GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 20, 2025

Joseph Liestenfeltz
Maple Ridge Living Center of Cadillac LLC
7915 E. 16 Road
Manton, MI 49663

RE: License #: AL830395316
Investigation #: 2025A0009022
Maple Ridge Living Center Cadillac

Dear Mr. Liestenfeltz:

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 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 (616) 356-0100.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AL830395316
Investigation #:	2025A0009022
Complaint Receipt Date:	06/03/2025
Investigation Initiation Date:	06/03/2025
Report Due Date:	07/03/2025
Licensee Name:	Maple Ridge Living Center of Cadillac LLC
Licensee Address:	7915 E. 16 Road Manton, MI 49663
Licensee Telephone #:	Unknown
Administrator:	Joseph Liestenfeltz
Name of Facility:	Maple Ridge Living Center Cadillac
Facility Address:	9072 S. Mackinaw Trail Cadillac, MI 49601
Facility Telephone #:	(231) 878-2823
Original Issuance Date:	07/01/2019
License Status:	REGULAR
Effective Date:	01/01/2024
Expiration Date:	12/31/2025
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Direct care worker Linda Ybarra threw Resident A on the bed and grabbed her by the neck.	No
Direct care worker Caiden Moore teased Resident B with food. He put food up to her mouth and then pulled it away when she went to eat it. He pushed her in her wheelchair "aggressively" and called her "retarded" and a "stupid bitch".	Yes
Some staff do not have proper CPR and First Aid training.	Yes

III. METHODOLOGY

06/03/2025	Special Investigation Intake 2025A0009022
06/03/2025	Special Investigation Initiated – Telephone call made to adult protective services worker Michelle Frakes
06/03/2025	APS Referral
06/04/2025	Inspection Completed On-site Interviews with direct care worker Linda Ybarra and day shift supervisor Kelly Fischer Face to face contact with Resident A
06/17/2025	Contact – Telephone call made to adult protective services worker Michelle Frakes
06/18/2025	Contact – Telephone call made to Resident A's Guardian and Resident A's Family Member
06/18/2025	Contact – Telephone call made to administrator Joseph Liestenfeltz
06/18/2025	Contact – Telephone call made to Danny Jo Thorpe, nurse with Heartland Hospice
06/18/2025	Contact – Telephone call made to former administrator Nicole Smith
06/20/2025	Contact – Document (email) received from administrator Joseph Liestenfeltz

06/20/2025	Contact – Telephone call received from administrator Joseph Liestenfeltz
06/20/2025	Exit conference with administrator Joseph Liestenfeltz

ALLEGATION: Direct care worker Linda Ybarra threw Resident A on the bed and grabbed her by the neck.

INVESTIGATION: I spoke with adult protective services worker Michelle Frakes by telephone on June 3, 2025. She stated that she had already visited the Maple Ridge Living Center adult foster care facility. She had seen both Resident A and Resident B. She did not talk to either one because they are both non-verbal. She was able to speak with Resident A's husband who was present when she was there. He denied that he had any concerns about the facility and said that he really likes the staff there. He told her that he is there often and that most of his visits to the facility are unannounced. Ms. Frakes said that she plans on making more contacts before concluding her investigation.

I conducted an unannounced site visit at the Maple Ridge Living Center adult foster care facility on June 4, 2025. I spoke with direct care worker Linda Ybarra who was present at the time of my visit. I asked her about the allegation that had been reported. She denied that she, in any way, threw Resident A on a bed or choked her. Ms. Ybarra denied that anything similar had happened that could have been mistaken for that. She went on to say that she had worked at the facility for over five years and that there have never been any concerns regarding her work with residents. I asked Ms. Ybarra about any problems that she or other staff might have with Resident A. She denied that Resident A is combative at all. She said that she does "swat" at them sometimes but not in any significant way. Ms. Ybarra said that she only works the day shift so does not put Resident A to bed. Resident A is up and dressed by the time she arrives there in the morning. She did say that sometimes she transfers Resident A from her chair to her bed so she can rest. She has not had any problems while performing this task with Resident A. Ms. Ybarra denied that she has been angry with Resident A. She went on to say that there was no situation in which she may have accidentally put Resident A down too hard on the bed or had her hands near Resident A's throat. Ms. Ybarra stated that she always asks for assistance if a resident is being difficult, but this has not happened with Resident A. I asked if Resident A has had any marks or bruises at this time including her throat area. Ms. Ybarra said no, not that she is aware of. She said that the residents who require "total care" do sometimes have small marks or bruises on them from always being transferred but nothing one would consider unusual. Resident A is one of the residents who requires total care.

