



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 24, 2026

Shiphrah Price
Stallworth AFC 1 Corporation
645 E Grand Blvd.
Detroit, MI 48207

RE: License #: AL820007640
Investigation #: 2026A0993032
Stallworth AFC

Dear Ms. Price:

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 (313) 456-0380.

Sincerely,

A handwritten signature in cursive script, reading "DaShawnda Lindsey". The signature is written in a dark ink and is positioned above the printed name and address.

DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820007640
Investigation #:	2026A0993032
Complaint Receipt Date:	09/01/2026
Investigation Initiation Date:	09/02/2026
Report Due Date:	10/31/2026
Licensee Name:	Stallworth AFC 1 Corporation
Licensee Address:	645 E Grand Blvd. Detroit, MI 48207
Licensee Telephone #:	(734) 772-7522
Administrator:	Shiphrah Price
Licensee Designee:	Shiphrah Price
Name of Facility:	Stallworth AFC
Facility Address:	13965 Linwood Detroit, MI 48238
Facility Telephone #:	(313) 826-7681
Original Issuance Date:	05/15/1991
License Status:	REGULAR
Effective Date:	07/05/2025
Expiration Date:	07/04/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED
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II. ALLEGATION(S)

	Violation Established?
- Staff yelled at, screamed at, and spoke harshly and disrespectfully to residents. - Staff bullied the residents and approached them aggressively while yelling. - Staff treated residents like “dogs.” - Resident A was repeatedly snapped at and treated disrespectfully.	No
There is a fly infestation in the facility.	No
Resident A was only bathed two times while in the facility for approximately two weeks. Resident A went for about seven days without a bath.	No
- Resident A did not receive medication the night before departing the facility or the following morning and afternoon. - Medications are not consistently administered on schedule. - Resident A had 20 PRN Benzodiazepine pills but was only given 11 pills when she was discharged. - Staff did not administer Prilosec to Resident A despite repeated requests. - Staff handled medications and residents without gloves and did not consistently follow hygiene practices.	Yes

III. METHODOLOGY

09/01/2026	Special Investigation Intake 2026A0993032
09/02/2026	Special Investigation Initiated - Letter Email sent to the Complainant. The email bounced back. No other contact information was provided for the Complainant.
09/04/2026	Contact - Document Sent Follow up email sent to the Complainant. The email bounced back. No other contact information was provided for the Complainant.
09/04/2026	Inspection Completed On-site Conducted an unannounced onsite investigation. I interviewed staff, Joyce Lo, staff, Jasmine Foster, and staff, Angela Williams. I also interviewed licensee designee, Shiprah Price via telephone.

09/08/2026	Inspection Completed On-site Conducted an announced onsite investigation. I interviewed staff, Carleshay Leonard and staff, Sharmaine Rondeau. I also interviewed Resident B, Resident C, and Resident D.
09/08/2026	Contact - Document Sent Follow up email sent to the Complainant. The email bounced back. No other contact information was provided for the Complainant.
09/08/2026	Contact - Telephone call made Telephone call made to Relative B1. Mailbox full. Sent a text message.
09/08/2026	Contact - Telephone call received Telephone call received from Relative B1
09/09/2026	Contact - Document Received Received verification of staff medication administration training
09/10/2026	Referral - Recipient Rights Forwarded allegations to Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights
09/10/2026	APS Referral Forwarded allegations to Adult Protective Services (APS)
09/14/2026	Contact - Telephone call made Telephone call made to case manager, Kelsey Williams. Left a message.
09/14/2026	Contact - Telephone call made Telephone call made to case manager, Joseph Camble. Mailbox was full. Sent a text message.
09/14/2026	Contact - Telephone call made Telephone call made to case manager, Regina Hardt
09/14/2026	Contact - Telephone call made Telephone call made to Guardian E1. Left a message.
09/14/2026	Contact - Telephone call received Telephone call received from case manager, Kelsey Williams
09/14/2026	Contact - Telephone call made Telephone call made to Resident A

