GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 1, 2026

Leslee Poegel
American House Grosse Pointe Cottage
Ste 1600, 161 Kercheval Ave
Grosse Pointe Farms, MI 48236

RE: License #: AH820397738
Investigation #: 2026A1027030
American House Grosse Pointe Cottage

Dear Licensee:

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 authorized representative 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 877-458-2757.

Sincerely,
Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820397738
Investigation #:	2026A1027030
Complaint Receipt Date:	03/09/2026
Investigation Initiation Date:	03/10/2026
Report Due Date:	05/08/2026
Licensee Name:	AH Grosse Pointe Subtenant LLC
Licensee Address:	Ste 1500 C/o Renew Reit One SeaGate Toledo, OH 43804
Licensee Telephone #:	(248) 203-1800
Authorized Representative/ Administrator:	Leslee Poegel
Name of Facility:	American House Grosse Pointe Cottage
Facility Address:	Ste 1600 161 Kercheval Ave Grosse Pointe Farms, MI 48236
Facility Telephone #:	(313) 939-2631
Original Issuance Date:	08/13/2020
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	77
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The home was short staffed.	No
Residents were not receiving their medications on time.	Yes
Memory care residents were not receiving consistent activities.	No
Staff smell of marijuana while on duty.	No
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

03/09/2026	Special Investigation Intake 2026A1027030
03/10/2026	Special Investigation Initiated - Letter Email sent to Leslee Poegel requesting documentation
03/10/2026	Contact - Document Received Email received with requested information
03/18/2026	Inspection Completed On-site
03/20/2026	Contact – Document Sent Email sent to Leslee Poegel and Employee #1 requesting additional documentation
03/20/2026	Contact – Document Received Email received with requested documentation
03/26/2026	Special Investigation Sub Compliance
04/01/2026	Exit Conference Conducted by email with Leslee Poegel

ALLEGATION:

The home was short staffed.

INVESTIGATION:

On March 10, 2026, the Department received anonymous allegations claiming the home was short staffed. Due to the anonymous nature of the complaint, no additional information could be obtained.

On March 18, 2026, I conducted an on-site inspection and interviewed staff.

The authorized representative/administrator, Leslee Poegel, and Employee #1 stated that similar concerns had recently been reported to the Ombudsman by a memory care resident's family member who is currently involved in an estate dispute. They reported that the Ombudsman conducted a visit and no further action was taken.

The administrator and Employee #1 reported there were currently 28 assisted living residents and 15 memory care residents. Of the memory care residents, two were bedridden, and one required the use of a Hoyer lift with two-person assistance. They indicated that shifts were scheduled from 6:00 AM to 2:00 PM, 2:00 PM to 10:00 PM, and 10:00 PM to 6:00 AM. They stated that typically five staff members were on duty during the day and afternoon shifts, and three staff members on the night shift, with two staff assigned specifically to memory care.

While on-site, I observed two staff members present in the memory care unit. I also observed nine memory care residents and ten assisted living residents who appeared well-groomed and dressed in clean clothing.

A review of the staff schedule for March 8, 2026, through March 14, 2026, was consistent with staff statements.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.

ANALYSIS:	Staff attestations aligned with the staffing schedule and staffing levels appeared sufficient to meet residents' needs; therefore, the allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents were not receiving their medications on time.

INVESTIGATION:

On March 10, 2026, the Department received anonymous allegations which read that residents were not being administered their medications on time. Due to the anonymous nature of the complaint, no additional information could be obtained.

On March 18, 2026, I conducted an on-site inspection and interviewed staff.

The authorized representative/administrator, Leslee Poegel, and Employee #1 stated that similar concerns had recently been reported to the Ombudsman by a memory care resident's family member who is currently involved in an estate dispute. They reported that the Ombudsman conducted a visit and no further action was taken.

The administrator and Employee #1 indicated there had been no concerns raised by staff or residents' families regarding medication administration times. Employee #1 stated that medications were administered within one hour before or after their scheduled time. She further explained that the Yardi medication administration system does not allow administration outside of this timeframe unless an exception is entered by her, which requires staff to contact her directly. Employee #1 reported that she reviews a daily medication exception report to follow up on any missed or delayed medications.

I reviewed the March 2026 medication administration records (MARs) for two residents, Residents A and B. Resident A's MARs included medications such as Carbidopa-Levodopa every three hours while awake and Gabapentin four times daily, both of which were initialed as administered. Resident B's medications were also documented as administered in accordance with physician orders.

A Time Variance Report dated March 8 through March 14, 2026, was reviewed for Residents A and B. The report included the residents' name, medication name, administering staff member, variance time, user-entered administration time, scheduled administration time, action taken, eMAR administration time, and system-

recorded time. The report documented several discrepancies between the scheduled medication administration times, and the actual times medications were given. For example, on March 9, 2026, Resident A's Carbidopa-Levodopa was administered at 5:04 PM, although it was scheduled for 2:00 PM. Similarly, on March 11, 2026, some of Resident B's medications were scheduled for 8:00 AM but were administered at 9:46 AM.

