GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 27, 2026

Timothy Rantz
Ferny AFC Home, LLC
1564 N. M 63
Benton Harbor, MI 49022

RE: License #: AL110388345
Investigation #: 2026A0790027
Golden Shore

Dear Mr. Rantz:

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 (616) 356-0100.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
gillr@michigan.gov
(517) 980-1433

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL110388345
Investigation #:	2026A0790027
Complaint Receipt Date:	04/16/2026
Investigation Initiation Date:	04/16/2026
Report Due Date:	06/15/2026
Licensee Name:	Ferny AFC Home, LLC
Licensee Address:	1564 N. M 63 Benton Harbor, MI 49022
Licensee Telephone #:	(269) 449-5400
Administrator:	Timothy RANTZ
Licensee Designee:	Timothy RANTZ
Name of Facility:	Golden Shore
Facility Address:	1564 N. M 63 Benton Harbor, MI 49022
Facility Telephone #:	(269) 449-5400
Original Issuance Date:	11/07/2017
License Status:	REGULAR
Effective Date:	12/02/2024
Expiration Date:	12/01/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff member caused Resident A to fall and sustain injuries.	Yes

III. METHODOLOGY

04/16/2026	Special Investigation Intake 2026A0790027
04/16/2026	Special Investigation Initiated - Telephone Interviewed Complainant.
04/16/2026	APS Referral is not necessary because the allegations do not meet assignment criteria for Adult Protective Services (APS). The allegations pertain to licensing rule violation(s) and not abuse and/or neglect of a vulnerable adult.
04/20/2026	Inspection Completed On-site I interviewed direct care staff members (DCSMs) Beryl Ambia, Sandy Pullins who functions as the facility manager, Ebony Evans, and Resident A.
04/20/2026	Contact - Telephone call made I called DCSM Jennifer Pantelleria. I left a voicemail message requesting a return call.
04/22/2026	Contact - Telephone call received I interviewed DCSM Jennifer Pantelleria.
04/27/2026	Inspection Completed-BCAL Sub. Compliance
04/28/2026	Exit Conference / interview with licensee designee Timothy Rantz.
04/27/2026	Corrective Action Plan Requested and Due on 05/12/2026

ALLEGATON:

Direct care staff member caused Resident A to fall and sustain injuries.

INVESTIGATION:

On 4/16/26, I reviewed a letter received via email. The letter indicated that on 3/12/26, direct care staff member (DCSM) Jennifer Pantelleria was witnessed rolling Resident A from her room. The letter indicated that Resident A was yelling at the top of her lungs to leave her alone and stop pushing her in her wheelchair. Resident A repeated this request six times. Finally, licensee designee Timothy Rantz, who witnessed the incident, told Ms. Pantelleria to stop pushing Resident A.

The letter indicated that Mr. Rantz asked Ms. Pantelleria to follow him to the nurses' station. Mr. Rantz calmly instructed Ms. Pantelleria telling her, "The next time Resident A or any resident unhappy with your care asks you to stop, immediately stop and walkway." He informed Ms. Pantelleria that Resident A will eventually calm down and allow her to resume care within twenty minutes or so once she remembers her. Mr. Rantz told Ms. Pantelleria that if Resident A remains upset with her to have another DCSM care for Resident A.

The letter indicated that later that day, 4/12/26, DCSM Ebony Evans disclosed that she heard Resident A screaming for approximately a minute from the kitchen. Ms. Evans turned to walk down the hallway and witnessed Ms. Pantelleria pushing Resident A away from Ms. Evans and before Ms. Evans could tell Ms. Pantelleria to stop, the wheelchair immediately stopped. Resident A leaped out of the wheelchair and her shoe got caught in the wheel. The letter indicated that Resident A bumped her head on the cement floor causing swelling and had a skin tear on her elbow.

The letter indicated that DCSMs helped Resident A into bed, cleaned and dressed her elbow, and applied a cold compress to her head where she had hit it on the cement.

The letter indicated that Mr. Rantz requested that Ms. Pantelleria step into the nurses' station again. Mr. Rantz calmly spoke with Ms. Pantelleria asking her if she remembered their conversation regarding how to handle Resident A when she is resisting care. The letter indicated that Ms. Pantelleria said, "Yes". Mr. Rantz then asked Ms. Pantelleria why she did not follow his instructions regarding what to do

when she is resisting care. Ms. Pantelleria respond, “I did not want to interrupt Ms. Evans.”

The letter indicated that Mr. Rantz informed Ms. Pantelleria that her actions were unacceptable and as a result she was immediately dismissed from her duties and no longer employed at the facility.