09/15/2026	Contact - Telephone call received Telephone call received from Resident E and Guardian E1
09/21/2026	Contact - Document Sent Requested a copy of Resident A's assessment plan
09/21/2026	Telephone call made to case manager, Joseph Camble. Mailbox was full. Sent a text message.
09/21/2026	Contact - Document Received Received a copy of Resident A's assessment plan
09/21/2026	Exit Conference Held with licensee designee, Shiphrah Price

ALLEGATION:

- **Staff yelled at, screamed at, and spoke harshly and disrespectfully to residents.**
- **Staff bullied the residents and approached them aggressively while yelling.**
- **Staff treated residents like "dogs."**
- **Resident A was repeatedly snapped at and treated disrespectfully.**

INVESTIGATION:

On 09/01/2026, I received allegations from Licensing and Regulatory Affairs (LARA) Bureau of Child and Adult Licensing (BCAL) Online Complaints.

On 09/04/2026, I conducted an unannounced onsite investigation. I interviewed staff, Joyce Lo, staff, Jasmine Foster, and staff, Angela Williams. I also interviewed licensee designee, Shiphrah Price via telephone.

In separate interviews, Ms. Lo, Ms. Foster, Ms. Williams, and Ms. Price denied that staff yell at, scream at or speak harshly and disrespectfully to the residents. They denied that staff bully the residents or approach them aggressively. They denied that staff treat any of the residents like "dogs." They denied that staff snapped at Resident A or treated her disrespectfully when she lived in the facility.

On 09/08/2026, I conducted an announced onsite investigation. I interviewed staff, Carleshay Leonard and staff, Sharmaine Rondeau. I also interviewed Resident B, Resident C, and Resident D.

In separate interviews, Ms. Leonard and Ms. Rondeau denied that staff yell at, scream at or speak harshly and disrespectfully to the residents. They denied that staff bully the

residents or approach them aggressively. They denied that staff treat any of the residents like “dogs.” They denied that staff snapped at Resident A or treated her disrespectfully when she lived in the facility.

Resident B denied that staff yell at, talk aggressively to, or mistreat the residents. She denied that staff treat the residents like “dogs.”

Resident C stated staff treat the residents okay. He denied that staff yell at, talk aggressively to, or mistreat the residents. He denied that staff treat the residents like “dogs.”

Resident D stated staff treat the residents good. He described staff as “nice.” He denied that staff yell at, talk aggressively to, or mistreat the residents. He denied that staff treat the residents like “dogs.”

On 09/08/2026, I conducted a telephone interview with Relative B1. She stated staff seem so kind at the facility. Resident B informed her she got into it with staff in the past, but that staff has not worked in the facility in about two years. Relative B1 denied knowledge of staff yelling at, talking aggressively to, or mistreating the residents. She also denied knowledge of staff treating the residents like “dogs.”

On 09/10/2026, I forwarded allegations to Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights.

On 09/10/2026, I forwarded allegations to Adult Protective Services (APS).

On 09/14/2026, I conducted a telephone interview with case manager, Regina Hardt. Ms. Hardt is Resident B’s, Resident D’s, Resident E’s, Resident G’s, Resident H’s, and Resident J’s case manager. Ms. Hardt stated she last went to the facility on 09/14/2026. None of the residents reported any concerns to her regarding staff treatment of the residents. Ms. Hardt denied ever observing issues with the way staff treated the residents.

On 09/14/2026, I conducted a telephone interview with case manager, Kelsey Williams. Ms. Williams is Resident A’s case manager. Per Ms. Williams, Resident A has never reported any concerns to her regarding staff treatment of the residents.

On 09/14/2026, I conducted a telephone interview with Resident A. Resident A confirmed she lived in the facility for about two weeks. While at the facility, staff yelled at, screamed at and spoke harshly and disrespectfully to the residents. Staff bullied the residents and approached them aggressively. Staff treated the residents like “dogs.” She stated staff snapped at her and treated her disrespectfully. Resident A did not know the names of staff who mistreated her and the other residents.

