GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 4, 2026

Christine Loria
Sterling Residence LLC
8097 Wildwood Trail
Mancelona, MI 49659

RE: License #: AS050395830
Investigation #: 2026A0009023
Sterling Residence

Dear Ms. Loria:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frame 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 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,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS050395830
Investigation #:	2026A0009023
Complaint Receipt Date:	04/10/2026
Investigation Initiation Date:	04/10/2026
Report Due Date:	05/10/2026
Licensee Name:	Sterling Residence LLC
Licensee Address:	8097 Wildwood Trail Mancelona, MI 49659
Licensee Telephone #:	(231) 409-6602
Administrator:	Christine Loria
Licensee Designee:	Christine Loria
Name of Facility:	Sterling Residence
Facility Address:	8097 Wildwood Trail Mancelona, MI 49659
Facility Telephone #:	(231) 409-6602
Original Issuance Date:	02/12/2019
License Status:	REGULAR
Effective Date:	02/13/2026
Expiration Date:	02/12/2028
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is without a proper bed.	Yes
Resident A has hit his head during transfers and the licensee is refusing to allow him to have physical therapy.	No

III. METHODOLOGY

04/10/2026	Special Investigation Intake 2026A0009023
04/10/2026	Special Investigation Initiated – Telephone call received from adult protective services worker Nicole Lull
04/10/2026	APS Referral
04/14/2026	Inspection Completed On-site Interview with licensee designee Christine Loria Face to face with Resident A
04/16/2026	Contact – Document (email) received from adult protective services worker Nicole Lull
04/24/2026	Contact - Telephone call made to Nancy Stutler, nurse with Kalkaska Medical Associates
04/30/2026	Contact – Telephone call made to Antonya Lanter, nurse with Kalkaska Medical Associates
04/30/2026	Contact – Telephone call made to Resident A's Guardian
05/04/2026	Exit conference with licensee designee Christine Loria

ALLEGATION: Resident A is without a proper bed.

INVESTIGATION: I spoke with adult protective services worker Nicole Lull by telephone on April 10, 2026. She stated that it was reported to adult protective services (APS) that Resident A does not have a proper bed. She did observe that he was using a mattress placed on some plywood. Licensee designee Christine Loria told her that it was because he had been falling out of the bed and scraping himself on the frame.

I conducted an unannounced site visit at the Sterling Residence adult foster care

home on April 14, 2026. Licensee designee Christine Loria was present and spoke with me about the concerns that were received. She said that she had already discussed the concerns with adult protective services worker Nicole Lull. I asked to see Resident A and his room. Resident A was present in his room at the time of the visit. I noted that his bed was a mattress on a piece of plywood. Ms. Loria stated that Resident A had broken his bed. She said that he has behaviors that cause him to break things. She said that he had broken it apart and that it had sharp edges. She believed that this was dangerous so she removed the bedframe from his room. Ms. Loria said that she also has concerns of him falling out of bed. He had fallen out of bed before. Resident A has not been hurt since she moved the mattress closer to the floor. I explained to Ms. Loria that Resident A needs to have a proper bed unless the resident's representative requests it be removed, his healthcare professional approves an alternate sleeping arrangement, and it is documented in Resident A's assessment plan. Ms. Loria acknowledged that she has not met those conditions.

I spoke with Resident A's guardian by telephone on April 30, 2026. She stated she was not aware that Resident A had broken his bed or that he was currently sleeping on a mattress on a piece of plywood. Ms. Loria had not notified her of that. She said that Resident A does have money and can purchase himself a new bed.

APPLICABLE RULE	
R 400.661	**Bedroom furnishings.**
	(1) Bedroom furnishings must include all of the following: (a) A bed that is not less than 36 inches wide and not less than 72 inches long with a foundation that is clean, in good condition, and provides adequate support. (2) The bed and mattress in subrule (1) of this rule can be removed from the bedroom if the resident or resident representative requests that it be removed, the resident's health care professional approves an alternative sleeping arrangement, and it is documented in the assessment plan.
ANALYSIS:	On April 14, 2026, I observed Resident A using a mattress placed on a piece of plywood. Resident A's guardian had not requested that it be removed, his health care professional did not approve it and it was not documented in his assessment plan. In was confirmed through this investigation that Resident A did not have a proper bed with a foundation at the time of the home inspection on April 14, 2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A has hit his head during transfers and the licensee is refusing to allow him to have physical therapy.

