GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 22, 2025

Teresa Wendt
HGA Non-Profit Homes Inc.
917 West Norton
Muskegon, MI 49441

RE: License #: AS640012795
Investigation #: 2025A0870034
Morningside

Dear Teresa Wendt:

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 (231) 922-5309.

Sincerely,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS640012795
Investigation #:	2025A0870034
Complaint Receipt Date:	09/02/2025
Investigation Initiation Date:	09/03/2025
Report Due Date:	11/01/2025
Licensee Name:	HGA Non-Profit Homes Inc.
Licensee Address:	917 West Norton Muskegon, MI 49441
Licensee Telephone #:	(231) 728-3501
Administrator:	Melanie Billings
Licensee Designee:	Teresa Wendt
Name of Facility:	Morningside
Facility Address:	3871 Melody Lane Hart, MI 49420
Facility Telephone #:	(231) 873-7445
Original Issuance Date:	09/25/1991
License Status:	REGULAR
Effective Date:	03/21/2024
Expiration Date:	03/20/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was injured after falling from his wheelchair during an outing with staff.	Yes
Resident A was not taken for a medical evaluation until several days after he fell from his wheelchair.	Yes

III. METHODOLOGY

09/02/2025	Special Investigation Intake 2025A0870034
09/03/2025	APS Referral This referral came from the Michigan Department of Health and Human Services, Adult Protective Services.
09/03/2025	Special Investigation Initiated - Telephone Telephone case discussion with APS worker Brooke Taylor.
09/05/2025	Inspection Completed On-site Interviews conducted with facility staff and Resident A.
09/08/2025	Contact - Telephone call made Telephone interviews with facility staff.
09/10/2025	Contact - Telephone call made Email discussion with Administrator Melanie Billings.
09/22/2025	Contact - Telephone call made Telephone interview with Administrator Melanie Billings.
09/22/2025	Exit Conference Completed with Administrator Melanie Billings.
09/22/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A was injured after falling from his wheelchair during an outing with staff.

INVESTIGATION: On September 3, 2025, I spoke by telephone with Oceana County MDHHS Adult Protective Services (APS) Specialist Brooke Taylor. Ms. Taylor noted that APS had received a referral alleging that Resident A was not

properly secured into the company van while on an outing from the home, that he was injured when the van made a sudden stop, and Resident A was not taken for medical evaluation for his injuries. She noted she had not yet met with Resident A, but the APS on-call worker had already met with him over the weekend. Ms. Taylor stated she would email me the notes taken by the on-call worker.

On September 3, 2025, I received an email from Ms. Taylor with the contact notes from on-call worker APS worker Monique Collins. A synopsis of Ms. Collins' notes are as follows : "ASW completed the 24/72 hour face-to-face with (Resident A) at his current AFC home located at 3871 Melody Lane, Hart, MI. ASW observed (Resident A) sitting in his wheelchair coloring. ASW read the allegations and (Resident A) reported he did fall out his wheelchair in the van on 08/29/25. Staff member Bili Jo reported that they had taken the residents on an outing to Wal-Mart and Shoe Sensation in Ludington, MI. Billi Jo reported that there were three staff members, Loretta, Kasandra and herself. Billi Jo reported that she is not van trained and is not allowed to put the residents on or take them off the van. Loretta put (Resident A) and another resident in the van and their wheelchairs were locked down in the van. Loretta did not put a seatbelt on (Resident A) as she is alleged to have stated she did not know how to operate the seatbelt. (Resident A) was transported from Hart, MI to Ludington, MI without a seatbelt. Staff member Loretta, while in Ludington, had to slam on her brakes due to the car in front of her hitting their brakes. (Resident A) fell forward out of his wheelchair when the brakes were hit. He was pinned between his wheelchair and another resident's wheelchair. (Resident A) sustained bruising to the lower right side of his back and right hip area. Loretta pulled into the parking lot and the staff were able to pick (Resident A) up and place him back in his wheelchair. (Resident A) was observed with the bruises on 08/30/25. Raymond is a home staff member who works the home on Saturday and Sundays. Raymond observed the bruises on (Resident A) when cleaning him up and asked what occurred. Raymond contacted Loretta to inform her of the injuries, and she informed him not to worry about the injuries."

