GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 22, 2026

Timothy Rantz
Ferny AFC Home, LLC
1564 N. M 63
Benton Harbor, MI 49022

RE: License #: AL110388345
Investigation #: 2026A0790031
Golden Shore

Dear Mr. Rantz:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing, and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (616) 356-0100.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
gillr@michigan.gov
(517) 980-1433

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL110388345
Investigation #:	2026A0790031
Complaint Receipt Date:	06/08/2026
Investigation Initiation Date:	06/08/2026
Report Due Date:	08/07/2026
Licensee Name:	Ferny AFC Home, LLC
Licensee Address:	1564 N. M 63 Benton Harbor, MI 49022
Licensee Telephone #:	(269) 449-5400
Administrator:	Timothy Rantz
Licensee Designee:	Timothy Rantz
Name of Facility:	Golden Shore
Facility Address:	1564 N. M 63 Benton Harbor, MI 49022
Facility Telephone #:	(269) 449-5400
Original Issuance Date:	11/07/2017
License **Status:**	REGULAR
Effective Date:	12/02/2024
Expiration Date:	12/01/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Licensee designee threatened to get a gun and kill everyone at Golden Shore.	Yes
Licensee designee slapped Resident B.	No
DCSM shouted at Resident A.	Yes
Direct care staff members neglect Resident A and Resident C causing pressure ulcers.	No
Resident A did not receive afternoon pain medication at time prescribed.	No
DCSM did not use a Hoyer lift to transfer Resident A.	No

III. METHODOLOGY

06/08/2026	Special Investigation Intake 2026A0790031
06/08/2026	Special Investigation Initiated - Telephone I interviewed Family Member A1.
06/08/2026	Contact - Telephone call made I interviewed direct care staff member (DCSM) # 3.
06/09/2026	Inspection Completed On-site I interviewed DCSM # 1 and DCSM # 2. Resident A, Resident B, and Resident C were unable to be interviewed because of cognitive limitations.
06/18/2026	Contact – Telephone call made I called DCSM #6. I left a voicemail message requesting a return call.
06/18/2026	Contact - Telephone call made

	I interviewed clinical manager Amanda Vasquez from Optimal Care Hospice out of Jackson, MI.
06/22/2026	Inspection Completed-BCAL Sub. Non-Compliance
06/22/2026	Inspection Completed-BCAL Sub. Compliance
06/22/2026	Corrective Action Plan Requested and Due on 07/08/2026
06/22/2026	Contact – Telephone call made I called DCSM #6. I left a voicemail message requesting a return call.
06/23/2026	Contact – Telephone call made I called DCSM #6. I left a voicemail message requesting a return call.
06/23/2026	Comment APS worker Kim Celmer emailed providing pertinent information regarding her investigation into the allegations in this special investigation.
06/23/2026	Exit Conference with licensee designee Timothy Rantz.

ALLEGATION:

Licensee designee threatened to get a gun and kill everyone at Golden Shore.

INVESTIGATION:

On 6/8/26, I reviewed a Michigan Department of Licensing and Regulatory Affairs (LARA) – Bureau of Community and Health Systems (BCHS) Online Complaint Form dated 6/5/26. The complaint indicated several complaints from direct care

staff members (DCSMs) were received regarding licensee designee Timothy Rantz acting aggressively and making threats to DCSMs and residents.

The complaint indicated that on one occasion, Mr. Rantz shouted that he would get a gun and kill everyone in the building. DCSMs reported this incident to Adult Protective Services and law enforcement resulted in an investigation.

On 6/8/26, I interviewed Family Member A1 via phone. Family Member A1 indicated that Resident A has been living at Golden Shore Adult Foster Care (AFC) large group home for several years and there have been no previous concerns or incidents.

Family Member A1 disclosed she heard secondhand that licensee designee Timothy Rantz had been verbally aggressive and made threats to harm DCSMs and residents alike. She stated she was unaware what exactly the threats entailed.

On 6/8/26, I interviewed DCSM #3 via phone. DCSM #3 stated that Mr. Rantz did threaten to get a gun and kill everyone at Golden Shore. DCSM #3 stated that Mr. Rantz admitted he made the statement when speaking with law enforcement. She said Mr. Rantz made the statement when speaking directly to a DCSM.

DCSM #3 indicated that emergency medical technicians (EMTs) are currently refusing to come to Golden Shore without law enforcement after Mr. Rantz lost his temper when speaking with them. DCSM #3 said Mr. Rantz was yelling, verbally abusing, and threatening them.

I completed an unannounced onsite investigation on 6/9/26. I interviewed DCSM #2. DCSM #2 requested that she and other DCSMs remain anonymous. DCSM #2 disclosed that Mr. Rantz did threaten to get a gun and kill everyone at Golden Shore. DCSM #2 also heard Mr. Rantz make the comment. Mr. Rantz later admitted being extremely frustrated and to making the statement when speaking with law enforcement.

