STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

February 26, 2025

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

RE: License #: AL700397745
Investigation #: 2025A0467025
AHSL Jenison Maplewood

Dear Mr. Book,

Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan was required. On 02/25/2025, 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) 356-0183.

Sincerely,

Anthony Mullins

Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397745
Investigation #:	2025A0467025
Complaint Receipt Date:	02/24/2025
Investigation Initiation Date:	02/24/2025
Report Due Date:	04/25/2025
Licensee Name:	AH Jenison Subtenant LLC
Licensee Address:	Ste 1600 1 Towne Sq Southfield, MI 48076
Licensee Telephone #:	(248) 203-1800
Administrator:	Jonathan Book
Licensee Designee:	Jonathan 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:	09/11/2023
Expiration Date:	09/10/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
On 2/20/25, staff member Pamela Berridge was verbally abusive to Resident A.	Yes

III. METHODOLOGY

02/24/2025	Special Investigation Intake 2025A0467025
02/24/2025	Special Investigation Initiated - Telephone
02/25/2025	Inspection Completed On-site
02/25/2025	Exit conference
02/25/2025	Contact – document received
02/26/2025	APS Referral

ALLEGATION: On 2/20/25, AFC staff member Pamela Berridge was verbally abusive to Resident A.

INVESTIGATION: On 2/24/25, I spoke to licensee designee, Jonathan Book via phone. Mr. Book informed me that staff member, Pamela Berridge was observed by staff member, Izabella Gingrich being verbally abusive to Resident A. Specifically, Ms. Berridge reportedly told Resident A, "I'm not doing this with you again tonight. What you're seeing is not real." Resident A was reportedly experiencing visual hallucinations, which led to her pulling the call light for assistance. It was noted that as Ms. Berridge was leaving Resident A's room, she silenced Resident A's call light, turned the lights out in the room, and slammed her door. Per Mr. Book, staff member Ms. Gingrich reported this to the on-call supervisor, and Ms. Berridge was removed from the facility and placed on administrative leave. I informed Mr. Book that I will be to the facility tomorrow to conduct my investigation.

On 2/25/25, I made an announced onsite investigation facility. Upon arrival, introductions were made with staff and they assisted me to Resident A's room. After knocking on the door, Resident A allowed entry into her room and agreed to discuss the allegation. It should be noted that Resident A's daughter was present for the conversation via phone. This past Thursday (02/20/25), Resident A confirmed that she was having visual hallucinations when an a staff member came inside her room and said, "I don't want to hear any more about it. Shut up about it and let's go on." Resident A stated that the staff member then slammed the door on her way out of the room and that was the last time she saw her. Resident A was unable to recall the staff member's name, but she added that this same staff member came in her room approximately 1 month ago and told her, "we aren't going to talk about it," again

referring to the visual hallucinations that she was dealing with at the time. Resident A was adamant that this staff member is the only person that has treated her this way. Resident A was thanked for her time as this interview concluded.

After speaking to Resident A, I made my way to the office of licensee designee, Jonathan Book. Present in the room with Mr. Book was the wellness director, Brandy Milanowski. Mr. Book and Mrs. Milanowski informed me that they have tried to interview staff member Pamela Berridge regarding this incident. However, she has not answered or returned their calls. Mr. Book informed me that Ms. Berridge will be terminated effective today due to her actions towards Resident A. Mr. Book provided me with a copy of staff member, Izabella Gingrich's statement regarding what she observed on the night in question. Ms. Gingrich's statement indicated that she heard Ms. Berridge tell Resident A, "stop it, I am not doing this with you tonight" while turning her lights off and closing the door. Ms. Gingrich went to check on Resident A and observed her, "crying, shaking, and hyperventilating about what happened." Ms. Gingrich was able to console Resident A during this time. Mrs. Milanowski informed me that the day after this incident occurred (02/21/25), she held an in-service training for all staff members throughout the American House Jenison campus on all different forms of abuse and how to treat residents. Mrs. Milanowski showed me copies of all staff members signing-off on completing the training.

While onsite, I conducted an exit conference with licensee designee, Mr. Book. Mr. Book shared that he would complete the corrective action plan (CAP) today, which will include language regarding the staff completing additional training and Ms. Berridge being terminated.

On 2/25/25, I received an acceptable corrective action plan from Mr. Book that included the information listed above.

APPLICABLE RULE	
R 400.15305	**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:	Mr. Books, Mrs. Milanowski, Ms. Gingrich, and Resident A all confirmed that staff member Pamela Berridge was verbally abusive towards Resident A on 2/20/25. Therefore, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no changes to the current license status.

02/26/2025

Anthony Mullins Date
Licensing Consultant

Approved By:

02/26/2025

Jerry Hendrick Date
Area Manager