On September 5, 2025, I made an unannounced on-site special investigation at the Morningside AFC home. I met with Administrator Melanie Billings. I informed Ms. Billings of the allegations as stated above. She provided me with an *AFC Licensing Division Incident/Accident Report (BCAL-4607),* which was completed by Home Manager Loretta Bristol. Ms. Billings noted that Ms. Bristol, along with staff members Kassandra Mayle and Billi Jo Nustaikis were on an outing/shopping trip with Resident A and another resident when Ms. Bristol, who was driving the van, had to rapidly apply the brakes causing Resident A to fall from his wheelchair onto the van floor. This incident occurred on August 29, 2025. She further noted that Resident A was taken to the local hospital emergency department for evaluation, as a precaution, on September 4, 2025. Ms. Billings noted that no medical concerns were noted at that time, but Resident A is scheduled for X-Rays next week, as an additional precaution.

On September 5, 2025, I observed Resident A while he sat in his wheelchair at the home. He appeared clean and well dressed.

A review of Resident A's *Assessment Plan for AFC Residents (BCAL-3265)*, notes that he requires "assistance with transportation," and he "uses a wheelchair for mobility."

On September 5, 2025, I conducted a private in-person interview with staff member Kassandra Mayle. Ms. Mayle stated that "last Friday" August 29, 2025, she, along with staff member Billi Jo Nustaikis and home manager Loretta Bristol were on a shopping outing with all four of the facilities residents. She noted they used the company van and Ms. Bristol was the driver. Ms. Mayle stated that they drove to the Ludington Walmart store and were proceeding to go to another store when a car in front of them slammed on their brakes. Ms. Mayle stated that when the car in front slammed on its brakes, so did Ms. Bristol. She noted they did not hit the car, but Resident A slid from his wheelchair onto the van floor. Ms. Mayle stated that Resident A was not buckled into his wheelchair with the straps provided in the van. She noted the chair was fastened to the van floor with hooks. Ms. Mayle stated that Ms. Bristol proceeded to a parking lot where she, Ms. Bristol and Ms. Nustaikis picked Resident A up from the van floor and placed him back in his wheelchair. Ms. Mayle stated they checked Resident A for any injury, did not find any obvious injuries and Resident A stated he was "fine." She stated Resident A was not taken for medical evaluation at that time as there were no noticeable injuries and Resident A was saying he was "ok" and "fine."

On September 8, 2025, I conducted a telephone interview with home manager Loretta Bristol. Ms. Bristol stated she was driving the company van while on a shopping outing with all four facility residents. She noted two staff members, Kassandra Mayle and Billi Jo Nustaikis, were with her during this outing and riding in the company van along with the residents, which included Resident A. Ms. Bristol stated they had just left the Walmart parking lot in Ludington when the car in front of her braked quickly, and she had to hit the brakes causing Resident A to slide from his wheelchair onto the van floor. Ms. Bristol noted that although Resident A's wheelchair was secured to the van by hooks, the straps that go across Resident A's chest were not in place. She stated that she had never been trained on proper use of this type of seat belt restraints, nor has any of the staff. Ms. Bristol confirmed she was the driver of the van, and she was aware that Resident A did not have the seat belt restraints in place, as did the other two staff members present, Ms. Mayle and Ms. Nustaikis. Ms. Bristol noted after Resident A slid onto the floor, she quickly pulled into a parking lot and the staff picked up Resident A and placed him back in his wheelchair. She stated there were no signs of injury although Resident A did say his leg hurt. Ms. Bristol noted that he later stated he was "fine." She stated that the following day, facility staff had called her and informed her that Resident A had a bruise, but she did not instruct anyone to take Resident A for a medical evaluation.

On September 8, 2025, I conducted a telephone interview with staff member Billi Joe

