



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 02, 2025

Madiha Zeeshan
Grand Blanc Assisted Living, LLC
219 Church St.
Auburn, MI 48611

RE: License #: AL250390289
Investigation #: 2025A0572046
Grand Blanc Fields Assisted Living

Dear Madiha Zeeshan:

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, looping flourish at the end.

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 #:	AL250390289
Investigation #:	2025A0572046
Complaint Receipt Date:	08/06/2025
Investigation Initiation Date:	08/08/2025
Report Due Date:	10/05/2025
Licensee Name:	Grand Blanc Assisted Living, LLC
Licensee Address:	12628 Pagels Drive Grand Blanc, MI 48439
Licensee Telephone #:	(810) 606-0823
Administrator:	Madiha Zeeshan
Licensee Designee:	Madiha Zeeshan
Name of Facility:	Grand Blanc Fields Assisted Living
Facility Address:	12628 Pagels Drive Grand Blanc, MI 48439
Facility Telephone #:	(810) 606-0823
Original Issuance Date:	08/03/2018
License Status:	REGULAR
Effective Date:	02/03/2025
Expiration Date:	02/02/2027
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
<ul style="list-style-type: none"> • Resident A had an unwitnessed fall with injury. The family was not contacted. 	No
<ul style="list-style-type: none"> • Resident A's injury was caused from abuse. 	No
<ul style="list-style-type: none"> • Without formal eviction, the home told the family that Resident A cannot return to the home. 	No
Additional Findings	Yes

III. METHODOLOGY

08/06/2025	Special Investigation Intake 2025A0572046
08/08/2025	APS Referral
08/08/2025	Special Investigation Initiated - Letter Complainant.
08/08/2025	Contact – Telephone Call Received Resident A's Family Member #1.
08/08/2025	Inspection Completed On-site Assistant Manager, Nichole Hartfield.
08/08/2025	Contact - Face to Face Home Manager, Hope Pattison.
08/08/2025	Contact - Telephone call made Owner, Asif Zeeshan.
08/11/2025	Contact - Telephone call made Staff, Caroline Porter.
08/11/2025	Contact - Telephone call made Ex-staff, Amber Wright.
08/11/2025	Contact - Document Received Melanie Gallego.
09/22/2025	Contact - Telephone call made

	Staff, Stacey Briggs.
09/25/2025	Contact - Telephone call made Ex-staff, Amber Wright.
09/26/2025	Contact - Telephone call made Hospice Nurse, Connie Wojciechowski.
09/26/2025	Exit Conference Licensee Designee, Madiha Zeeshan.
10/02/2025	Contact - Telephone call made Home Manager, Hope Pattison and Co-owner Asif Zeeshan.

ALLEGATION:

- **Resident A had an unwitnessed fall with injury. The family was not contacted.**
- **Resident A's injury was caused from abuse.**

INVESTIGATION:

On 08/06/2025, the local licensing office received a complaint for investigation. Adult Protective Services (APS) made the referral to licensing.

On 08/08/2025 contact was made with the complainant regarding the allegation. The complainant informed me that they received information that abuse has occurred in the home. They do not have much information as they believe that the home has not been very forthcoming.

On 08/08/2025, I made an unannounced onsite at Grand Blanc Assisted Living, in Genesee County Michigan. I spoke with Assistant Manager, Nichole Hartfield, Home Manager, Hope Pattison, and spoke with one of the owners of the facility, Asif Zeenshan via phone.

On 08/08/2025, I interviewed Assistant Manager, Nichole Hartfield regarding the allegation. Nichole Hartfield informed me that Resident A had moved out of the home but does not know when as she has just begun working for the company recently. She contacted Home Manager, Hope Pattison so that I could interview her.

On 08/08/2025, contact was made with Resident A's Family Member #1. Family Member #1 informed me that nobody told her that Resident A fell, as no one witnessed a fall. Family Members #1 and #2 came to the home to visit on 08/02/2025 during lunch and Resident A was looking down, not responding. Resident A was clean but barely eating. At this time, no one told her that Resident A may have fallen. At 7pm, she received a call from Hope Pattison saying that there

was an incident. The incident is in regard to a large skin tear. Hope Pattison bandaged the wound and said that she couldn't take Resident A to the hospital but believed that all it needed was a bandage. The next day, Family Member #1 came to the home and she attempted to change Resident A's pajamas but Resident A kept saying, "No, no, no." At the time, Family Member #1 did not know that Resident A had suffered a fracture. The only time Family Member #1 refused to allow the home to send Resident A out for medical care was when she told Hope Pattison that she wanted Family Member #2 to come out to the home first. Hope Pattison told her that it wasn't Family Member #2 decision as Family Member #1 is the Guardian. Resident A was transported to the hospital and diagnosed with a fractured wrist. She received an Incident Report from the home on 08/04/2025 at 4:07pm. Family #1 informed me that Resident A was a fall risk.

