



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 16, 2026

Michelle Williams
Cascading Grace LLC
855 Maplehill Avenue SE
Ada, MI 49301

RE: License #: AS410420052
Investigation #: 2026A0583058
Cascading Grace

Dear Ms. Williams:

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. 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,

A handwritten signature in cursive script, appearing to read "Toya Zylstra".

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410420052
Investigation #:	2026A0583058
Complaint Receipt Date:	09/02/2026
Investigation Initiation Date:	09/03/2026
Report Due Date:	10/02/2026
Licensee Name:	Cascading Grace LLC
Licensee Address:	5563 Cascade Rd SE Grand Rapids, MI 49546
Licensee Telephone #:	(574) 276-8612
Administrator:	Sherman Williams
Licensee Designee:	Michelle Williams
Name of Facility:	Cascading Grace
Facility Address:	5563 Cascade Rd SE Grand Rapids, MI 49546
Facility Telephone #:	(574) 276-8612
Original Issuance Date:	01/08/2026
License Status:	REGULAR
Effective Date:	07/08/2026
Expiration Date:	07/07/2028
Capacity:	6
Program Type:	PHYS HANDICAPPED, AGED, DEVELOP DISABLED, MENTALLY ILL, TRAUMATICALLY BRAIN INJURED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff failed to provide Resident A with adequate personal care.	Yes

III. METHODOLOGY

09/02/2026	Special Investigation Intake 2026A0583058
09/03/2026	Special Investigation Initiated - On Site
09/08/2026	APS Referral
09/16/2026	Exit Conference Licensee Designee Michelle Williams

ALLEGATION: Staff failed to provide Resident A with adequate personal care.

INVESTIGATION: On 09/02/2026 I received a phone call from licensee designee Michelle Williams. She stated that on 09/01/2026 staff April Smith observed maggots in Resident A's trach. She stated that Ms. Smith contacted administrator Sherman Williams and reported the incident. Ms. Williams stated that Mr. Williams arrived at the facility within ten minutes and observed the maggots in Resident A's trach. Ms. Williams stated that Ms. Smith contacted "911" and Resident A was transported to Corewell Health hospital. Ms. Williams stated that Resident A was hospitalized and requires surgery to clean out the wound and lungs. Ms. Williams stated that staff are required to observe, clean and change Resident A's trach once daily. She stated that to her knowledge staff were changing Resident A's trach once in the evening and observing the trach during the daytime. She stated that Resident A has limited speech and language skills.

On 09/03/2026 I completed an onsite investigation at the facility and interviewed licensee designee Michelle Williams, administrator Sherman Williams, and staff April Smith.

Ms. Williams stated that staff Christopher Lord worked independently from 08/31/2026 7:00 PM until 09/01/2026 7:00 AM and staff Brook Dusendang worked independently on 08/30/2026. She stated that she spoke to Mr. Lord on the evening of 8/31/2026 and he reported that he was "in the middle" of changing Resident A's trach. She stated that Mr. Lord reported he had observed more mucus than usual during the trach change. She stated that staff perform Resident A's trach cleaning and changes in Resident A's bedroom for privacy. Ms. Williams stated that Resident A was currently at the hospital and expected to be discharged back to the facility the following day.

Mr. Williams stated that on the afternoon of 09/01/2026 he received a telephone call from Ms. Smith who reported she observed maggots around Resident A's trach. He stated that he arrived at the facility ten minutes later and observed a small amount of fly larva around Resident A's trach site. He stated that he advised Ms. Smith to call "911" and Resident A was immediately transferred via EMS to Corewell Health. Mr. Williams stated that to his knowledge, staff complete Resident A's trach care daily.

Ms. Smith stated that she worked at the facility 09/01/2026 7:00 AM until 7:00 PM. She stated that right after Resident A ate lunch, he began pulling at this trach. She stated that she examined Resident A's trach and observed maggots around the area. She stated that she immediately contacted Mr. Williams, who arrived at the facility within ten minutes. She stated that within ten minutes of Mr. Williams arrival she contacted 911 and Resident A was transferred to Corewell Health hospital. She stated that she had spoken to Mr. Lord on the morning of 09/01/2026 and he reported that he had changed Resident A's trach the evening of 08/31/2026 and observed more mucus than normal. She stated that to her knowledge, staff have consistently changed Resident A's trach daily.

