GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 9, 2026

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

RE: License #: AS250418941
Investigation #: 2026A0569028
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 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 (517) 643-7960.

Sincerely,

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 #:	2026A0569028
Complaint Receipt Date:	06/04/2026
Investigation Initiation Date:	06/08/2026
Report Due Date:	08/03/2026
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?
Jermaine Hildreth, staff person, physically mistreated Resident A on 06/01/2026.	Yes

III. METHODOLOGY

06/04/2026	Special Investigation Intake 2026A0569028
06/08/2026	APS Referral Referral to APS.
06/08/2026	Special Investigation Initiated - Letter Email to ORR.
07/09/2026	Inspection Completed On-site
07/09/2026	Contact - Telephone call made Contact with Jermaine Hildreth, staff person.
07/09/2026	Contact - Telephone call made Contact with Alexis Morgan, staff person.
07/09/2026	Inspection Completed-BCAL Sub. Compliance
07/09/2026	Exit Conference Exit conference with Ryan Wickson, licensee designee.
07/09/2026	Corrective Action Plan Requested and Due on 07/25/2026

ALLEGATION:

Jermaine Hildreth, staff person, physically mistreated Resident A on 06/01/2026.

INVESTIGATION:

This complaint was received via LARA-BCHS-Complaints@michigan.gov. The complainant reported that on 06/01/2026 Jermaine Hildreth, staff person, was observed pushing Resident A into Resident A's bedroom, then hitting Resident A in the head. The complainant did not report any injuries to Resident A.

An unannounced inspection of this facility was conducted on 07/09/2026. 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 did know Staff person Hildreth. Resident A stated that there was an incident when Staff Hildreth pushed Resident A into Resident A's bedroom, then hit Resident A in his chest and head. Resident A stated that he did not recall the exact date of when this incident occurred. Resident A stated that he does feel safe residing in this facility. Resident A stated that "it hurt" when Staff Hildreth hit Resident A, but Resident A did not recall if he received any injuries as a result.

Resident A's file contains an incident report (IR) dated 06/01/2026. The IR documents that on 06/01/2026 Alexis Morgan, staff person, observed Staff Hildreth "aggressively" push Resident A into Resident A's bedroom. The IR documents that when this happened, Resident A stumbled and tried to reach out his hand and cut his hand on his television when trying to brace himself. The IR documents that Staff Hildreth then hit Resident A and that following the incident Resident A was observed to have bruising on his chest and head. The corrective measures documented in the IR were that recipient rights were immediately notified and Staff Hildreth was suspended pending an investigation. Resident A also received first aid, and staff would continue to support Resident A per Resident A's plan of service.

Staff Hildreth stated on 07/09/2026 that he was assigned to administering the residents' medication on 06/01/2026. Staff Hildreth stated that he began administering the resident medications at 8:00pm. Staff Hildreth stated that Resident A was "having a behavior" and started spiting at Staff Hildreth and attempted to hit Staff Hildreth. Staff Hildreth stated that he redirected Resident A to his bedroom and Resident A went to his bedroom. Staff Hildreth stated that Resident A then came out of his bedroom again and was spitting and trying to urinate on the floor. Staff Hildreth stated that Resident A was in his bedroom when Resident A "suddenly became unsteady" and fell against the bedroom wall. Staff Hildreth stated that he did not push or hit Resident A at any point.

Alexis Morgan, staff person, stated on 07/09/2026 that she was in the bathroom assisting another resident when this incident occurred. Staff Morgan stated that she has observed Staff Hildreth to have very little patience with Resident A on several

occasions. Staff Morgan stated that she observed Staff Hildreth “yelling at” Resident A so she came out of the bathroom to see if she could assist. Staff Morgan stated that she observed Staff Hildreth using a “blocking pad” to push Resident A into his bedroom and onto Resident A’s bed. Staff Morgan stated that a half hour or less later, she walked by Resident A’s bedroom and observed Staff Hildreth punch Resident A in his head and chest “with a closed fist, three or four times”. Staff Morgan stated that Staff Hildreth then stopped when he realized Staff Morgan had observed what was happening. Staff Morgan stated that she notified management of the incident, and watched Resident A for the remainder of the shift to make sure nothing further happened. Staff Morgan stated that she did observe bruising on Resident A’s face that was not there prior to this incident.

Zander Naegele, staff person, stated on 07/09/2026 that he did not witness this incident, but has worked at this facility for about a year and has worked with Staff Hildreth on several occasions. Staff Naegele stated that Staff Hildreth’s demeanor with Resident A can be aggressive and Staff Naegele has observed Staff Hildreth “yell and swear” at Resident A in the past. Staff Naegele stated that on one occasion he observed Staff Hildreth tell Resident A to “get his ass up” when diner had finished. Staff Naegele stated that Staff Hildreth becomes frustrated with Resident A very quickly and will become impatient. Staff Naegele stated that he did not witness this incident but believes that it could have happened based on his observed interactions between Resident A and Staff Hildreth in the past.

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:	Resident A stated that Staff Hildreth pushed him and hit him in Resident A’s bedroom. Staff Morgan stated that she witnessed this incident and her account coincided with Resident A’s statement. Staff Naegele stated that he observed Staff Hildreth be aggressive with Resident A and yell and swear at Resident A in the past. Staff Morgan and Staff Naegele both stated that Staff Hildreth gets impatient with Resident A. Staff Hildreth denied that he physically mistreated Resident A and stated that any injuries Resident A had were the result of becoming unsteady and falling against the wall of his bedroom. Based on the statements given and documentation reviewed, it is

	determined that there is a preponderance of evidence to substantiate a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with Ryan Wickson, licensee designee, on 07/09/2026. The findings in this report were reviewed, and a corrective action plan was requested.

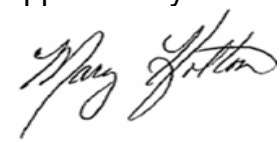
IV. RECOMMENDATION

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

07/09/2026

Kent W Gieselman Date
Licensing Consultant

Approved By:



07/09/2026

Mary E. Holton Date
Area Manager