DCSM #2 also heard Mr. Rantz make the following comment on a previous occasion: “I could shoot everybody!”

On 6/23/26, Adult Protective Services (APS) worker Kim Celmer emailed indicating she believes licensee designee Timothy Rantz made the threatening comment that he was going to get a gun and kill everyone at Golden Shore. Ms. Celmer indicated that the local ambulance service will not go to the AFC large group home without a police escort due to Mr. Rantz’s outbursts. Ms. Celmer said she would be substantiating Mr. Rantz for the threatening language.

Ms. Celmer stated she interviewed Officer Noah Peppers who was assigned the LEN and he also believes Mr. Rantz was stressed out when he made the shooting

comment. Ms. Celmer stated that she has recommended that Mr. Rantz attend an anger management class.

APPLICABLE RULE	
R 400.621	**Capability.**
	Licensees, staff, volunteers, and members of the household shall be capable of ensuring the welfare of residents.
ANALYSIS:	Based on the information gathered during this special investigation through interviews with Family Member A1, DCSM #3, DCSM #2, and Ms. Celmer there was sufficient evidence found indicating that Mr. Rantz threatened to get a gun and kill everyone at Golden Shore.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Licensee designee slapped Resident B.

INVESTIGATION:

The complaint indicated that Mr. Rantz has also been accused of slapping Resident B.

DCSM #3 stated that she heard secondhand that Mr. Rantz slapped Resident B. She said she heard the allegation from DCSM #6 who no longer works at Golden Shore but supposedly she either witnessed Mr. Rantz slap Resident B or Resident B had disclosed to her that Mr. Rantz had slapped Resident B.

DCSM #3 said officer Noah Peppers came to the AFC large group home and investigated these allegations. She stated when Officer Peppers questioned Resident B regarding Mr. Rantz slapping her that Resident B denied the allegation

and stated that Mr. Rantz never slapped her and has always been kind when speaking with her.

DCSM #2 stated that she heard secondhand from several of the other DCSMs that Mr. Rantz slapped Resident B. DCSM #2 stated she knows that Resident B denied that Mr. Rantz slapped her when speaking with law enforcement.

Ms. Celmer said she is not substantiating the allegation regarding Mr. Rantz slapping Resident B. She stated that she and Officer Peppers found no credible evidence to substantiate this allegation.

I attempted on many occasions to interview DCSM #6 via phone. DCSM #6 never answered and would not return my call.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(a) Use any form of punishment.**
ANALYSIS:	Based on the information gathered during this special investigation through personal observation and interviews with DCSM #3, DCSM #2, and APS worker Ms. Celmer there was a lack of evidence found indicating that Mr. Rantz slapped Resident B. There was no evidence found indicating that any form of punishment was used.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

DCSM shouted at Resident A.

INVESTIGATION:

The complaint indicated that DCSM #1 yelled at Resident A who was crying out in pain during a manual transfer and shouted at her "stop screaming". Resident A

should be transferred using a Hoyer lift because of her weight to avoid pain and enhance safety.

On 6/17/26, I reviewed a Business Service Center Complaint Intake Form dated 5/31/26. The complaint indicated that DCSM #1 began verbally abusing Resident A and threatened to drop Resident A on the floor if she did not stay quiet. The complaint indicated that family members were entering Resident A's room and overheard the interaction from outside of the closed door.

The complaint indicated that Resident A's family members spoke with licensee designee Timothy Rantz face to face regarding the incident and he began to yell at both family members stating that he and his DCSMs are allowed to speak to residents any way they like in order to get their point across. Mr. Rantz did not offer any apology and continued to be very rude to the family members.

The complaint indicated that Ms. Clemons admitted to the wrongdoing and apologized while Mr. Rantz continued to talk over family members, belittle their concerns, and explain how verbally abusing the elderly residents is okay and not a big deal because they are not coherent anyway.

Family Member A1 stated that she and another family member were at the AFC large group home on 5/30/26. She indicated they were standing outside Resident A's room just ready to open the door when they heard DCSM #1 yelling at Resident A. Family Member A1 stated that DCSM #1 yelled at Resident A to stop yelling in my ear and threatened to drop Resident A if she did not stop screaming.

Family Member A1 said Resident A was crying, shaking, and telling DCSM #1 she was in pain while the verbal altercation was taking place. She said DCSM #1 was transferring Resident A with the Hoyer lift when the verbal altercation occurred.

Family Member A1 said DCSM #1 immediately apologized for yelling at Resident A when she saw them. Family Member A1 said she asked DCSM #1 to never yell at or speak to Resident A that way again.

