GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 6, 2025

Christina Sanders
JC Assisted Living II LLC
250 Monroe Ave. NW Suite 400
Grand Rapids, MI 49503

RE: License #:	AS410417567
Investigation #:	2025A0356036
	JC Assisted Living II

Dear Ms. Sanders:

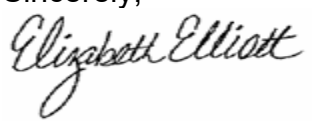
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410417567
Investigation #:	2025A0356036
Complaint Receipt Date:	04/17/2025
Investigation Initiation Date:	04/17/2025
Report Due Date:	06/16/2025
Licensee Name:	JC Assisted Living II LLC
Licensee Address:	250 Monroe Ave. NW, Suite 400 Grand Rapids, MI 49503
Licensee Telephone #:	(616) 500-2190
Administrator:	Christina Sanders
Licensee Designee:	Christina Sanders
Name of Facility:	JC Assisted Living II
Facility Address:	631 3 Mile Rd. NE Grand Rapids, MI 49505
Facility Telephone #:	(616) 278-3868
Original Issuance Date:	09/07/2023
License Status:	REGULAR
Effective Date:	03/07/2024
Expiration Date:	03/06/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff at the facility failed to provide Resident A with proper supervision and protection.	No
Additional Findings	Yes

III. METHODOLOGY

04/17/2025	Special Investigation Intake 2025A0356036
04/17/2025	Special Investigation Initiated - Telephone Michael Kuik, Network 180, ORR and Jeannie Haff, Network 180 ORR.
04/21/2025	APS Referral Centralized Intake referral made.
04/21/2025	Contact - Telephone call received Brett Kortman, APS, DHHS, Kent County.
04/24/2025	Inspection Completed On-site
04/24/2025	Contact - Face to Face Christina Sanders, Licensee, Jeannie Haff, Network 180 ORR, Michael Kuik, Network 180, ORR. Kylee Noffsinger, DCW.
04/24/2025	Contact - Telephone call made Resident A's legal guardian, Kristina Begley.
04/24/2025	Contact - Document Received Facility documents reviewed.
05/20/2025	Contact-Document Received Grand Rapids Police Report
05/21/2025	Contact-Document sent Email to C. Sanders requesting the IR.
05/28/2025	Contact-Telephone call made Ms. Begley, Ms. Sanders and Ms. Noffsinger.
05/29/2025	Contact-Face to Face Kaylee Noffsinger, DCW. Resident A.

06/05/2025	Exit conference-Christina Sanders, Licensee.

ALLEGATION: Staff at the facility failed to provide Resident A with proper supervision and protection.

INVESTIGATION: On 04/17/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported that on 04/07/2025, Resident A presented to Spectrum Butterworth ED (emergency department) for cold exposure via EMS (emergency medical services). Resident A was found on the side of a busy road, unresponsive, her body temperature was 93.1, breathing was normal, and vital signs were stable. The complainant reported Resident A wandered away from her Adult Foster Care home and it is unknown how long she had been missing.

On 04/17/2025, I followed-up and coordinated with Michael Kuik and Jeannie Haff, Office of Recipient Rights, Network 180 (Kent County community mental health) to meet at the facility for a joint investigation.

On 04/21/2025, I interviewed Brett Kortman, Kent County Department of Health and Human Services (DHHS) Adult Protective Services (APS) worker via telephone. Mr. Kortman stated Resident A has a guardian and has been in-patient at Trinity Health PMU (psychiatric medical unit) since the incident and has not been back to the AFC facility. Mr. Kortman stated Network 180 changed Resident A's medications and Resident A did not responded well to those medication changes. Mr. Kortman stated on the evening of 04/06/2025 or early in the morning hours of 04/7/2025, Resident A left the facility. As soon as staff at the facility discovered Resident A was gone, they called law enforcement, and the guardian. Mr. Kortman stated the Walker Police Department found Resident A at an unknown location. Mr. Kortman stated Resident A told staff that she wanted to leave on the evening of 04/06/2025 but staff redirected and talked her out of leaving. However, in the morning when staff checked on her, it appeared as though she was still in bed, under the covers, but later when Resident A did not come out of her room for breakfast, staff checked under the bed covers and discovered that Resident A was not there. Mr. Kortman stated he interviewed Resident A's guardian, Kristina Begley, who reported staff acted appropriately and contacted the proper authorities as soon as they discovered Resident A was missing. Mr. Kortman stated Ms. Begley reported that Resident A's medication changes caused "out of the norm" behaviors for Resident A and she attributed this incident to that.

