 09/30/2026, I called Harmony Cares to speak with Resident A's provider for clarification on the provider's instructions regarding Resident A's diabetes management. I left a message for a return phone call.

On 09/30/2026, I interviewed Medication Lead Tech Melinda Mann who works at this facility. I asked Ms. Mann if she was familiar with Resident A's diabetes management requirements. Ms. Mann stated yes. Ms. Mann stated she attends all Resident A's medical appointments with Resident A and Guardian 1A. Ms. Mann stated the most recent endocrinologist appointment was on 08/06/2026. Ms. Mann stated Resident A goes to the endocrinologist approximately every three months for follow-ups. I asked Ms. Mann what the recommendation is for low blood sugar episodes. Ms. Mann stated Resident A wears a Dexcom device and when Resident A's blood sugar level gets to 70 on the Dexcom device makes an alarm noise. Ms. Mann stated staff are to do a manual blood sugar test with a lancet, then give Resident A juice, a glucose tablet, or something else to eat to help bring his blood sugar up. They are to monitor his blood sugar and check his blood sugar level every 15 minutes until it comes back up. I asked Ms. Mann if Resident A's endocrinologist had instructed or recommended documenting the low blood sugar levels. Ms. Mann stated no. Ms. Mann stated that Guardian 1A and Guardian 2A have requested the low blood sugar levels be documented, which has been started since the end of August 2026. I asked Ms. Mann if there was any time when the home did not have juice, a glucose tablet, or other food to help bring the blood sugar up when he had a low blood sugar episode. Ms. Mann stated no.

On 09/30/2026, I interviewed Angela Fisher who is Resident A's case manager at Network 180. I asked Ms. Fisher if she knew what the endocrinologist's recommendations were for documenting low blood sugar episodes for Resident A. Ms. Fisher stated she had conflicting reports on the endocrinologist's recommendations and she was working to get the facility, Guardian 1A, and the medical providers on the same page to manage Resident A's diabetes. Ms. Fisher stated she is working with Resident A's endocrinologist office to go to the facility to do an educational session with staff on how to manage Resident A's diabetes.

On 10/06/2026, I interviewed Chiahui Neilly with Harmony Cares and asked what service Harmony Care provides for Resident A. Ms. Neilly stated she sees Resident A for wraparound services and helps to follow-up on recommendations from Resident A's providers. Ms. Neilly stated she is a primary care physician for other residents in this facility as well though. I asked Ms. Neilly if the facility should be documenting Resident A's low blood sugar episodes. Ms. Neilly stated yes. Ms. Neilly stated high and low blood sugar episodes should be documented to share with the endocrinologist appointments. Ms. Neilly stated Resident A's blood sugar levels must be documented prior to mealtimes and before insulin is given. I asked Ms. Neilly if the facility was documenting the blood sugar levels. Ms. Neilly stated no. Ms. Neilly stated she was at the facility on 08/10/2026 and requested to see Resident A's blood sugar levels from the day before. Ms. Neilly stated the facility did not have a record of any blood sugar levels from 08/09/2026 at the time of her request. Ms. Neilly stated the facility had records prior to that day but was missing the entire day for 08/09/2026. I asked Ms. Neilly when Resident A would need the PRN for Lancets Ultr Mis Thin 30G that is on his MAR. Ms. Neilly stated ideally that would be used when Resident A requires a manual blood sugar test because of a low or high blood sugar episode.

On 10/07/2026, I completed an exit conference with licensee designee Jordan Walch. I informed her of my investigative findings and recommendations. Ms. Walch did not have any questions and agreed to complete a Corrective Action Plan.

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:	The complaint stated that facility staff do not follow the recommendations to manage Resident A's diabetes when he has low blood sugar episodes. Staff reported the steps to address Resident A's low blood sugar levels is to give Resident A juice, a glucose tablet, or something similar to eat and monitor his blood sugar level until it comes

	back up. Staff denied being out of juice, glucose tablets, or another snack to give Resident A if he has a low blood sugar episode. Interviews with staff were consistent that low blood sugar episodes were not being documented by staff. Ms. Cunnigham stated the recommendations of the provider for documenting blood sugar levels is on Resident A's MAR. Guardian 1A and 2A both stated the home is not following protocols for when Resident A has low blood sugar levels. Resident A wears a Dexcom CGM device, which Guardian 1A has access to the readings and reported the Dexcom CGM device had several low blood sugar levels. Guardian 1A and Guardian 2A did not feel the facility was adequately addressing Resident A's blood sugar levels due to the number of lows Resident A had. Guardian 1A stated there was a time when she was picking up Resident A and he had a low blood sugar episode before they left the driveway. Guardian 1A stated she went into the home for juice to give Resident A and the home did not have any juice. Ms. Neilly stated that high and low blood sugar episodes should be documented and brought to the endocrinologist appointments. Resident A's MAR from August 2026 and September 2026 have a PRN spot for Lancets to use to manually test Resident A's blood sugar level. Ms. Neilly stated this would be an area to document when that manual test is given for a high or low blood sugar episode. The PRN spots were blank for both August 2026 and September 2026. There is evidence for a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Facility staff do not follow the menu.