On 09/15/2026, I conducted a telephone interview with Resident E and Guardian E1. Resident E stated Ms. Rondeau harasses and messes with him by saying she heard he

said the food was nasty. Resident E did not state that the other staff mistreated him or the other residents.

Guardian E1 stated he just wants Ms. Rondeau to stop messing with Resident E. She did not provide any details about the mistreatment.

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:	Interviewed staff denied that staff yell at, scream at or speak harshly and disrespectfully to the residents. They denied that staff bully the residents or approach them aggressively. They denied that staff treat any of the residents like “dogs.” They denied that staff snapped at Resident A or treated her disrespectfully when she lived in the facility. Resident B, Resident, C, and Resident D denied that staff yell at, talk aggressively to, or mistreat the residents. He denied that staff treat the residents like “dogs.” Relative B1 denied knowledge of staff yelling at, talking aggressively to, or mistreating the residents. She also denied knowledge of staff treating the residents like “dogs.” Ms. Hardt denied ever observing issues with the way staff treated the residents. Ms. Williams stated Resident A has never reported any concerns to her regarding staff treatment of the residents. Evidence supports that staff did not mistreat the residents. 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.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

There is a fly infestation in the facility.

INVESTIGATION:

On 09/04/2026, I conducted an unannounced onsite investigation. I interviewed staff, Joyce Lo, staff, Jasmine Foster, and staff, Angela Williams. I also interviewed licensee designee, Shiphrah Price via telephone.

In separate interviews, Ms. Lo, Ms. Foster, and Ms. Williams confirmed that there were flies in the facility. Ms. Lo and Foster stated the facility is treated by a company about every two weeks, but they did not know the name of the company.

Ms. Price denied there were flies in the facility. She stated the facility is treated by Terry Exterminating Service twice per month.

On 09/08/2026, I conducted an announced onsite investigation. I interviewed staff, Carleshay Leonard and staff, Sharmaine Rondeau. I also interviewed Resident B, Resident C, and Resident D. In separate interviews, they confirmed there were flies in the facility but denied a fly infestation.

While at the facility, I observed flies in the office and hallways. I also observed receipts from Terry's Exterminating Service confirming the facility was treated on 07/10/2026, 07/24/2026, 08/14/2026, and 08/28/2026 for "all bugs."

In 09/08/2026, I conducted a telephone interview with Relative B1. She stated there may be a fly infestation in the bathrooms.

On 09/14/2026, I conducted a telephone interview with case manager, Regina Hardt. She stated she observed flies in the facility likely resulting from the door being left open.

On 09/14/2026, I conducted a telephone interview with Resident A. She confirmed there was a fly infestation in the facility.

On 09/15/2026, I conducted a telephone interview with Resident E. He stated there are flies in the facility due to it being summertime, and the windows are open.

APPLICABLE RULE	
R 400.645	Environmental health.
	(6) An insect, rodent, or pest control program must be maintained and carried out in a manner that continually protects the health of residents.

ANALYSIS:	Interviewed staff and residents confirmed there are flies in the facility. While at the facility, I observed flies in the office and hallways. I also observed receipts from Terry's Exterminating Service confirming the facility was treated on 07/10/2026, 07/24/2026, 08/14/2026, and 08/28/2026 for "all bugs." Evidence supports that the facility has an insect, rodent, or pest control program that is maintained and carried out in a manner that continually protects the health of residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A was only bathed two times while in the facility for appropriately two weeks. Resident A went for about seven days without a bath.

INVESTIGATION:

On 09/04/2026, I conducted an unannounced onsite investigation. I interviewed staff, Joyce Lo, staff, Jasmine Foster, and staff, Angela Williams. I also interviewed licensee designee, Shiphrah Price via telephone.

