



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 11, 2026

Vashu Patel
Collaborative Care Partners Inc
10900 James Way
Portage, MI 49002

RE: License #: AL030406376
Investigation #: 2026A0469018
Stanford Lodge

Dear Ms. Patel:

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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in blue ink that reads "Natasha Grew". The signature is written in a cursive style with a large initial 'N' and 'G'.

Natasha Grew, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL030406376
Investigation #:	2026A0469018
Complaint Receipt Date:	05/28/2026
Investigation Initiation Date:	05/29/2026
Report Due Date:	07/27/2026
Licensee Name:	Collaborative Care Partners Inc
Licensee Address:	10900 James Way Portage, MI 49002
Licensee Telephone #:	(269) 718-9040
Administrator:	Kim Barber
Licensee Designee:	Vashu Patel
Name of Facility:	Stanford Lodge
Facility Address:	409 Naomi Street Plainwell, MI 49080
Facility Telephone #:	(269) 685-5821
Original Issuance Date:	01/21/2021
License Status:	REGULAR
Effective Date:	07/21/2025
Expiration Date:	07/20/2027
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not get Bumex medication following a hospital discharge and oxygen was turned off.	Yes
Resident A was mocked and treated poorly by staff.	No

III. METHODOLOGY

05/28/2026	Special Investigation Intake 2026A0469018
05/28/2026	APS Referral Complaint received from APS
05/29/2026	Special Investigation Initiated - Letter APS Michelle O'Brien
06/04/2026	Inspection Completed On-site
06/11/2026	Exit Conference Licensee Designee Vashu Patel and Administrator Kim Barber

ALLEGATION: Resident A did not get Bumex medication following a hospital discharge and oxygen was turned off.

INVESTIGATION: On 05/28/2026 I received a complaint from Adult Protective Services (APS) that stated: Resident A is dependent on staff at Stanford Lodge for ADL's due to blindness and physical health diagnoses. Resident A went to the hospital due to retaining fluid. Upon discharge from the hospital and returning to the facility, Resident A was not given Bumex medication. Resident A is on oxygen, and there are times when her oxygen has been turned off when staff told her it was on. Resident A is treated badly by staff and staff do not tend to Resident A's needs. There are two staff during the night shift who mock Resident A.

On 05/29/2026, I interviewed APS worker Michelle O'Brien. Ms. O'Brien stated she does not have any open investigations at this facility. Ms. O'Brien stated the last onsite visit was on 05/05/2026 to this facility and she had no concerns with staff or resident care.

On 06/04/2026, I completed an unannounced on-site inspection. While I was on-site, I interviewed administrator Kim Barber, Resident A, and direct care workers Nickie Curtiss and Brittney Smith.

I asked Ms. Barber if Resident A was getting Bumex medication following a hospital discharge. Ms. Barber stated yes. Ms. Barber stated Resident A has been administered all medications as prescribed but does refuse medications. Ms. Barber stated when Resident A refuses medications, Resident A will not take them. I asked Ms. Barber if there were any times when Resident A's oxygen was turned off when it should have been on. Ms. Barber stated no. Ms. Barber stated Resident A requested staff turn down the oxygen, and then later asked to turn it back up as Resident A was not getting enough oxygen on the lower setting. Ms. Barber stated Resident A was admitted to the facility on 05/15/2026, and is still adjusting. Ms. Barber stated Resident A was out of the facility from 05/15/2026 to 05/19/2026 due to hospitalization. Resident A has Senior Care through P.A.C.E. and this is where she gets medications and medical equipment. Ms. Barber is coordinating with Resident A's care coordinator with P.A.C.E. to get Resident A the medications changed, and medical equipment she has requested.

I interviewed Resident A individually. I asked Resident A if she was getting medications as prescribed. Resident A stated sometimes. Resident A stated she was mostly frustrated with her services with P.A.C.E. and the medications being prescribed. I asked Resident A if she was being given all her medications. Resident A stated maybe. Resident A stated she does not trust staff or the medications they tell her they are giving her. Resident A stated she has refused medications because she does not want them. Resident A stated she will ask for her Bumex medication to be taken later than when staff are passing it to her. I asked Resident A if her oxygen was turned off when it should have been on. Resident A stated yes. Resident A stated she was without oxygen "for hours last Saturday". Resident A stated she cannot accurately recall dates or times. I asked Resident A if the level of oxygen was turned down and needed to be turned up. Resident A stated yes.