Family Member A1 said she and the other family member spoke with licensee designee Timothy Rantz after the verbal altercation took place. Family Member A1 said Mr. Rantz took DCSM #1's side and said he would have yelled at Resident A if she was screaming in his ear as well. Family Member A1 said Mr. Rantz was unable to see anything wrong with the way DCSM #1 handled the situation; whereas DCSM #1 apologized and told them that she was very tired, had worked a double shift, and was not feeling herself. Family Member A1 stated she has witnessed DCSM #1 care for Resident A on many previous occasions and treat Resident A

with kindness and compassion. She said DCSM #1 had always been observed working hard and interacting appropriately with all the residents.

Family Member A1 stated after they explained to Mr. Rantz what they had observed, Mr. Rantz specifically said, “I hear what you are saying, but what is the problem?” Family Member A1 said she told Mr. Rantz that you should never yell at someone in pain and/or threaten to drop them, especially an elderly resident that is on hospice. Family Member A1 explained that Mr. Rantz still did not see a problem with what had occurred. He reiterated that if Resident A was screaming in my ear, I would yell at her to shut up, too.

Family Member A1 said she informed Mr. Rantz that Resident A did not receive her 2:00 p.m. scheduled pain medication before being transferred. She stated that she told Mr. Rantz that things could have gone more smoothly and Resident A may not have experienced the same level of pain if she would have been administered her prescribed pain medication prior to being transferred.

Family Member A1 said Mr. Rantz ended the conversation by stating that he stands by his DCSMs. He indicated that DCSMs have a window of time in which to administer all of the residents’ medications as prescribed.

Family Member A1 said she and the other family member returned to the AFC large group home on 6/3/26. She stated that Mr. Rantz had a DCSM hand them a letter explaining his understanding of what had occurred on 5/30/26. Family Member A1 stated that Mr. Rantz showed no sympathy or empathy and indicated that his solution to avoid a similar incident from happening was to provide the DCSMs with earmuffs so they would not be able to hear Resident A screaming in their ear.

Family Member A1 said there have been no subsequent issues, she has no additional concerns, and overall, she is pleased with the care Resident A has received while living at Golden Shore.

Family Member A1 said she and the other family member visited Resident A again on 6/7/26. She stated that they witnessed another DCSM give Resident A her prescribed afternoon pain medication prior to transferring Resident A. Family Member A1 indicated that the transfer went very smoothly. She said Resident A did not complain once or disclose feeling pain.

DCSM #3 and DCSM #2 both indicated that DCSM #1 admitted to shouting at Resident A.

On 6/9/26, I interviewed DCSM #1. DCSM #1 disclosed that on 5/30/26, she was transferring Resident A from her bed to her recliner. She stated she did not realize Resident A had not yet received her 2:00 p.m. pain medication before transferring

Resident A. DCSM #1 indicated that she was not administered medications that afternoon.

DCSM #1 stated that Resident A was yelling that she was experiencing pain and she yelled at Resident A to “Please stop yelling!” and “I am trying to concentrate.” She said she did not realize that Resident A was experiencing breakthrough pain because of not getting her pain medication.

DCSM #1 said she then requested that DCSM #5 assist with the transfer and then administer Resident A’s pain medication. She said they were able to finish the transfer, and Resident A was then administered her pain medication.

DCSM #1 said there have been no subsequent incidents and she now ensures that Resident A receives her prescribed afternoon pain medication before transferring her.

DCSM #1 indicated that she apologized to Resident A, Family Member A1, and the other family member present for shouting at Resident A.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks.** **(iv) Threats.**
ANALYSIS:	Based on the information gathered during this special investigation through personal observation and interviews with Family Member A1, DCSM #3, DCSM #2, and DCSM #1 there was sufficient evidence found indicating that DCSM #1 shouted at Resident A. There was sufficient evidence indicating that DCSM #1 verbally abused Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Direct care staff members neglect Resident A and Resident C causing pressure ulcers.

INVESTIGATION:

The complaint indicated that Resident A and Resident C have pressure ulcers because of prolonged time spent in bed and not being repositioned or helped out of bed. Resident C's pressure ulcers are reported to be on her feet.

The complaint indicated that Resident A has a bed sore that is not being taken care of properly.

Family Member A1 stated that DCSMs have always taken good care of Resident A. She indicated that she does not have any concerns of neglect on the part of DCSMs. Family Member A1 said that she and other family members visit Resident A several times a week. She stated that she has observed DCSMs caring for Resident A, Resident C, as well as other residents and have never observed any evidence of neglect.

DCSM #3 denied that DCSMs neglect Resident A. She stated that Resident C has an ulcer on her right heal and left ankle. DCSM #3 said she always follows protocol when caring for Resident C. She stated that she puts Resident C's boots and heal protector on her before transferring her. DCSM #3 said she is unsure if all the DCSMs do this because she has witnessed Resident C not wearing her boots and heal protector after other DCSMs got her up and ready. DCSM #3 said she has informed the other DCSMs that they must always put Resident C's boots and heal protector on before getting her up and ready to transfer.

