GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 29, 2025

Jennifer Herald
Glen Abbey Assisted Living
445 North Lotz Road
Canton, MI 49512

RE: License #: AH820372250
Investigation #: 2025A1027078
Glen Abbey Assisted Living

Dear Licensee:

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 authorized representative 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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH820372250 |
| | |
| **Investigation #:** | 2025A1027078 |
| | |
| **Complaint Receipt Date:** | 08/20/2025 |
| | |
| **Investigation Initiation Date:** | 08/20/2025 |
| | |
| **Report Due Date:** | 10/19/2025 |
| | |
| **Licensee Name:** | Lotz Road Opco LLC |
| | |
| **Licensee Address:** | 4500 Dorr Street<br>Toledo, OH 43615 |
| | |
| **Licensee Telephone #:** | (419) 247-2800 |
| | |
| **Administrator:** | Sarah Molner |
| | |
| **Authorized Representative:** | Jennifer Herald |
| | |
| **Name of Facility:** | Glen Abbey Assisted Living |
| | |
| **Facility Address:** | 445 North Lotz Road<br>Canton, MI 49512 |
| | |
| **Facility Telephone #:** | (734) 981-9224 |
| | |
| **Original Issuance Date:** | 07/21/2017 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/01/2025 |
| | |
| **Expiration Date:** | 07/31/2026 |
| | |
| **Capacity:** | 64 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Residents lacked care. | No |
| The home has a bug infestation. | No |
| The home serves raw food. | Yes |
| Additional Findings | No |

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

The allegations pertaining to medication errors and wrong medications administered were investigated in Special Investigation Report 2025A1027066.

## III. METHODOLOGY

| | |
|---|---|
| 08/20/2025 | Special Investigation Intake<br>2025A1027078 |
| 08/20/2025 | Special Investigation Initiated - Letter<br>Email sent to Sarah Molner requesting documentation |
| 08/20/2025 | Contact - Document Received<br>Email received from Sarah Molner with requested documentation |
| 08/22/2025 | Inspection Completed On-site |
| 08/22/2025 | Inspection Completed-BCAL Sub. Compliance |
| 09/29/2025 | Exit Conference<br>Conducted by email with Jennifer Herald and Sarah Molner |

**ALLEGATION:**

**Residents lacked care.**

**INVESTIGATION:**

On 8/20/2025, the Department received two anonymous allegations. The first claimed that residents were only being changed once per shift. The second alleged

that residents were not being regularly checked or changed and included a report that one resident had maggots in her ear. Due to the anonymous nature of these complaints, no further details could be obtained.

Also, on 8/20/2025, Administrator Sarah Molner provided a resident census indicating a total of 45 residents, 16 in memory care and 29 in assisted living.

On 8/22/2025, I conducted an on-site inspection at the home and interviewed staff.

The Administrator stated that, as a general policy, residents were checked and changed every two hours; however, all residents have individualized service plans tailored to their specific needs. These plans were reviewed every six months, or sooner if a change in condition occurs. She also noted that a toileting program was in place to ensure residents were offered toileting regularly based on their needs.

Regarding the incident involving maggots in a resident's ear, the Administrator confirmed this occurred in May 2025 and involved Resident A, who was under hospice care. She reported that the incident was promptly communicated to the Department via email and that Adult Protective Services (APS) were also notified. Following this incident, the home implemented a mobile communication application to allow staff and hospice teams to coordinate care in real time, ensuring timely interventions. The Administrator confirmed that Resident A’s wound has since healed and she is currently doing well.

While on-site, I reviewed a detailed investigation report pertaining to Resident A’s wound, provided by the Administrator, which was consistent with her verbal statements. The report indicated that on 5/11/2025, staff identified bugs in Resident A’s wound and reported the issue to her hospice agency at 1:45 PM. According to the report, a hospice nurse visited the home later that evening at 10:30 PM to assess the wound but noted that no bugs were present at the time of evaluation.