On 04/24/2025, I conducted an inspection at the facility and interviewed Christina Sanders, Licensee, with Mr. Kuik and Ms. Haff from Network 180. Ms. Sanders stated Resident A can be in the community without staff supervision. Ms. Sanders called Kristina Begley, guardian and Ms. Begley joined the conversation via telephone. Ms. Begley stated the Walker PD found Resident A approximately 4 miles away from the facility and called EMS. Ms. Begley stated Resident A was lying

on her back and was able to tell the police her name. Ms. Sanders stated staff, Kaylee Noffsinger, was working on the date Resident A left the facility. Ms. Sanders stated that Ms. Noffsinger checked on Resident A early in the morning on 04/07/2025 and reported it appeared that Resident A was under the blankets in her bed. Ms. Sanders stated that Ms. Noffsinger made breakfast and went to get Resident A at approximately 7:30a.m.-8:00a.m. on 04/07/2025 and Resident A was not in bed nor was she in the facility. Ms. Sanders stated it is unknown how long Resident A had been gone. Ms. Begley and Ms. Sanders stated Resident A does not have a history of eloping and this was out of the ordinary for her to leave the facility. Ms. Begley stated Resident A mentioned she wanted to leave the facility on 03/04/2025 after she had been inpatient at Trinity Health PMU. Staff redirected her at that time, and Resident A never made any attempt to leave the facility.

Ms. Begley and Ms. Sanders stated they have been trying to get Resident A back to her baseline and reported a large part of the issue began when Network 180 stopped Resident A's medication, Clozaril on 02/24/2025. Ms. Begley and Ms. Sanders reported Resident A began to exhibit serious psychotic signs and they tried unsuccessfully to get help for her. Ms. Begley stated on 02/25/2025, 02/26/2025, 02/27/2025 she and Ms. Sanders called Network 180 and asked about a lab blood draw for a Clozaril level check and were told Resident A does not need one at that time. However, on 02/28/2025, Network 180 called and told Ms. Begley that Resident A required a lab draw as soon as possible and Ms. Begley stated on 02/28/2025, Clozaril labs were done on Resident A. Ms. Begley reported on 03/01/2025, 03/02/2025, 03/03/2025 and 03/04/2025, she (Ms. Begley) and Ms. Sanders called Network 180, spoke to the nurse, Jamie Gortsema and reported that Resident A's condition was deteriorating and asked about getting Resident A back on the medication Clozaril. Ms. Begley stated Ms. Gortsema told her there was no lab draw done and until a lab draw was completed, they could not restart the medication. Ms. Begley stated she told Ms. Gortsema that the labs were completed on 02/28/2025 and when Ms. Gortsema called back on 03/04/2025, she said Resident A's Clozaril levels were very low and they needed to start the medication again right away. Ms. Begley stated however, on 03/04/2025, Resident A was already at Trinity PMU because her psychiatric condition had deteriorated to the point that she required hospitalization. Ms. Begley stated Resident A was transferred to Pine Rest on 03/05/2025 and the psychiatrist at Pine Rest reported that Resident A should never have been taken off Clozaril.

Ms. Begley and Ms. Sanders reported on 04/02/2025, Resident A returned to the AFC home from Pine Rest on a medication comparable to Clozaril and things seemed to be better. However, on 04/03/2025, Ms. Begley stated Resident A began talking to voices loudly and to decompensate. On 04/05/2025 and 04/06/2025, Resident A continued to talk to voices, flailing her arms and yelling. Ms. Begley stated on 04/07/2025, Ms. Sanders called Network 180 to report issues with Resident A and was told she needed to make an appointment. Ms. Begley stated on 04/06/2025 or 04/07/2025 Resident A walked away from the facility without staff knowledge at an unknown time. Ms. Sanders stated Grand Rapids Police were

notified immediately when they discovered Resident A was missing and an IR (incident report) written. Ms. Begley and Ms. Sanders reported Resident A was found by the Walker Police Department approximately 4 miles away from the facility and taken to Corewell Health Butterworth hospital. Ms. Sanders stated at 10:00a.m. on 04/07/2025, the Walker Police called her to inform her they had found Resident A, and she was now in the hospital, and they were at the hospital with her while she was getting tests done. Ms. Begley stated after they were done evaluating Resident A, the hospital called her for discharge and Ms. Begley stated she pleaded with them to keep Resident A but they discharged her back to the AFC.