INVESTIGATION: In my interview with Ms. Moorhead on 08/31/2026, I asked her if she knew if facility staff were following the menu or documenting substitutions. Ms. Moorhead stated she was not sure but said staff have served things like soup and casseroles.

In my interview with Ms. Niyigena on 09/11/2026, I asked if there was a menu she followed to make meals. Ms. Niyigena stated yes. I asked Ms. Niyigena if the menu was always followed. Ms. Niyigena stated no. Ms. Niyigena stated sometimes they do not have ingredients for the meal, but they have other ingredients, so she makes

something like homemade soup or stew and serves it with sandwiches. I asked Ms. Niyigena if she documents the substitutions for meals. Ms. Niyigena stated no.

While on-site on 09/11/2026, I reviewed the menu. The menu included a two-week rotation of meals. The meal that was supposed to be served for dinner on Friday, 09/11/2026 was ham and cheese wraps with veggies and pork rinds. I looked in the refrigerator, pantry, and around the kitchen for the ingredients. I could not find ham and asked Mr. Chien if there was another spot this ingredient could be at. Mr. Chien left the kitchen area to look in other places. After a few minutes, Mr. Chien came back into the kitchen and stated he had made chicken for the wraps tonight. The chicken was observed. I asked if substitutions are written down or documented somewhere when there are changes to the menu. Mr. Chien stated no.

In my interview with Ms. Mann on 09/30/2026, I asked her if there was a menu that staff followed for meals. Ms. Mann stated yes there is a two-week menu. Ms. Mann stated there are times when the facility may be out of an ingredient, so staff make something different. I asked Ms. Mann if staff would write down substitutions when they cook something different. Ms. Mann stated no.

On 10/07/2026, I completed an exit conference with licensee designee Jordan Walch. I informed her of my investigative findings and recommendations. Ms. Walch did not have any questions and agreed to complete a Corrective Action Plan.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(6) Menus, excluding special diets, must be written at least 1 week in advance and posted. Any change or substitution must be documented.
ANALYSIS:	The complaint was that facility staff do not follow the menu. From interviews with staff, it was consistent that even though there was a menu for meals, there have been times when they would cook something else. It was consistently reported that substitutions or menu changes are not being documented. While I was on-site, I observed the menu they have on a two-week rotation, and there was no documentation for menu changes or substitutions. Therefore, there is evidence for a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff are not assisting with Resident A's hygiene or personal care needs.

INVESTIGATION: In my interview with Ms. Moorhead on 08/31/2026, I asked when she last saw Resident A. Ms. Moorhead stated she saw Resident A on 08/26/2026, and he appeared clean. Ms. Moorhead could not interview Resident A due to his diagnoses, and he was sleeping during her visit to the facility.

In my interview with Ms. Niyigena I asked if she assists with Resident A's grooming and hygiene. Ms. Niyigena stated no because his grooming and hygiene have been completed before her shift begins. Ms. Niyigena stated third shift usually assists Resident A with his morning grooming and hygiene. Ms. Niyigena stated second shift assists Resident A with his grooming and hygiene before he goes to bed at night. I asked if Ms. Niyigena had ever come in for her shift and had concerns of Resident A's grooming or hygiene not being completed. Ms. Niyigena stated no.

In my interview with Mr. Gisubizo on 09/11/2026, I asked if he has assisted Resident A with grooming or personal hygiene needs. Mr. Gisubizo stated yes. Mr. Gisubizo stated he typically works third shift and will help Resident A if he is awake and needs assistance. I asked Mr. Gisubizo if he had concerns with Resident A not getting assistance with grooming or hygiene. Mr. Gisubizo stated no.

While on-site, I observed Resident A, B, and C but was unable to interview them due to their diagnoses. Resident A, B, and C appeared to be wearing clean clothing and did not have any odors coming from any of them. I did not observe concerns with Resident A, B, or C's appearance regarding grooming or personal hygiene.

