GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 5, 2026

Renae-Marie Kiehler
Innovative Housing Dev Corp
Suite 5
3051 Commerce Drive
Fort Gratiot, MI 48059

RE: License #: AS740253774
Investigation #: 2027A0779003
Mayfield

Dear Ranae-Marie Kiehler:

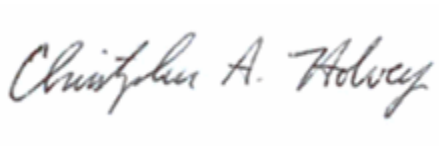
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 643-7960.

Sincerely,



Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS740253774
Investigation #:	2027A0779003
Complaint Receipt Date:	10/14/2026
Investigation Initiation Date:	10/15/2026
Report Due Date:	12/13/2026
Licensee Name:	Innovative Housing Dev Corp
Licensee Address:	Suite 5 3051 Commerce Drive Fort Gratiot, MI 48059
Licensee Telephone #:	(810) 385-4463
Administrator:	Melinda Campbell
Licensee Designee:	Renae-Marie Kiehler
Name of Facility:	Mayfield
Facility Address:	3055 Mayfield, Port Huron, MI 48060
Facility Telephone #:	(810) 982-8968
Original Issuance Date:	03/18/2003
License **Status:**	REGULAR
Effective Date:	09/18/2025
Expiration Date:	09/17/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
This home was not following physician/Hospice orders for Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

10/14/2026	Special Investigation Intake 2027A0779003
10/14/2026	APS Referral Complaint was received from APS.
10/15/2026	Special Investigation Initiated - Telephone Spoke to APS worker.
10/19/2026	Inspection Completed On-site
10/19/2026	Contact - Telephone call made Spoke to Hospice nurse.
10/22/2026	Contact - Telephone call received Received voicemail from Resident A's legal guardian.
11/02/2026	Contact - Telephone call made Spoke with supervisor, Brandy Troy.
11/05/2026	Exit Conference Held with administrator, Melinda Campbell.

ALLEGATION:

This home was not following physician/Hospice orders for Resident A.

INVESTIGATION:

On 10/15/2026, a phone call was made to APS worker, Steven Dutcher, who confirmed that he had investigated the same allegations. APS Dutcher stated that he went to this home on 9/18/2026 and observed Resident A to be actively dying. APS Dutcher stated

that Resident A passed away later that same night on 9/18/2026. APS Dutcher reported that Resident A recently had one fall out of her wheelchair that Hospice was aware of. APS Dutcher stated that he had spoken to both the Hospice nurse and Resident A's legal guardian and neither had any concerns or complaints regarding the care that Resident A received at this home. APS Dutcher stated that he did not substantiate any abuse/neglect and has closed his case.

On 10/19/2026, an unannounced on-site inspection was conducted. Three separate residents were viewed to be clean, well-groomed and appeared to be doing well.

On 10/19/2026, supervisor Brandy Troy confirmed that Resident A was on Hospice and had passed away at the home on 9/18/2026. Supervisor Troy stated that Resident A had severe cognitive deficiencies, was non-verbal, utilized a wheelchair and required full assistance to complete all her activities of daily living. Supervisor Troy stated that Resident A was very restless in the end and did not want to stay in her bed or in her wheelchair for long. Supervisor Troy confirmed that Resident A did have a fall out of her wheelchair on 9/17/2026 and sustained a bruise on her forehead, but an ambulance was called to have EMTs assess and help Resident A to get off the floor. Supervisor stated that a Hospice nurse came to the home on 9/17/2026 to evaluate Resident A and deemed that she did not require medical care for the bruise. Supervisor Troy stated that Resident A peacefully passed away in her bed and a Hospice nurse pronounced her deceased. Supervisor Troy reported that Resident A could be a handful at times, but that all the staff loved Resident A and took good care of her.

On 10/10/2026, a phone call was made to Hospice nurse, Amanda Kibbi, from Elara Caring Hospice. Nurse Kibbi stated that Resident A only received Hospice services a few months. Nurse Kibbi stated that Resident A had terminal restlessness and would crawl out of her bed and strip her clothes off. Nurse Kibbi reported that Hospice was aware of Resident A's fall on 9/17/2026, which resulted in a small bruise on her forehead, and a nurse was at the home the same day of the fall and deemed there was no need for additional medical care. Nurse Kibbi stated that Resident A's cause of death was hypertensive heart with chronic kidney disease and that the staff of this home tried very hard to keep Resident A comfortable at the end. Nurse Kibbi stated that she was not aware of any staff not following physician/Hospice orders and that Hospice had no concerns regarding the care that Resident A received at this home.

On 10/22/2026, a voicemail message was received from Resident A's legal guardian, who reported that once Resident A started receiving Hospice services, her health unfortunately rapidly declined. Guardian reported that he had no concerns regarding the Hospice care at this home or how Resident A's care was managed by the staff at this home.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Resident A passed away at this home, while on Hospice, on 9/18/2026. Hospice nurse, Amanda Kibbi, stated that that she was not aware of any staff not following physician/Hospice orders and that Hospice had no concerns regarding the care that Resident A received at this home. Resident A's legal guardian stated that he had no concerns regarding how Resident A's care was managed by the staff at this home. There was no evidence found that staff at this home failed to follow physician/Hospice instructions and recommendations.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site inspection on 10/19/2026, Supervisor Troy, spent time looking for an *Assessment Plan for AFC Residents* regarding Resident A. Supervisor Troy stated that she would continue to look for it.

On 11/2/2026, a phone call was made to the home. Supervisor Troy stated that she could not find a copy of Resident A's assessment in her file.

On 11/5/2026, an exit conference was held with administrator, Melinda Campbell. Admin Campbell stated that the supervisor in charge of completing Resident A's admission paperwork no longer works at this home and that they are currently conducting an internal audit of resident files to ensure that no further paperwork is missing. Admin Campbell was in formed of the outcome of this investigation and that a written corrective action plan is required.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	This home did not have a copy of a written assessment plan available to review for Resident A, therefore citation of this rule is warranted.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon completion of an approved written corrective plan, it is recommended that the status of this AFC license remains unchanged.

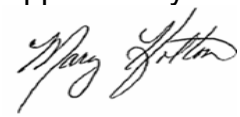


11/5/2026

_____

Christopher Holvey Date
Licensing Consultant

Approved By:



11/5/2026

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Mary E. Holton Date
Area Manager