GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 15, 2026

Cari Foerster
Cari Ann Foerster
11366 Sarle Rd
Freeland, MI 48623

RE: License #: AL560419216
Investigation #: 2026A1038050
Avielle Haven

Dear Mrs. Foerster:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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,

Johnnie Daniels, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa Ave NW
Grand Rapids MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL560419216
Investigation #:	2026A1038050
Complaint Receipt Date:	08/25/2026
Investigation Initiation Date:	08/26/2026
Report Due Date:	09/24/2026
Licensee Name:	Cari Ann Foerster
Licensee Address:	11366 Sarle Rd Freeland, MI 48623
Licensee Telephone #:	(989) 798-6506
Administrator:	Cari Foerster
Licensee Designee:	Cari Foerster
Name of Facility:	Avielle Haven
Facility Address:	2760 E Yoder Dr Midland, MI 48640
Facility Telephone #:	(989) 695-5200
Original Issuance Date:	04/07/2026
License Status:	TEMPORARY
Effective Date:	04/07/2026
Expiration Date:	10/06/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility did not provide emergency measures for Resident A.	No

III. METHODOLOGY

08/25/2026	Special Investigation Intake 2026A1038050
08/26/2026	Special Investigation Initiated - Letter email sent to complainant
08/27/2026	Contact - Telephone call received from complainant.
09/02/2026	Inspection Completed On-site
09/02/2026	Contact - Face to Face interviews were conducted with LD Cari Foreruter, DCS Christ King and DCS Michelle Masson.
09/11/2026	Contact - Telephone call made to hospice worker Jessica Baumer
09/11/2026	Inspection Completed-BCAL Sub. Compliance
09/14/2026	Contact - Telephone call made to LD regarding additional information.

ALLEGATION:

The facility did not provide emergency measures for Resident A.

INVESTIGATION:

On 9/2/26, I conducted an unannounced investigation at the facility. I conducted an interview with licensee designee Cari Foerster. Ms. Foerster stated she was not working at the time of Resident A's passing but was made aware of what happened.

Ms. Foerster stated Resident A's guardian was contacted along with Hospice. Ms. Foerster stated EMS was called, but she called them off once she was advised Resident A was deceased. Ms. Foerster stated the facility followed their emergency plan of the staff contacting on call workers, who then contact supervisors who contact emergency personnel and then the licensee for guidance. Ms. Foerster stated she contacted the parents of Resident A to make them aware of his passing. Ms. Foerster stated Hospice advised the facility to monitor Resident A over the weekend as he was acting as though his health was worsening.

On 9/2/26, I conducted an interview with direct care staff (DCS) Michelle Masson who stated she was working the day of Resident A's passing. DCS Masson provided a statement consistent was those made by Ms. Foerster. DCS Masson added she was in Resident A's room as he stopped breathing. DCS Masson stated DCS Christ King contacted EMS and they followed the facility emergency plan. DCS Masson stated no one performed cardiopulmonary resuscitation as Resident A was deceased.

On 9/2/26, I conducted an interview with DCS Christ King who provided a statement consistent with those made by Ms. Foerster and DCS Masson.

On 9/11/26, I conducted an interview with Advance Hospice worker Jessica Baumer via telephone. Ms. Baumer verified the facility was in contact with hospice over the weekend before the passing of Resident A. Ms. Baumer verified Resident A was full code and required CPR once he was no longer breathing. Ms. Baumer stated Hospice was not made aware of the passing of Resident A right away. Ms. Baumer stated hospice spoke to the facility and family after the passing of Resident A.

On 9/11/26, I received text messages showing staff in contact with Hospice worker Ms. Baumer on July 27, 2026 at 6:19am, the day of Resident A's passing. Ms. Baumer advised it was fine with hospice to follow the mother's wishes of sending Resident A to the hospital. Ms. Baumer advised she was on her way to the facility.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.

ANALYSIS:	Based on my investigation, interview with staff and hospice. There was no corroborating evidence of the facility not providing emergency measures for Resident A. The facility followed their emergency policy and made Hospice aware of Resident A's declining health the day of his passing.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend the status of the license to remain unchanged.

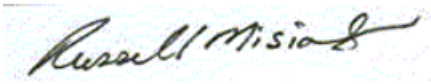


9/15/26

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Johnnie Daniels Date
Licensing Consultant

Approved By:



9/21/26

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Russell B. Misiak Date
Area Manager