GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 22, 2025

Daniela Cleminte
Citadel AFC, LLC
1370 Leon Rd.
Walled Lake, MI 48390

RE: License #: AS810417037
Investigation #: 2026A0122007
Memory Lane Stoneham

Dear Danela Cleminte:

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 12/06/2025, 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 (517) 284-9720.

Sincerely,

Vanita Bouldin

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS810417037
Investigation #:	2026A0122007
Complaint Receipt Date:	12/11/2025
Investigation Initiation Date:	12/12/2025
Report Due Date:	01/10/2026
Licensee Name:	Citadel AFC, LLC
Licensee Address:	1370 Leon Rd. Walled Lake, MI 48390
Licensee Telephone #:	(248) 739-1964
Administrator:	Daniela Cleminte
Licensee Designee:	Daniela Cleminte
Name of Facility:	Memory Lane Stoneham
Facility Address:	8253 Stoneham Drive Ypsilanti, MI 48197
Facility Telephone #:	(248) 739-1964
Original Issuance Date:	12/27/2023
License **Status:**	REGULAR
Effective Date:	06/27/2024
Expiration Date:	06/26/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was pushed by staff member, Vashawna Jones.	Yes
On 12/08/2025 and 12/09/2025, Resident A was struck in the temple by staff member, Katrice Barber.	No

III. METHODOLOGY

12/11/2025	Special Investigation Intake 2026A0122007
12/11/2025	APS Referral
12/12/2025	Special Investigation Initiated - On Site Conducted interviews with Resident B and home manager, Monique Sartor, and corporation member, Jason Setsuda. Reviewed Resident A's file.
12/12/2025	Contact – Telephone call made. Guardian A1. Unavailable, left voice message requesting return phone call.
12/15/2025	Contact – Telephone calls made. Completed interview with staff member, Katrice Barber. Left voice message for staff member, Vashawna Jones. Unavailable – requested a return phone call.
12/18/2025	Contact – Telephone call received Completed interview with Guardian A1.
12/18/2025	Contact – Document received Received video footage from Guardian A1 of the incident involving Resident A and staff member, Vashawna Jones.
12/18/2025	Contact – Telephone call made Vashawna Jones, unavailable. Left voice message requesting return phone call.
12/18/2025	Exit Conference Discussed findings with licensee designee, Daniela Cleminte.

ALLEGATION:

- **Resident A was pushed by staff member, Vashawna Jones.**
- **On 12/08/2025 and 12/09/2025, Resident A was struck in the temple by staff member, Katrice Barber.**

INVESTIGATION: On 12/12/2025, I conducted an interview with corporate member, Jason Setsuda. Mr. Setsuda confirmed that he had viewed video footage dated 12/06/2025, that displayed staff member, Vashawna Jones responding to the door alarm in which Resident A opened the door and stepped outside. Ms. Jones directed Resident A back inside and as Resident A "walked back inside, Ms. Jones pushed Resident A to turn around in the direction Ms. Jones wanted her to go." Mr. Setsuda stated that Ms. Jones' employment was terminated after review of the video footage and Guardian A1 was informed of the incident as well.

On 12/12/2025, I conducted an interview with home manager, Monique Sartor. Ms. Sartor reported the incident involving Resident A and staff member, Vashawna Jones, on 12/11/2025. Ms. Sartor completed an incident report and sent the document to my attention via email on 12/11/2025. Ms. Sartor stated that an internal investigation was completed on the incident, confirmed what Mr. Setsuda reported, and stated that Vashawna Jones' employment was terminated based upon findings of the investigation.

Regarding the allegations of Resident A being struck in the temple by staff member, Katrice Barber, Ms. Sartor stated that she worked with Ms. Barber on those dates and she neither observed nor received reports that Resident A was struck in the temple by Ms. Barber. Ms. Sartor further explained that there were only three residents residing in the facility on the dates of the alleged incidents, so only limited staffing was needed to address the residents' needs. On 12/15/2025, I reviewed the staff schedule and confirmed that on 12/08/2025 and 12/09/2025, staff members Katrice Barber and Monique Sartor were assigned to work on those dates.

On 12/12/2025, I was unable to interview Resident A as she was not present at the facility. Ms. Sartor reported that Resident A had been removed from the facility by Guardian A1 as of 12/11/2025.

