GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 29, 2025

Jonathon Book
AH Jenison Subtenant LLC
Ste 1600
1 Towne Sq
Southfield, MI 48076

RE: License #: AL700397745
Investigation #: 2025A0579058
AHSL Jenison Maplewood

Dear Jonathon Book:

Attached is the Special Investigation Report for the above-mentioned facility. Due to the violations identified in the report, a written corrective action plan was required. On 9/26/25, you submitted an acceptable written corrective action plan. It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

Cassandra Duursma

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W., Unit 13
Grand Rapids, MI 49503
(269) 615-5050
enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AL700397745
Investigation #:	2025A0579058
Complaint Receipt Date:	09/23/2025
Investigation Initiation Date:	09/23/2025
Report Due Date:	11/22/2025
Licensee Name:	AH Jenison Subtenant LLC
Licensee Address:	Ste 1600, 1 Towne Sq, Southfield, MI 48076
Licensee Telephone #:	(616) 432-2112
Administrator:	Jonathon Book
Licensee Designee:	Jonathon Book
Name of Facility:	AHSL Jenison Maplewood
Facility Address:	887 Oak Crest Lane Jenison, MI 49428
Facility Telephone #:	(616) 457-3576
Original Issuance Date:	03/11/2019
License Status:	REGULAR
Effective Date:	09/11/2025
Expiration Date:	09/10/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED/ AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was mistreated by direct care worker Selina Braddock.	Yes

III. METHODOLOGY

09/23/2025	Special Investigation Intake 2025A0579058
09/23/2025	Special Investigation Initiated - Letter Jonathon Book, Licensee Designee
09/24/2025	Contact- Telephone Call Received Jonathon Book, Licensee Designee
09/24/2025	Contact - Document Received Additional Information
09/24/2025	APS Referral
09/24/2025	Contact - Document Sent Erin Wallace APS
09/25/2025	Contact- Face to Face Resident A Jonathon Book, Licensee Designee Brandy Milanowski, Administrative Staff
09/25/2025	Contact- Telephone Call Made Selina Braddock, Direct Care Worker
09/25/2025	Contact- Telephone Call Received Selina Braddock, Direct Care Worker
09/25/2025	Contact- Document Sent Erin Wallace, APS
09/25/2025	Exit Conference Jonathon Book, Licensee Designee

ALLEGATION: Resident A was mistreated by direct care worker Selina Braddock.

INVESTIGATION: On 9/23/25, I entered this referral into the Bureau Information Tracking System after being notified by Licensing Consultant Toya Zylstra, that Licensee Designee Jonathon Book had reported to her that on 9/21/25, Resident A reported Direct Care Worker ("DCW") Selina Braddock hurt Resident A's left arm while providing care for Resident A. Resident A presents with marks on her arm but it is not certain if they are accidental or from abuse. Ms. Braddock was suspended from her position until an investigation is completed. Adult Protective Services is involved.

On 9/23/25, I contacted Mr. Book to confirm my receipt of the allegation and to report that I am the assigned consultant.

On 9/24/25, I received additional information regarding the allegation. It was reported that Resident A has been "handled roughly" on two occasions at this home. On 9/20/25, Resident A was assisted with transferring by Ms. Braddock who grabbed Resident A's left arm. Resident A stated, "That hurt." Ms. Braddock responded, "That didn't hurt. If I wanted to hurt you, you would know." Resident A reported on 9/22/25, that her left arm was still bothering her.

On 9/24/25, I contacted Adult Protective Services Worker Erin Wallace to confirm her involvement. I confirmed I was also investigating the allegation.

On 9/25/25, I completed an unannounced on-site investigation at the home. Interviews were completed with Resident A, Mr. Book, and administrative staff, Brandy Milanowski.

I interviewed Resident A privately in her room. Resident A stated Ms. Braddock was assisting her with transferring and Ms. Braddock was mad that she was busy and behind schedule. She stated Ms. Braddock forcefully grabbed her arm and placed it "on the machine." She explained the machine is the lift used to transfer her. She stated she told Ms. Braddock, "That hurt." She stated Ms. Braddock said something like, "Why are you hollering? If you think that hurts, I could do more." She stated she does not recall exactly what Ms. Braddock said but Ms. Braddock was implying she could "really hurt" Resident A if she wanted to. Resident A stated she is blind so she cannot see if there are marks or bruises on her arm, but her arm is still bothering her. She stated she has not asked for and does not feel that she needs medical treatment. She stated she does not recall another time that she was mistreated by a DCW and believes there was only one incident.

Resident A showed me where her arm hurt. I did not observe swelling, marks, or bruises. However, Resident A had numerous spots of discoloration and dry patches of skin on her arm. Having not met Resident A before, I could not determine whether her skin was atypical at this time.

I interviewed Ms. Milanowski and Mr. Book in Mr. Book's office. They both reported once they were aware of the allegation, Ms. Braddock was immediately taken off the

schedule pending an internal investigation. Ms. Milanowski stated through their internal investigation they found sufficient evidence to end Ms. Braddock's employment. Ms. Milanowski presented a photograph that she reported was of Resident A's arm the day after the allegations were reported. The photograph appeared consistent with Resident A's arm as I observed it. In the photo, clear indentations that appeared consistent with adult fingers and being grabbed were observed in the same area Resident A showed me when I interviewed her.

