GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 30, 2025

Sondra Yantz
Charter Senior Living of Stepping Stone Falls
4444 W. Court Street
Flint, MI 48532

RE: License #: AH250236841
Investigation #: 2025A1019060
Charter Senior Living of Stepping Stone Falls

Dear Licensee:

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 authorized representative and a date.

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

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250236841
Investigation #:	2025A1019060
Complaint Receipt Date:	06/11/2025
Investigation Initiation Date:	06/11/2025
Report Due Date:	08/11/2025
Licensee Name:	Flint Michigan Retirement Housing LLC
Licensee Address:	14005 Outlook Street Overland Park, KS 66223
Licensee Telephone #:	(240) 595-6064
Administrator and Authorized Representative:	Sondra Yantz
Name of Facility:	Charter Senior Living of Stepping Stone Falls
Facility Address:	4444 W. Court Street Flint, MI 48532
Facility Telephone #:	(810) 720-5184
Original Issuance Date:	02/01/2001
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	114
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's pain medication ran out.	Yes
Additional Findings	No

III. METHODOLOGY

06/11/2025	Special Investigation Intake 2025A1019060
06/11/2025	Special Investigation Initiated - Telephone Notified APS of the allegations.
06/11/2025	APS Referral
06/12/2025	Inspection Completed On-site
06/12/2025	Inspection Completed-BCAL Sub. Compliance

The complainant identified an allegation of potential abuse, which the facility self-reported to law enforcement and Adult Protective Services (APS). The licensee followed homes for the aged administrative rule requirements pertaining to incident reporting. Therefore, that allegation is not included in this report and the following is what could be considered under the scope of licensing.

ALLEGATION: Resident A's pain medication ran out.

INVESTIGATION:

On 6/11/25, the department received a complaint alleging that Resident A's pain medication ran out and had not been reordered. The complaint did not list the name of the medication or the dates that Resident A did not receive the medication.

On 6/12/25, I conducted an onsite inspection. I interviewed executive director [Employee 1] at the facility. Employee 1 confirmed that Resident A is prescribed hydrocodone for pain, and that he recently ran out. Employee 1 reported that it was not a matter or calling in a refill for the medication, but that Resident A required a new prescription, which needed to go through PACE to complete. Employee 1 did not know what day the medication was reordered but reported that Employee 2 called PACE on 6/9/25 to inquire about the medication. Employee 1 reported that the

medication was not delivered to the facility until 6/11/25, causing Resident A to miss doses on 6/10/25 and 6/11/25.

While onsite, I reviewed Resident A's medication administration records for June 2025. I observed that Resident A had an order for hydrocodone that instructed *"take 1 tablet by mouth every 8 hours*". Staff documented that Resident A missed one or more doses of medication on the following dates: 6/5 (one missed dose), 6/7 (two missed doses), 6/10 (three missed doses) and 6/11 (two missed doses). Staff documented in all instances "*medication not available*" and on 6/7, 6/10 and 6/11 also documented that the medication was not in the cart.

In follow up correspondence, Employee 1 reported that per the electronic narcotic count record, the medication was administered to Resident A as scheduled on 6/5 but that staff incorrectly documented that one dose was not given. Employee 1 reported that on 6/7, per the electronic narcotic count record, Resident A received two doses instead of three that day, but also incorrectly documented on the MAR (the MAR read only one dose was given). Employee 1 reported that the med tech on duty on 6/7 confirmed that the medication was available to administer and that the MAR was inaccurate. Additionally, Employee 1 provided supporting documentation demonstrating that PACE was contacted on 5/27/25 requesting a new prescription for Resident A's hydrocodone, and additional contacts were made on 5/29/25, 5/30/25 and 6/9/25 to obtain the medication.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional. **(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following:** **(b) Complete an individual medication log that contains all of the following information:** **(i) The name of the prescribed medication.** **(ii) The prescribed required dosage and the dosage that was administered.** **(iii) Label instructions for use of the prescribed medication or any intervening order.** **(iv) The time when the prescribed medication is to be administered and when the medication was administered.**

ANALYSIS:	Resident A missed several scheduled doses of his hydrocodone during the timeframe reviewed. Furthermore, on two occasions, staff incorrectly documented on Resident A's medication administration record that the medication was not administered when it had been.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon completion of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

06/12/2025

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

06/30/2025

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section