Ms. Begley reported that on 04/12/2025, Ms. Sanders called her and reported that Resident A was doing very poorly so Ms. Begley went to the facility and Resident A locked herself in her room. Ms. Begley stated she talked to Resident A, calmed her down, she took her medications and things seemed to be better when she (Ms. Begley) left.

Ms. Begley stated on 04/13/2025, Ms. Sanders again called her (Ms. Begley) and reported that Resident A was again locked in her room, yelling and cussing. Resident A would not open the door or take her medications. Ms. Sanders stated she called 911 and sent Resident A to the hospital again and GRPD arrived also. Resident A went to Trinity Health PMU and they tried to send Resident A back to the facility but eventually Resident A was evaluated by a psychiatrist and admitted and remains there at this time.

Ms. Begley and Ms. Sanders stated Resident A had never left or tried to leave the facility without staffs' knowledge in the past. Ms. Begley and Ms. Sanders stated even after she said she wanted to leave; she did not make any attempt to leave the facility. Ms. Begley added that Ms. Sanders made sure Resident A had blood draws every 28 days as required for Clozaril, and that Ms. Sanders never missed an appointment, Ms. Haff confirmed.

On 04/24/2025, Mr. Kuik, Ms. Haff and I briefly interviewed Kylee Noffsinger, Direct Care Worker at the facility. Ms. Noffsinger acknowledged that she was a new direct care staff at the facility and confirmed she was working on the date Resident A left the facility. Ms. Noffsinger stated on the morning of 04/07/2025, she went into Resident A's room, saw a lump in Resident A's bed and thought she was in bed. Ms. Noffsinger stated she made breakfast and went back to the room to get Resident A when she did not come out for breakfast and realized the lump in the bed was blankets and bedding and that Resident A was not in the facility. Ms. Noffsinger stated she notified Ms. Sanders immediately, 911 was called, and Ms. Begley notified. Ms. Noffsinger stated in the time she has worked at the facility Resident A had not shown exit seeking behavior nor has she tried to leave the facility unattended.

On 04/24/2025, I reviewed Resident A's assessment plan for AFC residents. The assessment plan is dated 11/29/2024 and signed by Ms. Begley and Ms. Sanders.

The assessment plan documented Resident A moves independently in the community and does not indicate that Resident A required increased supervision while in the community. The assessment plan documented Resident A is alert to her surroundings and documented her physical exercise as walking. There is no information documented in the assessment plan that Resident A required “eyes on” or any form of enhanced supervision. There is no information documented on the assessment plan that Resident A posed a risk or had a history of elopement from the facility.

On 04/24/2025, I reviewed Resident A’s Individual Plan of Service (IPOS), dated 02/04/2025. Network 180 staff Dorie Sullivan is documented as the “recorder” and case manager, attendees to the IPOS meeting on 01/29/2025 are documented as “Kristina” and listed as the AFC manager but there is no last name on the document leaving it unknown as to whether this is Christian Sanders, the licensee and AFC manager or Kristina Begley, the legal guardian and Resident A. The IPOS is signed by Ms. Sullivan and Ms. Begley on 02/12/2025.

The IPOS documented Resident A’s diagnosis as, schizoaffective disorder (depressive type) and generalized anxiety disorder. The IPOS documented *‘(Resident A’s) health/safety in the community, (Resident A) is unable to be in the community independently. (Resident A) is unable to navigate the community, she will become disoriented, lost, and will not ask for help. AFC staff will support (Resident A) in navigating the community, safely, including traveling, crossing the street, and speaking with strangers.’* There is no information documented in the IPOS that Resident A required “eyes on” or enhanced supervision. In addition, there is no information documented on the IPOS that Resident A posed a risk or had a history of elopement.

