STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

May 7, 2025
Nancy Stanton
Stone Ridge AFC, LLC
4825 Fruin Rd
Bellevue, MI 49021

RE: License #: AL080415343
Investigation #: 2025A1024020
Stone Ridge AFC

Dear Nancy Stanton:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On April 29, 2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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) 356-0183.

Sincerely,

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL080415343
Investigation #:	2025A1024020
Complaint Receipt Date:	03/14/2025
Investigation Initiation Date:	03/17/2025
Report Due Date:	05/13/2025
Licensee Name:	Stone Ridge AFC, LLC
Licensee Address:	4825 Fruin Rd Bellevue, MI 49021
Licensee Telephone #:	(269) 758-3388
Administrator:	Nancy Stanton
Licensee Designee:	Nancy Stanton
Name of Facility:	Stone Ridge AFC
Facility Address:	4825 Fruin Rd Bellevue, MI 49021
Facility Telephone #:	(269) 758-3388
Original Issuance Date:	03/22/2024
License Status:	REGULAR
Effective Date:	09/22/2024
Expiration Date:	09/21/2026
Capacity:	18
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is not getting the proper care he needs because the staff members will not change his mattress and are too rough with him when assisting with transferring him causing joint pain.	No
Licensee did not provide a proper written discharge notice to Resident A.	Yes

III. METHODOLOGY

03/14/2025	Special Investigation Intake 2025A1024020
03/16/2025	APS Referral- not necessary as transferred from APS.
03/17/2025	Special Investigation Initiated – Telephone with direct care staff member Megan Goshorn
03/17/2025	Contact - Telephone call made with administrator/licensee designee Nancy Stanton
03/17/2025	Contact - Document Received Resident A's *Assessment Plan for AFC Residents*
03/18/2025	Contact - Document Received-*Physician Order* for hospital bed and pressure pad for mattress emailed from Nancy Stanton
03/24/2025	Contact - Document Received-additional allegations regarding eviction notice from Intake #204835
03/24/2025	Contact-Telephone call made with administrator/licensee designee Nancy Stanton
03/27/2025	Contact - Document Received-picture of hospital bed with mattress pad texted from Nancy Stanton
03/27/2025	Contact-Telephone call made with Adult Protective Service (APS) Specialist Rebecca Karrar
04/15/2025	Inspection Completed On-site-with direct care staff members Shaaron Solomon and Debra Steeb
04/16/2025	Inspection Completed-BCAL Sub. Compliance

04/16/2025	Exit Conference with licensee designee Nancy Stanton
04/29/2025	Corrective Action Plan Received
04/29/2025	Corrective Action Plan Approved
05/06/2025	Corrective Action Plan Requested and Due on 04/16/2025

ALLEGATION:

Resident A is not getting the proper care he needs because the staff members will not change his mattress and are too rough with him when assisting with transferring him causing joint pain.

INVESTIGATION:

On 3/14/2025, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged Resident A is not getting the proper care he needs because the staff members will not change his mattress and are too rough with him when assisting with transferring him causing joint pain.

On 3/17/2025, I conducted an interview with direct care staff member Megan Goshorn who stated that Resident A was admitted to the facility on 1/30/2025 and has complained since his admission about living in an adult foster care facility. Megan Goshorn stated Resident A specifically complains about his hospital bed and mattress pad that are both prescribed by a physician for Resident A to use to prevent bed sores. Megan Goshorn stated Resident A can transfer on his own, however staff members are present to assist as needed to ensure Resident A does not fall. Megan Goshorn stated Resident A is very unhappy about his health condition of having Parkinson's Disease and complains a lot about his joints and often states that he wants to have a normal bed like other people. Megan Goshorn stated staff members assist Resident A with care and according to his assessment plan and she has not seen any staff members be rough with Resident A.

On 3/17/2025, I conducted an interview with administrator/licensee designee Nancy Stanton who stated that Resident A often complains about everything and is not happy with living in an adult foster care setting caused by his health condition of severe Parkinson's Disease. Nancy Staton stated Resident A is very thin and complains of pain whenever he moves. Nancy Stanton stated Resident A also complains about having a mattress pad which is prescribed to him because he came to the facility with a bed sore. Nancy Stanton stated she has tried to explain to Resident A that the hospital bed and mattress pad were ordered by his physician, however, Resident A continues to be displeased with using it and gets upset when staff members because they will not remove the pad from his bed. Nancy Stanton stated Resident A also has home help services through Veteran's Affairs such as occupational and physical therapy, who

comes out to the home weekly however she believes Resident A would prefer to live in his own home with these services in place. Nancy Stanton stated Resident A can perform most of his activities of daily living task on his own with supervision from staff to help as needed due to Resident A constantly shaking with tremors and staff members are always gentle when they assist him.

On 3/17/2025, I reviewed Resident A's *Assessment Plan for AFC Residents* dated 2/1/2025. According to this plan, Resident A uses a wheelchair for mobility due to tremors and uses a hospital bed and a mattress pressure pad with pump.

On 3/18/2025, I reviewed Resident A's *Physician Order* dated 2/7/2025 which stated that Resident A requires an alternating mattress pressure pad and hospital bed due to Parkinson's Disease and due to pressure ulcer of the buttocks.

On 3/27/2025, I conducted an interview with APS Specialist Rebecca Karrar who stated she also investigated this allegation and found no evidence to support neglect or abuse by any staff members. Rebecca Karrar stated Resident A is unhappy with his mattress pad ordered by his physician due to his health condition. Rebecca Karrar further stated that Resident A doesn't want to receive the help he needs from staff members and prefers to live in his own private residence, which he is not able to do due to his deteriorating health.

