



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 3, 2025

Dennis Strode
Strudwick & Strode AFC Inc
3726 Delta River Dr.
Lansing, MI 48906

RE: License #: AS230334095
Investigation #: 2025A1033057
Strudwick AFC Inc. #5

Dear Mr. Strode:

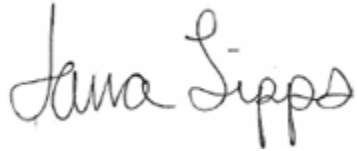
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 335-5985.

Sincerely,

A handwritten signature in cursive script that reads "Jana Lipps".

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS SEXUALLY EXPLICIT LANGUAGE**

I. IDENTIFYING INFORMATION

License #:	AS230334095
Investigation #:	2025A1033057
Complaint Receipt Date:	09/02/2025
Investigation Initiation Date:	09/02/2025
Report Due Date:	11/01/2025
Licensee Name:	Strudwick & Strode AFC Inc
LicenseeAddress:	3726 Delta River Dr. Lansing, MI 48906
Licensee Telephone #:	(151) 797-7124
Administrator:	Dennis Strode
Licensee Designee:	Dennis Strode
Name of Facility:	Strudwick AFC Inc. #5
Facility Address:	1423 Elmwood Drive Lansing, MI 48917
Facility Telephone #:	(517) 881-1811
Original Issuance Date:	10/02/2012
License Status:	REGULAR
Effective Date:	07/25/2024
Expiration Date:	07/24/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
The facility is not adequately staffed to provide resident care.	Yes
Direct care staff, Jerry Kelley, solicited Resident A to engage in an intimate sexual relationship with him.	Yes

III. METHODOLOGY

09/02/2025	Special Investigation Intake 2025A1033057
09/02/2025	Special Investigation Initiated - On Site Interviews conducted with direct care staff, Montoya Boyd, Resident A, Resident B, Licensee Designee, Dennis Strode, and direct care staff, John Strudwick.
09/02/2025	APS Referral- Referral made per protocol.
09/02/2025	Contact - Document Received- Email correspondence received from licensee designee, Dennis Strode.
09/02/2025	Contact - Telephone call received- Interview conducted with licensee designee, Dennis Strode, via telephone.
09/02/2025	Exit Conference- Conducted on-site with Licensee Designee, Dennis Strode.
09/02/2025	Contact – Telephone call made- Attempt to interview CEI-CMH case manager, Ashley Saltsman. Voicemail message left, awaiting response.
09/03/2025	Contact – Telephone call made- Attempt to interview direct care staff, Jerry Kelley, via telephone. Voicemail box was “full” a message could not be left.

ALLEGATION: The facility is not adequately staffed to provide for resident care.

INVESTIGATION:

On 9/2/25 I received allegations that the Strudwick AFC Inc. 5, adult foster care facility (the facility), was operating without sufficient direct care staff to provide for supervision,

protection, and personal care of the current residents. I had previous telephone conversations with licensee designee, Dennis Strode, regarding questions related to closing the facility and providing unlicensed care to two Community Mental Health consumers who currently reside at the facility. Mr. Strode had previously reported that he was considering closing the licensed facility. He had not yet submitted a written closure request to this licensing consultant. On 9/2/25 I interviewed Mr. Strode, via telephone, regarding the allegation. Mr. Strode reported that he has decided to provide "room and board" care to two remaining residents at the facility and identified Resident A and Resident B as these individuals. He reported that the other residents had been relocated to different placements in the surrounding area. Mr. Strode reported that the Community Mental Health case managers for Resident A and Resident B agreed that these individuals no longer required 24/7 supervision, protection, and personal care and were able to reside independently at the facility without regular monitoring from direct care staff. Mr. Strode reported that it was agreed upon that Resident A and Resident B would receive assistance with laundry and housekeeping services but the other aspects of daily living, including meals, transportation, personal care, and medication management could be handled by Resident A and Resident B without supervision or assistance from a direct care staff member. Mr. Strode reported that he no longer has a contract with Clinton-Eaton-Ingham Community Mental Health (CEI-CMH) for residential care services and instead these residents will be "room and board" in terms of their payment structure. Mr. Strode reported that there has not been direct care staff at the facility 24/7 since 8/31/25 when the changes were made. I advised Mr. Strode that I had not yet received a letter of closure for this facility and until the licensed facility is closed supervision, protection, and personal care services must be provided continuously. Mr. Strode reported confusion regarding the need to close the license and reported he would send a letter requesting the department of Licensing and Regulatory Affairs (the Department) to close this license.

