



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 10, 2026

Paula Danville
1383 E. Pine River Rd.
Midland, MI 48640

RE: License #: AL730398402
Investigation #: 2026A0580011
Pine Haven Assisted Living LLC, AFC

Dear Paula Danville:

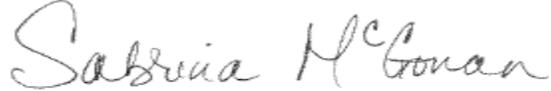
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 643-7960.

Sincerely,

A handwritten signature in cursive script that reads "Sabrina McGowan". The signature is written in black ink and is positioned above the typed name and address.

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL730398402
Investigation #:	2026A0580011
Complaint Receipt Date:	01/07/2026
Investigation Initiation Date:	01/12/2026
Report Due Date:	03/08/2026
Licensee Name:	Paula Danville
Licensee Address:	1383 E. Pine River Rd. Midland, MI 48640
Licensee Telephone #:	(989) 295-6632
Administrator:	Paula Danville
Licensee Designee:	N/A
Name of Facility:	Pine Haven Assisted Living LLC, AFC
Facility Address:	515 N Brennan Hemlock, MI 48626
Facility Telephone #:	(989) 642-5761
Original Issuance Date:	03/04/2020
License Status:	REGULAR
Effective Date:	09/04/2024
Expiration Date:	09/03/2026
Capacity:	18
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On 12/07/2025, Resident A was involved in a physical altercation with staff, Deanna Stewart. Staff Stewart smacked Resident A on the hand, yelled at him and pushed him into his chair.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/07/2026	Special Investigation Intake 2026A0580011
01/12/2026	Special Investigation Initiated - Telephone Call to Erica Partlow, APS.
01/12/2026	APS Referral Opened by APS for investigation.
01/20/2026	Inspection Completed On-site Unannounced onsite.
01/20/2026	Contact - Face to Face Interview with Resident B.
01/20/2026	Contact - Face to Face Interview with Resident C.
01/20/2026	Contact - Face to Face Interview with Resident D.
01/20/2026	Contact - Face to Face Interview with staff, Dani Snapp.
01/22/2026	Contact - Document Received Documents received.
02/04/2026	Contact - Telephone call made Interview with Direct Staff, Lyndsay Snapp.
02/05/2026	Contact - Telephone call made Call to the Richland Township Police Department.

02/05/2026	Contact - Document Received Copy of police report received.
02/05/2026	Contact - Telephone call made Call to former employee, Deanna Stewart.
02/05/2026	Contact - Telephone call made Call to Relative Guardian A.
02/05/2026	Contact - Document Received Review of Workforce Background Check System.
02/06/2026	Contact - Telephone call made Call to Abbey Tennant, Direct Staff.
02/09/2026	Exit Conference Exit Conference with the Licensee, Paula Danville.

ALLEGATION:

On 12/07/2025, Resident A was involved in a physical altercation with staff, Deanna Stewart. Staff Stewart smacked Resident A on the hand, yelled at him and pushed him into his chair.

INVESTIGATION:

On 01/07/2026, I received a complaint via. LARA-BCHS-Complaints This complaint was opened by Adult Protective Services (APS) for investigation.

On 01/12/2026, I contacted Erica Partlow, assigned APS Investigator in Saginaw County. Investigator Partlow stated that she observed a video taken on 12/07/2025, of Direct Staff, Deana Stewart, grabbing Resident A by the wrists and slapping his hand, however, she believes that Staff Stewart's response was more of a reaction and/or defense mechanism as opposed to abuse, therefore she will not be substantiating for Physical Abuse. Investigator Partlow added that upon making a referral to law enforcement, she spoke with Richland Township Police Department (RTPD). RTPD denied the investigation for abuse, citing repeated calls to the home regarding Resident A's violent and abusive behavior.

Upon speaking with the Licensee, Paula Danville on 01/05/2026, it was determined that Staff Stewart quit working at the facility as a result of the incident that occurred on 12/07/2025. This was after Staff Stewart indicated that she did not recall grabbing Resident A by the wrists and slapping his hand as alleged.

Resident A ended up going to the hospital that evening and after discharge, he returned to the care of Relative Guardian A, having passed away on 12/22/2025. Investigator Partlow provided a copy of the video taken in the living room area of the AFC home as well as a copy of the death certificate for Resident A.