I did observe Resident A during my time at the facility. She was dressed and sitting in her chair watching television. She seemed content and well-cared for during my cursory observation of her.

I then spoke with day shift supervisor Kelly Fischer during my site visit at the facility. She said that she wanted me to know that they did terminate an employee and that he is “disgruntled”. She went on to say that Resident A requires a “lift transfer” so does require staff to lift her from her chair to her bed and vice versa. Ms. Fischer has worked with Ms. Ybarra extensively and has never observed her to be inappropriate with Resident A or any other resident. Resident A’s husband is in several times a week to spend time and check on her. Resident A has never had any suspicious injuries that Ms. Fischer has been aware of. There has been no reason to believe that Resident A has been mistreated at the facility.

I spoke with Resident A’s guardian and Resident A’s Family Member by telephone on June 18, 2025. They reported that their mother is very close to direct care worker Linda Ybarra. She is also the medication administrator at the facility. They stated that she is a very “competent woman”. Resident A loves Ms. Ybarra and Ms. Ybarra seems to love her. They have never had any concerns about Ms. Ybarra or any of the other staff at the facility. Resident A has never had any marks or bruises. There have been no signs of any mistreatment at the facility in the three years that she has lived there. Resident A’s Family Member stated that her mother is on hospice and that the hospice nurse does a “full body check” of her mother every week. Resident A’s guardian stated that he is aware that there was an employee there who was fired and has tried to “cause trouble” for the organization.

I spoke with administrator Joseph Liestenfeltz by telephone on June 18, 2025. I asked him about the concern of mistreatment of Resident A by direct care worker Linda Ybarra. Mr. Liestenfeltz stated that he felt the assertion was “quite far-fetched”. Ms. Ybarra has worked for their agency since 2017 or 2018. There have been no allegations against her before either by other staff, residents or family members. The only thing that was ever said was during the time they were terminating an employee who had worked as a cook there. He did bring up the fact that he had observed Ms. Ybarra mistreat Resident A. This was in March of 2025. The former employee reportedly had a personality conflict with Ms. Ybarra before he made the assertion. He had stated that Ms. Ybarra had “antagonized” him. The former employee had brought his daughter with him to work on one occasion and Ms. Ybarra had told the girl that she was not allowed to go into residents’ rooms by herself. The former employee had been angry with Ms. Ybarra for saying something directly to his daughter instead of coming to him about it. Mr. Liestenfeltz stated that the former employee did not report any mistreatment of Resident A by Ms. Ybarra until he was being terminated. He seemed to be trying to bring several other employees down with him as he left. When asked why he hadn’t said something about Ms. Ybarra mistreating Resident A after it happened, the former employee replied that he hadn’t thought it was a big deal at the time.

Mr. Liestenfeltz stated that Resident A’s husband is present in the facility every day feeding his wife lunch or dinner. He said that he thought that he would have raised a concern if he believed his wife was being mistreated. There is also a hospice nurse who visits with Resident A at least once a week. Mr. Liestenfeltz said that Ms.

Ybarra is one of their most trusted employees and has worked for them for several years with no issues.