On 9/2/25 I conducted an unannounced on-site investigation at the facility. I interviewed Resident A during this inspection. Resident A reported that there has been a change in staffing at the facility. She reported that she and Resident B are the only people who reside at the facility and the staffing has been cut as their CEI-CMH case managers determined that she and Resident B no longer required 24/7 supervision, personal care, and protection. She reported that she can prepare her own meals if the food is provided for her. She reported that someone brings groceries to the facility, and she is able to heat things in the microwave, make sandwiches, and eat fresh fruits and vegetables. Resident A reported that she does not require assistance with her personal care. She stated she schedules her own transportation through Capital Area Transportation Authority (CATA) or through her insurance company. Resident A reported that she is her own guardian and has free access to the community. Resident A further reported that she has been taught how to administer her own medications, which come delivered in bubble packs and she is able to follow this process. She reported that the staffing at the facility changed a few days ago and there is now no longer a direct care staff member providing for her care needs. She reported that someone is scheduled to come once a week to clean and do laundry.

During the on-site investigation on 9/2/25 I interviewed Resident B regarding the allegation. Resident B reported that the staffing requirements at the facility have changed. She reported that she and Resident A reside at the facility together, but do not require 24/7 staffing support. Resident B reported that she can make simple meals and that groceries are delivered to the facility for her and Resident A's use. Resident B reported that she completes her own personal care and hygiene tasks and does not require assistance. Resident B reported that she has a case manager, through CEI-CMH, and this individual has agreed that she no longer requires 24/7 supervision and support from a licensed adult foster care setting. Resident B reported that she can schedule her own transportation through CATA and has independent access to the community. Resident B reported that she can administer her own medications. Resident B reported that she is her own guardian and payee. She reported that the staffing changed at the facility within the past week and there is no longer 24/7 supervision and care provided.

During the on-site investigation on 9/2/25 I interviewed Citizen 1 regarding the allegation. Citizen 1 is a direct care staff member who works at the neighboring licensed adult foster care facility, as the facility is located within a duplex. Citizen 1 reported that there is no longer 24/7 staffing available at the facility as they are changing the way this facility operates. She reported that the license for the facility will be closed as the two remaining residents no longer require 24/7 supervision, protection, and personal care services provided by a licensed adult foster care facility.

During the on-site investigation on 9/2/25 I observed that Resident A and Resident B were found alone at the facility. There was not a scheduled direct care staff member providing care during this on-site inspection.

On 9/2/25 & 9/3/25 I made attempts to interview CEI-CMH case manager, Ashley Saltsman, and was unable to reach her by telephone.

APPLICABLE RULE	
R 400.14206	Staffing requirements.
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.

ANALYSIS:	Based upon interviews conducted during this investigation it can be determined that Mr. Strode has intentions to close the licensed adult foster care facility, however he stopped providing 24/7 supervision, protection, and personal care, prior to notifying the Department in writing of his intent to close the existing adult foster care license. Due to the facility still existing as a licensed adult foster care home a violation has been established as there are residents currently residing in a licensed setting who are not receiving 24/7 supervision, protection, and personal care services.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Direct care staff, Jerry Kelley, solicited Resident A to engage in an intimate sexual relationship with him.

INVESTIGATION:

On 9/2/25 I received allegations that direct care staff member, Jerry Kelley, had solicited Resident A to engage in an intimate sexual relationship with him. On 9/2/25 I received a telephone call from Mr. Strode reporting that Mr. Kelley had been terminated from employment at the facility due to the allegation. Mr. Strode reported that Mr. Kelley had been a no call, no show for his shifts for the past two weeks and he was having difficulty contacting Mr. Kelley by telephone. Mr. Strode reported that Resident A came to him and reported that Mr. Kelley had been harassing her and requesting that she engage in intimate sexual relationships with him while he had been working at the facility. Mr. Strode reported that he was able to view text message conversations on Resident A's telephone between Mr. Kelley and Resident A. Mr. Strode reported that it was obvious by the nature of the text exchanges between Mr. Kelley and Resident A that they had been involved in an intimate sexual relationship. Mr. Strode reported that he discovered Mr. Kelley had requested to view Resident A's breasts on more than one occasion and had requested she send him pictures of herself naked. Mr. Strode reported that he was first informed by Resident A that this situation was occurring on 8/31/25. Mr. Strode reported that Resident A stated she informed her CEI-CMH case manager, Ashley Saltsman, about this situation in July 2025, and Ms. Saltsman had not reported any of this information to Mr. Strode. Mr. Strode reported that he wanted to update this licensing consultant as he was aware of the severity of the situation and wanted it known that he terminated Mr. Kelley's employment and contact with Resident A as a direct care staff member.