In separate interviews, Ms. Lo and Ms. Foster stated Resident A received a bath daily.

In separate interviews, Ms. Williams and Ms. Price denied that Resident A only received a bath twice during the period she lived in the facility. They also denied that she went seven days without a bath.

On 09/08/2026, I conducted an announced onsite investigation. I interviewed staff, Carleshay Leonard and staff, Sharmaine Rondeau. In separate interviews, they reported Resident A received a bath daily while she was at the facility.

On 09/14/2026, I conducted a telephone interview with case manager, Kelsey Williams. Ms. Williams denied knowledge of Resident A only receiving two baths while at the facility. She stated Resident A mainly discussed wanting to move out of the facility.

On 09/14/2026, I conducted a telephone interview with Resident A. Resident A stated she was only given a bath about four times while at the facility. She did not state the days/dates of those baths.

On 09/21/2026, I reviewed Resident A's assessment plan. Per the plan, Resident A required staff assistance with baths.

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:	Ms. Lo, Ms. Foster, Ms. Leonard, and Ms. Rondeau stated Resident A received a bath daily. Ms. Williams and Ms. Price denied that Resident A only received a bath twice during the period she lived in the facility. They also denied that she went seven days without a bath. Per Resident A's assessment plan, Resident A required staff assistance with baths. Evidence supports Resident A was provided supervision, protection, and personal care as specified in a resident's assessment plan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.677	Resident hygiene, clothing.
	(1) A licensee shall offer a resident appropriate opportunity, access to, and instructions for the following daily: (a) Bathing or showering, or both.
ANALYSIS:	Ms. Lo, Ms. Foster, Ms. Leonard, and Ms. Rondeau stated Resident A received a bath daily. Ms. Williams and Ms. Price denied that Resident A only received a bath twice during the period she lived in the facility. They also denied that she went seven days without a bath. Per Resident A's assessment plan, Resident A required staff assistance with baths. Evidence supports that Resident A was offered an appropriate opportunity, access to, and instructions for bathing or showering.

CONCLUSION:	VIOLATION NOT ESTABLISHED
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ALLEGATION:

- **Resident A did not receive medication the night before departing the facility or the following morning and afternoon.**
- **Medications are not consistently administered on schedule.**
- **Resident A had 20 PRN Benzodiazepine pills but was only given 11 pills when she was discharged.**
- **Staff did not administer Prilosec to Resident A despite repeated requests.**
- **Staff handled medications and residents without gloves and did not consistently follow hygiene practices.**

INVESTIGATION:

On 09/04/2026, I conducted an unannounced onsite investigation. I interviewed staff, Joyce Lo, staff, Jasmine Foster, and staff, Angela Williams. I also interviewed licensee designee, Shiphrah Price via telephone. In separate interviews, they stated staff administer medications as prescribed. All staff who administer medications are trained to do so. They denied knowledge of Resident A not receiving medication when she asked for it and/or when she discharged. In addition, they stated staff wear gloves when administering medications and/or providing care to the residents.

On 09/08/2026, I conducted an announced onsite investigation. I interviewed staff, Carleshay Leonard and staff, Sharmaine Rondeau. I also interviewed Resident B, Resident C, and Resident D.

In separate interviews, Ms. Leonard and Ms. Rondeau stated staff administer medications as prescribed. All staff who administer medications are trained to do so. They denied knowledge of Resident A not receiving medication when she asked for it and/or when she discharged. In addition, they stated staff wear gloves when administering medications and/or providing care to the residents.

In separate interviews, Resident B, Resident C, and Resident D stated they received their medications as prescribed.

While at the facility, I reviewed Resident A's, Resident B's, Resident C's, Resident D's, Resident E's, Resident F's, Resident G's, Resident H's, Resident I's, Resident J's, Resident K's, and Resident M's August 2026 medication administration record (MAR). I did not review Resident L's MAR as he is currently not prescribed medications. I did not observe any administration errors in the MARs I reviewed.