I spoke with Danny Jo Thorpe, a nurse with Heartland Hospice, by telephone on June 18, 2025. Ms. Thorpe stated that she sees Resident A once a week at the Maple Ridge Living Center. She has been visiting her there for the last three years. She has had no concerns about Resident A's care during that time. Resident A did fall out of bed recently and no one there knows how it happened. It was unusual because Resident A was reportedly found laying the opposite direction of how she would have been lying in bed. An on-call hospice nurse from their agency had dealt with that situation. Ms. Thorpe did not know of any concern about this other than the fact that there were some unanswered questions about it. I told Ms. Thorpe about the allegation that had been leveled at direct care worker Linda Ybarra. She replied that she had been working with Ms. Ybarra during the years she has had Resident A on her caseload. She said that she couldn't imagine Ms. Ybarra doing something like that to Resident A. Ms. Thorpe denied that she had ever observed Ms. Ybarra mistreat a resident during her visits to the facility. One time, a younger worker had left some bruising on Resident A. This was not intentional on the worker's part who had just needed to be educated on how to reposition a resident. Other than that, Ms. Thorpe said she had never seen unusual bruising or marks on Resident A. She said that the family visits with Resident A every day and is also quite involved with her care there.

I spoke with former administrator Nicole Smith by telephone on June 18, 2025. I asked her about the allegation regarding Resident A. Ms. Smith said that nothing like that ever happened when she was there. She said that she couldn't believe that Ms. Ybarra would ever do something like that. Ms. Ybarra provided excellent resident care. Ms. Smith said that she knew that Resident A was very well-cared for at the facility during her time there.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk of physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	A report was received that direct care worker Linda Ybarra had thrown Resident A on her bed and choked her. I made contacts with those most involved in Resident A's care including her husband, adult daughter, hospice nurse, the shift supervisor, the current administrator the former administrator. None of them

	had any indication that this had ever happened or believed that it could have happened given what they know of Ms. Ybarra. There have been no suspicious or unexplained injuries to Resident A. The family members who visit frequently and the hospice nurse who visits at least once weekly have no concerns regarding Resident A. Ms. Ybarra denied that she had ever thrown Resident A or choked her. She denied that there anything that had happened that could even be mistaken for what was reported. Information was not discovered through this investigation which would indicate that Resident A was mistreated, exposed to a serious risk of physical or emotional harm, punished, or that physical restraint was used other than that allowed in the rules.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Direct care worker Kaden Moore teased Resident B with food. He put food up to her mouth and then pulled it away when she went to eat it. He pushed her in her wheelchair "aggressively" and called her "retarded" and a "stupid bitch".

INVESTIGATION: I asked day shift supervisor Kelly Fischer about the allegation regarding direct care worker Kaden Moore teasing and being verbally abusive with Resident B. She replied that Mr. Moore was "let go" around Christmas time. This was because he had been observed by another employee teasing Resident B with food. He would go to feed her and then pull the food back when she went to eat it. This was reportedly observed by the employee who no longer works for the agency. Ms. Fischer was not aware of any other employee observing this. She did not know if Mr. Moore admitted to it or not. She had not heard of any allegation regarding Mr. Moore pushing Resident B "aggressively" in a wheelchair or calling her names such as "retard" or "stupid bitch". Ms. Fischer denied any knowledge of any staff mistreating residents besides the incident with Mr. Moore and Resident B.

It was reported that Resident B was in the hospital at the time of my visit and I did not see her while at the facility.

I asked administrator Joseph Liestenfeltz about former direct care worker Kaden Moore on June 18, 2025. He stated that Mr. Moore was terminated due to performance issues at the facility. He was not aware of the allegation that Mr. Moore had teased Resident B with food. He did confirm that Resident B needed assistance with feeding. Resident B passed away last week. Mr. Liestenfeltz said that Nicole Smith was the former administrator who dealt with Mr. Moore's performance issues. He provided me with contact information for the former administrator.