While I interviewed Guardian 1A and 2A on 09/16/2026, I asked if they had concerns regarding Resident A's grooming and hygiene needs not being met. Guardian 1A and 2A stated yes. Guardian 1A and 2A stated staff are not helping Resident A with shaving or brushing his teeth. Guardian 2A stated Resident A's teeth are in "bad condition". Guardian 1A stated some of the dental health could be related to Resident A's diabetes but not to the extent it is. Guardian 2A stated Resident A must see a podiatrist due to his diabetes and foot care needs. Guardian 2A expressed concern that Resident A's footcare is not being managed as it should be. Guardian 2A stated there is concern that staff are not prompting Resident A to empty his bladder because Guardian 2A has picked Resident A and before they leave the facility Resident A will have soaked through his pants and must be changed.

On 09/22/2026, I reviewed Resident A's assessment plan. Resident A's assessment plan notes Resident A is dependent on caregivers to shave him, brush his teeth, and clip his nails for Grooming. Resident A's assessment plan notes Resident A needs staff assistance to put on deodorant.

While I interviewed Ms. Fisher on 09/30/2026, I asked if she had concerns regarding staff not assisting Resident A with hygiene, grooming, or personal care needs. Ms. Fisher stated no. Ms. Fisher stated she sees Resident A twice a month and has not had concerns. Ms. Fisher stated staff assistance with these areas is part of Resident A's Individual Plan of Service (IPOS). Ms. Fisher stated she is working with the

facility and guardians to get Resident A to a podiatrist due to Resident A's diabetes and needs for specialized foot care.

While I interviewed Ms. Mann on 09/30/2026, I asked if she helps Resident A with grooming or personal hygiene needs. Ms. Mann stated yes. Ms. Mann stated Resident A will bring his toothbrush to staff at times when he wants to brush his teeth and staff with assist him. Ms. Mann stated second or third shift usually helps Resident A groom his beard. Ms. Mann stated staff need to remind Resident A to use the bathroom and empty his bladder. I asked Ms. Mann if she ever had concerns when her shift would start that Resident A's grooming or personal hygiene needs were not completed. Ms. Mann stated no.

On 10/07/2026, I completed an exit conference with licensee designee Jordan Walch. I informed her of my investigative findings and recommendations. Ms. Walch did not have any questions.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	The complaint stated staff are not assisting with Resident A's hygiene or personal care needs. Guardian 1A and 2A expressed concern that staff are not assisting Resident A with shaving, brushing his teeth, or providing care as recommended for his feet. However, staff were consistent in saying that they either assist Resident A or that they have no concerns. Ms. Moorhead and Ms. Fisher also expressed no concern regarding Resident A's grooming and hygiene needs not being met. There is no evidence for a rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The facility is not adequately staffed.

INVESTIGATION: In my interview with Ms. Moorhead on 08/31/2026, I asked her how many staff were present at the facility during her visit. Ms. Moorhead stated there were two staff present.

In my interview with Ms. Niyigena on 09/11/2026, I asked how many staff are present for each shift. Ms. Niyigena stated there are always at least two staff working on each shift. Ms. Niyigena stated during the week and during first shift, the house manager Mr. Chien is also present and will assist as needed.

In my interview with Mr. Gisubizo on 09/11/2026, I asked how many staff are present for each shift. Mr. Gisubizo stated there are always at least two staff working on each shift. Mr. Gisubizo stated during the week and during first shift, the house manager Mr. Chien is also usually working and will assist as needed.

In my interview with Mr. Chien and Ms. Cunningham on 09/11/2026, I asked how many staff work each shift. Mr. Chien and Ms. Cunningham stated there are two staff working each shift. Mr. Chien stated he is also at the facility usually during the week.

While on-site, I reviewed the staff schedule for 09/06/2026 to 09/19/2026. There were three shifts for each day, and each shift had two staff. While I was at the facility, there were two staff, Ms. Niyigena and Mr. Gisubizo, and House Manager Mr. Chien.

In my interview with Guardian 1A and 2A on 09/16/2026, I asked how many staff they typically see when they come to the facility. Guardian 1A and 2A stated it is usually one or two staff, but most of the time it is one staff.

On 09/22/2026, I reviewed Resident A's assessment plan. Resident A's assessment plan notes he needs to be prompted to empty his bladder, assistance wiping after a bowel movement, and prompting every two hours for Toileting. Resident A's assessment plan notes prompting and physical support for Bathing. Resident A's assessment plan notes Resident A is dependent on caregivers to shave him, brush his teeth, and clip his nails for Grooming. Resident A's assessment plan notes Resident A needs staff assistance to put on deodorant.

In my interview with Ms. Mann on 09/30/2026, I asked how many staff work on each shift. Ms. Mann stated there are always at least two staff working each shift. Ms. Mann stated there is a first shift, second shift, and third shift. Ms. Mann stated during first shift during the week, Mr. Chien is usually present as well.

