GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 22, 2025

Katie Edwards
Cliffside Company
3905 Lorraine Path
St. Joseph, MI 49085

RE: License #: AL110077442
Investigation #: 2025A0790051
Caretel Inns Of Royalton - Dover

Dear Ms. Edwards:

Attached is the Special Investigation Report for the above-referenced facility. Due to the violation 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
gillr@michigan.gov
(517)980-1433

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
"THIS REPORT CONTAINS QUOTED PROFANITY"

I. IDENTIFYING INFORMATION

License #:	AL110077442
Investigation #:	2025A0790051
Complaint Receipt Date:	09/17/2025
Investigation Initiation Date:	09/17/2025
Report Due Date:	11/16/2025
Licensee Name:	Cliffside Company
Licensee Address:	3905 Lorraine Path St. Joseph, MI 49085
Licensee Telephone #:	(947) 282-7555
Administrator:	Katie Edwards
Licensee Designee:	Katie Edwards
Name of Facility:	Caretel Inns Of Royalton - Dover
Facility Address:	3905 Lorraine Path Saint Joseph, MI 49085
Facility Telephone #:	(269) 363-1906
Original Issuance Date:	08/13/1998
License Status:	REGULAR
Effective Date:	12/11/2023
Expiration Date:	12/10/2025
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff member pushed Resident A and made derogatory remarks about him.	Yes

III. METHODOLOGY

09/17/2025	Special Investigation Intake 2025A0790051
09/17/2025	Contact – Telephone call made to Complainant. I interviewed the Complainant and confirmed the allegations are accurate and comprehensive.
09/17/2025	Contact - Telephone call made to administrator Heather Bier. I left a voicemail message requesting a return call.
09/17/2025	Special Investigation Initiated - Telephone I interviewed administrator Heather Bier.
09/17/2025	Contact – Document Received Ms. Bier emailed me the requested supporting documentation.
09/18/2025	Inspection Completed On-site I interviewed direct care staff member Juliane Hahn who functions as the assistant director of the assisted living facilities, Resident A, and administrator Heather Bier. I requested additional supporting documentation.
09/22/2025	Inspection Completed-BCAL Sub. Compliance
09/22/2025	Corrective Action Plan Requested and Due on 10/08/2025.
09/23/2025	Exit Conference / interview with licensee designee Katie Edwards.

ALLEGATION:

Direct care staff member pushed Resident A and made derogatory remarks about him.

INVESTIGATION:

On 9/17/25, I reviewed an email dated 9/16/25 reporting an incident that happened at Caretel Inns of Royalton – Dover on 9/16/25. The email indicated that direct care staff member (DCSM) Hailey Ferris reported that DCSM Leomary Alvarez came out of Resident A's room stating that Resident A pushed her twice, so she pushed Resident A back knocking him down into his chair.

The email indicated that Ms. Alvarez was suspended and asked to leave the building pending an internal investigation.

The email indicated that Resident A was examined and showed no physical signs of bruising or injury.

The email indicated that Resident A's family would be contacted and dementia care in servicing scheduled.

On 9/17/25**,** I interviewed the Complainant and confirmed the allegations to be accurate and comprehensive.

On 9/17/25, I interviewed administrator Heather Bier. Ms. Bier also confirmed the allegations to be accurate. She said that on 9/16/25, DCSM Leomary Alvarez pushed Resident A. Ms. Bier said DCSMs informed of the altercation immediately informed the director of assisted living facilities Araceli Mendez and Ms. Mendez directly informed her.

Ms. Bier said Resident A had no visible signs of injury, harm or distress.

Ms. Bier stated that Ms. Alvarez was placed on administrative leave pending an internal investigation and was immediately escorted out of the facility.

Ms. Bier said she is satisfied and pleased with how the situation was handled after the altercation by both DCSMs and management.

On 9/18/25, I conducted an unannounced onsite investigation. I observed and spoke with Resident A. Resident A appeared confused unaware of where he was or his surroundings. I was unable to interview Resident A because of cognitive deficiencies.

On 9/18/25, I interviewed DCSM Juliane Hahn who functions as the assistant director of the assisted living facilities. Ms. Hahn indicated that on 9/16/25, DCSM

Hailey Ferris immediately informed her after DCSM Leomary Alvarez disclosed to Ms. Ferris that she pushed Resident A causing him to fall back into his recliner chair. Ms. Hahn stated that Ms. Ferris also disclosed to her that Ms. Alvarez said, “Resident A is being a bitch today.”

