GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 25, 2025

Toni LaRose
AH Spring Lake Subtenant LLC
Ste 1600
1 Towne Sq
Southfield, MI 48076

RE: License #: AL700397743
Investigation #: 2025A0579042
AHSL Spring Lake Willowbrook

Dear Toni LaRose:

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 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 (616) 356-0100.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W., Unit 13
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397743
Investigation #:	2025A0579042
Complaint Receipt Date:	05/30/2025
Investigation Initiation Date:	05/30/2025
Report Due Date:	07/29/2025
Licensee Name:	AH Spring Lake Subtenant LLC
Licensee Address:	Ste 1600, 1 Towne Sq, Southfield, MI 48076
Licensee Telephone #:	(248) 203-1800
Administrator:	Toni LaRose
Licensee Designee:	Toni LaRose
Name of Facility:	AHSL Spring Lake Willowbrook
Facility Address:	17379 Oak Crest Parkway Spring Lake, MI 49456
Facility Telephone #:	(616) 844-2880
Original Issuance Date:	03/28/2019
License Status:	REGULAR
Effective Date:	09/28/2023
Expiration Date:	09/27/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED/ AGED/ ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct care worker Pauleysha Adams cashed a check for $200 given to her by Resident A.	Yes
Additional Finding	No

III. METHODOLOGY

05/30/2025	Special Investigation Intake 2025A0579042
05/30/2025	Contact- Documentation Received Toni LaRose, Licensee Designee
05/30/2025	Special Investigation Initiated - Telephone Pauleysha Adams, Former Direct Care Worker
06/05/2025	Contact- Face to Face Resident A Toni LaRose (Licensee Designee)
06/09/2025	Contact- Telephone Call Received Relative A1
06/09/2025	Contact- Document Sent Toni LaRose, Licensee Designee
06/17/2025	Contact- Document Received Relative A1
06/18/2025	Contact- Document Received Relative A1
06/18/2025	Contact- Document Sent Toni LaRose, Licensee Designee
06/19/2025	Contact- Document Sent Toni LaRose, Licensee Designee
07/24/2025	Exit Conference Toni LaRose, Licensee Designee

ALLEGATION: Direct care worker Pauleysha Adams cashed a check for $200 given to her by Resident A.

INVESTIGATION: On 5/30/25, I entered this referral into the Bureau Information Tracking System after licensee designee, Toni LaRose, reported to me that referrals were made to Adult Protective Services and law enforcement after relatives of Resident A reported Resident A wrote a check for $200 to direct care worker ("DCW"), Pauleysha Adams which Ms. Adams cashed. She reported Ms. Adams' employment was immediately terminated and training was done with current DCWs regarding resident abuse, neglect, and misappropriation. She stated law enforcement advised her that since Resident A is her own guardian, this is not a criminal matter. She stated Resident A reported she gave the money to Ms. Adams because Ms. Adams needed it, and she liked Ms. Adams.

On 5/30/25, I placed a telephone call to the number Ms. LaRose provided for Ms. Adams. An automated message played stating the number was no longer in service**.**

On 6/5/25, I completed an unannounced on-site investigation at the home. Interviews were complete with Resident A and Ms. LaRose.

Resident A reported she has given DCWs money on multiple occasions. She stated this occurred when she moved in, she gave $20 to someone who assisted her with moving. She stated she believes she also gave $20 to some third shift DCWs on occasion. She stated she likes to tip workers for good service and feels bad if she does not. She stated she does not recall who she gave money to, aside from Ms. Adams. She stated Ms. Adams requested a loan, so she wrote Ms. Adams a check. She stated now she is upset because Ms. Adams is not going to pay her back. It was discussed that per licensing rules, DCWs cannot accept gifts or money from her so she does not need to feel bad about not providing tips for DCWs who provide good service. She was advised that tipping DCWs would lead to their employment being terminated if it were accepted, so it is not helpful to give cash or gifts to DCWs even if she wants to or if they ask for it.

Ms. LaRose reported Resident A's family brought to her attention that Resident A had written a check to Ms. Adams which was cashed. She stated Ms. Adams admitted to cashing the check prior to her employment being terminated. She stated Resident A has a history of inappropriately managing her money, but she does not have a guardian or payee. She stated Resident A's family expressed being upset that Resident A was tipping her public transportation drivers and requested Ms. LaRose become involved with stopping this behavior, but she could not because it was occurring in the community and Resident A has the right to use her funds without restriction. She stated law enforcement reported the same thing about this incident, stating a crime did not occur because Resident A has the right to manage her own money and give it to DCWs if she chooses. She stated she has trained DCWs that they are not to accept gifts or money from residents, but Resident A is very persistent and without restriction to her funds, she fears this will occur again.