On 10/06/2026, I reviewed Resident B, C, D, E, and F's assessment plans.

- Resident B's assessment plan notes staff will assist with prompts and reminders for Toileting, staff will assist with daily showers for Bathing, staff will assist with Grooming, and staff will assist with keeping up with Resident B's hygiene for Personal Hygiene.
- Resident C's assessment plan notes staff will assist and provide prompts for Toileting, assist with daily showers for Bathing, and staff will assist with Grooming, and Personal Hygiene.

- Resident D's assessment plan notes complete physical assistance is needed for Bathing, prompting and partial assistance from staff for Grooming and Personal Hygiene.
- Resident E's assessment plan notes "independent" for Toileting, Bathing, Grooming, and Personal Hygiene.

On 10/07/2026, I completed an exit conference with licensee designee Jordan Walch. I informed her of my investigative findings and recommendations. Ms. Walch did not have any questions.

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: **(b) 12 residents for small group and family homes.**
ANALYSIS:	The complaint was that the facility is not adequately staffed. It was consistent throughout staff interviews and reviewing the staff schedule that there are at least two staff each shift. In addition, Mr. Chien is usually present during the week. Guardian 1A and 2A reported that there has been one staff member in the home at times on the weekends when they pick Resident A up to take him into the community. While interviewing Ms. Moorhead and Ms. Fisher, they reported at least two staff are present during their visits to the facility. In reviewing the assessment plans for Resident A, B, C, D, and E it was evident that these residents required at least some staff assistance for areas such as Toileting, Grooming, Bathing, or Personal Hygiene. Resident F was noted to be independent in Toileting, Grooming, Bathing, and Personal Care. There is no evidence for a rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Resident A's assessment plan was not completed timely, and when it was completed did not have the signature of the licensee.

INVESTIGATION: While on-site on 09/11/2026, I requested Resident A's assessment plan. I was provided with Resident A's IPOS from Network 180.

On 09/14/2026, I emailed Ms. Cunningham requesting Resident A's assessment plan.

On 09/17/2026, I received an email from Ms. Cunningham with Resident A's assessment plan. The assessment plan was signed by Guardian 1A on 09/16/2026, and there was no signature of the licensee designee on this document. I emailed Ms. Cunningham back and requested Resident A's assessment plan that was prior to this one.

On 09/22/2026, I received Resident A's assessment plan that was signed by Guardian 1A on 08/25/2025 and signed by the licensee designee on 09/11/2025.

On 10/07/2026, I completed an exit conference with licensee designee Jordan Walch. I informed her of my investigative findings and recommendations. Ms. Walch did not have any questions and agreed to complete a Corrective Action Plan.

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:	The assessment plan for Resident A was signed by Guardian 1A on 09/16/2026 and was missing the signature of the licensee or designee. The assessment plan for Resident A that was completed prior to the one signed on 09/16/2026, was signed by Guardian 1A on 08/25/2025. Resident A's assessment plan was not completed within the annual timeframe and was missing the licensee designee's signature. There is evidence for a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Resident A did not get medication as prescribed.

INVESTIGATION: While reviewing the MAR for Resident A from August 2026 and

September 2026, the following was documented:

- On 08/01/2026, 08/02/2026, and 08/03/2026 the 8:00pm dose for Quetiapine 200mg was blank.
- On 08/01/2026, 08/02/2026, and 08/03/2026 the 2:00pm dose for Quetiapine 25 mg was blank.
- On 08/01/2026, 08/02/2026, 08/03/2026, and 08/04/2026 the 8:00am dose for Quetiapine 25 mg was blank.
- On 08/12/2026 the 12:00pm dose for Insulin injection 100/ml, Trueplus 30G Lancets, Blood Sugar Check, and Insulin Units Given were blank.
- On 08/12/2026, the 2:00pm dose for Quetiapine 25 mg was blank.
- On 09/04/2026, 09/05/2026, and 09/09/2026 the 2:00pm dose for Quetiapine 25 mg was blank.

On 10/07/2026, I completed an exit conference with licensee designee Jordan Walch. I informed her of my investigative findings and recommendations. Ms. Walch did not have any questions and agreed to complete a Corrective Action Plan.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	There were blank spots on the MAR for Resident A on various days in August 2026 and September 2026. The blanks on the MAR indicate Resident A was not given medications as prescribed. Therefore, there is evidence for a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



10/07/2026

Natasha Grew Date
Licensing Consultant

Approved By:



10/08/2026

Jerry Hendrick Date
Area Manager