On 08/08/2025, I interviewed Home Manager, Hope Pattison regarding the allegation. Hope Pattison informed me that she received a phone call on 08/02/2025 at 8:30am from 1st shift staff informing her that when they got Resident A up, they noticed a skin tear on her arm. It is their belief that it may have been an unwitnessed fall on 3rd shift as nothing was reported until 1st shift staff got her up from bed. Hope Pattison went to the home, checked on Resident A, provided some wound care, called Hospice and Resident A's Family Member #1 to let them know about the incident. Hope Pattison showed me her phone which indicates that those contacts were at 8:32am. The call was approximately 30 seconds and then another call was made at 11:45am. In speaking with Resident A's Family Member #1, she did not want the facility to send Resident A out as of yet, because they were an hour away. Hope Pattison continued to encourage Resident A's Family Member #1 to allow them to have Resident A seen, but she declined. Hope Pattison just continued to try to clean the wound but was met with agitation by Resident A as she kept swinging at her, which is a known behavior of Resident A. Hope Pattison also showed me that there were contacts made at 9:41am for 14 minutes and 2:46pm for 8 minutes. In each of those contacts, Hope Pattison continued to ask Family Member #1 to allow them to send her out, but she continued to decline.

Hope Patterson further stated that on 08/03/2025, several more phone calls were made to Resident A's Family Member #1, still attempting to encourage her to allow Resident A to be seen. Family Member #1 is the POA but wanted another family member that was closer to go see Resident A. Family Member #1 then stated, "Let me ask you this, do you think that my (family member) is being abused." Hope Pattison responded, "I don't think so, but you do, so you should let us send her out." Resident A's Family Member #2 came to the facility and after looking at the injury, agreed for Resident A to be sent out. Resident A was not a fall risk and used a wheelchair to move about. Resident A had a bed alarm, chair alarm and fall matt. There was no history of falls and only had the alarms because she is on hospice care. No one ever saw Resident A on the ground, never heard her yell or scream for help. The only evidence of a fall was a large skin tear on her arm. Hope Pattison did not suspect a fracture because when she was trying to clean the wound, Resident A

was swatting at her, which is typical behavior for Resident A. Hope Pattison gave Family Member #1 an Incident Report on 08/04/2025.

On 08/08/2025, I reviewed the Visitation Log. According to the log, Resident A's Family Member #1 was not at the home on 08/02/2025. She was there on Friday, 08/01/2025 from 11:30am to 12:30pm and on Monday, 08/04/2025 from 1pm to 4pm to clean out Resident A's room.

On 08/08/2025, I spoke with the co-owner of Grand Blanc Assisted living, Asif Zeeshan. Asif Zeeshan informed me that as soon as they were made aware of the injury, they contacted Family Member #1, but she did not allow them to send her out. Because they had been accused of abuse before by the family, they wanted to have Resident A seen, but she kept refusing. Hope Pattison was finally able to convince them to have Resident A seen after a couple of days. Asif Zeeshan does not know why they are being accused of abuse when they informed the family of the injury and wanted to have Resident A be sent to the hospital for further evaluation.

On 08/11/2025, contact was made with Staff, Caroline Porter regarding the allegation. Caroline Porter recalled hearing about a skin tear but did not see the injury. Staff Porter heard that Resident A may have been picking at her arm. Staff Porter does not recall Resident A ever falling or hearing anyone say that she fell. Resident A used to walk very well and then all of a sudden, she wanted to start using her wheelchair. Staff Porter does not know how the injury could have occurred because she works from 7pm to 7am and Resident A is usually in bed when she arrives to work. Resident A is always in bed during bed checks. Resident A could have attempted to get up on her own and maybe bumped her hand against something. Resident A was a 2-person assist but was not a fall risk. Caroline Porter denied physical abuse or neglect.

On 08/11/2025, I attempted to contact former employee, Amber Wright. The number appeared to be disconnected. Another attempt was made on 09/25/2025.

On 08/11/2025, I received medical records, Incident Reports and pictures of injury from APS Investigator, Melanie Gallego.

On 08/11/2025, I reviewed the pictures of Resident A and she had a very large skin tear on her right wrist. There were other pictures of bruises on Resident A's body, but the most severe was the one located on the wrist area.