She reported Resident A's family has not been willing to assist with restricting her funds, so she is not sure how to address this. I advised that I spoke to Resident A and confirmed DCWs cannot accept tips, gifts, or cash and if they do their employment will be terminated. I advised to educate DCWs that accepting money or gifts from Resident A will lead to their immediate termination even if Resident A offers and even if she is persistent. She agreed.

On 6/9/25, I received a telephone call from Relative A1 who stated she was upset Resident A advised her that I did not interview Resident A privately and had her answer questions in front of DCWs. I advised that was not what occurred, and that a DCW was present when I introduced myself to Resident A and I was ensuring Resident A was comfortable speaking to me prior to asking the DCW to leave. However, after I introduced myself, Resident A immediately requested the DCW leave before I could, and the DCW left, closing Resident A's door behind her.

Relative A1 stated Resident A has given money to DCWs on multiple occasions because she likes to tip for good service, even though she has been told not to. She denied knowing specific DCWs Resident A has given cash to. She stated on Halloween one year, DCWs brought their children to trick-or-treat at the homes, Resident A ran out of candy, so she gave the children $10 bills. She stated this incident with Ms. Adams is the first time she has written a check for a significant amount. It was discussed that DCWs cannot accept funds or gifts from residents. It was discussed that Resident A does have the right to spend her funds in the community or give money to children, if her funds are not being restricted. It was discussed that it may be helpful to prevent further incidents if Resident A's family can monitor or restrict Resident A's spending moving forward or look at obtaining a payee or guardian for her if needed. She reported Resident A no longer has access to her check books and her spending will be monitored by her family.

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Resident A, Relative A1, and Ms. LaRose reported DCW Pauleysha Adams cashed a check for $200 from Resident A. Ms. Adams' employment was immediately terminated. Ms. LaRose reported Ms. Adams admitted to accepting the funds prior to her employment being terminated. A telephone interview was attempted with Ms. Adams, but the number was reported to no longer be in service.

	Based on the interviews completed, there is sufficient evidence Ms. Adams accepted money from Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

On 6/5/25, Resident A expressed that she was upset it took so long for her desk to be moved from her previous placement. She stated she had to complain multiple times before her desk was moved into this home. She stated she still has belongings in her previous placement, but she believes she will be moving back into that home, so she is not as concerned about those belongings.

On 6/9/25, Relative A1 reported Resident A has gone weeks without her belongings which are at another American House Spring Lake home. She stated there was damage in that home, so Resident A moved into this home. She stated Resident A was very upset about not having her desk in her new home and it took a while before her desk was brought over. She stated Resident A still has belongings at the other home and it is not known when Resident A will be moving back into that home, although it is expected to be soon.

Relative A1 reported an unknown DCW took a very long phone cord that was purchased for Resident A and replaced it with a small phone cord so Resident A cannot move around her room when she is on the phone.

Relative A1 reported that an unknown DCW does not respect Resident A's privacy and has used Resident A's cell phone to put the TikTok application on it. She stated Resident A does not know how to use TikTok, there is no reason for it to be on her phone, and DCWs should not be putting applications on Resident A's phone.

Relative A1 reported she does not feel Resident A is treated with dignity by DCWs and feels Resident A would soil her briefs less frequently if DCWs responded to Resident A's call light. She stated Resident A also has been found with her pants not completely pulled up. She stated Resident A cannot pull her pants up or down, so it is due to DCWs not pulling her pants up when they assist her with toileting. She stated Resident A may also fall asleep and lean in her wheelchair or chair and DCWs do not move her. She expressed concern that Resident A's care is very rushed.

Relative A1 sent two photos of Resident A with her pants not pulled completely up with her brief and/or stomach exposed. The photos were not dated. There were two photos of Resident A who appeared to be asleep and leaning, one in a recliner and one in her wheelchair. It was known from my contact with Resident A that she can move her upper body, move her legs, and use her feet to move her wheelchair

slightly. It appears possible that Resident A may lean and shift in her wheelchair causing her pants to be pulled down with her movements.

On 6/10/25, I exchanged emails with Ms. LaRose discussing Relative A1's concerns. Ms. LaRosa reported Resident A requires two-person transfer assistance so two DCWs are present to assist Resident A when transferring and toileting. She denied knowledge of DCWs not pulling Resident A's pants up after toileting her or positioning her properly. She stated DCWs regularly do "rounds" checking on residents, although there is not a set time (such as 15-minute checks) for any resident. She reported Resident A has a call button that she can use to call for assistance with toileting and positioning and Resident A is aware of how to use it.

