



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 16, 2026

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

RE: License #: AH820397738
Investigation #: 2026A1027033
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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. 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,

A handwritten signature in cursive script that reads "Jessica Rogers".

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 241-1970
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820397738
Investigation #:	2026A1027033
Complaint Receipt Date:	03/26/2026
Investigation Initiation Date:	03/27/2026
Report Due Date:	05/25/2026
Licensee Name:	AH Grosse Pointe Subtenant LLC
Licensee Address:	Ste 1500 C/o RenewReit 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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was denied visitation.	Yes
Additional Findings	No

III. METHODOLOGY

03/26/2026	Special Investigation Intake 2026A1027033
03/27/2026	Special Investigation Initiated - Letter Email sent to Leslee Poegel requesting information and documentation pertaining to Resident A
03/28/2026	Contact - Document Received Email received from Leslee Poegel with requested information and documentation
03/30/2026	Contact - Document Sent Email sent to Leslee Poegel requesting additional information
03/30/2026	Contact - Document Sent Email sent to Employee #2 requesting documentation
03/30/2026	Contact - Document Received Email received from Employee #2 with requested documentation
04/03/2026	Contact - Telephone call made Telephone interview conducted with Employee #1
04/03/2026	Contact - Telephone call made Voicemail left for Employee #2
04/03/2026	Contact - Telephone call received Telephone interview conducted with Employee #2
04/07/2026	Contact - Document Sent Email sent to complainant requesting additional information
04/07/2026	Contact - Document Received Email received from complainant with additional information
04/09/2026	Contact - Telephone call made

	Telephone interview conducted with the Administrator
04/13/2026	Contact - Telephone call made Telephone interview conducted with Employee #4
04/13/2026	Inspection Completed-BCAL Sub. Compliance
04/16/2026	Exit Conference Conducted by email with Leslee Poegel

ALLEGATION:

Resident A was denied visitation.

INVESTIGATION:

On March 26, 2026, the Department received a complaint alleging that Resident A was denied visitation from Relative A2. The complaint indicated that Relative A2 had previously visited weekly but was denied visitation on March 21, 2026, by Employees #1 and #3 per direction from the Administrator.

On March 28, 2026, email correspondence with the authorized representative and Administrator, Leslee Poegel, read in part that Resident A did not have any visitation restrictions. However, Relative A1 was prohibited from entering the building due to an active trespass order issued by the Grosse Pointe Farms Police Department. The correspondence also indicated that Resident A has a court-appointed guardian through the State of Michigan. The guardianship had recently changed due to a court ruling, and documentation had been requested for facility records. The guardian is expected to remain in place until September, at which time an additional evidentiary hearing is scheduled.

On April 3, 2026, I conducted a telephone interview with Employee #1, who reported that a meeting had been held with the Administrator, Employee #2, and staff regarding visitation restrictions for Relatives A1 and A2. Employee #1 stated that on March 21, 2026, she observed Relative A2 enter the facility with another visitor and informed her that she could no longer visit Resident A in the memory care unit. Employee #1 stated that Relative A2 and the accompanying visitor then left the facility.

On the same date, a telephone interview with Employee #2 revealed that the Administrator had been assaulted by Relative A1 the day prior to the alleged denial of visitation on March 21, 2026. Employee #2 stated that the facility was still determining how to address the situation at that time and clarified that the restriction

ultimately applied only to Relative A1 through a no-trespass order. She reported that Resident A's family was notified by telephone and email that Relative A1 was the only restricted visitor.

On April 7, 2026, email correspondence with the complainant indicated that on March 23, 2026, her attorneys contacted the facility regarding the denial of visitation on March 21, 2026. According to the complainant, the facility's attorney stated that the denial had been an "accident" and that she should have been permitted to visit.