On 01/12/2026, I reviewed a copy of the video taken 12/07/2025 sent by Investigator Partlow. The video takes place in the living room area of the home. Before coming into view, someone could be over heard saying, "Hey, don't touch her". As Deanna Staff Stewart, Resident A and Staff Lyndsay Snapp came into the camera frame, Staff Stewart can be heard saying "Good, now sit down". Staff Stewart then proceeded to walk towards a chair in the living room, pointing at it while continuing to tell Resident A, "Over here and sit down". As Resident A tried to walk past her, Staff Stewart went to block him and grabbed his wrists in an effort to guide him towards the chair. Once Resident A got one hand free and reached towards Staff Stewart's neck. Staff Stewart slapped his hand in return and stated, "Hey, don't you do that ever again". Resident A then lunged at Staff Stewart in an attempt to grab her neck again. Staff Stewart then forcefully made Resident A sit down in the chair. Resident A tried to get back up from the chair. Staff Stewart proceeded to push him back down in the chair, telling him "No". Resident A kicked Staff Stewart as a result of not being allowed to get up. Staff Stewart kicked him back in return. Resident A again attempted to kick Staff Stewart. As a result, Staff Stewart grabbed Resident A's legs and pulled him to the floor, stating "I'll put you I the floor. Now sit there", while Staff Snapp called 911.

On 01/20/2026, I conducted an unannounced onsite inspection at Pine Haven Assisted Living LLC, AFC. Contact was made with the licensee, Paula Danville. Licensee Danville stated that on 12/08/2025, she received a call from staff Lyndsay Snapp informing her of what had occurred between Staff Stewart and Resident A. Upon reviewing the camera Licensee Danville stated that she instantly contacted APS to make a referral. Upon interviewing Staff Stewart the following day, she stated that Resident A tried to choke her. Staff Stewart recalled raising her voice, however, Staff Stewart denied pushing, pulling, or hitting Resident A. Staff Stewart was suspended pending further investigation. That same day, on 12/09/2025, Staff Stewart called and indicated that since she cannot recall what she'd done to Resident A, that she thinks it best that she quit, effective 12/09/2025. Resident A ended up being transported to the hospital on 12/07/2025. Resident A did not return to the AFC home.

Licensee Danville stated that Staff Stewart worked at the facility for the past 3 years. Staff Stewart is typically a very sweet person; however, she has been dealing with stressors in her personal life. Licensee Danville denied any prior incidents involving resident mistreatment or reports of resident mistreatment by Staff Stewart.

Residents were observed in both the living room and the bedroom areas of the home. These residents were adequately dressed and groomed. No concerns regarding their care were noted. They appeared to be receiving proper care.

On 01/20/2026, I interviewed Resident B. Resident B stated that she observed the incident which occurred between Staff Stewart and Resident A. Resident B stated that Resident A was trying to choke Staff Stewart. Resident B denied seeing Staff Stewart slap Resident A's hand. Resident B denied that Staff Stewart pushed Resident A in a chair stating that "he fell". Resident B added that Resident A was trying to attack Staff Stewart and she was just trying to stabilize his behavior. Resident B denied any problems or mistreatment from Staff Stewart, adding that she feels safe in the home.

On 01/20/2026, I interviewed Resident C. Resident C stated that staff do a good job and she has no complaints. Resident C denied any harsh words or mistreatment from any of the staff.

On 01/20/2026, I interviewed Resident D. Resident D stated that she has resided at the facility for less than 1 year. Resident D denied any mistreatment from Staff Stewart or any other staff, adding that they meet her needs.

On 01/20/2026, while onsite, I interviewed direct staff on duty, Dani Snapp. Staff Dani Snapp stated that she has worked with Staff Stewart in the past and has never witnessed her mistreat any residents. None of the residents have ever complained about mistreatment from Staff Stewart.

On 01/22/2026, I received a copy of the documents requested. The AFC Assessment Plan for Resident A indicates that Resident A is able to control his aggressive behavior. Resident A is able to follow instructions but struggles during sundowning and is able to be redirected with calm and simple cues. Resident A can walk on his own but needs cues and reminders on where to go and with safety.

The Incident Report (IR) dated 12/07/2025 states that Licensee, Paula Danville was notified by staff Lyndsay Snapp that on 12/07/2025, while training with staff, Deanna Stewart, there was an incident with Resident A in the living room that made her uncomfortable. Licensee Danville reviewed the facility camera and observed Staff Stewart hitting Resident A's arm, kicking his leg and shoving him in a chair. Staff Stewart was also observed trying to pull Resident A out of the chair. Upon confronting Staff Stewart the following day, she admitted to raising her voice, but denied on three separate occasions that she hit, kicked, shoved, or pulled Resident A off his chair. Staff Stewart was informed that she could not return to work, pending further investigation. As a corrective measure, staff are trained on de-escalating situations and this training will continue, adding that Staff Stewart was trained the day prior to this incident on how to calmly redirect residents.