Ms. Milanowski stated Resident A is not always a reliable historian and she hallucinates at times. She stated all the residents in the home were interviewed regarding their care after Resident A reported these allegations. She stated Resident B reported Ms. Braddock was rude to him, intentionally put quilts over his feet after he requested that she not do that and then would not assist him with removing them when he could not, and "flicked his ears" which Relative B confirmed witnessing. She stated Resident B is a reliable historian. Mr. Book stated Relative B did not report witnessing Ms. Braddock flicking Resident B's ears prior to their investigation and while Ms. Braddock may have intended to be playful, it was not appropriate behavior from a DCW.

Ms. Milanowski stated Ms. Braddock denied the allegation. She stated she was intentionally vague about why she was interviewing Ms. Braddock and did not list the gender of the resident she was calling about, but Ms. Braddock knew it was Resident A. She stated Ms. Braddock has since stated she has a learning disability and needs to be interviewed with an advocate. She stated Ms. Braddock completed her medical clearance at the time of hire and was medically cleared as suitable to provide direct care with no notes of having a learning disability or needing an advocate with her.

Mr. Book stated there was one previous incident on 9/11/25, when Resident A reported "rough handling." He stated they investigated these allegations with cooperation from Resident A's hospice team and Relative A. He stated Resident A was observed by the staff completing her shower and no marks or bruises were found. Resident A could not report which DCW was involved in this alleged incident and due to Resident A being a poor historian, there was insufficient evidence to support that allegation.

On 9/25/25, I placed a phone call to Ms. Braddock who reported she was not comfortable speaking with me without having an advocate. She clarified she would like her mother to be present for a phone interview. She stated she is able and willing to answer questions herself. She stated her mother was not available now, but she would place a return call when her mother is available.

On 9/25/25, I received a return phone call from Ms. Braddock's mother. I inquired if Ms. Braddock was present and Ms. Braddock announced her presence in the background. I began asking Ms. Braddock questions and Ms. Braddock's mother responded to the questions. I advised since Ms. Braddock was a DCW in this home

and named in this allegation and her mother is not; I needed to hear Ms. Braddock's responses, not her mother's. Ms. Braddock stated she did not understand my questions and wanted her mother to respond. I advised her she could tell me if she did not understand my question, would like me to rephrase, or if she was not comfortable answering a question, but if her mother was going to speak to me and she was not, we could end the interview.

Ms. Braddock agreed to speak to me herself. Throughout the interview, she took long pauses before responding, and Ms. Braddock's mother interrupted Ms. Braddock to provide a different answer than Ms. Braddock was providing or redirect her response. Ms. Braddock's mother also responded to me before Ms. Braddock could and provided her own leading answer that Ms. Braddock then repeated.

I asked Ms. Braddock if she knew of an incident involving Resident A. Ms. Braddock stated she was accused of grabbing Resident A's arm when she was transferring her but that did not occur. She stated she was caring for Resident A that day and no incident occurred. She stated she transferred Resident A and placed Resident A's arm on a bar on Resident A's Sara Lift. She denied being mad, forcefully placing Resident A's arm on the bar, grabbing her arm, or threatening her. I inquired if she witnessed any marks, swelling, or bruising on Resident A's arm that day and she stated, "No, because I already told you I didn't do it." I advised that I was not accusing her, I was inquiring if it was possible there was an injury that occurred elsewhere, and she may have noticed it since she was caring for Resident A that day. She denied seeing or knowing how Resident A obtained a handprint shaped injury on her arm that day.

Ms. Braddock stated she had only touched Resident B's ear to remove his hearing aids at the request of his family so that he did not pull on the hearing aid antennae at night. She denied knowing why Resident B or Relative B would report her flicking his ears because that did not occur. She denied being rude to any resident. She stated, "Last week (Resident B) called me a bitch and I never even retaliated against him."

On 9/25/25, I exchanged emails with Ms. Wallace. She stated she still needed to interview Ms. Braddock but would be doing so with law enforcement. I discussed my interview with Ms. Braddock and my investigation.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or

	physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Resident A reported Ms. Braddock forcefully grabbed her arm and threatened to harm her. Ms. Milanowski presented a photograph of Resident A's arm she reported was taken the day after the incident. Indentations consistent with adult fingers and being grabbed were visible on Resident A's arm in the photograph. Ms. Milanowski and Mr. Book reported investigating the allegations and Resident A and Resident B both reported mistreatment by Ms. Braddock, so her employment was terminated. Ms. Braddock reported she assisted Resident A that day, transferred Resident A, and placed Resident A's arm on a bar on her lift. Ms. Braddock denied grabbing, injuring, or threatening Resident A or mistreating Resident B. Based on the interviews completed and photo observed, there is sufficient evidence that Resident A was mistreated when her arm was grabbed leading to indentations in her arm and ongoing pain.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/25/25, I completed an exit conference with Mr. Book. I acknowledged that he was very transparent, ensuring that LARA became involved with the allegations immediately, and that he took the allegations seriously by immediately removing Ms. Braddock from the schedule. He expressed understanding that a rule violation occurred and agreed he would quickly complete a corrective action plan for the rule violation as corrective measures were already implemented.

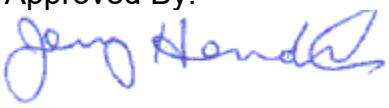
IV. RECOMMENDATION

Due to the receipt of an acceptable plan of corrective action, I recommend the status of the license remains the same.

Cassandra Duursma 09/26/2025

Cassandra Duursma Date
Licensing Consultant

Approved By:



09/29/2025

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Jerry Hendrick Date
Area Manager