GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 22, 2026

Jasmine Boss
JARC
Suite 100
6735 Telegraph Rd
Bloomfield Hills, MI 48301

RE: License #: AS630012780
Investigation #: 2026A0626024
Pierce

Dear Ms. Boss:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (248) 972-9136.

Sincerely,

Sara Shaughnessy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 320-3721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630012780
Investigation #:	2026A0626024
Complaint Receipt Date:	05/21/2026
Investigation Initiation Date:	05/21/2026
Report Due Date:	07/20/2026
Licensee Name:	JARC
Licensee Address:	Suite 100 6735 Telegraph Rd Bloomfield Hills, MI 48301
Licensee Telephone #:	(248) 940-9617
Administrator:	Jasmine Boss
Licensee Designee:	Jasmine Boss
Name of Facility:	Pierce
Facility Address:	30339 Buttonwood Beverly Hills, MI 48025
Facility Telephone #:	(248) 940-2597
Original Issuance Date:	02/01/1993
License **Status:**	REGULAR
Effective Date:	12/27/2025
Expiration Date:	12/26/2027
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was given an overdose of insulin after a direct care staff member did not follow the directions regarding her insulin pump. She had to be hospitalized for stabilization.	Yes
Additional Findings	No

III. METHODOLOGY

05/21/2026	Special Investigation Intake 2026A0626024
05/21/2026	APS Referral A referral was not made to Adult Protective Services due to them already being involved.
05/21/2026	Special Investigation Initiated - Telephone I initiated the special investigation by completing a telephone interview with recipient rights specialist, Amber Oliver.
05/22/2026	Contact - Document Received I received, via email, Resident A's medication administration record, individual plan of service, and incident report from recipient rights specialist, Amber Oliver. Ms. Oliver also included training documents regarding Resident A's insulin pump and the poster that is on the wall in Resident A's bedroom, outlining the directions for changing the pump's cartridges.
05/26/2026	Contact - Face to Face I completed an unannounced onsite investigation at Pierce, with recipient rights investigator, Amber Oliver, and Adult Protective Services investigator, Anne Hauger. I completed an interview with the executive director, Shaindle Braunstein and Resident A.
05/27/2026	Contact - Telephone call made

	I completed a telephone interview with direct care services staff member, Alana Anderson.
06/04/2026	Contact - Face to Face I completed an in person interview with licensee designee, Jasmine Boss.
06/10/2026	Contact - Document Received I received emails from Amber Olivera nd Anne Hauger, indicating they are both substantiating in their investigations.
06/18/2026	Contact - Telephone call made I completed a telephone interview with Relative A1.
06/18/2026	Exit conference I completed an exit conference, via telephone, with licensee designee, Jasmine Boss.

ALLEGATION:

Resident A was given an overdose of insulin after a direct care staff member did not follow the directions regarding her insulin pump. She had to be hospitalized for stabilization.

INVESTIGATION:

On 05/21/2026, I received a complaint, via email, indicating Resident A suffered an insulin overdose and was hospitalized due to it. The overdose was caused by a direct care services staff member not following the direction while changing the cartridge on Resident A's insulin pump.

On 05/21/2026, I initiated the special investigation by completing a telephone interview with recipient rights specialist, Amber Oliver. Ms. Oliver stated that she was contacted the day before, by Shaindle Braunstein, informing her of the situation. She stated Ms. Braunstein told her that a staff member went to change Resident A's cartridge on her insulin pump and did not follow the posted protocol. The insulin pump is a new device for Resident A. Ms. Oliver explained that the home had posters regarding how to use the pump, and all staff members were trained by the pump manufacturer two times and participated in in-service training regarding proper usage. The pump is supposed to be disconnected from Resident A's body prior to

inserting the new cartridge, direct care staff member, Alana Anderson, failed to do this and Resident A ended up with an extra dose of insulin and was hospitalized at Royal Oak Beaumont Hospital. She explained that Resident A is a brittle diabetic and required hospitalization to stabilize her blood sugar. Adult Protective Services investigator, Anne Hauges, went to see Resident A in the hospital and she could not answer questions for her. Ms. Anderson is suspended and will most likely be terminated.

On 05/22/2026, I received an email from Ms. Oliver containing the incident report regarding Resident A. The report indicates that on 05/19/2026 at 11am, Resident A's insulin pump was empty when Alana Anderson was getting Resident A her lunch. It indicates it was changed and then Ms. Anderson proceeded to feed Resident A lunch. The pump was checked and was empty again. Ms. Anderson gave her two glucose tabs and called 911 and she was not taken to the hospital. It indicates later, Resident A's glucose levels were still low, and she was taken to the hospital.