The complainant further reported that she attempted to visit again on March 26, 2026, and was again denied entry. She stated that Employee #4 initially allowed her into the memory care unit, escorted her to Resident A's room, and unlocked the door. While in the room and Face Timing Relative A1, two to three additional staff members entered and requested her name. After she provided her name, she was informed that she was not on the "family approved visitor list" and was required to leave. The complainant reported that staff contacted the Administrator, who confirmed she was not permitted to remain in the home due to not being on the approved list.

The complainant's email also read that her attorney contacted the facility's attorney again on March 27, 2026, and was informed that she had been asked to leave because she was allegedly attempting to shower the resident. The complainant denied this allegation, stating she was only in the room for a few minutes and did not attempt to provide any care. She indicated that facility video footage and Employee #4 could corroborate her account.

The complainant reported that she has since been informed she may resume visitation; however, she expressed reluctance due to what she described as prior false statements regarding the incident.

On April 9, 2026, I conducted a telephone interview with the Administrator, who clarified that the assault by Relative A1 occurred on February 26, 2026, and that Relative A1 remains prohibited from visiting due to a court order. The Administrator stated the facility does not have a formal visitation policy; however, Resident A's guardian has implemented specific restrictions, including prohibiting assistance with personal hygiene and limiting visits to before 8:00 PM. The Administrator further indicated that, on one occasion, she could not recall the exact reason Relative A2 was unable to visit but believed it may have been due to Relative A1 being present. On another occasion, she reported that Resident A became distraught when Relative A2 asked her to shower and was recording video, and Relative A2 was subsequently asked to leave the building, though not formally denied visitation.

On April 13, 2026, I conducted a telephone interview with Employee #4, who corroborated the complainant's account. Employee #4 stated that Relative A2 was buzzed into the facility and escorted to Resident A's room. Relative A2 indicated she had brought cookies and attempted to FaceTime Relative A1 while Resident A was in bed. At that time, Employee #5 entered the room and instructed Relative A2 to leave. Employee #4 stated that although Relative A2 indicated she was permitted to visit, she ultimately left the facility.

Resident A's face sheet indicated she moved into the facility on April 19, 2024. Relative A3 was listed as the emergency contact, responsible party, and both financial and healthcare power of attorney. Resident A's service plan dated March 11, 2026, noted a diagnosis of Alzheimer's dementia with memory impairment and indicated that she requires staff assistance with activities of daily living.

APPLICABLE RULE	
MCL 333.20201	<p>Policy describing rights and responsibilities of patients or residents; adoption; posting; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.</p>
	<p>(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following:</p> <p>(k) A patient or resident is entitled to associate and have private communications and consultations with his or her physician or a physician's assistant with whom the physician has a practice agreement, with his or her advanced practice registered nurse, with his or her attorney, or with any other individual of his or her choice and to send and receive personal mail unopened on the same day it is received at the health facility or agency, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse. A patient's or resident's civil and religious liberties, including the right to independent personal decisions and the right to knowledge of available choices, shall not be infringed and the health facility or agency shall encourage and assist in the fullest possible exercise of these rights. A patient or resident may meet with, and participate in, the activities of social, religious, and community groups at his or her discretion, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.</p>

ANALYSIS:	<p>Staff attestations confirmed that Relative A1 was subject to a no-trespass order prohibiting visitation with Resident A.</p> <p>Staff interviews and the complainant's statements identified two separate incidents involving Relative A2, one in which visitation was reportedly denied and another in which she was asked to leave after visiting with Resident A for a short time period.</p> <p>Staff interviews did not align regarding the two incidents and were unable to identify the specific circumstances surrounding the denial of visitation and short visit prior to being asked to leave. Additionally, the home lacked documentation or an established policy addressing visitation restrictions related to recording staff and residents or providing care to residents within the facility.</p> <p>Nonetheless, Resident A had no visitation restrictions other than those imposed on Relative A1 by court order; therefore, this allegation was substantiated, as Relative A2 was denied visitation on one occasion and asked to leave after a short visit on the other occasion.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Jessica Rogers

04/13/2026

 Jessica Rogers
 Licensing Staff

 Date

Approved By:

Andrea L. Moore

04/16/2026

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

 Date