On 08/11/2025, I reviewed 3 of the Incident Reports related to the injury. The 1st Incident Report dated for 08/02/2025, indicates that Home Manager, Hope Pattison was informed on 08/02/2025 of a possible unwitnessed fall on 08/01/2025 during 3rd shift. 1st shift noticed a skin tear and bruising while dressing Resident A.

On 08/11/2025, I reviewed Resident A's file. Resident A is an elderly individual at 93 years of age who is receiving hospice care services. According to Home Manager,

Hope Pattison, Resident A is a fall risk due to diagnosis of dementia, but according to the files, there was no previous fall history. Resident A was no longer walking on her own and needed assistance to transport and for toileting.

On 08/11/2025, I reviewed an Incident Report that Staff, Amber Wright wrote that states that on 08/02/2025 at 5:30pm, when she took Resident A to change her clothes, Resident A began picking at arm when shirt was removed and that's when she noticed skin tear.

On 08/11/2025, I reviewed an Incident Report that was written by Home Manager, Hope Pattison. It was reported to her on 08/02/2025 at 7:30pm that Resident A has a skin tear on left arm. Staff Pattison went to the facility to assess the arm. Resident A kept swinging and pushing her hand away from her. Staff Pattison was able to apply ointment on the wound and dressing. Staff Pattison called the POA to encourage her to have Resident A be sent out for further evaluation. Family Member declined and did not want Resident A sent out. Hospice Nurse was also contacted.

On 08/11/2025, I received the hospital report from APS, Melanie Gallego. It indicates that Resident A suffered a wrist fracture from a reported unwitnessed fall.

On 09/22/2025, I contacted Staff Stacey Briggs regarding the allegation. Stacey Briggs was working on the other side of the building but heard about a possible unwitnessed fall. It supposedly happened the night before. Staff Briggs was present when a family member arrived to the facility and saw the bruises and transported Resident A to the hospital. Stacey Briggs denied that the home was abusing Resident A and informed that she also works for the school system so she is mandated to report any abuse or neglect. Whenever Staff Briggs sees marks or bruises, she reports them immediately to management, because they never know what is going on with their bodies.

On 09/26/2025, I contacted Hospice Nurse, Connie Wojciechowski regarding the allegation. Connie Wojciechowski informed me that she was the on-call nurse the weekend of the injury and came out to see Resident A. It was assumed to be a fall that was unwitnessed because of the skin tear. When she went to bed, there was no bruises or a skin tear, but there was the next morning. Connie Wojciechowski cleaned the wound and wrapped it. Resident A often had bruises on the same area because she would often have her hands down near her lap at the dining room table, but when approached, she would swing at people. In doing so, the top of her arm/wrist area would catch the bottom of the table whenever she tried to hit staff. Connie Wojciechowski does not believe anyone grabbed Resident A to cause the injury because the skin tear and bruising were on the top of the wrist. If it were a grab, it would be on the entire circumference of the wrist. In her opinion, the facility staff did what they were supposed to do when they witnessed the skin tear. Connie Wojciechowski was contacted and the family were contacted. The day after the injury, herself, the Home Manager and Family Member #2 spoke in the office about the injury and being seen by a doctor for further evaluation.

On 09/22/2025, I contacted Staff Stacey Briggs regarding the allegation. Stacey Briggs does not believe that the home gave the family a discharge notice because the family had been looking for a new placement for quite some time. Stacey Briggs believes that when the family obtained new placement, Resident A did not return.

APPLICABLE RULE	
R 400.15311	Incident notification, incident records.
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: (a) Unexpected or unnatural death of a resident. (b) Unexpected and preventable inpatient hospital admission. (c) Physical hostility or self-inflicted harm or harm to others resulting in injury that requires outside medical attention or law enforcement involvement.
ANALYSIS:	Based on the interviews of staff, complainant, hospice, review of records, and phone records, there is not enough evidence to establish a rules violation. Contact was made with Hospice Nurse and family as soon as staff realized that Resident A had a skin tear. At the time, they were not aware of a fall.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the interviews of staff, complainant, hospice, and review of records, there is not enough evidence to establish a rules violation. The injury that Resident A suffered was during the night shift. Resident A was in bed throughout the night during bed checks, therefore; there was no way of knowing how Resident A suffered an injury. It wasn't until the next morning when they began to change Resident A's clothing that staff observed a large skin tear on wrist area.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION::

Without formal eviction, the home told the family that Resident A cannot return to the home.