I interviewed Ms. Curtiss individually. I asked Ms. Curtiss if Resident A is getting medications as prescribed. Ms. Curtiss stated yes. Ms. Curtiss stated she is the med tech today and she passes medications to all residents during her shifts. Ms. Curtiss stated Resident A often refuses to take medications, especially Bumex. Ms. Curtiss stated Resident A has requested to take Bumex later than the time on the MAR. Ms. Curtiss stated Resident A told her that she does not feel she gets toileted as often or as quickly as she should. Ms. Curtiss stated she has encouraged Resident A to press her call button sooner to get staff to tend to her more quickly when she needs assistance with toileting. I asked Ms. Curtiss if she observed Resident A's oxygen being off when Resident A had needed to use it. Ms. Curtiss stated no. Ms. Curtiss stated she has observed Resident A's oxygen concentrator being turned off when the concentrator needs to be moved with Resident A to a common area and then it is turned back on. Ms. Curtiss stated they tried portable oxygen with Resident A, however staff were told that Resident A's insurance will not provide more portable oxygen tanks because Resident A is using them too quickly. Ms. Curtiss stated the facility plans to request a second oxygen concentrator for Resident A so one concentrator can stay in Resident A's room, and the other concentrator can stay in the common area for Resident A.

I asked Ms. Smith if Resident A is getting medications as prescribed. Ms. Smith stated yes. Ms. Smith stated she has completed her medication training and helped pass medications to all residents. Ms. Smith stated Resident A has refused to take medications and will not have them during those refusals. I asked Ms. Smith if she observed Resident A's oxygen being off when Resident A needed to use it. Ms. Smith stated no.

On 06/04/2026, I emailed Ms. Barber asking if Resident A was out of the facility for any dates other than when Resident A was hospitalized. Ms. Barber sent me an email saying that Resident A was out of the facility from 05/15/2026 to 05/19/2026 due to hospitalization and had no other leave from the facility.

On 06/09/2026, I interviewed Kristi Mathes, RN, with Senior Care Partners who is the care coordinator for P.A.C.E. for Resident A. I asked Ms. Mathes if she had any concern regarding Resident A not getting medications at this facility. Ms. Mathes stated no. Ms. Mathes stated she visits Resident A at least monthly, if not more frequently due to Resident A's higher level of needs. Ms. Mathes stated Resident A's health is declining, and she has borderline personality disorder which affects her perceptions at times. Ms. Mathes stated Resident A's Bumex prescription is a generic name. Ms. Mathes stated Resident A initially did not think she was getting Bumex because of the generic name being used when staff were giving it to her. I asked Ms. Mathes if there were any reports or observations with Resident A's oxygen being turned off when she needs it. Ms. Mathes stated no. Ms. Mathes stated the facility has requested a second concentrator for Resident A so one concentrator can stay in Resident A's room and the other concentrator can stay in the common area for Resident A.

On 06/09/2026, I reviewed the medication administration record (MAR) for May 2026 and June 2026 for Resident A.

- Resident A's MAR documented:
 - On 05/26/2026 the 9:00pm dose for Antifungal POW 2%, Brimonidine SOL 0.2%, Dorzolamide SOL 0.2%, Eliquis 5mg, and Midodrine 5mg are blank.
 - From 05/26/2026 to 05/31/2026 the 4:00pm dose for Brimonidine SOL 0.2%, Bumetanide (Bumex) 1mg, Dorzolamide SOL 0.2%, and Midodrine 5mg are blank.
 - From 05/26/2026 to 05/31/2026 the 9:00pm dose for Antifungal POW 2%, Brimonidine SOL 0.2%, Dorzolamide SOL 0.2%, Eliquis 5mg, Midodrine 5mg, Rocklatan drops, are blank.
 - From 05/27/2026 to 05/31/2026 the 9:00am dose for Antifungal POW 2%, Digoxin 0.125mg, Dorzolamide SOL 0.2% OP, Eliquis 5mg, Metoprol 25mg, Midodrine 5mg, and Probiotic are blank.
 - On 06/01/2026 and 06/02/2026 the 9:00am dose for ABH 0.5mg/12.5mg/0.5mg cream are blank.

- On 06/01/2026 the 9:00pm dose for ABH 0.5mg/12.5mg/0.5mg cream is blank.
- From 06/01/2026 to 06/04/2026 the 9:00am blood pressure checks are blank.

On 06/11/2026, I completed an exit conference with Licensee Designee Vashu Patel and Administrator Kim Barber. They were informed of the investigation findings and recommendations. They agreed to complete and submit a corrective action plan.