The report further stated that on 5/12/2025, staff contacted the hospice nurse again due to bleeding from the wound. On 5/13/2025, following a subsequent evaluation, the hospice nurse recommended that Resident A be transported to the hospital. Emergency medical services were contacted, and both EMS and law enforcement responded. Resident A was then transported to the hospital for further care. The report also documented that on 5/14/2025, the facility held a meeting with the hospice agency to address concerns regarding the care and treatment provided. Additionally, APS was made aware of the full details of the incident. Finally, the report noted that Resident A returned to the home on

5/14/2025. Her hospice agency was notified to resume services and provide continued wound care.

While on-site, Employee #1's interview regarding residents' checks and changes was consistent with the Administrator's statements, adding that residents in the memory care unit are checked even more frequently.

During the visit, eight memory care and ten assisted living residents were observed. All appeared well groomed and dressed in clean clothing. No foul odors were noted in the home.

A review of the Administrator's email submitted to the home's licensing staff on 5/14/2025, supported the Administrator's account and included an attached incident report.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1931** | **Employees; general provisions.** |
| | **(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.** |
| **ANALYSIS:** | Based on staff attestations, direct observations, and a review of documentation, there is insufficient evidence to support the allegations that residents were not being checked or changed regularly.<br><br>In addition, the incident involving Resident A's wound was appropriately managed, with staff promptly notifying her hospice team for treatment and reporting the matter to APS. While the Department was not required to be notified of the incident, licensing staff reviewed the Administrator's email with incident report on 5/14/2025 and found no concerns regarding the actions taken by facility staff. Given this information, this allegation was not substantiated. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**The home has a bug infestation.**

**INVESTIGATION:**

On 8/20/2025, the Department received anonymous allegations which read that the home had roaches. Additional anonymous reports received the same day alleged the presence of bed bugs. Due to the anonymous nature of these complaints, no further information could be obtained.

On 8/22/2025, I conducted an on-site inspection at the home and interviewed staff.

The Administrator stated that the home maintains a contract with Griffin Pest Solutions, who provide regular pest control services. She confirmed with maintenance staff that Giffin Pest Solutions services the home monthly, and additional services could be requested as needed. She also stated that there had been no reports or concerns regarding roaches, bed bugs, or other infestations.

While on-site, I reviewed the service log from Griffin Pest Solutions, which was consistent with staff statements. The log documented consistent monthly visits and did not note any pest-related concerns.

Employee #1 reported that she had only seen a single spider approximately three months ago, which was immediately removed by staff. She reported no other pest-related concerns.

During the inspection, I observed both the assisted living and memory care hallways, as well as both dining areas. Bug traps were noted in various locations throughout the facility, but no pests were observed.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1978** | **Insect and vermin control.** |
| | **(1) A home shall be kept free from insects and vermin.(2) Pest control procedures shall comply with MCL 324.8301 et seq.** |
| **ANALYSIS:** | Based on staff interviews, documentation review, and on-site observations, there was insufficient evidence to support the allegations of a pest infestation. Therefore, this allegation is not substantiated. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**The home serves raw food.**

**INVESTIGATION:**

On 8/20/2025, the Department received additional anonymous allegations claiming that the home served raw food. Due to the anonymous nature of the complaint, no further details could be obtained.

On 8/22/2025, I conducted an on-site inspection at the home and interviewed staff.

The Administrator reported that kitchen staff take the internal temperatures of all food items prior to serving. She stated there had been no recent concerns or complaints from residents or staff regarding undercooked food. However, the Administrator acknowledged that while food temperatures are routinely taken, the kitchen staff do not maintain documentation of these temperature checks.

During the inspection, I reviewed the facility's weekly menu, which indicated that the home serves three meals per day. Many of the main entrees for lunch and dinner included meat items such as chicken, pork, and beef, which require proper temperature verification to ensure food safety.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1976** | **Kitchen and dietary.** |
| | **(6) Food and drink used in the home shall be clean and wholesome and shall be manufactured, handled, stored, prepared, transported, and served so as to be safe for human consumption.** |
| **ANALYSIS:** | Although staff reported taking food temperatures, they did not maintain a record indicating the task was completed and that the food was safe for human consumption. Therefore, a violation was substantiated for this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remains unchanged.

Jessica Rogers 08/27/2025

Jessica Rogers Date
Licensing Staff

Approved By:

09/29/2025

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section