On 4/16/26, I interviewed the Complainant. The Complainant confirmed that the allegations were accurate and comprehensive.

I conducted an unannounced onsite investigation on 4/20/26. I interviewed direct care staff member (DCSM) Beryl Ambia. Ms. Ambia said she was not on shift when the alleged incidents occurred on 4/12/26 so she had no firsthand information to provide. Ms. Ambia said she was informed of the incidents when next on shift. She stated she was informed that DCSM Jennifer Pantelleria allegedly was pushing Resident A in her wheelchair from Resident A’s room to the dining room and Resident A was yelling at Ms. Pantelleria to leave her alone and stop pushing her in her wheelchair. Ms. Ambia said she was informed that Resident A repeated this request several times.

Ms. Ambia said she was informed that later that same day Ms. Pantelleria was again pushing Resident A in her wheelchair and DCSM Ebony Evans disclosed that she heard Resident A screaming for approximately a minute from the kitchen. She said she was informed that Ms. Evans turned to walk down the hallway and witnessed Ms. Pantelleria pushing Resident A away from her and before Ms. Evans could tell Ms. Pantelleria to stop, the wheelchair immediately stopped. Ms. Ambia said she was informed that Resident A leaped out of the wheelchair and her shoe got caught in the wheel. She was informed that Resident A banged her head on the cement floor causing swelling and had a skin tear on her elbow.

I observed Resident A in her room watching television. Resident A was well groomed and had a blunted affect. I attempted to interview Resident A but was unable to because of her cognitive deficits and memory difficulties.

Resident A did disclose that she remembers DCSM Jennifer Pantelleria pushing her in her wheelchair and she not wanting Ms. Pantelleria to push her.

I interviewed DCSM Sandy Pullins who functions as the facility manager. Mrs. Pullins confirmed that Resident A received injuries from falling out of her wheelchair on 4/12/26. She said that Resident A had a goose egg on her forehead and a skin tear on her right elbow. Mrs. Pullins indicated that Resident A has a registered nurse through Program of All-Inclusive Care for the Elderly (PACE) out of Benton Harbor, MI that visits her three times a week and provides wound care.

Mrs. Pullins said she was not at work on 4/12/26 when the incidents happened causing Resident A’s injuries but was later informed of the events. She said Ms.

Pantelleria did not want to take instructions from licensee designee Timothy Rantz from what she heard.

Mrs. Pullins explained that Resident A suffers from sundowners or sundowning, which is a set of dementia-related behaviors occurring in the late afternoon or evening. She explained that the symptoms of sundowners are confusion, agitation, anxiety, and restlessness that increase in the late afternoon or early evening as the sun sets. The symptoms many include pacing, wandering, or rocking in a chair. Other symptoms may consist of difficulty sleeping, insomnia, hallucinations, paranoia, mood swings, crying, and/or yelling. Mrs. Pullins said Resident A's sundowners causes her to experience paranoia, mood swings, meltdowns, and yelling.

Mrs. Pullins said she was informed that Ms. Pantelleria did not walk away when Resident A yelled at her many times to do so and instead continued pushing her in her wheelchair back to her room. Mrs. Pullins said she knows that Mr. Rantz had told Ms. Pantelleria to walk away from Resident A when Resident A was having a meltdown and come back every so often and try again. She indicated she was told that this is what led to Resident A falling out of her wheelchair on 4/12/26 causing injuries. Mrs. Pullins said she was informed that Resident A was holding her feet down when she fell out of her wheelchair which caused her to fall forward hitting her forehead on the cement floor. Mrs. Pullins indicated that she has no further details regarding the incidents.

I interviewed DCSM Ebony Evans. Ms. Evans confirmed she was working with DCSM Jennifer Pantelleria on 4/12/26 when the incidents occurred causing Resident A's injuries.

Ms. Evans stated that Ms. Pantelleria went to get Resident A from the dining area and wheel her back to her room in her wheelchair. She said she witnessed Ms. Pantelleria wheeling Resident A down the ramp to and from the dining area. Ms. Evans said Ms. Pantelleria and Resident A were fussing back and forth. She stated that she had been telling Ms. Pantelleria not to fuss with Resident A for a long time, approximately a month.

Ms. Evans said she witnessed Ms. Pantelleria refusing Resident A's loud requests for Ms. Pantelleria to stop wheeling Resident A back to her room. She stated that she witnessed Resident A leap out of her wheelchair while holding her feet down and fall forward out of her wheelchair hitting her forehead on the cement floor. Ms. Evans stated that Resident A sustained injuries because of the incident. She indicated that Resident A obtained a goose egg on her forehead and a skin tear on her right elbow.

