GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 5, 2026

Edward Powell
Grand B1, Inc.
6523 N. Sheridan Rd.
Edmore, MI 48829

RE: License #: AM590269332
Investigation #: 2026A0622012
Grateful Hearts AFC

Dear Mr. Powell:

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,

Amanda Blasius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM590269332
Investigation #:	2026A0622012
Complaint Receipt Date:	12/05/2025
Investigation Initiation Date:	12/09/2025
Report Due Date:	02/03/2026
Licensee Name:	Grand B1, Inc.
Licensee Address:	6523 N. Sheridan Rd. Edmore, MI 48829
Licensee Telephone #:	(989) 304-3419
Administrator:	Edward Powell
Licensee Designee:	Edward Powell
Name of Facility:	Grateful Hearts AFC
Facility Address:	6523 N. Sheridan Rd. Edmore, MI 48829
Facility Telephone #:	(989) 304-3419
Original Issuance Date:	04/14/2005
License Status:	REGULAR
Effective Date:	02/26/2025
Expiration Date:	02/25/2027
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Direct care worker, Cassandra Stoelb improperly disposed of Resident A's refused medications by flushing them down the toilet.	No
Additional Findings	Yes

III. METHODOLOGY

12/05/2025	Special Investigation Intake 2026A0622012
12/09/2025	Special Investigation Initiated - Letter
12/12/2025	Inspection Completed-BCAL Sub. Compliance
12/30/2025	Exit Conference with licensee designee, Edward Powell.

ALLEGATION: Direct care worker, Cassandra Stoelb improperly disposed of Resident A's refused medications by flushing them down the toilet.

INVESTIGATION:
On 12/05/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, direct care worker (DCW), Cassandra Stoelb disposed of Resident A's medications that she refused by flushing them down the toilet. The complaint stated that DCW Stoelb completed an incident report stating that the resident refused her medications, and she did not know how to properly dispose of them.

On 12/09/2025, I interviewed Recipient Rights Advisor, Jessica Butler. Ms. Butler provided the incident report that she had received.

The incident report provided was from Montcalm Care Networks online incident report system. According to the incident report, dated 11/15/2025, "DCW Cassandra Stoelb tried multiple times in the morning to get [Resident A] to take her medications. She ended up refusing all her morning medications. By the end she had spit them back out so many times and they sat in apple sauce they had now melted down. I had to flush the mix down the toilet. I was unsure what to do with the pill soup." According to the incident report completed, DCW Stoelb put refused medications in the medication management system, completed an incident report and informed her manager.

On 12/12/2025, I completed an unannounced onsite investigation to Grateful Hearts. During the unannounced onsite investigation, I interviewed direct care workers and viewed documentation.

On 12/12/2025, I interviewed direct care worker, Nathan Powell who identified as the home manager. He reported that Resident A had just moved into the home when she refused her medications. DCW Nathan Powell reported that Resident A did not want to take her medications the first few days after arriving and they soon discovered that she preferred pudding over applesauce. DCW Nathan Powell reported that in the medication cart there are old coffee grounds in a container that staff are supposed to put refused medications in. DCW Nathan Powell stated that he was not working when Resident A refused her medications on 11/15/25, but it was his understanding that the medications dissolved in the applesauce and DCW Stoelb did not want to put the mixture of applesauce in the coffee grounds, therefore she flushed it down the toilet. DCW Nathan Powell reported that all staff are trained through Montcalm Care Network on passing medications and then are monitored for three medication passes after their class. DCW Nathan Powell stated that DCW Cassandra Stoelb has been employed at Grateful Hearts since they opened and has not had any medication errors.