INVESTIGATION: During my site visit on April 14, 2026, I asked Ms. Loria about Resident A hitting his head during transfers. She said that he did accidentally hit his head once during a transfer, but he was not injured. She explained that it is because of him having mobility issues and they do need to help him. Resident A uses his own momentum when they are helping him and staff have to be ready to help him carefully in those instances. She has trained her staff on this issue and they do it as safely as they can manage. Ms. Loria stated that she did explain to some service providers who were recently in the home how they do transfers and mentioned how carefully they do it because he did accidentally hit his head once. She told them that staff now perform the transfers as carefully as possible to avoid him hitting his head again.

I asked her about the report of her refusing to allow Resident A to have physical therapy. She denied that is true. She said that the service providers who were recently in the home suggested physical therapy for Resident A. Ms. Loria said that she told them that she has had physical therapy in the home before. She went on to say that she does not have a problem with him having physical therapy. She said that if his physician orders physical therapy for him she will comply with that. She always complies with any doctor's recommendation or order. Ms. Loria said that the only time physical therapy had been brought up for Resident A was recently when the service providers visited the home. She said that she never denied it or stated that he could not have physical therapy in the home.

I received an email from adult protective services worker Nicole Lull on April 16, 2026. She stated that she had spoken with the involved parties for Resident A including Dr. Leno's nurse and was not substantiating an adult protective services case.

I spoke with nurse Antonya Lanter with the Kalkaska Medical Associates by telephone on April 30, 2026. She reported that they saw Resident A in the office in January of 2026 for "shaking". They have also seen him virtually since that time. There has been no indication or report of him having a head injury. I told her of the report that licensee Christine Loria was not allowing Resident A to receive physical therapy. Ms. Lanter said that going back to July of 2025, she did not see any recommendation or order from Dr. Leno for him to receive physical therapy.

I also spoke with Resident A's guardian by telephone on April 30, 2026. She said she did not know anything about Resident A hitting his head or that he had a head injury. She believes she would have known about that if it was anything significant. She said it was plausible that he had only hit his head one time during a transfer as Ms. Loria reported and was not injured as a result. I asked her if she was aware of a recommendation or doctor's order for Resident A to receive physical therapy. She denied she was aware of his doctor recommending or ordering that. She thinks she

would have known if that was ordered for him. Resident A's guardian said that because of Resident A's disability, physical therapy would likely have limited success or none at all.

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:	It was reported that Resident A was hitting his head when staff were transferring him from his chair to his bed. Ms. Loria stated that this had only happened once and that Resident A was not injured as a result. She reported that she had only mentioned this to a service provider to explain how they have become very careful when transferring him now because of the incident. His doctor's office denied that Resident A ever presented to them with a head injury or that it was ever reported to them. Resident A's guardian also denied that any head injury to Resident A had been reported to her. In consideration of the above information, it is determined that Resident A has been treated with dignity and respect, free from exploitation, protected and safe.
CONCLUSION:	VIOLATION NOT 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:	It was reported that Ms. Loria was refusing to allow Resident A to participate in physical therapy. Ms. Loria stated that the only time it was suggested was by a service provider who was recently in the home. She never told them that she would not allow him to participate in physical therapy. Ms. Loria stated that if his doctor recommended or ordered physical therapy, she would make sure he received it. A nurse from Dr. Leno's office searched Resident A's records going back to July of 2025 and did not find any recommendation or order for him to receive physical therapy. Resident A's guardian denied knowing of a

	recommendation or order for Resident A to receive physical therapy. She believed that because of the nature of his disability, it would have limited or no benefit. Information was not discovered through this investigation which would indicate the licensee is not following the instructions and recommendations of Resident A's physician or other designated health care professional.
CONCLUSION:	VIOLATION NOT ESTABLISHED

I conducted an exit conference with licensee designee Christine Loria on May 4, 2026. I told her the findings of my investigation and gave her the opportunity to ask questions.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

05/04/2026

Adam Robarge Date
Licensing Consultant

Approved By:

05/04/2026

Jerry Hendrick Date
Area Manager