



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 13, 2025

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

RE: License #: AL080415343
Investigation #: 2025A1024039
Stone Ridge AFC

Dear Ms. 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 July 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,

A handwritten signature in cursive script that reads "Ondrea Johnson".

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 #:	2025A1024039
Complaint Receipt Date:	06/25/2025
Investigation Initiation Date:	06/25/2025
Report Due Date:	08/24/2025
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 had two unwitnessed falls which led to hospitalization for critical polytrauma. There is concern medical attention was not obtained timely when the falls were brought to staff's attention.	Yes

III. METHODOLOGY

06/25/2025	Special Investigation Intake 2025A1024039
06/25/2025	Special Investigation Initiated – Telephone medical provider nurse Kourtney Schipper
06/25/2025	APS Referral not warranted
06/26/2025	Inspection Completed On-site with direct care staff member Sharron Solomon and administrator/licensee designee Nan Stanton
06/26/2025	Contact - Telephone call made with Relative A1
06/26/2025	Contact - Document Received- text correspondence with Relative A1 and Nancy Stanton and direct care staff member Debbie
06/27/2025	Contact - Document Received- <i>AFC Licensing Division Incident/Accident Report</i>
06/30/2025	Contact - Document Received- <i>Admission Summary</i>
07/09/2025	Contact - Document Received- <i>Assessment Plan for AFC Residents (assessment), Health Care Appraisal (HCA)</i>
07/15/2025	Exit Conference with licensee designee Nancy Stanton
07/15/2025	Inspection Completed-BCAL Sub. Compliance
07/15/2025	Corrective Action Plan Requested and Due on 8/12/2025
07/29/2025	Corrective Action Plan Received
07/29/2025	Corrective Action Plan Approved

ALLEGATION: Resident A had two unwitnessed falls which led to hospitalization for critical polytrauma. There is concern medical attention was not obtained timely when the falls were brought to staff's attention.

INVESTIGATION:

On 6/25/2025, I received a complaint through the LARA-BCHS online complaint system. This complaint alleged Resident A had two unwitnessed falls which led to hospitalization for critical polytrauma. There is concern medical attention was not obtained timely when the falls were brought to staff's attention.

On 6/25/2025, I conducted an interview with medical provider nurse Kourtney Schipper who stated that she received a phone call from Relative A1 on 6/23/2025 asking if Resident A could be ordered to have x-rays completed to evaluate for injury due to Resident A experiencing pain from having falls in the bedroom and bathroom over the weekend where she hit her head on a door. Kourtney Schipper stated she advised Relative A1 that Resident A should be taken to the emergency room to receive immediate medical care to evaluate for injuries. Kourtney Schipper further stated that when Resident A was taken to the hospital she was admitted to the Intensive Care Unit and diagnosed with having a skull fracture, rib fracture, and back fracture. Kourtney Schipper stated she is very concerned and believes staff did not follow appropriate steps as staff members did not call her medical office or take Resident A to the emergency room to obtain medical assistance at the time Resident A had the falls.

On 6/26/2025, I conducted an onsite investigation at the facility with direct care staff member Sharon Solomon who stated during the weekend of 6/23/2025 it was reported that Resident A fell and was found on the floor by the overnight staff member when she was conducting routine bedroom checks. Sharon Solomon stated she was made aware that Resident A tripped over her step stool assistive device that she has in her bedroom attached to her bed that was installed by Relative A1 which caused her to fall on the floor. Sharon Solomon stated it was reported to her that Relative A1 was contacted when Resident A fell and she is unsure if Resident A received any injuries from her falls.

I also conducted an interview with the administrator/licensee designee Nancy Stanton who stated that she did not witness any of Resident A's falls directly over the weekend of 6/20/2025 when she worked, however, it was reported to her that Resident A had two separate incidents of her falling while she was in the bedroom and once in the bathroom during this weekend. Nancy Stanton stated on 6/21/2025, staff found Resident A on her bedroom floor and her husband, who also shares the bedroom with Resident A, was attempting to help Resident A get up off the floor. Nancy Stanton stated the other incident was on 6/22/2025 which involved Resident A hitting her head on the bathroom door after falling causing her to sustain a scrape to her head. Nancy Stanton stated the staff should have notified Relative A1 during the time of the incident however she is unsure if Relative A1 was notified. Nancy Stanton stated she did not directly observe

Resident A to be in pain or uncomfortable until Sunday morning 6/22/2025 when Relative A1 came to the facility to pick Resident A up for church at which time Resident A complained about her chest hurting. Nancy Stanton stated she informed Relative A1 that Resident A complained about her chest hurting prior to them leaving for church and when they returned, Relative A1 stated that Resident A continued to complain about her chest hurting however Relative A1 left the facility without taking any action about Resident A's complaint of pain. Nancy Stanton stated on 6/22/2025 and 6/23/2025 she contacted Relative A1 again to advise her to take Resident A to see a doctor due to Resident A constantly complaining of being in pain at which time Relative A1 finally picked Resident A up on 6/23/2025 and took her to the emergency room to be evaluated. Nancy Stanton stated she did not take Resident A to be medically evaluated when she noticed Resident A having pain on 6/22/2025 because she informed Relative A1 about this and advised Relative A1 to take Resident A to have x-rays done and to be checked for an UTI since Relative A1 typically takes Resident A to doctor appointments.