Ms. Evans stated that she told Ms. Pantelleria to slow down but Ms. Pantelleria refused to do so. She said Ms. Pantelleria continued to push Resident A too fast

and firm. Ms. Evans stated that she witnessed Resident A's right foot rap around the wheel and Resident A fall headfirst onto the cement floor.

On 4/22/26, I interviewed DCSM Jennifer Pantelleria via phone. Ms. Pantelleria confirmed that she messed up on 4/12/26. She indicated that she should have listened to the instructions provided by Mr. Rantz and other DCSMs regarding how to interact with and care for Resident A.

Ms. Pantelleria said she should have stopped pushing Resident A and walked away when Resident A began yelling for her to do so. Ms. Pantelleria provided many excuses as to why she continued to push Resident A in her wheelchair from her room to the dining area and later from the dining area back to her room while Resident A yelled again and again for her to stop. Ms. Pantelleria admitted that because she continued pushing Resident A while she was having a meltdown and yelling for her to stop caused Resident A to jump out of her wheelchair and sustain multiple injuries.

Ms. Pantelleria stated that licensee designee Timothy Rantz terminated her employment at the Adult Foster Care (AFC) large group facility because of her actions involving Resident A.

On 4/28/26, I reviewed Resident A's *Resident Records.* I specifically reviewed an *AFC Licensing Division – Incident / Accident Report* dated 4/12/26 written by DCSM Jennifer Pantelleria. The report indicated that Resident A was being aggressive and not wanting to go to her room after dinner and then jumped out of her wheelchair headfirst. The report indicated that licensee designee Timothy Rantz was contacted as well as DCSM Sandy Pullins who functions as the home manager informing them what had happened and what corrective measures to take.

I reviewed a statement written by DCSM Jennifer Pantelleria on 4/12/26. Ms. Pantelleria indicated that Valerie Scilingo went into Resident A's room around 3:30 p.m. and was antagonizing and stirring Resident A up. Ms. Pantelleria indicated that Ms. Scilingo was stirring up trouble with Resident A about Ms. Pantelleria and other DCSMs. Ms. Pantelleria said Ms. Scilingo was saying that Ms. Pantelleria and other DCSMs were being abusive toward Ms. Scilingo and Resident A.

Ms. Pantelleria said Ms. Scilingo continued to push Resident A in her wheelchair in the hallway and was egging Resident A on. Ms. Pantelleria said because of this, Resident A was fighting with her, howling and cussing at her, escalating, and leading to the fall and the incident in the hallway.

I reviewed Resident A's Golden Shore *Information and Identification Record.* The record indicated that Resident A is on Medicaid.

I reviewed Resident A's *Health Care Appraisal* dated 5/22/25. The appraisal indicated that Resident A diagnoses are Arthritis, Macular Degeneration, Chronic

Obstructive Pulmonary Disease (COPD), Degenerative Disc Disease (DDD), Herpes simplex virus (HSV), high blood pressure (HTN), Hyperlipidemia, osteoporosis, mild cognitive impairment, diabetes (diet controlled), and pulmonary nodules.

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:	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with the Complainant, Resident A, DCSMs Ms. Ambia, Mrs. Pullins, Ms. Evans, Ms. Pantelleria, and Mr. Rantz there was sufficient evidence found indicating that Ms. Pantelleria mistreated Resident A causing her to fall and sustain injuries.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.671	**Resident care.**
	(2) Care and services provided to a resident must be designed to maintain or improve a resident's physical and intellectual functioning and independence.

ANALYSIS:	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with the Complainant, Resident A, DCSMs Ms. Ambia, Mrs. Pullins, Ms. Evans, Ms. Pantelleria, and Mr. Rantz there was sufficient evidence found indicating that the care and services provided to Resident A by Ms. Pantelleria were not designed to maintain or improve her physical and intellectual functioning and independence.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/28/26, I conducted an exit conference / interview via phone with licensee designee Timothy Rantz. Mr. Rantz confirmed that the allegations were accurate and comprehensive. He had no additional information to add to the investigation.

Mr. Rantz was informed of the outcome of this special investigation and did not dispute the findings. He agreed to complete an acceptable Corrective Action Plan (CAP) within the required timeframe.

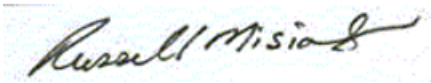
IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

4/28/26

Rodney Gill — Date
Licensing Consultant

Approved By:



4/29/26

Russell B. Misiak — Date
Area Manager