On 9/2/25 I conducted an unannounced, on-site investigation at the facility. I interviewed Resident A regarding the allegations. Resident A reported that Mr. Kelley began asking her to do things she did not feel comfortable doing around 7/26/25. She reported that Mr. Kelley worked nights at the facility and when the other residents were sleeping, she was sitting in the living room with Mr. Kelley and he asked her to take her shirt off so he could see her breasts. Resident A reported that she did not feel comfortable doing this but felt pressured by Mr. Kelley to follow through. Resident A

reported that she did show Mr. Kelley her breasts on this date. She reported that Mr. Kelley would then ask her on other occasions if he could see her breasts. She reported that when she would decline to do so he stated, "I see them while you're sleeping anyway." Resident A reported that Mr. Kelley would send her text messages and ask her to meet him at the local park before his shift at the facility would begin. She reported that Mr. Kelley would tell her he needed to see her breasts so that he could masturbate while the other residents were asleep. Resident A reported that Mr. Kelley did not ever physically touch her. She reported he would just verbally ask to see her breasts and send her text messages. She reported that all interactions of this nature made her feel uncomfortable. Resident A reported that she shared this information with Ms. Saltsman and then recently shared it with Mr. Strode. Resident A reported that Mr. Kelley no longer works at the facility.

During the on-site investigation on 9/2/25, I interviewed Resident B regarding the allegation. Resident B reported that she did not have any firsthand knowledge of the allegations against Mr. Kelley. She reported that Resident A had shared with her that Mr. Kelley asked her to remove her shirt and show him her breasts. Resident B stated that Resident A reported to her that Mr. Kelley showed Resident A his genitals.

During the on-site investigation on 9/2/25 I interviewed Citizen 1 regarding the allegation. Citizen 1 reported that she had no direct knowledge of the allegations against Mr. Kelley. She reported that Resident A recently divulged this information to Mr. Strode and herself. She reported that Resident A stated that Mr. Kelley requested to see her breasts and would show his genitals to Resident A. Citizen 1 reported that Resident A stated she was not comfortable with Mr. Kelley's requests.

On 9/2/25 I was provided a written statement from Mr. Strode regarding the allegation. The statement was dated 9/1/25 and signed by Mr. Strode. This statement identifies the following information:

- Incident reported to Mr. Strode on 8/30/25.
- Mr. Kelley's employment terminated.
- Resident A reported this issue to Ms. Saltsman in July 2025. Ms. Saltsman did not share this information with Mr. Strode.
- Resident A's parents have been notified of the situation.
- Law enforcement not contacted to date.
- Training being provided to direct care staff on professional boundaries.

On 9/2/25 I received email correspondence from Mr. Strode. This email contained content from text messages between Resident A and Mr. Kelley. I could not determine validity of the contacts as the content provided was just the text and did not have dates, times, or phone numbers associated with the dialogue to identify who was texting.

On 9/3/25 I attempted to interview Mr. Kelley, via telephone. There was no answer, his voicemail box was "full" and a message could not be left.

APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based upon interviews conducted with Mr. Strode, Resident A, Resident B, & Citizen 1, it can be determined that there is evidence to suggest Mr. Kelley was engaging in an intimate sexual relationship with Resident A while he was employed as a direct care staff member tasked with providing for her supervision, protection, and personal care needs. Mr. Kelley was not providing for Resident A's protection and safety, therefore a violation has been established. Upon learning of Mr. Kelley's inappropriate behavior toward Resident A, Mr. Strode immediately terminated Mr. Kelley's employment.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of the license remains the same and is closed upon receipt of a written request from the licensee.



9/3/25

Jana Lipps
Licensing Consultant

Date

Approved By:



09/03/2025

Dawn N. Timm
Area Manager

Date