GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 14, 2025

Rita Doss
Grand Blanc Ventures, LLC
1030 Lake Angelus Shores
Lake Angelus, MI 48326

RE: License #: AM250387480
Investigation #: 2025A0779053
Dixie Lodge

Dear Rita Doss:

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,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250387480
Investigation #:	2025A0779053
Complaint Receipt Date:	08/25/2025
Investigation Initiation Date:	08/25/2025
Report Due Date:	10/24/2025
Licensee Name:	Grand Blanc Ventures, LLC
Licensee Address:	10483 Dixie Hwy Holly, MI 48442
Licensee Telephone #:	(810) 866-4277
Administrator:	Rita Doss
Licensee Designee:	Rita Doss
Name of Facility:	Dixie Lodge
Facility Address:	10483 Dixie Hwy Holly, MI 48442
Facility Telephone #:	(810) 866-4277
Original Issuance Date:	02/06/2018
License **Status:**	REGULAR
Effective Date:	08/06/2024
Expiration Date:	08/05/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was taken to hospital on 8/31/2025 and the facility has refused to allow him back.	Yes
Staff accidentally threw away medications, retrieved them from the trash, and repassed them to the resident.	No

III. METHODOLOGY

08/25/2025	Special Investigation Intake 2025A0779053
08/25/2025	Special Investigation Initiated - Letter Contacted APS.
08/25/2025	APS Referral Complaint was referred to APS centralized intake.
08/31/2025	Contact - Document Received Received email from licensee designee, Rita Doss.
09/12/2025	Inspection Completed On-site
09/12/2025	Contact - Telephone call made Spoke to licensee designee
09/15/2025	Contact - Telephone call made Spoke to residential manager of home.
09/17/2025	Contact - Telephone call made Spoke to staff person, Bobbie Jo Everett.
09/24/2025	Contact - Face to Face Spoke with Resident B.
09/25/2025	Contact - Face to Face Spoke to Resident A.
10/14/2025	Exit Conference Held with licensee designee, Rita Doss.

ALLEGATION:

Resident A was taken to hospital on 8/31/2025 and the facility has refused to allow him back.

INVESTIGATION:

On 8/31/2025, an email was received from licensee designee, Rita Doss. LD Doss stated that Resident A had to be sent out to the hospital due to it being determined that he was a threat to other residents and staff. Included in the email was a copy of a 24-hour discharge letter describing the reason for Resident A's emergency discharge from the facility.

On 9/2/2025, another intake/complaint was received. The complaint stated that Resident A went to the hospital on 8/31/2025 but was not deemed appropriate for admission and this facility refused to allow him to return there.

On 9/12/2025, an on-site inspection was conducted. Multiple residents were viewed to be clean, well-groomed and appeared to be doing well.

On 9/12/2025, staff person, Cheryl Jackson, stated that she did not work the day that Resident A displayed his behaviors and had to be sent to the hospital. Staff Jackson stated that Resident A could be difficult and often refused to take his medication.

On 9/12/2025, staff person, Mercedez Sharp, confirmed that she worked on 8/31/2025 and witnessed Resident A's erratic behavior. Staff Sharp stated that Resident A verbally threatened another resident, tried to punch that resident, threatened to kill staff, threw things at staff and barricaded himself in his room. Staff Sharp reported that while Resident A was in his room, he destroyed his room, damaged furniture and broke the window, before leaving out the window and being restrained by police officers. Staff Sharp stated that prior to that day, Resident A was frequently refusing his medications, was often verbally and physically confrontational with other residents and staff and that many staff and residents did not feel safe around Resident A.

A review of Resident A's record took place, including his Assessment Plan for AFC Residents, the 24-hour discharge notice and the AFC Licensing Division Incident/Accident Report (IR). The information in these documents matched the information obtained during interviews with facility staff. Resident A is quite independent and is able to complete all his activities of daily living on his own.

On 9/12/2025, a phone conversation took place with LD Doss, who stated that Resident A was sent to the hospital on 8/31/2025, due to the facility's concern that Resident A was a danger to himself, other residents and staff. LD Doss stated that Resident A had been talking about being suicidal and was verbally and physically attacking another resident. LD Doss Reported that on 8/31/2025, Resident A was throwing things at staff, threatened violence against another resident, barricaded himself in his room, destroyed

the inside of his room and broke windows. LD Doss stated that the police were called and it took several officers to restrain Resident A, before he left the facility by ambulance. LD Doss stated that Resident A entered this facility on 7/8/2025 and was having some behaviors, but they were manageable. LD Doss stated that Resident A's behavior started to escalate and he started refusing medications and refused to attend psych appointments. LD Doss reported that they were in discussions with Resident A about the need for his discharge and looking into alternative placements and she believes that is what set him off. LD Doss stated that Resident A is his own guardian, was given a 24-hour discharge notice on 8/31/2025 and that they informed the hospital that they would not be allowing Resident A to return to the facility.