On 12/12/2025, I interviewed direct care worker, Cassandra Stoelb in person. She reported that on 11/15/2025 was the first time she had given Resident A her medications, as she had just moved in. DCW Stoelb stated that Resident A was refusing her medications and she attempted to give them to her three or four times within the hour time frame. DCW Stoelb stated that Resident A has orders to provide her medications in applesauce or pudding and she is given her medications with a spoon in applesauce. She explained that Resident A refused six medications in total. DCW Stoelb reported that she is aware that refused medications need to be put into the coffee grounds, but since these medications were dissolved in applesauce, she did not want to add the mixture together as she was afraid it would smell or mold. DCW Stoelb stated that after Resident A refused her medications, she put the bowl of applesauce and medications in the locked medication cart as she had to continue giving other residents their medications. She explained that the bowl sat in the locked medication cart for about 20 minutes before she was able to dispose of it. DCW Stoelb stated that she did not want to put the mixture in coffee grounds, therefore she felt the best next option was to flush the mixture down the toilet as all the medications had dissolved.

On 12/12/2025, I viewed documentation. I viewed Cassandra Stoelbs medication administration training from Montcalm Care Network, which was dated 6/14/2021.

On 12/12/2025, I viewed doctors' orders for Resident A, which stated that she could receive applesauce, pudding or yogurt with her medications.

I also viewed Resident A's medication administration record. According to her record she refused the following morning medications on 11/15/2025:

- Calcium carb, plus Vitamin D 600/400mg.
- Fluoxetine 20mg
- Fluoxetine 40mg
- Loratadine 10mg

- Oxcarbazepine 150mg
- Risperidone 3mg

On 12/30/2025, I completed an exit conference with licensee designee, Edward Powell. He informed me that they have decided to no longer use coffee grounds and will be using cat litter moving forward after the recommendation of their pharmacist. He stated that staff have been informed to no longer dispose of applesauce and medications down the toilet and to add them to the cat litter and a manager will dispose of it in the trash can.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident or expired must be properly disposed of.
ANALYSIS:	Based upon interviews and documentation reviewed it was determined that direct care worker, Cassandra Stoelb disposed of the dissolved medications in an appropriate manner but it was not the preferred method per Grateful Hearts policy. DCW Stoelb reported that she is aware that refused or expired medications should be placed in coffee grounds within the locked medication cart, but due to the applesauce mixture and not seeing any physical medication pills she flushed the mixture down the toilet. As a violation was not established as the refused medications were not accessible to residents, staff members or other community members after being disposed of in the toilet.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 12/12/2025, I completed an unannounced onsite investigation to Grateful Hearts. During the unannounced onsite investigation, I interviewed direct care worker, Nathan Powell who identified as the home manager. He reported that he did not inform a licensed health care professional after Resident A refused her medications on 11/15/2025.

On 12/12/2025, I interviewed direct care worker, Cassandra Stoelb in person. She reported that she also did not contact a licensed health care professional regarding Resident A refusing her medications on 11/15/2025. DCW Stoelb reported that she completed an incident report for Montcalm Care Network and also informed her manager, Nathan Powell.

On 12/12/2025, there was no documentation available for review regarding staff contacting a licensed health are professional after Resident A refused her six medications on 11/15/2025.

On 12/30/2025, I completed an exit conference with licensee designee, Edward Powell via phone. He reported that he was unaware that it was required to contact a licensed health professional after a resident refuses medication. Mr. Powell stated that sometimes staff will contact the nurse through Montcalm Care Network, but they have no documentation established to document the nurses instructions. Licensee designee, Edward Powell reported that moving forward contact with a licensed health professional will be made and documentation of the instructions will be completed.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(g) Contact the appropriately licensed health care professional when a resident refuses a prescribed medication or procedure. A licensee, administrator, or staff shall document and follow the instructions given by the licensed health professional. Documented instructions may include procedures to follow when a resident refuses medication or procedures in the future.**
ANALYSIS:	Based upon interviews with direct care workers, Nathan Powell and Cassandra Stoelb it was found that no direct care worker contacted a licensed health care professional after Resident A refused her six medications on 11/15/2025. Licensee designee, Edward Powell also confirmed that he was unaware that there was a rule requiring staff to contact a licensed health care professional when a resident refused a prescribed medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains unchanged.

01/02/2026

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Amanda Blasius Date
Licensing Consultant

Approved By:

01/05/2026

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Dawn N. Timm Date
Area Manager