While onsite I observed Resident A's Assessment Plan, signed 01/28/2026. The Assessment Plan stated that Resident A requires staff assistance with eating, toileting, bathing, grooming, dressing, personal hygiene, and walking. The plan states that staff will "administer daily trach cleaning, inner cannula replacement, and strap changes, along with other grooming". The plan states that Resident A is "wheelchair bound".

On 09/04/2026 I received a voicemail message from Resident A's public guardian Kristina Begley. She stated that she did not have concerns regarding the care Resident A receives at the facility.

On 09/08/2026 I interviewed Adult Protective Services staff Sheena McBride via telephone. She stated that she is assigned to investigate the allegations and observed Resident A at the hospital on 09/03/2026. She stated that Resident A has limited language skills but can answer "yes" or "no" questions. She stated that she asked Resident A if staff clean his trach daily and he responded, "no". She stated that she asked Resident A if staff are supposed to clean his trach daily and he responded, "yes".

On 09/10/2026 I interviewed Ms. Begley via telephone. She confirmed that she is Resident A's legal guardian. She stated that Resident A was hospitalized due to fly larvae observed in Resident A's trach area. She stated that Resident A underwent surgery to clean the area and was discharged back to the facility. She stated that medical professionals wondered if facility staff had provided adequate trach care. She stated she is happy with the level of care provided by facility staff and she has no concerns regarding the level of care provided.

On 09/10/2026 I completed an onsite investigation at the facility and interviewed

Resident A with Ms. Smith present. Resident A is unable to vocalize the words “yes” or “no” but shook his head up and down to denote “yes” and side to side to denote “no”. Resident A was asked if wanted Ms. Smith present during the interview and shook his head in agreement. He expressed that staff change his trach daily and he is happy with the level of care provided. He expressed that he enjoys residing at the facility.

On 09/10/2026 I interviewed staff Christopher Lord via telephone. He confirmed that he worked at the facility 08/31/2026 7:00 PM until 09/01/2026 7:00 AM. He stated that he inspected and changed Resident A’s trach on 08/31/2026 at “around 8:00 PM” in Resident A’s private bedroom. He stated that Resident A’s trach had “more mucous than normal” but no indication of maggots or redness. He stated he also provided Resident A with a “nebulizer treatment” just prior to changing Resident A’s trach. He stated that he is adequately trained to provide Resident A’s trach care.

On 09/14/2026 I interviewed RN case manager Ashley Gilette. She stated that Resident A was treated by Dr. Nikko Sirdenis MD while inpatient at Corewell Health hospital and Dr. Sirdenis stated that based upon his observation of the fly larvae located in Resident A’s trach area; it is “highly unlikely” that staff provided adequate trach care.

On 09/16/2026 I completed an exit conference via telephone with licensee designee Michelle Williams. She stated that she did not dispute that a violation had occurred and that she will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Resident A’s Assessment Plan, signed 01/28/2026, states that Resident A requires staff assistance with eating, toileting, bathing, grooming, dressing, personal hygiene, and walking. The plan states that staff will “administer daily trach cleaning, inner cannula replacement., and strap changes, along with other grooming”. RN case manager Ashley Gilette stated that Resident A was treated by Dr. Nikko Sirdenis MD while inpatient at Corewell Health hospital and Dr. Sirdenis stated based upon his

	observation of the fly larvae located in Resident A's trach area; it is "highly unlikely" that staff provided adequate trach care. A preponderance of evidence indicates that a violation of the applicable rule occurred. Staff failed to provide Resident A with adequate personal care.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license.



09/16/2026

Toya Zylstra
Licensing Consultant

Date

Approved By:



09/16/2026

Jerry Hendrick
Area Manager

Date