



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 27, 2026

Lindsey Schnautz
Maple Grove AFC LLC
17460 12 Mile Rd
Big Rapids, MI 49307

RE: License #: AM540412752
Investigation #: 2026A0466009
Maple Grove AFC

Dear Ms. Schnautz:

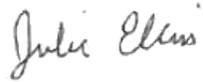
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 "Julie Elkins".

Julie Elkins, 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**

I. IDENTIFYING INFORMATION

License #:	AM540412752
Investigation #:	2026A0466009
Complaint Receipt Date:	12/05/2025
Investigation Initiation Date:	12/08/2025
Report Due Date:	02/03/2026
Licensee Name:	Maple Grove AFC LLC
Licensee Address:	17460 12 Mile Rd Big Rapids, MI 49307
Licensee Telephone #:	(231) 220-9123
Administrator:	Lindsey Schnautz
Licensee Designee:	Lindsey Schnautz
Name of Facility:	Maple Grove AFC
Facility Address:	17460 12 Mile Big Rapids, MI 49307
Facility Telephone #:	(616) 350-7865
Original Issuance Date:	11/28/2022
License Status:	REGULAR
Effective Date:	05/28/2025
Expiration Date:	05/27/2027
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION

	Violation Established?
Resident A's medical needs were not met regarding his bedsore.	Yes
Residents at the facility babysit, do dishes and drink alcohol in the owners' area of the home.	No

III. METHODOLOGY

12/05/2025	Special Investigation Intake 2026A0466009.
12/05/2025	Referral - Recipient Rights Keegan Sarkar assigned.
12/08/2025	APS referral denied.
12/08/2025	Special Investigation Initiated – Letter sent to/from Keegan Sarkar, ORR.
12/12/2025	Contact - Document Received intake #208532 added to this report.
12/12/2025	Contact - Telephone call made to Resident A's case manager Tiffani Arends, message left.
12/17/2025	Inspection Completed On-site.
1/07/2026	Special Investigation Initiated – Letter sent to/from Keegan Sarkar, ORR.
1/22/2026	Contact - Telephone call made to Resident A's case manager Tiffani Arends, message left, second time.
1/22/2026	Contact- Document sent to Letter sent to Keegan Sarkar, ORR.
1/23/2026	Contact- Document sent to/from Keegan Sarkar, ORR.
1/23/2026	Contact- telephone call made to Guardian A1, interviewed.
1/23/2026	Exit Conference- Telephone call made to licensee designee/administrator Lindsey Schnautz, exit conference.

ALLEGATION: Resident A's medical needs were not met regarding his bed sore.

INVESTIGATION:

On 12/05/2025, Complainant reported that on 12/3/25 Resident A was discharged from Maple Grove AFC to another licensed facility. Complainant reported that while training the new facility staff on Resident A's care needs, it was discovered that Resident A had a bed sore between the size of a quarter and a half dollar that appeared puss filled. Complainant expressed concern that Maple Grove AFC may have failed to seek proper medical care/treatment for Resident A's bed sore.

On 12/08/2025, the Department of Licensing and Regulatory Affairs (LARA) received a denied Complaint from Central Intake Adult Protective Services (APS) that stated Resident A was 64 years old and diagnosed with cerebral palsy, depression, and an intellectual disability. On 12/3/2025 Resident A was transported to another adult foster care (AFC) home and during transport Resident A had a bowel movement that required changing. The new facility staff member changed Resident A and discovered an infected pressure ulcer on his coccyx that was between the size of a quarter and half dollar. Resident A was then transported to the hospital where he was found to have a severe urinary tract infection (UTI) and scratches and bruising on his hip. The denied APS referral stated hospital staff is waiting for the results on the culture for his wound. When asked what happened, Resident A could only say the sore had been there a while. He did not have anything to say about the scratches or bruising. When asked why he did not tell anyone, Resident A said he was afraid. It is unknown what this statement meant according to the denied APS referral.

On 12/08/2025, I interviewed Keegan Sarkar, office of recipient rights (ORR) recipient rights advisor who reported that Resident A had been hospitalized for the bed sore on 12/05/2025. ORR Sarkar reported that Resident A's record documented that he saw a physician in mid-October 2025 but it was unknown if this visit was regarding the bed sore.