On 12/12/2025, I conducted an interview with Resident B. Resident B was admitted to the facility on 10/24/2025. Resident B had acknowledged that she knew staff members, Vashawna Jones and Katrice Barber. Resident B stated that both Ms. Jones and Ms. Barber assisted her appropriately as needed. Resident B stated she had not observed Ms. Jones or Ms. Barber interact inappropriately with other residents either verbally or physically. Resident B did comment on an issue she had with an ex-staff member taking her vital signs without her permission but acknowledged that employee no longer worked at the facility.

On 12/15/2025, I requested to view the video footage of the incident of 12/06/2025 from licensee designee, Daniela Cleminte and Mr. Setsuda. Both sent copies of video footage polices which state, "…surveillance footage accessible only to authorized members of the facility's administrative and management team. Not shared with residents, family members, staff, contractors, or outside parties. Not released, duplicated, or transmitted except as required by law or regulatory authority…" Both denied access to the video footage based upon their corporation policy.

On 12/15/2025, I conducted an interview with Jason Setsuda. Mr. Setsuda stated he had reviewed video footage and observed no inappropriate interactions between the residents of the facility and staff members on the dates of 12/08/2025 and 12/09/2025. Specifically, he did not observe Resident A being struck in the temple by staff member, Katrice Barber.

On 12/18/2025, I conducted an interview with Guardian A1, to which she confirmed that she had been notified of the incident involving Resident A and staff member Vashawna Jones, and that she had received a copy of the video footage. Guardian A1 reported that she had been told that Ms. Jones' employment was terminated, and she felt that incident was handled appropriately. Guardian A1 forwarded a copy of the video footage to me at my request.

On 12/18/2025, I viewed the video footage of the incident on 12/06/2025, provided by Guardian A, which shows Resident A exiting a facility door, the door alarm sounding, and staff member, Vashawna Jones, exiting the facility grabbing Resident A by her arm and pulling Resident A back into the facility. Resident A responds by asking Ms. Jones, "What are you doing," Ms. Jones responds by shoving Resident A on her shoulder telling her, "You can't go out this door." Ms. Jones and Resident A continue to have a verbal exchange with Ms. Jones directing Resident A to the front part of the facility.

On 12/15/2025, I conducted an interview with staff member, Katrice Barber, who confirmed that she worked on 12/08/2025 and 12/09/2025 providing care to all the residents, including Resident A. Ms. Barber denied using physical force with Resident A or any other resident. Ms. Barber denied striking Resident A in the temple.

On 12/18/2025, I conducted an interview with Guardian A1, who confirmed that she had been informed about the allegations stating that Katrice Berber struck Resident A in the temple. Guardian A1 stated that she did not receive a report from Resident A that she was struck in the temple by Ms. Barber. Guardian A1 stated that she had not observed any physical injuries on Resident A, suggesting that she had been struck in the temple. Guardian A1 informed me that due to Resident A's diagnosis of dementia she has made false allegations in the past about being physically assaulted by others. Guardian A1 stated due to Resident A's cognitive limitations

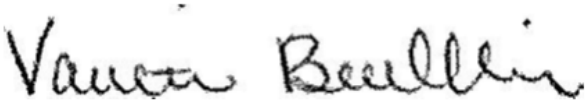
she is unable to participate in an interview and has no evidence to support the allegations made against Katrice Barber.

On 12/19/2025, I conducted an exit conference with licensee designee, Daniela Cleminte and discussed my findings with her. Ms. Cleminte agreed with my findings and submitted a corrective action plan on 12/16/2025.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: (b) Use any form of restraint without an order from an appropriately licensed health care professional or physical force, other than physical restraint for crisis intervention.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with corporate member, Jason Setsuda, home manager, Monquie Sartor, Resident B, Guardian A1, and staff member, Katrice Barber, and review of pertinent documentation relevant to this investigation, there evidence to substantiate the allegation that Resident A was pushed by staff member, Vashawna Jones. Therefore, it has been determined that on 12/06/2025, staff member, Vashawna Jones used physical force with Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

You have submitted an acceptable corrective action plan, therefore I recommend no change to the status of the license.



Vanita C. Bouldin — Date: 12/19/2025
Licensing Consultant

Approved By:

Ardra Hunter — Date: 12/22/2025
Area Manager