GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 2, 2025

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

RE: License #: AH250236841
Investigation #: 2026A0585008
Charter Senior Living of Stepping Stone Falls

Dear Ms. Yantz:

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) 335-5985.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250236841
Investigation #:	2026A0585008
Complaint Receipt Date:	11/12/2025
Investigation Initiation Date:	11/12/2025
Report Due Date:	01/12/2025
Licensee Name:	Flint Michigan Retirement Housing LLC
Licensee Address:	14005 Outlook Street Overland Park, KS 66223
Licensee Telephone #:	(240) 595-6064
Authorized Representative/Administrator:	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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did get medication as prescribed.	Yes
Staff did not answer the call light to assist Resident A with incontinent care.	Yes
The dining room is not heated on the weekend.	Yes
Additional Findings	No

III. METHODOLOGY

11/12/2025	Special Investigation Intake 2026A0585008
11/12/2025	Special Investigation Initiated - Telephone Call the compliant to discuss allegations.
11/13/2025	APS Referral A referral was made to Adult Protective Service (APS).
11/13/2025	Inspection Completed On-site Completed with observation, interview and record review.
11/13/2025	Inspection Completed-BCAL Sub. Compliance
12/03/2025	Exit Conference Conducted via email to authorized representative Sondra Yantz.

ALLEGATION:

Resident A did get medication as prescribed.

INVESTIGATION:

On 11/12/2025, the licensing department received an anonymous complaint via BCHS online complaint. The complaint alleged that Resident A's medication is not being given at the required times of 6 a.m., 2 p.m. and 10 p.m.

On 11/13/2025, onsite was completed at the facility. I interviewed the executive director Kimberly Gaunt who stated that Resident A only lived at the facility for five days and there was a delay in getting her medication due to the pharmacy being

out of state. She said that Resident A was admitted to the facility on 11/5/2025 and her medication was ordered on that day. She said that Resident A's medication got to the facility on 11/05/2025 when they picked it up because the pharmacy had not sent it.

On 11/13/2025, I interviewed Employee #1 who stated that most medication is on a refill cycle that automatic renews. Employee #1 said that medication is ordered from an out-of-town pharmacy.

Resident A's medication administration record (MAR), read that she moved in the facility on 11/05/2025. Resident A's MAR notes the following with exception:

Medication	**Frequency**	**Scheduled-Not given**	**Exception**
Aspirin	Once daily	9:00 am 11/7	Medication not on cart
Brimonidine	Twice daily	9:00 pm 11/5	Medication not on cart
Diclofenac Sol	Two times daily	9:00 pm 11/5	Medication not available
Hydralazine	Three times daily	9:00 am 11/6 2:00 pm 11/5 9:00 pm 11/5	Medication not available
Labetalol	Two times daily	9:00 pm 11/5	Medication not available
Lidocaine 4% patch	Apply one daily, 12 hrs. on and 12 hrs. off	9:00 am 11/6	Medication not available
Timolol	Both eyes two times a day	9:00 pm 11/5	Medication not available

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.

ANALYSIS:	The complaint alleged that Resident A did not get her medication as prescribed and her blood pressure or heart rate is not being checked before administering her three blood pressure medications. Although Resident A only lived at the facility for a short time, medication should have been ordered ahead of time to ensure that it was received timely. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff did not answer the call light to assist Resident A with incontinent care.

INVESTIGATION:

The complaint alleged that Resident A pressed her call light for incontinence care there was only one caregiver available, and the other caregiver didn't show up until a couple hours later. The complaint alleged that the call light don't aways get answered.

The executive director stated that the expected respond time to call lights is ten minutes or less. She said that Resident A lived in building #1 which housed 19 residents. She said that there are three staff on the day shift and the evening shift. She said there are two caregiver/medication techs on the night shift.

The service plan for Resident A read, "provided toileting assistance to promote dignity. Resident requires the assistance of two staff members for safety."

The call light audit notes that Resident A had 69 alerts with an average response time as 17 minutes. The audit for Resident A shows the following:

Date	Response time	Outcome
11/5	49.9	Non-emergency
11/6	26.4	Toileting
11/6	49.8	Toileting
11/6	23.5	Non-emergency
11/7	87.2	Toileting
11/7	288.5	Non-emergency
11/7	27.3	Non-emergency
11/8	34.3	ADL
11/8	22.8	Toileting

11/9	39.6	Request – did not receive 6 am meds
11/9	32.5	Toileting

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
R 325.1901	**Definitions.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Staff did not answer the call light to assist Resident A with incontinent care. Although, the call light does not show that the call light was not answered to assist Resident A with incontinent care, it does show that there were times when the call light was not answered in a timely manner. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The dining room does not have heat on the weekend.

INVESTIGATION:

The complaint alleged that there is not always heat in the dining room during the weekend. The complaint alleged that residents had to wear heavy blankets and jackets to attend meals in the dining room.

The executive director stated that they were having problem with the heating system where a resident was bothering the thermostat. She said they have changed the heating system where the residents cannot adjust the thermostat in the dining room.

During the onsite, I interviewed Employee #2 at the facility. Employee #2 stated the residents are not able to adjust the temperature no higher than 72. She said that someone was switching the heat from off to on but now they can no longer turn it off on their own. Employee #2 shared copies of invoice where new basic tamper proof thermostat was ordered.

During the onsite, I interviewed Resident B who stated that her room is not cold, but the dining room is a little chilly and she wears a jacket.

I interviewed Resident C who was sitting in the dining room with her jacket on. Resident C said that it is always cold.

I interviewed Relative D in the dining room, sitting with Resident D. Relative D said that it warms up sometimes but it is not cold.

During the onsite, I inspected the dining room. The thermostat showed the temperature at 58 degrees. Employee #2 stated that the heat was working but the thermostat did not show the correct temperature.

A copy of the invoice shows that basic tamper proof thermostat was ordered with the shipping date of 11/13-11/17.

APPLICABLE RULE	
R 325.1973	**Heating.**
	(1) A home shall provide a safe heating system that is designed and maintained to provide a temperature of at least 72 degrees Fahrenheit measured at a level of 3 feet above the floor in rooms used by residents.
ANALYSIS:	The complaint alleged that the heat does not work in the dining room on the weekend. During the onsite, the thermostat in the dining room showed the temperature at 58 degrees. Residents interviewed said that the dining room is always cold. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

12/02/2026

Brender Howard — Date
Licensing Staff

Approved By:

12/02/2025

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