



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 15, 2026

Adam Schlueter
Commonwealth Senior Living at Grand Rapids
1175 68th Street S.E.
Grand Rapids, MI 49508

RE: License #: AH410407281
Investigation #: 2026A0627007
Commonwealth Senior Living at Grand Rapids

Dear Mr./Ms. Schlueter:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 black ink that reads "Rick Brummette".

Rick Brummette, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

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

I. IDENTIFYING INFORMATION

License #:	AH410407281
Investigation #:	2026A0627007
Complaint Receipt Date:	09/26/2025
Investigation Initiation Date:	10/03/2025
Report Due Date:	11/26/2025
Licensee Name:	MCAP Grand Rapids Opco, LLC
LicenseeAddress:	Suite 301 915 E. High Street Charlottesville, VA 22902
Licensee Telephone #:	(434) 963-2421
Administrator:	Jennifer Stanley
Authorized Representative/	Adam Schlueter, Authorized Repr.
Name of Facility:	Commonwealth Senior Living at Grand Rapids
Facility Address:	1175 68th Street S.E. Grand Rapids, MI 49508
Facility Telephone #:	(616) 281-8054
Original Issuance Date:	08/02/2023
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	90
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility is short-staffed with only 1 medication technician on the 3 rd shift and a resident was left in a wet brief all day.	No
Additional Findings	No

II. METHODOLOGY

09/26/2025	Special Investigation Intake 2026A0627007
10/03/2025	Special Investigation Initiated - Face to Face
1/14/2026	Exit Conference via email

ALLEGATION:

The facility is short-staffed with only 1 medication technician on the 3rd shift and a resident was left in a wet brief all day.

INVESTIGATION:

On 09/24/2025 the Bureau of Community and Health Systems received an anonymous complaint alleging staff were not available on the night shift for a resident to give pain relief medications for an actively dying resident and the resident was left in a wet brief all day.

On 10/3/2025 I interviewed Jenifer Stanley Executive Director who reported they have a 90-bed capacity with a current census of 72 Residents. Staffing levels were discussed and the Executive Director reported that staffing for day and afternoon shifts has 7 staff covering the facility; 4 caregivers for the Assisted living area and 3 caregivers for the memory care unit along with other support staff including Dietary aides, Housekeeping and an Activity Director. For the night shift the staffing ratio is 5 for the entire facility and specifically there were 5 staff present on 8/15/2025 and 8/16/2025 of which 2 staff were medication technicians. The Executive Director reported that in the event there are staff absent, the facility has 4 caregivers assigned to “on-call” staff with members of management rotating as back up for the on-call staff. The Executive Director also reports that any interaction with residents using incontinent briefs, it is the expectation for each caregiver to check for soiling.

On 10/3/2025, I toured both the units at the facility with the Executive Director. Residents in the units were well dressed, clean and tidy. I interviewed Resident A who reported getting good care and that staff answer Resident A's call button promptly. I interviewed Resident B who reported getting good care and that staff answer Resident B's call button promptly. I interviewed Resident C who reported getting good care and that staff answer Resident C's call button promptly. Resident C incidentally had pressed her call button while I was present, and a caregiver came within 5 minutes. The Executive Director demonstrated how staff can see on their facility cell phones to see in real time how long call buttons were on before being answered. I interviewed Resident D who reported getting good care and that staff answer Resident D's call button promptly. I interviewed Resident E who also reported getting good care and that staff answered her call promptly.

APPLICABLE RULE	
R 325.1922	Admission and retention of residents.
	(3) At the time of an individual's admission, a home or the home's designee shall complete a written resident admission contract between the resident and/or the resident's authorized representative, if any, and the home. The resident admission contract shall, at a minimum, specify all of the following: (a) That the home shall provide room, board, protection, supervision, assistance, and supervised personal care consistent with the resident's service plan.
ANALYSIS:	Based on documents reviewed and interview there was no evidence that the facility was experiencing any short staffing issues or residents that were left in soiled incontinent briefs for excessive periods of time.
CONCLUSION:	VIOLATION NOT ESTABLISHED

III. RECOMMENDATION

I recommend no change in the status of the license.



11/13/2025

Rick Brummette
Licensing Staff

Date

Approved By:



01/15/2026

Andrea L. Moore, Manager
Long-Term-Care State Licensing Section

Date