On 12/17/2025, I conducted an unannounced investigation and I interviewed direct care worker (DCW) Stephen Schnautz who reported that Resident A was admitted to the facility on 3/20/2025 and discharged on 12/03/2025. DCW Schnautz reported that Resident A had a bed sore which was being treated. DCW Schnautz reported that Harmony Care was aware of the sore and they were putting ointment (nystatin) on the sore. DCW Schnautz could not recall the name of anyone that was working with Resident A at Harmony Cares. DCW Schnautz was unaware of any scratches or bruising on Resident A.

I interviewed DCW Ashley Harvey who reported that Resident A had a bed sore for a couple of weeks that was being treated by Harmony Care. DCW Harvey could not recall the name of the physician/nurse from Harmony Care that was working with Resident A. DCW Harvey reported that they were using an ointment with gauze on

the sore for leakage. DCW Harvey reported that she was on duty when Resident A was discharged and she had put the ointment and the gauze on the sore prior to him leaving. DCW Harvey reported that she did not discuss Resident A's bedsore with anyone prior to him leaving or with the case manager that picked him up as she thought that they were aware of the condition. DCW Harvey reported that a Hoyer lift was used to assist with transferring Resident A. DCW Harvey reported that Resident A was always either in his bed, the recliner or a wheelchair. DCW Harvey reported that Resident A often refused assistance with personal care but always allowed DCWs to treat his bedsore. DCW Harvey reported that she documented using the ointment on the medication administration record (MAR). DCW Harvey reported that Resident A's medications were no longer at the facility as they were discharged with him. DCW Harvey was unaware of any scratches or bruising on Resident A. DCW Harvey reported that she has been a consistent staff member at the facility since January 2025 working two 12-hour shifts a week.

I interviewed DCW Heather Powell who reported that Resident A had a bedsore that was getting worse because he refused to stay on his side. DCW Powell believed that Resident A had a standing order for ointment (nystatin) to be applied along with covering with gauze, and rotating him so that he would stay off the sore. DCW Powell reported that she did not work the day Resident A was discharged. DCW Powell stated she was unaware of any scratches or bruising on Resident A. DCW Powell reported that she began working at the facility starting in January 2023 then she left and came back in March 2024 only worked weekends. DCW Powell reported that since August 2025 she has been working four days a week, 12-hour shifts.

I reviewed Resident A's resident record which documented that Resident A was admitted to the facility on 3/20/2025. Resident A's resident record contained a *Health Care Appraisal* dated 3/21/2025. The *Health Care Appraisal* documented that Resident A was diagnosed with "cerebral palsy, mild congestive impairment, hypertension (HTN) and chronic obstructive pulmonary disease (COPD)." The *Health Care Appraisal* did not document any bedsores. The *Health Care Appraisal* documented that Resident A utilized a cane and wheelchair for mobility. Resident A's record did not contain any other medical documentation. Although all the direct care workers interviewed mentioned treatment by Harmony Care there was no documentation in Resident A's of their services to Resident A. Resident A's resident record did not contain any name, address, and/or contact information for Resident A's preferred health care professional and hospital nor did it contain his medical insurance information or statements and instructions for supervising prescribed medication including dietary supplements and medical procedures. Lastly there were no instructions for emergency care and advanced medical directives in Resident A's resident record.

Resident A's resident record contained a written *Assessment Plan for AFC Residents* which documented that Resident A required assistance with activities of daily living (ADL) such as bathing, grooming, dressing and assisting with personal hygiene. In the "assistive devices" section of the report it documented that Resident

A utilizes a “wheelchair, cane and shower chair.” In the “physical limitation” section of the report stated, “right side weakness both limbs needs assistive device for mobility.” Resident A’s *Assessment Plan for AFC Residents* did not address any bedsores or any plan to rotate or move Resident A to avoid bedsores.

All DCWs interviewed reported that Resident A was discharged from the facility on 12/03/2025, therefore his medications no longer remained in the facility. Consequently, I could not complete a medication reconciliation with his medications and medication administration record (MAR). Resident A was not present at the facility at the time of the unannounced investigation as he is now residing in another licensed facility therefore he was not available to be interviewed at the time of the investigation.

I reviewed Resident A’s MARs for October 2025 through December 2025. The MARs documented Resident A was prescribed on 03/23/2025, “Mupirocin 2% ointment Sub for Bactroban, apply topically to affected area(s) of penis glans twice daily.” Per my review of Resident A’s MARs this ointment was applied on the following dates:

- Twice on 12/1, 12/2 and once on 12/3.
- Not administered at all in November 2025.
- Not administered at all in October 2025.

