



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 31, 2026

Ryan Wickson
Hope Shores Stanley, LLC
13224 Lake Shore Dr
Fenton, MI 48430

RE: License #: AS250418941
Investigation #: 2026A0569015
Hope Shores Stanley, LLC

Dear Ryan Wickson:

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 party responsible 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) 643-7960.

Sincerely,

A handwritten signature in dark ink, appearing to read "Kent W. Gieselman". The signature is fluid and cursive, with the first name "Kent" being more prominent and the last name "Gieselman" following in a similar style.

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

| | |
|---------------------------------------|--|
| License #: | AS250418941 |
| Investigation #: | 2026A0569015 |
| Complaint Receipt Date: | 02/23/2026 |
| Investigation Initiation Date: | 02/23/2026 |
| Report Due Date: | 04/24/2026 |
| Licensee Name: | Hope Shores Stanley, LLC |
| Licensee Address: | 7055 Stanley Rd Flushing, MI 48433 |
| Licensee Telephone #: | (810) 964-0412 |
| Administrator: | Ryan Wickson |
| Licensee Designee: | Ryan Wickson |
| Name of Facility: | Hope Shores Stanley, LLC |
| Facility Address: | 7055 Stanley Rd Flushing, MI 48433 |
| Facility Telephone #: | (810) 964-0412 |
| Original Issuance Date: | 05/16/2025 |
| License Status: | REGULAR |
| Effective Date: | 11/16/2025 |
| Expiration Date: | 11/15/2027 |
| Capacity: | 6 |
| Program Type: | DEVELOPMENTALLY DISABLED MENTALLY ILL |

II. ALLEGATION(S)

| | Violation Established? |
|---|-----------------------------------|
| On 2/16/2026, staff member Anniya Branch left Resident A alone in a vehicle. | Yes |

III. METHODOLOGY

| | |
|------------|--|
| 02/23/2026 | Special Investigation Intake 2026A0569015 |
| 02/23/2026 | APS Referral Referral to APS. |
| 02/23/2026 | Special Investigation Initiated - Letter Email to Pat Shepard, RRO. |
| 03/04/2026 | Inspection Completed On-site |
| 03/04/2026 | Contact - Telephone call made Attempted contact with Anniya Branch. Left voicemail requesting return phone call. |
| 03/16/2026 | Contact - Telephone call made Attempted contact with Anniya Branch. |
| 03/30/2026 | Contact - Telephone call made Attempted contact with Anniya Branch. |
| 03/30/2026 | Contact - Telephone call made Contact with Haley Saylor, facility manager. |
| 03/31/2026 | Exit conference Exit conference with Ryan Wickson, licensee designee, and Haley Saylor, facility manager. |

ALLEGATION:

On 2/16/2026, staff member Anniya Branch left Resident A alone in a vehicle.

INVESTIGATION:

This complaint was received via LARA-BCHS-Complaints@michigan.gov. The complainant reported that Anniya Branch, staff person, took Resident A on an outing on 02/16/2026. The complainant reported that during this outing, Staff Branch left Resident A alone in a vehicle while she went into a store. The complainant reported that Resident A does not require a 1:1 staff ratio but does require staff supervision while in the community.

An unannounced inspection of this facility was conducted on 03/04/2026. Resident A was alert and oriented to person, place, and time. Resident A was appropriately dressed and groomed with no visible injuries. Resident A stated that he gets to go on an outing once a month with a staff person. Resident A stated that “last month” Staff Branch took him on an outing. Resident A stated that there were no other staff or residents present on this outing. Resident A stated that Staff Branch wanted to get something at Wal-Mart and pulled into the parking lot. Resident A stated that Staff Branch instructed him to wait in the care while she went into Wal-Mart. Resident A stated that he was alone in the car “for a long time” waiting for Staff Branch to return. Resident A stated that as soon as he returned to the facility, he reported the incident to staff and Staff Branch “was fired”. Resident A stated that he is not supposed to be left unsupervised by staff. Resident A stated that he was not injured during this incident and that he feels safe residing at this facility. Resident A stated that he has not been left unsupervised by staff prior to this incident or since this incident. Resident A stated that he has not observed any other residents left unsupervised by staff.

Resident A’s file was reviewed. Resident A’s assessment documents that Resident A is not able to be in the community without staff supervision. The assessment documents that Resident A is capable of completing daily living tasks with verbal reminders from staff.

Several attempts have been made to contact Anniya Branch for a statement regarding this incident. Staff Branch has not responded to the attempts.

Haley Saylor, facility manager, stated on 03/30/2026 that Resident A does not require a 1:1 staffing ratio, but cannot be left unsupervised in the community. Staff Saylor stated that Resident A reported this incident when he returned from the outing on 02/16/2026. Staff Saylor stated that she questioned Staff Branch about this incident, and Staff Branch admitted that she had left Resident A in the vehicle unsupervised while she went into a store. Staff Saylor stated that Staff Branch was terminated from employment and will not be rehired.

| | |
|------------------------|---|
| APPLICABLE RULE | |
| R 400.671 | Resident care. |
| | (4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record. |
| ANALYSIS: | Resident A's assessment documents that Resident A requires supervision while in the community. Resident A stated that staff Branch left him, unsupervised, in a vehicle when she went into a Wal-Mart on 02/16/2026. Staff Saylor stated that Staff Branch admitted to this allegation when she was questioned regarding the incident. Based on the statements given and documentation reviewed, it is determined that there has been a violation of this rule. |
| CONCLUSION: | VIOLATION NOT ESTABLISHED |

An exit conference was conducted with Ryan Wickson, licensee designee, and Haley Saylor, facility manager, on 03/31/2026. The findings in this report were reviewed, and a corrective action plan was requested.

IV. RECOMMENDATION

I recommend that the status of this license remains unchanged with the receipt of an acceptable corrective action plan.



03/31/2026

Kent W Gieselman
Licensing Consultant

Date

Approved By:



03/31/2026

Mary E. Holton
Area Manager

Date