On 02/04/2026, I interviewed Direct Staff, Lyndsay Snapp. Staff Snapp stated that on 12/07/2025, Resident A was continuously trying to get out of the facilities doors. Resident A is diagnosed with Dementia and has what is considered Sundowners. After redirecting Resident A from the exit door, Staff Stewart got involved, using more of a stern voice approach in an attempt to get Resident A into the living room to sit down. As they began walking down the hall towards the living room, a shoving match ensued

between Staff Stewart and Resident A. As they entered the living room, Resident A grabbed at Staff Stewart's throat in an attempt to choke her. Staff Snapp stated that she tried to intervene, telling Resident A "We don't do that", however, Staff Stewart responded by swatting Resident A on the hand, then grabbing his wrists. Staff Stewart then aggressively threw Resident A down in a chair. Resident A then kicked Staff Stewart and Staff Stewart kicked him back, grabbed his legs, and pulled Resident A out of the chair, onto the floor. As Resident A was getting himself up and back into the chair, Staff Snapp contacted 911 for assistance. Resident A was still combative when the police arrived, however, they were able to get him to calm down. Resident A was then taken via ambulance to the hospital. Staff Snapp stated that she did not feel comfortable about how Staff Stewart handled the situation. As a result, Staff Snapp reported the incident to Licensee Danville.

On 02/05/2026, I placed a call to the Richland Township Police Department. Officer Durocher recalled the incident in which the police were called to the AFC located at 515 N. Brennan due to Resident A's aggressive behavior. Officer Durocher also recalled that Resident A was very aggressive towards the officers. A copy of the police report was requested.

On 02/05/2026, I received a copy of the Richland Township Police Report dated 12/07/2025. The report states that on 12/07/2025, Officer Durocher and Officer Mejia were dispatched to the venue for a combative patient at this facility. Upon arrival the combative patient, later identified as Resident A was refusing to listen to staff and was highly agitated. Officers Durocher and Mejia then stepped in to assist staff in subduing Resident a by attempting to have him sit down in a nearby chair. As Officers Durocher and Mejia went to grab Resident A's arm, he became even more agitated by resisting verbal and physical commands to sit down. At one point Resident A even attempted kicking Officer Mejia as he was being sat down. Although Resident A had to be assisted into the chair and made to sit down, he ceased resisting at this point and calmed down. Resident A was transported to Covenant Hospital by MMR for an evaluation.

On 02/05/2026, I placed a call to former employee, Deanna Stewart. Staff Stewart stated that she was employed at Pine Haven Assisted Living for almost 5 years, loved her job, and is broken hearted that an abuse complaint was made. Staff Stewart stated that on the day in question, Resident A had been trying to get out of the building. On 12/07/2025, when she caught Resident A trying to get out of the door, while trying to redirect him, Resident A grabbed her thumb and bent it back and grabbed her by the throat, slamming her against the wall. Staff Stewart recalled that she then grabbed Resident A's arm, walked him down the hall, and sat him in a chair. Then Resident A kept kicking her so she grabbed his foot to get him to stop. Staff Snapp called 911 and it took 2 officers to get Resident A to calm down. Staff Stewart stated that while she may have been angry and yelled, she denied ever hitting Resident A.

On 02/05/2026, I placed call to Relative Guardian A. Relative Guardian A stated that she was notified by Licensee Danville that there were abuse allegations against Staff, Deanna Stewart. Relative Guardian A stated that she was also informed by one of the

staff that Resident A reportedly choked Staff Stewart, who in turn responded by pushing Resident A into a chair, as well as slapping and kicking him. Relative Guardian A stated that Resident A has only resided at the facility for a short period of time and was still adjusting to being placed. Relative Guardian A added that due to Resident A's dementia diagnosis, he was not always cooperative and believes that staff at the AFC should be more equipped to handle residents with dementia. Relative Guardian A stated that Staff Stewart should not be working in an AFC setting and hopes she is not able to harm or mistreat any other residents. Relative Guardian A stated that she had no prior concerns regarding abuse or mistreatment in the home. Relative Guardian A stated that after leaving the AFC, Resident A was hospitalized for an estimated 1 week. Resident A returned home with hospice care. Resident A passed away on 12/22/2025.

The State of Michigan Certificate of Death records Resident A's date of death to be 12/22/2025. The time of death is listed as 2305 Military Time. The cause of death is listed as Severe Alzheimer's Disease, CLL, Normal Pressure Hydrocephalus, and CKD.. The manner of death is listed as natural. No autopsy was performed.