The MARs documented “nystatin 100000U/GM ointment” as being prescribed by Dr. Justin Davies on 3/21/2025. Instructions were “Apply topically to affected area(s) of groin once daily as needed.” Nystatin was documented as prescribed on each MAR for October 2025 through December 2025, however there were no DCW initial(s) on any MAR on any date verifying that the medication was ever applied during that time frame even though DCWs reported applying the ointment to Resident A.

On 01/23/2026, ORR Sarkar reported that she checked Resident A’s resident record on 01/23/2026 to see if his hospital discharge papers were scanned in and she stated did not see them. ORR Sarkar reported that she called the home manager where Resident A currently resides, but she is off until 01/26/2026 so she is not able to get those records.

I interviewed Guardian A1 who reported that Resident A has a history of chronic bedsores and as he is aging, he does not want to move or get up anymore which makes treating the bedsores even harder. Guardian A1 reported that Resident A was being treated for bedsores while at Maple Grove AFC and that he had seen the physician at community mental health (CMH) on unknown dates about the bedsore. Guardian A1 reported that Maple Grove AFC also had a physician that would see Resident A in the facility but she did not have a contact name/phone number for that physician. Guardian A1 reported that Resident A was hospitalized after leaving Maple Grove AFC but that the bedsore continued to get worse at the other licensed facility so he is now living at a skilled nursing center to see if they can better treat the bedsores. Guardian A1 stated being happy with the care that Resident A received at Maple Grove AFC. Guardian A1 reported that Maple Grove AFC met Resident A’s

medical needs and that his bedsores were better at Maple Grove AFC than at his next AFC placement.

I interviewed licensee designee/administrator Lindsey Schnautz who reported that she was aware of Resident A's bedsore and that it was being treated by applying an ointment, she thought Peri guard (zinc ointment), and being monitored by a home health agency. Licensee designee Lindsey Schnautz could not provide the name of a nurse or physician that oversaw Resident A's care as she said that prior to his discharge, the home health agency discontinued accepting Resident A's insurance, and another care provider was not sought because he was moving. Licensee designee Lindsey Schnautz reported Resident A's move date frequently changed for at least a few months before Resident A was finally discharged. Licensee designee Lindsey Schnautz reported that the home health care agency did not provide paperwork but that she would look into obtaining medical documentation regarding Resident A.

I reviewed Resident A's MARs from October 2025 through December 2025 a second time and there was no order/prescription documented for Peri guard (zinc ointment) for Resident A.

I left messages for Tiffani Arends, Resident A's case manager, on 12/12/2025 and 1/22/2026 asking for a return telephone call. As of the writing of this report a return call has not been received, therefore Resident A's case manager was not able to be interviewed.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	I reviewed Resident A's October 2025 through December 2025 MARs which documented that he was prescribed "Mupirocin 2% ointment Sub for Bactroban, apply topically to affected area(s) of penis glans twice daily", however this medication was not documented as applied at all in October or November 2025. Resident A was also prescribed nystatin cream that was not documented as administered even though direct care staff reported applying this cream regularly. Therefore a violation has been established as Resident A's prescribed medications were not administered as prescribed according to the MARs.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.689	Resident health care.
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	DCW Harvey and DCW Powell both reported that they were using an ointment with gauze to cover Resident A's bedsore for leakage. Resident A was prescribed two ointments which are documented on the MAR however Resident A's record did not contain any instructions for covering the bedsore with gauze from a physician or designated health care professional.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.691	Resident records
	(1) A licensee shall complete and maintain a separate record for each resident that includes all of the following: (d) Health care information including all of the following: (iii) Name, address, and contact information of the preferred health care professional and hospital. (iv) Medical insurance. (v) Statements and instructions for supervising prescribed medication including dietary supplements and medical procedures. (vi) Instructions for emergency care and advanced medical directives.
ANALYSIS:	Resident A was admitted to the facility on 3/20/2025 and Resident A's record contained a <i>Health Care Appraisal</i> dated 3/21/2025. The <i>Health Care Appraisal</i> did not document any bedsores. Resident A's resident record did not contain any additional medical documentation. Resident A's record did not contain name, address, and contact information of the preferred health care professional and hospital, his medical insurance or instructions for supervising prescribed medication including dietary supplements and medical procedures. Lastly, there were no instructions for emergency care and advanced medical directives as required.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Residents at the facility babysit, do dishes and drink alcohol in the owners' area of the home.