On 9/15/2025, a phone call was conducted with residential managers, Nicole Bowden and Julie Mooring. RM Bowden stated that Resident A was initially on 4-hour supervision checks upon his arrival and was later changed to 15-30 minute checks the last few days he was there, due to him talking about suicide. RM Bowden stated that staff called her on 8/31/2025 when Resident A started displaying erratic behaviors and she came up to the facility. RM Bowden confirmed that the police were called and it took multiple officers to restrain Resident A. RM Mooring stated that she had a discussion with Resident A about a possible 30-day discharge and the possible need for an alternative placement. RM Mooring stated that she was giving him the weekend to think about that and over the weekend was when he had behaviors and went to the hospital. RM Bowden and RM Mooring confirmed that Resident A would take his medications fine for a week and then refuse for several days in a row.

On 9/25/2025, in-person contact was made with Resident A at his AFC home. Resident A stated that he did get the 24-hour discharge but claimed that he was never spoken to prior to that about having to move. Resident A then stated that there were discussions about him maybe getting his own apartment. Resident A admitted to breaking his own coffee cup but denied breaking anything else or throwing anything at staff. Resident A admitted that he climbed out the window but denied that he was uncooperative with staff or the police. Resident A confirmed that he often refused his medications. Resident A stated that he did not want to return to this facility anyway.

On 10/13/2025, an exit conference was held with licensee designee, Rita Doss. LD Doss was informed of the licensing rule violation and that a written corrective action was required. LD Doss stated that she is not sure what brought about the change in Resident A's behavior, but feels he is more suitable for a behavioral type of home. LD Doss stated that they will use this as a learning experience and do better with type of situation moving forward.

APPLICABLE RULE	
R 400.14302	**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.**
	(5) A licensee who proposes to discharge a resident for any reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.**
ANALYSIS:	Although the facility provided Resident A with an emergency 24-hour discharge, they did not arrange and/or wait for another appropriate living arrangement to be found, before discharging Resident A. A hospital is not considered an appropriate long-term setting and this facility refused to allow Resident A to return there.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff accidentally threw away medications, retrieved them from the trash, and repassed them to the resident.

INVESTIGATION:

On 9/12/2025, a phone conversation took place with licensee designee, Rita Doss, who stated that she was aware of the medication incident. LD Doss confirmed that staff person, Bobbie Jo Everett, had dropped Resident B's medication in the trash can, while

still in the med cup, and then retrieved it out of the trash. LD Doss stated that Resident B stated that he did not see anything about his med being in the trash can. LD Doss reported that management did a formal consultation with Staff Everett regarding this issue.

On 9/15/2025, a phone call was made to residential manager, Nicole Bowden, who stated that she was the one who managed the med issue with Staff Everett. RM Bowden confirmed that Resident B's med was still in the med cup but was inside the trash can. RM Bowden stated that Staff Everett admitted that she picked the med cup up out of the trash and administered the med to Resident B. RM Bowden stated that she did a formal consultation with Staff Everett and that Staff Everett was given a written corrective counseling statement regarding this incident.

On 9/17/2025, a phone call was made to staff person, Bobbie Jo Everett. Staff Everett admitted that she accidentally placed the med cup in the trash, before Resident B had taken the med. Staff Everett stated that they have a trash can located at the nurses' station that is only used for paper products and the med cup was sitting on top of the trash, so she took it out. Staff Everett claims that she told Resident B that she would have to get a new pill, but Resident B said he would just take it, so she gave the med to Resident B. Staff Everett confirmed that Resident B took the medication that was taken out of the trash can and had no ill effects from doing so. Staff Everett reported that the med was always in the med cup and did not come into contact with any trash located in the trash can.

On 9/24/2025, face-to-face contact was made with Resident B at the facility. Resident B stated that he does not remember this incident happening, but that people have told him that it did. Resident B stated that he receives medications every day and that he is not aware of anything like this happening before. Resident B stated that staff here are great and that it is a nice place to stay.

The facility provided documentation regarding Staff Everett's medication training. That documentation confirms that on 3/20/2025, Staff Everett completed appropriate training on the proper handling and administration of medication.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**

ANALYSIS:	Although Resident B's medication was placed in a trash can, the medication was inside a med cup and did not come into contact with any actual trash, before it was removed from the can and given to Resident B. Resident B had no ill effects from being given this medication. It was confirmed that staff person, Bobbie Jo Everett, had completed appropriate training on the proper handling and administration of medication and was provided formal consultation from facility management regarding this issue. There was insufficient evidence found to warrant citation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/13/2025, an exit conference was held with licensee designee, Rita Doss. The findings of this investigation were reviewed.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action place, it is recommended that the status of this facility's license remain unchanged.

10/14/2025

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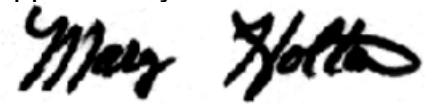
Christopher Holvey Date
Licensing Consultant

Approved By:



10/14/2025

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Mary E. Holton Date
Area Manager