On 02/06/2026, I interviewed Direct Staff, Abbey Tennant. Staff Tenant stated that she began working for the facility in May of 2025. Staff Tennant stated that she was trained by Staff Stewart when she began working at the facility. Staff Tenant denied ever observing Staff Stewart mistreat or be abusive to any of the residents, however, she describes her approach to the residents as "snotty" if they are not cooperating. Staff Tennant stated that she did not observe the alleged interaction between Staff Stewart and Resident A, however, it was brought to her attention by other residents who were uncomfortable with the interaction.

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	<p>It was alleged that as a result of a physical altercation Resident A, Direct Care Staff, Deanna Stewart smacked Resident A on the hand, yelled at him and pushed him into his chair.</p> <p>I reviewed a copy of the video taken on 12/07/2025 in the living room area of the AFC home. The video shows Staff, Deanna Stewart commanding Resident A to sit down several times. Staff Stewart then smacks Resident A's hand when Resident A attempts to choke Staff Stewart. Resident A kicked at staff Stewart, Staff Stewart then kicked Resident A's leg. Staff Stewart then pulled Resident A from his chair onto the floor.</p>

Licensee Danville stated she observed the video showing Staff Stewart kick, push and pull Resident A. Licensee Danville interviewed Staff Stewart, and then suspending her, pending the outcome of this investigation. Staff Stewart resigned on 12/09/2025.

Resident B stated that she observed the incident which occurred between Staff Stewart and Resident A. Resident B stated that Resident A was trying to choke Staff Stewart. Resident B added that Resident A was trying to attack Staff Stewart and she was just trying to stabilize his behavior. Resident B denied any problems or mistreatment from Staff Stewart.

Residents C and D denied any harsh words or mistreatment from any of the staff.

Direct staff, Dani Snapp, stated that she has worked with Staff Stewart in the past and has never witnessed her mistreating any residents. None of the residents have ever complained about mistreatment from Staff Stewart.

The AFC Assessment Plan for Resident A was reviewed, The Incident Report (IR) dated 12/07/2025 was reviewed.

Direct Staff, Lyndsay Snapp, stated that on 12/07/2025, while trying to Redirect Resident A, Staff Stewart got involved. Staff Stewart aggressively threw Resident A down in a chair. Resident A then kicked Staff Stewart and Staff Stewart kicked him back, grabbed his legs, and pulled Resident A out of the chair, onto the floor.

The Richland Township Police Report dated 12/07/2025 was reviewed. The police report indicated Resident A was combative with the police. Resident A eventually calmed down and was taken to the hospital.

Former Direct Staff, Deanna Stewart, stated that while she may have been angry and yelled, she denied ever hitting Resident A.

Relative Guardian A stated that she was notified by Licensee Danville that there were abuse allegations against Staff, Deanna Stewart. Relative Guardian A stated that Staff Stewart should not be working in an AFC setting and hopes she is not able to harm or mistreat any other residents.

	<p>Direct Staff, Abbey Tennant, denied ever observing Staff Stewart mistreat or be abusive to any of the residents, however, she describes her approach to the residents as “snotty” if they are not cooperating.</p> <p>Based upon my investigation, which consisted of interviews with multiple facility staff members and residents, Relative Guardian A, Licensee Paula Danville, and APS Investigator Erica Partlow, a review of relevant facility documents pertinent to the allegation, as well as an observation of the video taken on 12/07/2025, there is enough evidence to substantiate the allegation.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 02/05/2026, I reviewed the Workforce Background Check System for Pine Haven Assisted Living LLC, AFC. Direct Staff Members, Deanna Stewart, Lyndsay Snapp, and Abbey Tenant do not reflect as fingerprinted employees.

On 02/09/2026, I interviewed Licensee Danville regarding the employees that have not been fingerprinted. Licensee Danville stated that she was under the impression that they’d been cleared. Licensee Danville agreed to review the employee files for eligibility and/or will get the staff scheduled for fingerprinting immediately.

APPLICABLE RULE	
MCL 400.734b	Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal

	<p>history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.</p>
<p>ANALYSIS:</p>	<p>Staff employees Deanna Stewart, Lyndsay Snapp, and Abbey Tenant have not been fingerprinted.</p>
<p>CONCLUSION:</p>	<p>VIOLATION ESTABLISHED</p>

On 02/09/2026, I conducted an exit conference with Licensee, Paula Danville. Licensee Danville was informed of the findings of this investigation.

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.

Sabrina McGowan

February 10, 2026

Sabrina McGowan
Licensing Consultant

Date

Approved By:

Mary Holton

February 10, 2026

Mary E. Holton
Area Manager

Date