INVESTIGATION:

On 12/12/2025, anonymous Complainant reported that the AFC owner has residents babysit her child, allows residents to drink alcohol and makes residents do dishes in the owners' home.

On 12/17/2025, I conducted an unannounced investigation and I interviewed DCW Stephen Schnautz who reported that he and licensee designee/administrator Lindsey Schnautz and her son live upstairs in the facility. DCW Stephen Schnautz reported that all the residents have at one time have been upstairs as they sometimes grill for everyone up there. DCW Stephen reported that sometimes the residents will bring groceries up the stairs to help. DCW Stephen Schnautz denied that any resident has ever babysat, did dishes or drank alcohol upstairs in their living quarters. DCW Stephen Schnautz denied that any resident does dishes in the facility.

I interviewed DCW Harvey who reported that no residents go upstairs rather licensee designee Lindsey Schnautz comes downstairs to see the residents. DCW Harvey reported that licensee designee Lindsey Schnautz's minor son does not come down to the facility. DCW Harvey denied that she has ever observed nor has any resident reported to her that they were required to babysit, do dishes, and/or drink alcohol for licensee designee Lindsey Schnautz.

I interviewed DCW Powell who reported that occasionally if the facility needs a pan or groceries one of the residents may go upstairs to where licensee designee Lindsey Schnautz lives to ask for something. DCW Powell denied that any of the residents go upstairs to babysit, do dishes or drink alcohol. DCW Powell reported that none of the residents have ever babysat licensee designee Lindsey Schnautz's son in the facility nor do the residents do dishes or drink alcohol in the facility either. DCW Powell reported that a couple months ago Resident C made a joke about "wanting a beer" but everyone knew that was just a joke. DCW Powell reported that Resident B does not have unsupervised community access and he does not drink alcohol.

I interviewed Resident B who denied that she nor any of the other residents go into licensee designee Lindsey Schnautz's private quarters which is upstairs. Resident B reported that "it's a rule" that we cannot go upstairs. Resident B reported that she and all of the other residents "follow the rules." Resident B denied that she nor any other residents babysit for licensee designee Lindsey Schnautz's son, do her dishes or drink alcohol in her quarters nor in the facility. Resident B reported that she is allowed to be in the community unsupervised and she does not drink alcohol in the community either. Resident B reported that she has never observed anyone drinking alcohol or doing dishes in the facility.

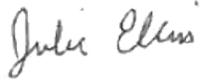
At the time of the unannounced investigation several of the residents were sick and not feeling well. DCWs on duty reported that they believed that the flu was going through the facility. The residents that were verbal and able to be interviewed declined due to not feeling well as they were in bed and did not want to be disturbed.

On 01/23/2025, I interviewed licensee designee Lindsey Schnautz who reported that she lives upstairs in the facility. Licensee designee Lindsey Schnautz denied that any of the residents have come to her living quarters to babysit, do dishes and/or drink alcohol. Licensee designee Lindsey Schnautz reported that she comes downstairs to see residents. Licensee designee Lindsey Schnautz reported that she stopped allowing residents to come up to her living quarters the last time a similar complaint was raised. Licensee designee Lindsey Schnautz reported that around the holidays she did have some of the non-alcoholic wine/grape juice with the residents.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	DCW Stephen Schnautz, DCW Harvey, DCW Powell, licensee designee Lindsey Schnautz and Resident A all denied that the AFC owner (Lindsey Schnautz) had residents babysit her child, allowed residents to drink alcohol, or made residents do dishes in her living quarters in the facility. Additionally DCW Stephen Schnautz, DCW Harvey, DCW Powell, licensee designee Lindsey Schnautz and Resident B all denied that residents drink alcohol and do dishes in the AFC facility therefore there is not enough evidence to establish a violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in license status.

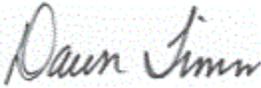


01/26/2026

Julie Elkins
Licensing Consultant

Date

Approved By:



01/27/2026

Dawn N. Timm
Area Manager

Date