I also reviewed Resident B's, Resident C's, Resident D's, Resident E's, Resident F's, Resident G's, Resident H's, Resident I's, Resident J's, and Resident K's September 2026 MAR and medications. I did not observe Resident A's and Resident M's MAR and

medication as they discharged from the facility on 08/24/2026 and 08/20/2026, respectively. I observed the following errors in the MARs and medications I reviewed:
Resident B:

- Resident B's Silver Sulfa Cream 1% cream was not in the locked cabinet. Ms. Price did not locate it during the inspection.

Resident E:

- Resident E's Betamethasone Valerate 0.1% Ointment was not in the locked cabinet. It was located somewhere else in the facility. Ms. Price did not state where she located it.

Resident J:

- Staff initial the MAR to show administration of the medication at 8pm on 09/07/2026 but did not administer the medication. I observed the pill in the bubble pack.
- Resident J is prescribed Levothyroxine 125mcg every other day. The medication was not listed on Resident J's MAR.

Resident K:

- Resident K's Hydrocortisone Cream 2.5% was not locked in the medication cabinet. It was in Resident K's possession.

On 09/09/2026, I received verification that staff, Donna Wheeler, staff, Jewel Siebert, staff, Kendra Day, staff, Mariel Anderson, staff, Tyann Shelton as well as Ms. Foster, Ms. Leonard, Ms. Lo, Ms. Rondeau, and Ms. Williams completed medication administration training.

On 09/14/2026, I conducted a telephone interview with Resident A. Resident A stated when she lived in the facility sometimes staff did not call her to get her medications. However, the other residents received their medications. Resident A stated she thought she did not receive all her medications when she left the facility but later found out that she did. Resident A also stated staff handled medications and residents without gloves and did not consistently follow hygiene practices.

On 09/15/2026, I conducted a telephone interview with Resident E. Resident E stated staff administered his medications as prescribed.

On 09/21/2026, I contacted licensee designee, Shiphrah Price and conducted the exit conference. I informed her of the findings. She agreed to 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:	On 09/08/2026, I observed that staff initialed the MAR to show administration of the medication at 8pm on 09/07/2026 but did not administer the medication. I observed the pill in the bubble pack. Evidence supports that medications were not given, taken or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.675	Resident medications.
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	On 09/08/2026, I observed that Resident B's Silver Sulfa Cream 1% cream was not in the locked cabinet. Ms. Price did not locate it during the inspection. Resident E's Betamethasone Valerate 0.1% Ointment was not in the locked cabinet. It was located somewhere else in the facility. Ms. Price did not state where she located it. Resident K's Hydrocortisone Cream 2.5% was not locked in the medication cabinet. It was in Resident K's possession. Evidence supports that prescribed medication was not kept in a locked cabinet or drawer.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.675	Resident medications.
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: (a) Be trained in the proper handling and administration of medication. (b) Complete an individual medication log that contains all of the following: (i) Medication name. (ii) Dosage. (iii) Label instructions for use. (iv) Time to be administered. (v) Initials of the individual who administered the medication at the time given. (vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.
ANALYSIS:	On 09/08/2026, I observed that Resident J was prescribed Levothyroxine 125mcg every other day. The medication was not listed on Resident J's MAR. Evidence supports that Resident J's MAR was not completed to include the medication name, dose, label instructions, and time to administer the medication. In addition, staff did not initial when the medication was administered.
CONCLUSION:	VIOLATION ESTABLISHED

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:	Interviewed staff stated staff wear gloves when administering medications and/or providing care to the residents. Evidence supports the residents were treated with dignity and respect, free from exploitation, and protected and safe.

CONCLUSION:	VIOLATION NOT ESTABLISHED
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IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



09/22/2026

DaShawnda Lindsey
Licensing Consultant

Date

Approved By:



09/24/2026

Ardra Hunter
Area Manager

Date