GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Robert Gulley
606 E High Street
Ishpeming, MI 49849

June 18, 2026

RE: License #: AF520379592
Investigation #: 2026A0873012 - High Street Assist Living

Dear Mr. Gulley:

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(906) 250-9318
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF520379592
Investigation #:	2026A0873012
Complaint Receipt Date:	04/14/2026
Investigation Initiation Date:	04/17/2026
Report Due Date:	06/13/2026
Licensee Name:	Robert Gulley
Licensee Address:	606 E High Street Ishpeming, MI 49849
Licensee Telephone #:	(906) 204-4378
Name of Facility:	High Street Assist Living
Facility Address:	606 E High Street Ishpeming, MI 49849
Facility Telephone #:	(906) 204-4378
Original Issuance Date:	10/21/2016
License Status:	REGULAR
Effective Date:	05/28/2025
Expiration Date:	05/27/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A got frostbite after being locked out of the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/14/2026	Special Investigation Intake 2026A0873012
04/16/2026	APS Referral Referred by APS
04/17/2026	Special Investigation Initiated - Telephone Call to Pathways CMH
04/23/2026	Contact - Telephone call received Interview with Ms. Williams LSS
04/28/2026	Contact - Face to Face
05/07/2026	Contact - Telephone call received Interview with Resident B
05/21/2026	Inspection Completed On-site
05/21/2026	Contact - Face to Face Interviews with Licensee and Residents
06/01/2026	Contact - Telephone call made Call to Sherry Ombrello
06/02/2026	Contact - Document Received Text exchange from Resident B
06/02/2026	Contact - Telephone call received Interview with Sherry Ombrello
06/04/2026	Inspection Completed On-site

06/05/2026	Contact - Telephone call received Interview with Resident B
06/05/2026	Exit Conference With Licensee

ALLEGATION:

Resident A got frostbite after being locked out of the facility.

INVESTIGATION:

On 4/14/26, I received a referral from adult protective services indicating Resident A had been to the hospital for frostbite.

On 5/21/26, I interviewed Resident A at the facility. Resident A was locked outside the house and could not get in. He tried knocking but no one came to the door for some time. It was a very cold night and he got frostbite. Resident A was not sure how long he was outside.

On 5/21/26, I interviewed licensee Robert Gulley at the facility. Resident A went outside on his own and was sitting on the porch when found. Mr. Gulley picked him up and led him back into the facility. The door was not locked. Mr. Gulley stated he took Resident A to the hospital the next day when they noticed the frostbite. It was unclear how long Resident A was outside. Resident A had fallen in the past since his brain cancer diagnosis.

On 5/22/26, I reviewed Resident A's assessment plan. Resident A is only able to be in public with staff due to a history of falling. Resident A had good days in which he was aware of his surroundings and other days where he was not aware of his surroundings. The assessment plan was signed but not dated.

On 6/2/26, I interviewed the facility's previous responsible person, Sherry Ombrello, over the telephone. Resident A went outside on his own and fell on the porch and got frostbite. He was not out there that long. The doors were not locked. Ms. Ombrello told Mr. Gulley to check on Resident A after they became aware he was not in the facility. Resident A is no longer allowed to go outside by himself.

On 6/15/26, I reviewed the incident report. On 12/31/25, at approximately 9:00pm, Resident A went out on the porch to smoke. At 9:15pm, Mr. Gulley went out to the porch and found Resident A on the floor with his hands in the snow. Mr. Gulley assisted Resident A back to his feet and into the facility. At approximately 10:00am on 1/1/26, Mr. Gulley noticed Resident A's hands were swollen and took him to the hospital where he was diagnosed with frostbite.

On 6/17/26, I reviewed historical weather data. The high and low temperatures on that day were 7°F and 5°F, respectively, with a windspeed in the high teens. At these temperatures being outside for less than 30 minutes may cause frostbite.

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:	After interviewing Resident A as well as the licensee and Ms. Ombrello, it was agreed that Resident A went outside on his own. According to historical weather data, the high and low temperatures on that day were 7°F and 5°F, respectively, with a windspeed in the high teens. Given these frigid temperatures and the face that licensee Gulley stated Resident A's had his hands in the snow Although there was a discrepancy between whether the front door was locked preventing Resident A from reentering the facility, Resident A presented at the hospital with frost bite because of this incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

On 5/21/26 and 6/4/26, I conducted an onsite inspection of the facility. I noticed that the kitchen was dirty and cluttered. The blender was caked with grime, the counter tops not clean, and there were used and dirty dishes and utensils scattered about.

APPLICABLE RULE	
R 400.665	**Food service.**
	(10) Food preparation surfaces and areas must be clean and in good repair.
ANALYSIS:	I observed unsanitary conditions in the kitchen and food prep areas.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/21/26 and 6/4/26, I conducted an onsite inspection of the facility. Both times I noticed that menus were not posted. On 6/5/26, I interviewed licensee Gulley who told me he could not provide copies of previous menus.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(7) A licensee shall keep records of menus, including special diets, for 90 days.
ANALYSIS:	Licensee Gulley was unable to provide copies of menus.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/4/26, I conducted an onsite inspection of the facility. I noticed residents medications were laying out on the counter in the kitchen. When asked about this Mr. Gulley told me that Resident B banged on the wall and the medication cabinet fell down about 25 minutes before I arrived.

APPLICABLE RULE	
R 400.675	**Resident medications**
	(2) Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required.
ANALYSIS:	During an onsite inspection, I observed resident medication to be unlocked and laying on the kitchen counter. While the licensee explained the incident having occurred approximately 25 minutes prior, no action was taken to secure the medications until my arrival.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Licensing study report (LSR) dated 5/27/25, corrective action plan (CAP) dated 7/21/25.**

On 4/23/26, I interviewed Luthern Social Services case manager Kat Williams. Resident B had not filled out any licensing required admission paperwork since moving to the facility over a month ago. On 6/4/26, I conducted an onsite inspection of the facility. During the inspection I requested copies of resident paperwork. All resident paperwork was signed, but not all were dated. On 6/5/26, I interviewed Resident B. Mr. Gulley had him sign paperwork the morning before my arrival on 6/4/26. Resident B was not sure what he signed.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	Resident B's assessment plan was not signed and dated at admission.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **LSR dated 5/27/25, CAP dated 7/21/25.**

On 6/5/26, I explained the findings of this report to licensee Mr. Gulley. I told him I was recommending a provisional license due to the number and severity of the violations. Mr. Gulley asked what "provisional" meant and we discussed what would be required.

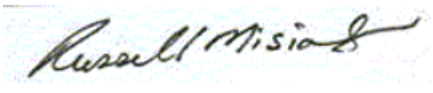
IV. RECOMMENDATION

Due to the amount and severity of the violations, I recommend a provisional license.

6/16/26

Garrett Peters Date
Licensing Consultant

Approved By:



6/16/26

Russell B. Misiak Date
Area Manager