On 05/26/2026, I completed an unannounced, onsite investigation at Pierce, with recipient rights investigator, Amber Oliver, and Adult Protective Services investigator, Anne Hauger. We completed an interview with executive director, Shaindle Braunstein. Ms. Braunstein informed us that Resident A is out of the hospital; she was admitted for approximately 36 hours. Ms. Braunstein stated that all staff members were trained in how to use Resident A's insulin pump, twice by a representative of the manufacturer and once by their nurse. She showed us the information sheet fixed to the wall, with step-by-step instructions for proper operation of the insulin pump. Ms. Braunstein explained that direct care staff member, Alana Anderson, was working with Resident A and had to change the cartridge in the pump. Ms. Braunstein stated that there is a phone with an application that comes with the pump which alerts them if the insulin needs to be changed and it shows the directions, step by step. She also stated that instructions show up on the pump itself, which makes the user answer questions prior to moving onto the next step, including the one stating to disconnect the pump. Ms. Anderson contacted the district manager and admitted that she thought she might have given Resident A too much insulin. The nurse educator was contacted, and Resident A's blood sugar levels were tested; she was at 55. Resident A was given two glucose tablets, according to her physician's instructions. They checked her blood sugar a little later and it was at 134, then 79. They contacted the pump manufacturer, and they told her that it could be that the pump was not disconnected prior to the change, which would give her an extra dose. Ms. Anderson admitted that she had not disconnected the pump and had bypassed the instructions on the pump, that asked if she had completed each step before showing the next one. They had to call 911 and after they assessed her, they transported Resident A to the hospital. Ms. Braunstein stated that Ms. Anderson could have called the nurse or anyone in management if she was confused regarding the process, as the machine instructs the person changing the cartridge to disconnect it prior to changing it. Human Resources informed Ms. Anderson that she is suspended, pending investigation, and Ms. Braunstein has already retrained all staff on the proper usage of the insulin pump.

On 05/26/2026, I completed a private face to face interview with Resident A. Resident A could only answer yes or no questions. She answered yes to being in the hospital last week and feeling sick. She indicated she feels safe in the home. Resident A then started singing songs from The Sound of Music and was done talking.

On 05/27/2026, I completed a telephone interview with direct care services staff member, Alana Anderson. Ms. Anderson stated it was the first time she changed the cartridge for Resident A's insulin pump, 05/19/2026, the day Resident A went to the hospital. Around 11am, Resident A's pump started beeping, indicating it needed to be changed. She attempted to change it and answered the questions. She stated she thought she had completed the steps properly and took Resident A to the dining room to feed her lunch. The monitor alerted her again that the cartridge was empty. She called the nurse and 911. Paramedics came to the home and checked Resident A, who looked fine and they left. Later, she called the nurse about the pump, as she didn't want to mess with it again. She then contacted the manufacturer, who told her to call 911 again. She thinks she might have pushed the button too much, as the vial should last around two days, and the one she had put in was empty after lunch. She stated she was supposed to disconnect the pump by taking the tubing out, taking the vial out, then follow the steps on the monitor to put in the new one. She admitted to not disconnecting it. She admitted to having participated in the training, as it was mandatory for all staff members, but she believes they needed more training, specifically hands-on training. She feels bad for Resident A and is happy she made it through.

On 06/04/2026, I completed an in-person interview with licensee designee, Jasmine Boss, while at another home owned by the corporation. Ms. Boss stated that, from her understanding, Pierce had an additional training today regarding Resident A's insulin pump. She stated all staff went through the training and the routine for changing the insulin. She believes Ms. Anderson bypassed the system by not answering the prompts correctly. She stated that Ms. Anderson is still suspended and is not on any schedule at this time.

On 06/10/2026, I received an email from recipient rights specialist, Amber Oliver, indicating she is substantiating on her investigation for Neglect II. I also received an email from Adult Protective Services investigator, Anne Hauger, indicating she is substantiating for neglect.

On 06/18/2026, I completed a telephone interview with Relative A1. Relative A1 denied having any prior concerns regarding the care of Resident A. She stated that Resident A has been at Pierce since 1993, and it is her home. Resident A is happy there and is well cared for, spoiled even. She informed me that the staff member who made the mistake is gone and the remaining staff are conscientious and follow directions. In her opinion, they are good at making sure that any staff members who are not a good fit are terminated from the home. She feels that Ms. Anderson's

intentions were good and she made a serious error, but she did respond appropriately after she realized what had happened. She stated Resident A got the extra insulin out of her system and is doing fine now.

On 06/18/2026, I completed an exit conference with licensee designee, Jasmine Boss. Ms. Boss was informed of the findings and indicated she understood. She informed me that she has done two additional trainings with staff regarding Resident A's insulin pump. Ms. Anderson is still suspended and Ms. Boss stated it is possible she has been, or will be, terminated.

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:	Based on the information gathered during my special investigation, it has been determined that Resident A's medication was not given as prescribed or ordered. Resident A was given an extra dose of insulin due to direct care staff member, Alana Anderson, not following the directions regarding Resident A's insulin pump. The directions indicated that the pump is supposed to be disconnected prior to a new cartridge being inserted, due to a potential for too much to be given during the change out. All staff members were trained on the use of the pump and there are instructions, not only in the home, but that show up on the pump itself, to ensure it is done correctly. Ms. Anderson admitted to making the error and due to it, Resident A had to be hospitalized to stabilize her blood sugar levels.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no changes to the license.

06/18/2026

Sara Shaughnessy — Date
Licensing Consultant

Approved By:

For 06/22/2026

Denise Y. Nunn — Date
Area Manager