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:	<p>The complaint stated Resident A did not get Bumex medication following a hospital discharge and oxygen was turned off.</p> <p>Resident A reported she sometimes gets her medications and was not confident she is being given all medications as prescribed. Resident A stated she was mostly frustrated with her services with P.A.C.E. and the medications being prescribed. Resident A stated she does not trust staff or the medications they tell her they are giving her. Resident A stated she has refused medications because she does not want them. Resident A stated she asks for her Bumex medication to be taken later than when staff are passing it to her. Resident A could not recall dates or times, but stated her oxygen was off “for hours last Saturday”. When I asked Resident A if her oxygen level was lower and needed to be turned up, Resident A stated yes.</p> <p>Ms. Barber, direct care workers, and Ms. Mathes reported no concerns with Resident A not being given her medication as prescribed. Ms. Barber, direct care workers, and Ms. Mathes also expressed no concerns with Resident A’s oxygen being turned off when it should have been on.</p> <p>After reviewing Resident A’s MAR, there are several blank spots where Resident A should have been administered medication. While Resident A could have been given medications as prescribed and as reported through interviews, the MAR does not reflect this. Therefore, this is a rule violation.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Resident A was mocked and treated poorly by staff.

INVESTIGATION: During my interview with Ms. Barber on 06/04/2026, I asked Ms. Barber if there were any concerns reported to her about staff mocking or treating residents poorly. Ms. Barber stated no. Ms. Barber stated there were two staff who worked third shift who recently were terminated from employment due to job performance.

During my interview with Resident A on 06/04/2026, I asked if staff were mocking her. Resident A stated no. Resident A continued to state that she is having a difficult time trusting staff at this facility as she is newer and had bad experiences at another facility prior to coming to this one. Resident A stated due to her blindness, she is unable to recognize faces, and is unsure which staff treated her poorly. I asked Resident A if she could provide an example of what occurred or what was said. Resident A did not want to provide any additional information about what occurred or what was said. Resident A stated she was not confident in what the staff's name was and stated it was overnight staff, but because she was not confident, she did not want to share any additional information. Resident A stated Ms. Barber informed her of two-night staff no longer being employed. Resident A stated since those staff are no longer employed at this facility, she has not had issues with staff at night. Resident A stated she relies on staff for mobility and feels she does not get moved as quickly as she wants and must wait until staff are available as they are typically helping other residents. Resident A stated she does not have issues with her care or most of the staff during the day. Resident A stated Ms. Barber seems to be addressing any concerns she has brought up.

During my interview with Ms. Curtiss on 06/04/2026, I asked if she had observed concerns with staff interactions with residents. Ms. Curtiss stated no. I asked Ms. Curtiss if she had observed or heard of staff mocking Resident A or any other resident. Ms. Curtiss stated no. Ms. Curtiss stated Resident A has a higher level of care and often needs assistance more frequently than other residents. Ms. Curtiss stated Resident A does not always accurately perceive situations and staff are working to build trust with Resident A.

During my interview with Ms. Smith on 06/04/2026, I asked if she has concerns with staff interactions with residents. Ms. Smith stated no. I asked Ms. Smith if she observed or heard staff mocking Resident A or any other resident. Ms. Smith stated no.

While on-site on 06/04/2026, I interviewed Resident B, C, D, E, F, G, H, and I individually. Resident B, C, D, E, F, G, H, and I all reported no concerns with staff interactions or resident care at this facility. I asked each Resident B, C, D, E, F, G, H, and I if there were concerns with staff mocking them or any resident. Resident B, C, D, E, F, G, H, and I all denied any concerns with this. Resident B stated he has "no complaints to report". Resident C stated the staff are "wonderful".

During my interview with Ms. Mathes on 06/09/2026, I asked Ms. Mathes if there were concerns with the care Resident A has been receiving. Ms. Mathes stated no. Ms. Mathes stated she has met with Ms. Barber and observed staff at this facility go “above and beyond” to meet Resident A’s requests and needs. I asked Ms. Mathes if there were any reports of Resident A being mocked by staff overnight. Ms. Mathes stated no.

On 06/11/2026, I completed an exit conference with Licensee Designee Vashu Patel and Administrator Kim Barber. They were informed of the investigation findings and recommendations.

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:	<p>The complaint stated Resident A was mocked and treated poorly by staff.</p> <p>Resident A reported concerns with overnight staff but was not willing to share details as she was not confident of the staff names. Resident A stated that since Ms. Barber told her two staff from overnight are no longer employed, she has not had issues with overnight staff.</p> <p>Ms. Barber, direct care staff, and Ms. Mathes reported no concerns regarding staff treating Resident A or any other resident poorly. There were no reported incidents of mocking Resident A or other residents. Residents B, C, D, E, F, G, H, and I reported no concerns with their care from staff or staff with other residents. Therefore, there is no rule violation.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no changes with the current license status.



06/11/2026

Natasha Grew
Licensing Consultant

Date

Approved By:

A handwritten signature in blue ink that reads "Jerry Hendrick". The signature is fluid and cursive, with the first name "Jerry" being more prominent than the last name "Hendrick".

06/11/2026

Jerry Hendrick
Area Manager

Date