I reviewed the order administration tracking log for March 8, 2026, through March 14, 2026, which was consistent with Employee #1's statements. The log included action notes explaining why medications were not administered as scheduled.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(iv) The time when the prescribed medication is to be administered and when the medication was administered.**
ANALYSIS:	Staff interviews indicated that a process was in place to address deviations from the required medication administration timeframe, and staff initialed Residents A and B's medications as administered on the MARs; however, the Time Variance Report showed that medications for both residents were administered outside the one-hour window before and after the scheduled dose time. Based on this information, the allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Memory care residents were not receiving consistent activities.

INVESTIGATION:

On March 10, 2026, the Department received anonymous allegations which read that memory care residents were not receiving consistent activities or engagement.

Due to the anonymous nature of the allegations, additional information could not be obtained.

On March 18, 2026, I conducted an on-site inspection at the home and interviewed staff.

The authorized representative/administrator, Leslee Poegel, and Employee #1 stated that similar concerns had recently been reported to the Ombudsman by a resident's family member who is currently involved in an estate dispute. They reported that the Ombudsman conducted a visit and no further action was taken.

The administrator and Employee #1 reported that activities for both memory care and assisted living residents were planned and posted on the Senior Simon app, as well as within the home. Activities included social hours, live entertainment, and live music twice weekly. They stated that both the activities coordinator and direct care staff participate in leading activities, and that separate activity schedules were maintained for memory care and assisted living residents.

While on-site, I observed memory care residents watching a movie with staff while awaiting lunch. I also observed assisted living residents participating in a game led by the activity's coordinator. I observed several activities calendars posted throughout the home.

I reviewed the posted activity schedules for both memory care and assisted living. The memory care daily schedule included activities such as morning news, devotions, music and memories, movement with a purpose, aqua painting, trivia, tic-tac-toe, manicures with music, reminiscing/storytelling, reading and relaxation, listening to podcasts, and lavender messages. Additionally, the home hosts a monthly event for residents and their families; the most recent, held on March 12, 2026, was titled "Hollywood Glam Night."

APPLICABLE RULE	
MCL 333.20178	**Nursing home, home for the aged, or county medical care facility; description of services to patients or residents with Alzheimer's disease; contents; ?represents to the public? defined.**
	(1) Beginning not more than 90 days after the effective date of the amendatory act that added this section, a health facility or agency that is a nursing home, home for the aged, or county medical care facility that represents to the public that it provides inpatient care or services or residential care or services, or both, to persons with Alzheimer's disease or a related condition shall provide to

	each prospective patient, resident, or surrogate decision maker a written description of the services provided by the health facility or agency to patients or residents with Alzheimer's disease or a related condition. A written description shall include, but not be limited to, all of the following: **(f) The frequency and types of activities for patients or residents with Alzheimer's disease or a related condition.**
ANALYSIS:	Based on staff interviews, review of activity schedules, and on-site observations, there was insufficient evidence of consistent activities and engagement; therefore, the allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff smell of marijuana while on duty.

INVESTIGATION:

On March 10, 2026, the Department received anonymous allegations which read that staff “smelled strongly” of marijuana. Due to the anonymous nature of the allegations, additional information could not be obtained.

On March 18, 2026, I conducted an on-site inspection at the home and interviewed staff.

The authorized representative/administrator, Leslee Poegel, and Employee #1 stated that similar allegations had recently been reported to the Ombudsman by a resident’s family member who is currently involved in an estate dispute. They reported that the Ombudsman conducted a visit and no further action was taken.

The administrator stated that the facility maintains a zero-tolerance policy for drug use. She reported that all employees were drug tested prior to hiring. She also indicated that she recently required a private duty caregiver to leave the premises after detecting the odor of marijuana and reported the incident to the resident’s family, who then arranged for a replacement caregiver. The administrator further stated that staff were expected to report any concerns regarding suspected marijuana use.

While on-site, I conducted observations on the second and third floors of the facility and among approximately ten staff members and did not detect any odor of marijuana.

A review of the facility's employee handbook, dated January 2024, indicated that as a condition of employment, employees are prohibited from reporting to work or performing duties while under the influence of unlawful drugs or alcohol. The policy states that violations may result in immediate termination or disqualification from employment. It further specifies that, regardless of state laws regarding marijuana use, marijuana is strictly prohibited on company property, and any employee who tests positive may be subject to disciplinary action, up to and including termination, unless otherwise limited by applicable state law.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Based on staff interviews, on-site observations, and a review of the facility's policies and procedures, there was insufficient evidence to support the allegation; therefore, it was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend the status of this license remain unchanged.

03/26/2026

Jessica Rogers
Licensing Staff

Date

Approved By:

03/31/2026

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