On 6/26/2025, I conducted an interview with Relative A1 who stated that she received one phone call on 6/21/2025 notifying her that Resident A had a fall while in her bedroom causing her to have shoulder pain, however, later found out that Resident A also fell while in the bathroom over this weekend which caused her to hit her head. Relative A1 stated on the morning of 6/22/2025 she went to the facility to pick Resident A up for church and there was no mention about Resident A having a second fall over the weekend which she believes caused injury to Resident A. Relative A1 stated she noticed her mother rubbing her chest and complaining of pain therefore they left church early, so Resident A could go back home to rest. Relative A1 stated when they returned from church, she asked Nancy Stanton how Resident A was doing, at which time she was notified of Resident A having a second fall while in the bathroom and having complaints of being in pain. Relative A1 stated on 6/23/2025, she was contacted again by Nancy Stanton stating that Resident A had been in continuous pain, "screaming like crazy" for two hours, therefore she contacted Resident A's primary physician to see if x-rays could be ordered to assess for injuries and Relative A1 was advised at that time to take Resident A to the emergency room. Relative A1 stated when she took Resident A to the emergency room on 6/23/2025, Resident A was admitted to ICU with multiple fractures. Relative A1 stated she was upset because if she had been informed by direct care staff of Resident A's multiple falls that weekend, Relative A1 stated she would have advised staff to seek medical attention sooner.

On 6/26/2025, I reviewed text correspondence from Nancy Stanton to Relative A1 dated 6/23/2025 which stated: "you need to take your mom in for her chest and a UTI test as she has been yelling and screaming craziness for the past 2 hours."

I also reviewed text correspondence from staff member Debbie, last name unknown, to Relative A1 dated 6/21/2025 which stated: "Hey [Relative A1] it's Debbie at Stone Ridge. [Resident A] is having a lot of pain on the right side should so please call facility when you get a minute".

On 6/27/2025, I reviewed the *AFC Licensing Division Incident/Accident Report* dated 6/21/2025 at 12:45am which stated that Resident A got up three times between 11pm and 11:45pm and staff member Connie Hawthorne helped her back to bed each time. This report stated Resident A got up again at 12:00am and 12:30am and Connie Hawthorne helped her back to bed. This report stated between 12:30am and 12:45am, Resident A's spouse rang the bell for help and staff found Resident A and spouse, Resident B, sitting on the floor next to step stool at which Connie Hawthorne placed her arms under Resident A's armpits to stand Resident A up and helped her back in bed. The report stated Resident A said "ouch" when she stood up and said that her hip was hurting which is something not out of the ordinary that she would say. Neither Resident A nor Resident B could explain how Resident A fell.

On 6/30/2025, I reviewed hospital *Admission Summary* with a date of service of 6/23/2025. This summary stated that Resident A came to the emergency room and was admitted to SICU due to a ground level fall which occurred three days ago. This summary stated Resident A has the following injuries: occipital bone fracture, sternal body fracture, hematoma, sacrum fracture and C7 indeterminate fracture.

On 7/9/2025, I reviewed Resident A's *Assessment Plan for AFC Residents* (assessment) which stated that Resident A does not need assistance with her personal care needs and uses a cane for walking.

I also reviewed Resident A's *Health Care Appraisal (HCA)* dated 7/17/2024 which stated Resident A is diagnosed with Alzheimer's, is forgetful and uses a cane.

APPLICABLE RULE	
R 400.15310	Resident health care.
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Based on my investigation which included interviews with direct care staff member Shannon Solomon, administrator/licensee designee Nancy Stanton, Relative A1, medical provider Kourtney Schipper, review of facility's incident report, Resident A's assessment plan, health care appraisal, and <i>Admission Summary</i> there is evidence to support that there was a delay in receiving medical care and evaluation after Resident A had two unwitnessed falls which led to hospitalization for critical polytrauma. These falls were communicated to direct care staff. According to the facility's incident report, Resident A had a fall on 6/21/2025. Nancy Stanton stated she was notified that Resident A fell on two separate occasions on 6/21/2025 and 6/22/2025 and she noticed Resident A to be in pain on 6/22/2025 and 6/23/2025 but medical attention was not obtained. Relative A1 stated that a staff member contacted her on 6/21/2025, 6/22/2025, and 6/23/2025 to report that Resident A was complaining of being in pain. In addition, I reviewed text messages that were consistent with the reported dates of when staff members contacted Relative A1 regarding Resident A experiencing pain at which time medical attention was still not sought by any staff member. Kourtney Schipper stated that she was notified on 6/23/2025 by Relative A1 that Resident A was in pain from previous falls therefore advised Relative A1 to seek medical attention for Resident A which resulted in Resident A being admitted to the ICU for multiple injuries. The staff members failed to obtain needed care immediately when they noticed an adverse change to Resident A which was indicated by Resident A being in pain.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

Nancy Stanton and Sharon Solomon both reported that Resident A had a step stool installed at the side of her bed purchased by Relative A1, however, this step stool was not authorized by a physician. Relative A1 also stated that there was no physician order for Resident A to have the step stool as an assistive device

APPLICABLE RULE	
R 400.15306	Use of assistive devices.
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Nan Stanton and Sharon Solomon both reported that Resident A had a step stool which was purchased by Relative A1 and installed at the side of her bed, however, this step stool was not authorized by a physician. Relative A1 also stated that there was no physician script for Resident A to have the step stool as an assistive device.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

Resident A was admitted to the ICU on 6/23/2025 for injuries sustained due to falls however an incident report was not written and not provided to Relative A1.

APPLICABLE RULE	
R 400.15311	Incident notification, incident records.
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: (b) Unexpected and preventable inpatient hospital admission.
ANALYSIS:	Resident A was admitted to ICU on 6/23/2025 for injuries sustained due to falls however an incident report was not written and/or provided to Relative A1.
CONCLUSION:	VIOLATION ESTABLISHED

On 7/15/2025, I conducted an exit conference with licensee designee Nancy Stanton. I informed her of my findings and allowed her an opportunity to ask questions and make comments. On 7/29/2025, 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
Licensing Consultant

8/12/2205
Date

Approved By:



08/13/2025

Dawn N. Timm
Area Manager

Date