Nustaikis. Ms. Nustaikis stated that she had never been trained in the use of the company van wheelchair seat belt restraint system and was not involved in placing Resident A in the van. Ms. Nustaikis stated that on August 29, 2025, she, along with home manager Loretta Bristol and Kassandra Mayle took the four facility residents, which included Resident A, on a shopping trip to Ludington. She stated that Ms. Bristol and Ms. Mayle loaded the residents into the van, noting that they did not buckle Resident A in, just locked down his chair. Ms. Nustaikis stated that this trip took them on US-131, a freeway, and they drove 75 miles per hour. She noted they went to Walmart in Ludington and then proceeded to another store. Ms. Nustaikis stated she observed that Resident A was not buckled, and she told Ms. Bristol he was not buckled in. She stated that Ms. Bristol then commented that she did not know how to buckle him in either and then Ms. Bristol proceeded to drive out of the Walmart parking lot. Ms. Nustaikis stated that Ms. Bristol had to slam on her brakes and Resident A slid out of his wheelchair. She noted they drove to a parking lot, checked Resident A for injuries, and did not observe any visible marks at that time, although Resident A was saying “owe, my legs hurt.” Ms. Nustaikis noted that Ms. Bristol was aware that Resident A was saying his legs were hurting him. She noted that Resident A was not taken for medical evaluation at the time. Ms. Nustaikis stated that she worked the following day and noted bruising on Resident A. She stated Ms. Bristol was informed of the bruising and told staff not to worry about it, as Resident A would be ok.

For Reference: Public Act No. 218 of 1979, as amended 400.706 (4) defines “Protection” as “the continual responsibility of the licensee to take reasonable action to insure the health, safety, and well-being of a resident, including protection from physical harm, humiliation, intimidation and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the licensee or agent or employee of the licensee, or when the resident’s assessment plan states that the resident need continuous supervision.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Home manager Loretta Bristol along with staff member Kassandra Mayle and Billi Jo Nustaikis all state that the seat belt restraint system was not utilized with Resident A while traveling in the company van. Resident A slid out of his wheelchair onto the van floor when Ms. Bristol activated the van brakes.

	Resident A stated that his legs hurt him shortly after this incident and he was noted to have bruising the following day. Facility staff did not provide Resident A with "Protection" as defined in the act when they failed to utilize the seat belt restraints with Resident A while traveling in the company van.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Facility staff did not provide Resident A with protection and safety in accordance with the provisions of the act when they failed to utilize the seat belt restraints with Resident A while traveling in the company van.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was not taken for a medical evaluation until several days after he fell from his wheelchair.

INVESTIGATION: Ms. Bristol stated there were no signs of injury at the time of the incident/accident, although Resident A did say his leg hurt. She stated that the following day, the facility staff had called her and informed her that Resident A had a bruise, but she did not instruct anyone to take Resident A for a medical evaluation.

Ms. Nustaikis noted that staff checked Resident A for injuries following the incident/accident and did not observe any visible marks at that time, although Resident A was saying "owe, my legs hurt." Ms. Nustaikis noted that Ms. Bristol was aware that Resident A was saying his legs were hurting him. She noted that Resident A was not taken for medical evaluation at the time. Ms. Nustaikis stated that she worked the following day and noted bruising on Resident A. She stated Ms. Bristol was informed of the bruising and told staff not to worry about it, as Resident A would be ok.

Administrator Melanie Billings noted that Resident A was taken to the local hospital emergency department for evaluation, as a precaution, on September 4, 2025. Ms.

Billings noted that no medical concerns were noted at that time, but Resident A is scheduled for X-Rays next week, as an additional precaution. It is noted that this incident/accident occurred on August 29, 2025.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Both Ms. Bristol and Ms. Nustaikis stated Resident A commented to them that his legs were hurt immediately following the incident/accident of August 29, 2025. Ms. Bristol stated that facility staff called to inform her the following day that Resident A had bruising. She acknowledged she did not instruct anyone to take Resident A for a medical evaluation. Ms. Nustaikis stated that she worked the following day and noted bruising on Resident A. She stated Ms. Bristol was informed of the bruising and told staff not to worry about it, as Resident A would be ok. Administrator Melanie Billings noted that Resident A was not taken for medical evaluation/treatment until September 4, 2025. The group home failed to obtain needed care immediately for Resident A following the accident/incident of August 29, 2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

On September 22, 2025, I conducted an exit conference with Administrator Melanie Billings. I explained my findings and conclusions as noted above and my recommendation as stated below. Ms. Billings stated she understood the findings and that she would submit a corrective action plan which addresses these established rule violations. She had no additional information to provide, nor questions to ask, concerning this special investigation.

IV. RECOMMENDATION

I recommend, contingent upon the submission of an acceptable corrective action plan, that the status of the licenses remain unchanged.

September 22, 2025

Bruce A. Messer Date
Licensing Consultant

Approved By:

September 22, 2025

Jerry Hendrick Date
Area Manager