INVESTIGATION:

Prior to receiving this complaint, on 08/05/2025, the Home Manager, Hope Pattison sent me an email stating, “On Friday, August 1st, on the third shift, Mrs. Chittick experienced an unwitnessed fall in her room. When the fall was discovered, her family was notified and encouraged to have her evaluated at the hospital. (Resident A) had a skin tear on the left arm, on top of the arm, just below the bend in the arm, along with a bruise. The family declined to send her out at that time. Wound care was provided on both Saturday and Sunday. On Sunday, staff strongly encouraged the family—on two separate occasions—to send (Resident A) to the hospital for evaluation. At approximately 3:40 p.m. on Sunday, the family agreed, and (Resident A) was sent to the hospital. Due to the family having already secured a new placement for (Resident A), it was determined that discharging her from Grand Blanc Fields would help ensure a smooth transition. This decision was made to minimize any further confusion for (Resident A) and support a seamless move to her new home.

On 08/08/2025, contact was made with the complainant regarding the allegation. The complainant stated, “The family has secured new placement and wanted new placement after a different incident. The supports coordinator informed me the family reported prior to the placement being secured that they were indeed told it would be best for (Resident A) not to return.”

On 08/08/2025, contact was made with Resident A’s Family Member #1. Family Member #1 informed me that they were searching for a new placement for Resident A and obtained placement prior to the home informing them that Resident A would not be able to return. Resident A’s Family Member #1 indicated that they did not receive a notice for the discharge.

On 08/11/2025, I reviewed a medical report that stated, “The home called to say they will not be accepting patient for unknown reason. Patient family members also did not want patient to go back to the facility as well.”

On 10/02/2025, I spoke with Home Manager, Hope Pattison and she informed me that when Resident A went to the hospital, the family had secured a new placement. The facility did not write a discharge notice and has not received a written notice from the family.

APPLICABLE RULE	
R 400.15302	Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting

	resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	Based on interviews and review of medical records, there is not enough evidence to establish a licensing rules violation. It appears that there was a mutual agreement between the facility and the family for Resident A not to return to the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

The home failed to seek immediate medical care when Resident A

INVESTIGATION:

On 08/08/2025, contact was made with Resident A's Family Member #1. At the time, Family Member #1 did not know that Resident A had suffered a fracture. Family Member #1 also informed me that because Resident A had on sleeves during their visit, she wasn't aware of a skin tear. The only time Family Member #1 refused to allow the home to send Resident A out for medical care was when she told Hope Pattison that she wanted Family Member #2 to come out to the home first. Hope Pattison told her that it wasn't Family Member #2 decision as Family Member #1 is the Guardian.

On 08/08/2025, I interviewed Home Manager, Hope Pattison regarding the allegation. Hope Pattison informed me that she received a phone call on 08/02/2025 at 8:30am from 1st shift staff informing her that when they got Resident A up, they noticed a skin tear on her arm. It is their belief that it may have been an unwitnessed fall on 3rd shift as nothing was reported until 1st shift staff got her up from bed. Hope Pattison went to the home, checked on Resident A, provided some wound care, called Hospice and Resident A's Family Member #1 to let them know about the incident. Hope Pattison informed me that she made several attempts to encourage Family Member #1 to allow Resident A to be seen.

On 08/08/2025, I spoke with the co-owner of Grand Blanc Assisted living, Asif Zeeshan. He informed me that as soon as they were made aware of the injury, they contacted Family Member #1, but she did not allow them to send her out. Because they had been accused of abuse before by the family, they wanted to have Resident

A seen, but she kept refusing. Hope Pattison was finally able to convince them to have Resident A seen after a couple days.

On 09/26/2025, an exit conference was held with Licensee Designee, Madiha Zeeshan regarding the results of the special investigation. On 10/02/2025, co-owner Asif Zeeshan contacted licensing and was not in agreement with the findings.

APPLICABLE RULE	
R 400.15310	Resident health care.
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the interviews conducted and review of medical records, there is enough evidence to establish a licensing rules violation. Resident A suffered a severe skin tear from a reported unwitnessed fall. Resident A was not immediately sent to the hospital for further medical evaluation. Resident A suffered from a fractured wrist.
CONCLUSION:	VIOLATION ESTABLISHED

On 09/26/2025, an exit conference was held with Licensee Designee, Madiha Zeeshan regarding the results of the special investigation. On 10/02/2025, co-owner Asif Zeeshan contacted licensing and was not in agreement with the findings.

IV. RECOMMENDATION

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



10/02/2025

Anthony Humphrey
Licensing Consultant

Date

Approved By:



10/02/2025

Mary E. Holton
Area Manager

Date