Ms. Hahn stated that Ms. Ferris indicated that Ms. Alvarez came out of Resident A’s room and reported the allegations to her. Ms. Hahn said Ms. Ferris indicated that Ms. Alvarez explained that she tried to get Resident A to sit down in his recliner chair but he refused. Ms. Alvarez indicated that Resident A shoved her, and she shoved Resident A back causing him to fall back into his recliner chair.

On 9/18/25, I spoke with Ms. Bier. Ms. Bier stated that she would email me DCSMs Hailey Ferris and Kali Botello’s written statements from 9/16/25 documenting their account of what they witnessed and heard firsthand pertaining to the allegation.

On 9/23/25, I reviewed Resident A’s *Resident Records.* I specifically reviewed Resident A’s Admission Record and found that Resident A’s diagnoses are chronic kidney disease (CKD), hypothyroidism, unspecified, hyperlipidemia, unspecified, other specified hearing loss, essential (primary) hypertension, gastro-esophageal reflux disease without esophagitis, and dementia.

I reviewed an *AFC Licensing Division – Incident / Accident Report* dated 9/17/25. The report indicated that a DCSM reported to the assistant director of the assisted living facilities Juliane Hahn that DCSM Leomary Alvarez told her that Resident A had pushed her and she had pushed Resident A back.

The report indicated that two DCSMs assessed Resident A for any marks or bruises and found no marks or bruises. The report stated no injuries noted.

The report stated that Resident A’s family was contacted and advised of the incident.

The report indicated that DCSM Ms. Alvarez was immediately sent home and removed from the schedule pending investigation.

The report was completed and signed by director of the assisted living facilities Araceli Mendez and dated 9/16/25.

I reviewed a written statement from DCSM Hailey Ferris dated 9/16/25. The statement reported the following: DCSM Leomary Alvarez took Resident A to the bathroom. Ms. Alvarez came up to Ms. Ferris and stated, “I’m not sure what’s going on with Resident A today.” Ms. Ferris asked Ms. Alvarez why she said that and Ms. Alvarez replied, “He pushed me and wouldn’t sit down, and then pushed me again.” The statement indicated that Ms. Alvarez stated that she pushed Resident A back and then he sat down.

The statement indicated Ms. Ferris reported a short time later that Ms. Alvarez told

her that Resident A was calling her a “bitch”. Ms. Ferris replied, “Awe, [Resident A] is having a rough day.” The statement indicated that Ms. Alvarez replied, “[Resident A] is being a bitch.” The statement further indicated Ms. Alvarez also stated, “[Resident A] does not need to be acting that way.”

The statement indicated Ms. Ferris reported that Ms. Alvarez was talking to residents harshly and yelled at them to sit down.

I reviewed a written statement from DCSM Kali Botello dated 9/16/25. The statement indicated that during the morning meal, Resident A was up and Ms. Alvarez would yell at him to sit down and then make remarks to another resident. The statement indicated that Ms. Alvarez repeatedly yelled at Resident A to sit down.

The statement indicated that Ms. Botello tried redirecting Ms. Alvarez and demonstrated how to appropriately redirect Resident A.

I reviewed a third written statement indicating that Ms. Ferris and Ms. Botello immediately reported the incidents and altercation to the director of assisted living facilities Araceli Mendez. Ms. Mendez directly reported the incidents and altercation to administrator Heather Bier.

The statement indicated that Ms. Alvarez was placed on administrative leave pending an internal investigation. Resident A was examined for marks and/or bruises. The statement indicated that Resident A showed no visible signs of injury, harm or distress.

The statement indicated that licensee designee Katie Edwards was notified of the incidents and altercation.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with the Complainant, Ms. Bier, Ms. Hahn, and Ms. Edwards there was sufficient evidence found indicating that Ms. Alvarez pushed Resident A.

CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(iii) Derogatory remarks about the resident or members of his or her family.**
	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with the Complainant, Ms. Bier, Ms. Hahn, and Ms. Edwards there was sufficient evidence found indicating that Ms. Alvarez made derogatory remarks about Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/23/25, I conducted an exit conference with licensee designee Katie Edwards. Ms. Edwards was informed of the outcome of this special investigation and did not dispute the findings. Ms. Edwards was asked to provide an acceptable Corrective Action Plan (CAP) within the required timeframe and agreed to do so.

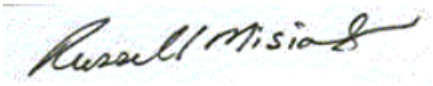
IV. RECOMMENDATION

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

9/24/25

Rodney Gill Date
Licensing Consultant

Approved By:



9/25/25

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Russell B. Misiak Date
Area Manager