I spoke with former administrator Nicole Smith by telephone on June 18, 2025. I asked her about former direct care worker Kaden Moore. She said Mr. Moore was observed sitting at a resident table eating his own food and drinking his own drink when he was supposed to be feeding Resident B at the time. He was focused on his own meal but occasionally held a spoon of food up to her mouth. As soon as she would try to take a bite, he would pull the spoon away. Ms. Smith said that she reviewed the video footage of the incident to make sure that what she was being told was true. She said that she did, in fact, observe Mr. Moore eating his own meal and drinking his own drink which he was mostly focused on. He occasionally held a spoon up for Resident B and then pulled it back when she tried to take a bite. After three or four times of pulling it back, he would then allow her to take a bite. Mr. Moore did this several times while he was sitting there. I asked her about the allegation of him pushing Resident B aggressively in her wheelchair and calling her "retarded" and "stupid bitch". Ms. Smith said that those assertions had been reported to her as well at the time but she was unable to substantiate them. It had only been "heresy". The person who had reported that to her had a personality conflict with Mr. Moore. It was hard to determine whether those allegations were true. Mr. Moore is a very slow-moving individual and she thought it unlikely he would push a wheelchair quickly, aggressively or not.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	At the end of 2024 or beginning of 2025, direct care worker Kaden Moore was observed by a coworker teasing Resident B with food. Administrator Nicole Smith watched video footage of the incident to confirm its veracity. Ms. Smith confirmed that she observed Mr. Moore eating his own food when his job duty was feeding Resident B at the time. He occasionally held a spoon full of food to her and then pull it back before she could take a bite. She saw that he did this several times. She could not confirm the other report of him calling her derogatory names or pushing her in a wheelchair. That report came from a coworker who did not like Mr. Moore and she could not corroborate it. Resident B was non-verbal before her passing and could not be interviewed about the claims. It was confirmed through this investigation that former direct care worker Kaden Moore did mistreat, withheld food and used

	mental or emotional cruelty to Resident B during his time of employment at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Some staff do not have proper CPR and First Aid training.

INVESTIGATION: During my site visit on June 4, 2025, I asked direct care worker Linda Ybarra about her cardiopulmonary resuscitation (CPR) and First Aid training. She said that she, herself, did complete certified CPR training. She has not received First Aid training. Ms. Ybarra does not believe that her coworkers at the facility have been trained in CPR or First Aid.

I asked shift supervisor Kelly Fischer about her training in CPR and First Aid during my site visit on June 4, 2025. She denied that she has been trained in either CPR or First Aid since beginning her employment at the Maple Ridge facility. She said that worked previously for another licensed adult foster care home from 2018 to 2020. She said that was the last time she was trained in either CPR or First Aid. Ms. Fischer said that she did think that they had scheduled some training for staff there in the near future.

I asked Mr. Liestenfeltz about staff's CPR and First Aid training. He said that he had just had in-person training for staff at another facility that he manages and planned on providing that same in-person component at the Cadillac location. He said that he understood that proper CPR training should have an in-person component. They have only done that on-line up to this point. He said that the staff do a Michigan adult foster care training through Care Courses. He thought that the entire orientation took about 12 hours for staff to complete. I asked him more specifically about the CPR and First Aid sections of the training. He said that he thought that both of those took staff about 45 minutes to an hour to complete. I asked Mr. Liestenfeltz to provide me with documentation regarding the CPR and First Aid components.

I asked former administrator Nicole Smith about staff training at the facility. She said that they received five days shadowing another worker at the facility before being allowed to work on their own. I asked her about CPR and First Aid training. Ms. Smith said that there was no formal or certified CPR or First Aid training for new staff. Ms. Smith said that she had requested that she be able to have someone certified come to the facility to train staff but never received a response from management about it. She even had someone lined up and ready to train the staff there on-site. Ms. Smith said that she knew that this was needed and said that it was really the only thing that ever bothered her about working there. It had come up during her time there that none of them were trained to help a choking resident if needed. Ms. Smith said that she could have tried to tell them what to do in that case but knew that she was not certified to train staff in the Heimlich maneuver. She said

that the only training staff received was a paper training on CPR and First Aid followed by a paper quiz. She thought that this probably took the staff about five minutes to complete. She said that she knew it was not adequate especially since a new staff is just trying to get through several things and not necessarily putting all their attention to it. She did not feel that they had been trained adequately in CPR or First Aid. Ms. Smith reported that she was the administrator from October 2024 to January 2025. She was only there for part of the month in January of 2025 due to an unforeseen personal circumstance. She probably hired and trained four or five staff during that time who all only received that minimal paper training on CPR and First Aid. I asked her about the Care Courses which had been reported to me as something the facility uses for training. She said that maybe that is where the training material was printed from. She said that all the paper training, including the CPR and First Aid, took about half an hour for each staff to complete.