On 05/20/2025, I reviewed the Grand Rapids Police Department report dated 04/07/2025, written by Officer John Wetzel. The report documented the following information, ‘*I was dispatched 631 3 Mile Rd NE, JC Assisted Living, for a missing person. I met with Kaylee Noffsinger who works there. She said that (Resident A), who has dementia, had left the residence without permission. (Resident A) had tried to leave last night, but was told she couldn’t leave. (Resident A) wanted to go see her boyfriend. She was last seen around midnight wearing red and white checkered pajama bottoms. Kaylee went to (Resident A’s) room to wake her for breakfast this morning and found (Resident A) was gone. I asked Kaylee if (Resident A) has ever walked away before, and she said she didn’t know much about (Resident A) because she is a new worker there. I was given the manager’s information for the residence, and I called Christina Sanders. Christina said (Resident A) has a boyfriend named Rick, and he would pick her up on prior occasions. She said that (Resident A) could care for herself but is very gullible. (Resident A) is allowed to leave the residence but must let the staff know where she is going. I tried to call Rick but there was no answer.*

I contacted Radio to make a tissue (sic) and LEIN entry for (Resident A). I also made a radio broadcast. Sgt Dionne was notified, and I checked the nearby Riverside Park since the river was at flood stage. The area surrounding the residence was also checked. I was then notified by dispatch that Walker PD had picked her up earlier this morning and that (Resident A) was currently at Butterworth Hospital (see their report 3370-2025). I contacted Radio and let them know the missing was located. I called Christina and let her know of (Resident A's) whereabouts.'

On 05/29/2025, I conducted an unannounced inspection at the facility and was able to observe Resident A in her bed at the home. Ms. Noffsinger acknowledged that Resident A is not to be without staff supervision while out in the community and stated Resident A likes to sit outside, and Ms. Noffsinger stated she supervises Resident A when she sits outside.

On 06/05/2025, I conducted an exit conference with Christina Sanders, Licensee via telephone. Ms. Sanders agreed with the information, analysis, and conclusion of this applicable rule.

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:	The complainant reported on 04/07/2025 Resident A wandered away from the facility, was found by the side of the road and hospitalized with exposure to the cold. Resident A's assessment plan documented Resident A can be independent in the community. It includes no information that indicated Resident A required "eyes on" or any form of enhanced supervision. There is no information that indicated Resident A was an elopement risk. Resident A's IPOS through Network 180 documented Resident A cannot be independent in the community and must always be with staff for safety reasons. There is no information documented that Resident A required "eyes on," any form of enhanced supervision or that Resident A was an elopement risk. Ms. Noffsinger, Ms. Begley and Ms. Sanders stated Resident A has not exhibited exit seeking behaviors in the past, she has no history of elopement, nor has she left the facility without staff knowledge prior to this incident.

	Resident A's IPOS indicated Resident A cannot be alone in the community without supervision, yet the assessment plan documented the opposite, that Resident A was capable of being independent in the community however, neither document addressed the need for increased supervision of Resident A or that she was an elopement risk. It was determined through this investigation that Resident A's protection and safety needs were met by staff at the facility, according to her assessed needs, and therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION: On 04/24/2025, I requested a copy of the IR for Resident A's elopement from the facility from Ms. Sanders during the inspection and interviews at the facility. Ms. Sanders stated she would send a copy of the IR to me as she did not have it on hand at the time.

On 05/21/2025, I emailed Ms. Sanders and requested the IR. Ms. Sanders responded and asked for the date of the incident so she could locate the IR. I emailed her with the date of 04/07/2025.

On 06/02/2025, to date, I have not received the IR from Ms. Sanders detailing the events that occurred on 04/07/2025 when Resident A eloped from the facility.

On 06/03/2025, I spoke to Gina Green, Resident A's supports coordinator through Network 180. Ms. Green stated she never received an IR from Ms. Sanders detailing the elopement incident that occurred on 04/07/2025 with Resident A.

On 06/05/2025, I conducted an exit conference with Christina Sanders, Licensee. Ms. Sanders stated she forgot to send the IR and stated she understood the information, analysis, and conclusion of this applicable rule violation. Ms. Sanders stated she will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:

	(b) Any accident or illness that requires hospitalization.
ANALYSIS:	I requested a copy of the IR on 04/24/2025 during an inspection at the facility and then again on 05/21/2025 and as of the date of this report, an IR has not been provided to the Department for review and, an IR was not submitted to Resident A's responsible agency, Network 180. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

06/06/2025

Elizabeth Elliott Date
Licensing Consultant

Approved By:

06/06/2025

Jerry Hendrick Date
Area Manager