



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

October 13, 2025

Jackline Andrew  
Epic Enterprising LLC  
Apt #326  
716 Idaho Ave  
Portage, MI 49024

RE: License #: AS390418237  
Investigation #: 2025A0578048  
Epic Home Care

Dear Jackline Andrew:

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 (517) 335-5985.

Sincerely,

A handwritten signature in black ink, appearing to read "Eli DeLeon". The signature is fluid and cursive, with a long horizontal stroke at the end.

Eli DeLeon, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(269) 251-4091

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS390418237
<b>Investigation #:</b>	2025A0578048
<b>Complaint Receipt Date:</b>	08/22/2025
<b>Investigation Initiation Date:</b>	08/25/2025
<b>Report Due Date:</b>	10/21/2025
<b>Licensee Name:</b>	Epic Enterprising LLC
<b>LicenseeAddress:</b>	Apt #326 716 Idaho Ave Portage, MI 49024
<b>Licensee Telephone #:</b>	(269) 330-2405
<b>Administrator:</b>	Jackline Andrew
<b>Licensee Designee:</b>	Jackline Andrew
<b>Name of Facility:</b>	Epic Home Care
<b>Facility Address:</b>	716 Idaho Ave Portage, MI 49024
<b>Facility Telephone #:</b>	(616) 528-0138
<b>Original Issuance Date:</b>	07/15/2024
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	01/15/2025
<b>Expiration Date:</b>	01/14/2027
<b>Capacity:</b>	4
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A was improperly restrained in his wheelchair.	Yes

**III. METHODOLOGY**

08/22/2025	Special Investigation Intake 2025A0578048
08/22/2025	APS Referral-Denied
08/25/2025	Special Investigation Initiated - On Site
08/25/2025	Unannounced investigation completed on-site- Interview with licensee designee Jackline Andrew.
08/25/2025	Contact-Documentation Reviewed- <i>Assessment Plan for AFC Residents</i> for Resident A, dated 07/15/2025.
08/25/2025	Contact-Documentation Reviewed- <i>AFC Licensing Division Incident / Accident Report</i> dated 08/19/2025.
08/25/2025	Exit Conference with licensee designee Jackline Andrew.
10/09/2025	Contact-Telephone with direct care staff Jakiya Nelson, unsuccessful.

**ALLEGATION: Resident A was improperly restrained in his wheelchair.**

**INVESTIGATION:**

On 08/22/2025, I received this complaint through LARA-BCHS-Complaints@michigan.gov. Complainant alleged that Resident A was sitting in a wheelchair, strapped with a gait belt and restrained. Complainant reported this facility has been educated multiple times to not use the gait belt as a restraint. Complainant reported direct care staff responded that they didn't know they couldn't use the gait belt in this way. Complainant reported Resident A was not observed demonstrating any behavioral concerns.

On 08/25/2025, I completed an unannounced investigation on-site at this facility and interviewed licensee designee Jackline Andrew regarding the allegations. Jackline Andrew confirmed the allegations and reported this incident occurred on 08/19/2025. Jackline Andrew reported direct care staff member Jakiya Nelson was new and it was her first day when a worker from occupational therapy had visited the facility.

Jackline Andrew confirmed that Resident A was observed sitting in his wheelchair while wearing a gait belt restraining him to the wheelchair. Jackline Andrew reported she reviewed this incident with direct care staff Jakiya Nelson who reported she was informed by one of the occupational therapists at the hospital that Resident A's gait belt could be used as long as it was loose fitting around Resident A and the wheelchair. Jackline Andrew acknowledged this information was not compliant with licensing rules. Jackline Andrew acknowledged that Resident A did not have a physician prescription for the use of a gait belt. Jackline Andrew was provided consultation on the use of assistive devices. Jackline Andrews added that the gait belt was removed from the facility even though she suspected this gait belt was provided by one of the occupational therapists that visited the facility. Jackline Andrew reported she informed the agency that provides occupational therapy to no longer bring gait belts to this facility.

While at the facility, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 07/15/2025. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A is unable to verbalize needs accurately and is a "high fall risk". The *Assessment Plan for AFC Residents* for Resident A documented that Resident A's only assistive devices are a wheelchair and shower chair.

While at the facility, I reviewed an *AFC Licensing Division Incident / Accident Report* dated 08/19/2025 and related to the allegations. The *AFC Licensing Division Incident / Accident Report* was completed by direct care staff Jakiya Nelson. The *AFC Licensing Division Incident / Accident Report* documented that on 08/19/2025, Resident A was wearing a "restraint" so that direct care staff Jakiya Nelson could "cook". The *AFC Licensing Division Incident / Accident Report* documented that direct care staff Jakiya Nelson was informed by a visitor to the facility that this practice was wrong and would be reported. The *AFC Licensing Division Incident / Accident Report* documented this restraint was removed from Resident A and licensee designee Jackling Andrew was notified.

<b>APPLICABLE RULE</b>	
<b>R 400.14308</b>	<b>Resident behavior interventions prohibitions.</b>
	<b>(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:</b> <b>(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.</b>

<b>ANALYSIS:</b>	Based upon my investigation, which consisted of interviews with licensee designee Jackline Andrew, as well as observations made during an unannounced investigation on-site and a review of pertinent documentation relevant to this investigation, direct care staff Jakiya Nelson restricted Resident A's movement when she used a gait belt and Resident A's wheelchair to immobilize Resident A while direct Jakiya Nelson engaged in another activity.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

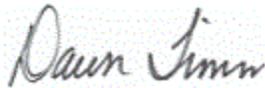


10/09/2025

Eli DeLeon  
Licensing Consultant

Date

Approved By:



10/13/2025

Dawn N. Timm  
Area Manager

Date