On 3/27/2025, I reviewed a picture of Resident A's hospital bed and mattress pad and found no concerns.

On 4/15/2025, I conducted an onsite investigation at the facility with direct care staff members Shaaron Solomon and Debra Steeb who both stated that they regularly work with Resident A who often complains about his bed and mattress pad prescribed to him by his physician due to his health condition. They both also stated they have not seen any staff member be rough with Resident A and believe Resident A is unhappy about his rapidly declining health condition. Shaaron Solomon stated Resident A's primary physician has been out to the facility to inspect Resident A's bed and mattress pad and has found it to be appropriate for Resident A despite Resident A having constant complaints about it. Shaaron Solomon stated Resident A transfers on his own however staff members stand by his side since Resident A has tremors and could be at risk of having a fall. Shaaron Solomon stated she believes Resident A biggest issue is accepting the fact that he is not as independent as he would like to be and need more help due to his health condition.

Debra Steeb stated that Resident A often expressed how he wasn't happy living in an adult foster care setting and was excited to go live with his sisters who lived out of state. Debra Steeb stated that Resident A moved out of the facility on 3/27/2025.

It should be noted Resident A was not at the facility at the time of this onsite investigation therefore was not interviewed.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on my investigation which included interviews with direct care staff members Megan Goshorn, Shaaron Solomon, Debra Steeb, administrator/licensee designee Nancy Stanton, APS Specialist Rebecca Karrar along with my review of Resident A's assessment plan, physician order, and picture of Resident A's hospital bed and mattress pad there is no evidence to support the allegation Resident A is not getting the proper care he needs because the staff members will not change his mattress and are too rough with him when assisting with transferring him causing joint pain. Rebecca Karrar stated she also investigated this allegation and found no evidence to support neglect or abuse by any staff members and believes Resident A complains about the facility because he prefers to live in his own private residence. Megan Goshorn, Shaaron Solomon, Debra Steeb and Nancy Stanton all stated Resident A often complained specifically about his mattress pad prescribed to him by his physician and living in an adult foster care setting caused by his health condition of severe Parkinson's Disease. These staff members also all stated they have not seen any staff members be rough with Resident A. I reviewed Resident A's physician order which stated that Resident A requires an alternating mattress pressure pad and hospital bed due to Parkinson's Disease and due to a pressure ulcer of the buttocks. I also reviewed Resident A assessment plan which stated that Resident A uses a wheelchair for mobility due to tremors and uses a hospital bed and a mattress pressure pad with pump therefore staff members have provided personal care, supervision and protection as specified in Resident A's assessment plan.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Licensee did not provide a proper written discharge notice to Resident A.

INVESTIGATION:

On 3/24/2025, I received additional allegations that stated licensee did not provide a proper written discharge notice to Resident A.

On 3/24/2025, I conducted an interview with administrator/licensee designee Nancy Stanton who stated that Resident A was placed at her facility by Veteran's Affairs however, Resident A was very unsatisfied with living in an adult foster care facility therefore, refused to sign any admission paperwork with her. Nancy Stanton stated she repeatedly informed Resident A and Resident A's case manager that Resident A was not able to reside in her facility if he did not complete the facility's required admission paperwork. Nancy Stanton stated due to Resident A's refusal to complete admission paperwork, on 3/13/2025 she verbally notified Resident A that he would have to be discharged from her facility by 3/30/2025, which he was very pleased to hear because he wanted to move out of the facility and live in a private residence with his sisters. Nancy Stanton stated Resident A eventually made arrangements with his two sisters to allow him to move in with them out of state and plans to move from the facility on 3/27/2025. Nancy Stanton stated she did not give Resident A a written discharge notice nor did she notify any LARA staff members of this discharge.

On 4/15/2025, I conducted an onsite investigation at the facility with direct care staff members Shaaron Solomon and Debra Steeb who stated that Resident A no longer resides in the facility because his sisters relocated him out of state where he can live in a private residence with them. Shaaron Solomon and Debra Steeb further both stated they have no knowledge of Resident A getting discharged from the facility and believes Resident A voluntarily moved out of the facility because he was not happy in an adult foster care setting.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law. **(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists:** **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home.** **(b) Substantial risk, or an occurrence, of self-destructive behavior.**

	(c) Substantial risk, or an occurrence, of serious physical assault. **(d) Substantial risk, or an occurrence, of the destruction of property.** **(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident:** **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.** **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge.** **If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
ANALYSIS:	Based on my investigation which included interviews with direct care staff members Megan Goshorn, Shaaron Solomon, Debra Steeb, and administrator/licensee designee Nancy Stanton there is evidence to support the allegation licensee did not provide a proper written discharge notice to Resident A. Nancy

	Stanton stated that Resident A was very unsatisfied with living in an adult foster care facility therefore, refused to sign any admission paperwork with her therefore on 3/13/2025 she verbally notified him that he would have to be discharged from her facility by 3/30/2025. Nancy Stanton stated she did not give Resident A a written discharge notice nor did she notify any LARA staff members of this discharge therefore Resident A did not receive proper written notice, and the appropriate parties were not all notified.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/16/2025, I conducted an exit conference with licensee designee Nancy Stanton. I informed Nancy Stanton of my findings and allowed her an opportunity to ask questions or make comments.

On 4/29/2025, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was received; therefore I recommend the current license status remain unchanged.

Ondrea Johnson | 5/6/2025
Ondrea Johnson | Date
Licensing Consultant

Approved By:
Dawn Timm | 05/07/2025

Dawn N. Timm | Date
Area Manager