DCSM #2 was not aware of any DCSM neglecting Resident A or Resident C.

On 6/18/26, I interviewed clinical manager Amanda Vasquez from Optimal Care Hospice out of Jackson, MI. Ms. Vasquez stated that she or other registered nurses visit the facility weekly providing wound care for Resident A. She said she has never witnessed any neglect on the part of DCSMs when at the facility. Ms. Vasquez indicated none of the other registered nurses have disclosed witnessing any incidences of neglect on the part of DCSMs while at the AFC large group home. Ms. Vasquez stated that Optimal Care Hospice is solely responsible for Resident C's wound care.

Ms. Celmer disclosed to concerns regarding neglect on the part of DCSMs.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(2) Care and services provided to a resident must be designed to maintain or improve a resident's physical and intellectual functioning and independence.
ANALYSIS:	Based on the information gathered during this special investigation through personal observation and interviews with Family Member A1, DCSM #3, DCSM #2, Ms. Vasquez, and Ms. Celmer there was a lack of evidence found indicating that DCSMs neglect Resident A and Resident C causing pressure ulcers.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A did not receive afternoon pain medication at time prescribed.

INVESTIGATION:

On 6/17/26, I reviewed a Business Service Center Complaint Intake Form dated 5/31/26. The complaint indicated that Resident A's pain medication was not given at the time prescribed and Resident A was in extreme pain. Resident A was transferred from her bed to her chair via Hoyer lift prior to receiving her afternoon pain medication.

The complaint indicated when Resident A expressed the need for her afternoon pain medication and that the Hoyer lift was causing extreme pain, DCSM Veronica Clemons began verbally abusing Resident A and threatened to drop Resident A on the floor if she did not stay quiet.

Family Member A1, DCSM #1, and DCSM #2 all disclosed that Resident A did receive her afternoon pain medication on 5/30/26. They indicated that the medication was not administered before Resident A was transferred but that it was administered after Resident A was transferred.

On 6/9/26, I reviewed Resident A's *Resident Records.* I specifically reviewed Resident A's *Medication Administration Record (MAR)* and found that Resident A did receive her pain medication. It is what time the pain medication was administered

but can be given up to a hour before and a hour after the prescribed time to administer the medication.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with Family Member A1, DCSM #2, and DCSM #1 there was a lack of evidence found indicating that Resident A did not receive afternoon pain medication at the time prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

DCSM did not use a Hoyer lift to transfer Resident A.

INVESTIGATION:

The complaint indicated that DCSM Veronica Clemons yelled at Resident A who was crying out in pain during a manual transfer and shouted at her "stop screaming".

Resident A should be transferred using a Hoyer lift because of her weight to avoid pain and enhance safety.

A Hoyer lift must be used by DCSMs whenever transferring Resident A. The Hoyer lift is to be used because of Resident A's weight to avoid or at least reduce pain and enhance safety.

Family Member A1 disclosed that DCSM #1 was using a Hoyer lift to transfer Resident A on 5/30/26 when she and another family member were at the AFC large group home visiting Resident A.

DCSM #1 disclosed that she did use the Hoyer lift to transfer Resident A. She said DCSMs were instructed to always use the Hoyer lift when transferring Resident A because of her weight to avoid or at least reduce pain and enhance safety.

On 6/9/26, I reviewed Resident A's *Resident Records.* I specifically reviewed Resident A's *Assessment Plan for AFC Residents* and *Health Appraisal,* and both indicated that a hospice appropriate Hoyer lift must be used to transfer Resident A.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with Family Member A1 and DCSM #1 there was no evidence found indicating that DCSM #1 did not use a Hoyer lift to transfer Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 6/23/26, I conducted an exit conference / interview via phone with licensee designee Timothy Rantz. Mr. Rantz admitted to being stressed out and threatening to get a gun and kill everyone at Golden Shore. He disclosed that he is ashamed for saying it and would attend anger management classes to get a handle on his anger and angry outbursts. Mr. Rantz also understood that DCSM #1 shouting at Resident A was inappropriate and unacceptable.

Mr. Rantz was informed of the outcome of this special investigation and did not dispute the findings. He agreed to complete an acceptable Corrective Action Plan (CAP) within the required timeframe.

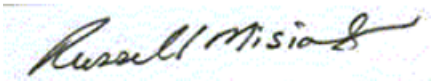
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, issuance of a provisional license is recommended.

6/23/26

Rodney Gill — Date
Licensing Consultant

Approved By:



6/25/26

Russell B. Misiak — Date
Area Manager