Ms. LaRose stated no one reported to her that a DCW was downloading applications on or accessing Resident A's phone. She stated she discussed this with Resident A who denied knowledge of an application being put on her phone or DCWs accessing her phone.

Ms. LaRose reported she was not aware of a DCW taking a phone cord from Resident A and replacing it with a shorter cord. She stated she spoke to Resident A about this, and Resident A reported Relative A2 took the long cord because it was a trip hazard and that she did not need a long cord for the room phone because she uses her personal cell phone.

Ms. LaRose reported when water damage first occurred at Resident A's previous placement, residents were moved, and the building was closed until it could be assessed by contractors and the American House Spring Lake corporate office. She stated once it was deemed safe, movers were hired to move items that residents requested for their new, temporary placements. She stated several trips were made by the movers for Resident A because she kept requesting additional items.

On 6/17/25, Relative A1 reported Resident A called her upset reporting a DCW took her charging cord so she could not charge her phone. She stated she was going to call 911 for a wellness check due to this.

On 6/18/25, Relative A1 reported she requested the name of the DCW assisting Resident A on 6/17/25 and the DCW would not provide it. She stated she overheard the DCW swear at her or Resident A. I agreed to follow up with Ms. LaRose regarding the allegations reported on 6/17/25 and 6/18/25. Relative A1 reported Resident A's belongings from her previous placement were all brought to her current placement, which she questions since Resident A is supposed to be moving back to her previous placement "in a couple weeks."

On 6/18/25, Ms. LaRose reported Resident A's relative reported she overheard a DCW swear at Resident A. She stated Resident A was spoken to and reported that the DCW was discussing her personal life with Resident A and swore. She stated Resident A's relative only heard the part about the DCW swearing and assumed it

was directed at Resident A. Resident A stated it was not. Ms. LaRose reported the DCW was suspended pending further investigation following normal abuse protocol. She stated Resident A and DCWs do not know where Resident A's phone charger went. She stated she has ordered a replacement phone charger for Resident A. It was known from previous discussions that Resident A had a corded phone in her room and there are public telephones in the home should Resident A need additional phone access.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long-distance, collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.** **(j) The right of reasonable access to and use of his or her personal clothing and belongings.** **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Relative A1 reported concern that Resident A does not have reasonable access to a telephone because a DCW took her phone charging cord. Ms. LaRose reported neither Resident A nor DCWs reported knowing where Resident A's charging cord was, so she ordered a replacement. It was known there is a corded phone in Resident A's room and public telephones available in the home as well.

	Relative A1 reported Resident A does not have reasonable access to her belongings because not all her belongings were moved into this home. Ms. LaRose reported Resident A's previous placement was closed due to water damage and when it was clear to enter, Resident A's belongings were brought to her as requested. Relative A1 reported all Resident A's belongings were brought to her as of 6/18/25. Relative A1 also reported a DCW took Resident A's long phone cord and replaced it with a short cord without her permission. Ms. LaRose reported it was confirmed Relative A2 took the long cord, due to it being a trip hazard, and Resident A using her cell phone. Relative A1 reported Resident A is not treated with dignity because her care is rushed, she is left leaning in chairs, and her pants are not pulled up all the way, and her call light is not used effectively. Photos were provided of Resident A leaning in chairs and her pants not pulled up. From my observation of Resident A, it appears she can move her upper body and legs slightly so she may be positioning herself or moving in a way that causes her pants to be pulled down. Ms. LaRose reported Resident A has access to a call light and knows how to use it. She reported two DCWs regularly assist Resident A with toileting and positioning. Relative A1 reported she overheard a DCW swear at her or Resident A while on the phone with Resident A. Ms. LaRose stated Resident A reported her relative overheard a personal conversation between her and the DCW and assumed the DCW swore at her. Relative A1 reported Resident A's privacy was not respected when a DCW put the TikTok application on Resident A's cell phone. Ms. LaRose reported Resident A denied knowledge of the application or DCWs accessing her cell phone. Based on the interviews completed, there is insufficient evidence to support allegations that Resident A was not allowed reasonable access to a telephone, reasonable access to her belongings, and was not treated with dignity and due respect for privacy.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 7/24/25, I completed an exit conference with Ms. LaRose who did not dispute my findings or recommendations at the time of report disposition.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

07/24/2025

Cassandra Duursma Date
Licensing Consultant

Approved By:

07/25/2025

Jerry Hendrick Date
Area Manager