According to the American Red Cross (found on redcross.org), Red Cross CPR/AED courses range in duration from 2 hours to just over 2 hours in length. A Red Cross First Aid class can vary in length but generally lasts for a few hours to a full day. On-line classes and blended classes typically take about 2 to 5 hours to complete. Instructor-led classes can take 2 to 3 hours for shorter programs or up to 5 to 6 hours for more comprehensive options. Successful participation in each course generates documentation for each participant when they complete the training.

I consulted the State of Michigan adult foster care licensing rules technical assistance which states: Training can be provided by the licensee or administrator, and they can use relevant training videos or other training resources. Exception is CPR. The licensee must have a method to assure competency. Competency in CPR is demonstrated by participation in and successful completion of a CPR training course. Documentation is to be maintained by the licensee confirming that each direct care staff has completed training in basic first aid covering such areas as: Emergency aid for someone who is choking, bleeding, or in shock, treating burns, bites, stings, trauma to eye, ear, or nose, aid for treatment for fractures, strokes, seizures, accidental drug overdose and poisonings, hypothermia and hyperthermia, and treatment for emergencies associated with diabetes. Acceptable sources of training include but is not limited to videos, local public health departments, hospitals, the American Red Cross, a licensed physician, registered nurse (R.N.), licensed practical nurse (L.P.N.), emergency medical technician (E.M.T.), or physician's assistant.

Administrator Joseph Liestenfeltz provided me with an example of what is printed off when a staff person completes the Care Courses (www.care-courses.com) training. There were five components of the training, one of which was titled Basic First Aid. The duration of the training was “1.0”. I noted that CPR was one of the areas covered in the Basic First Aid training. The direct care worker who had completed this the training on the example he provided received “85%”. I also spoke again with Mr. Liestenfeltz by telephone on June 20, 2025. I told him that current staff as well as the former administrator do not believe that the CPR and First Aid training

provided has been adequate. He acknowledged that is probably true if they are saying that although he would have liked if they would have vocalized that concern to him. He said that he did know that they needed to do more in that area and has already planned in-person training for CPR and First Aid. He mentioned the former administrator's unforeseen personal circumstance and stated that some things did "slip through the cracks" when she had needed to leave suddenly to address that. He had taken over full-time administration of the Cadillac location when she left.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all the following areas: (a) Reporting requirements. (b) First aid. (c) Cardiopulmonary resuscitation. (d) Personal care, supervision, and protection. (e) Resident rights. (f) Safety and fire prevention. (g) Prevention and containment of communicable diseases.
ANALYSIS:	Two current staff and the former administrator of the facility reported that they do not feel staff are adequately trained in CPR and First Aid. They reported there is no "formal" training provided. The training that was reported was paper training followed by a paper exam which might have taken the staff person as little as five minutes to complete. The current administrator provided me with documentation of the current Care Courses training provided. This included a First Aid training, with CPR, with a duration of what appeared to be one hour. This was an on-line course with no in-person component for practice or demonstrating competence. This is less than recommended guidelines of several hours of CPR and First Aid training, with at least an in-person CPR component, when dealing with a vulnerable population. In consideration of the above information, it is determined that the licensee did not provide adequate in-service CPR and First Aid training or make adequate training available through other sources.

CONCLUSION:	VIOLATION ESTABLISHED

I conducted an exit conference with administrator Joseph Liestenfeltz by telephone on June 20, 2025. I told her of the findings of my investigation and gave her the opportunity to ask questions.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

06/20/2025

Adam Robarge — Date
Licensing Consultant

Approved By:

06/20/2025

Jerry Hendrick — Date
Area Manager