GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 26, 2025

Steven Gerdeman
Serenity Homes - North, L.L.C.
747 Tamarack Ave NW
Grand Rapids, MI 49504

RE: License #: AL700382076
Investigation #: 2025A0467036
Serenity Homes - North

Dear Mr. Gerdeman:

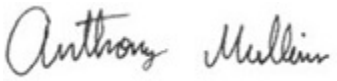
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. 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,



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 #:	AL700382076
Investigation #:	2025A0467036
Complaint Receipt Date:	04/28/2025
Investigation Initiation Date:	04/28/2025
Report Due Date:	06/27/2025
Licensee Name:	Serenity Homes - North, L.L.C.
Licensee Address:	747 Tamarack Ave NW Grand Rapids, MI 49504
Licensee Telephone #:	(419) 494-4008
Administrator:	Steve Gerdeman
Licensee Designee:	Steve Gerdeman
Name of Facility:	Serenity Homes - North
Facility Address:	830 Hayes Street Marne, MI 49435
Facility Telephone #:	(616) 677-6015
Original Issuance Date:	06/02/2016
License Status:	REGULAR
Effective Date:	09/26/2024
Expiration Date:	09/25/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
On 4/25/25 at approximately 2:40am, Resident A was reportedly hit by a vehicle. It is unknown if staff knew of his whereabouts.	No
Additional Findings	Yes

III. METHODOLOGY

04/28/2025	Special Investigation Intake 2025A0467036
04/28/2025	APS Referral Complaint received from Ottawa County APS worker, Emily Fewless
04/28/2025	Special Investigation Initiated - Letter Via email with APS worker Emily Fewless
04/28/2025	Contact – telephone call made to Resident A's guardian, Robert Thorndill
04/28/2025	Contact – Face to Face
04/28/2025	Inspection Completed On-site
04/28/2025	Contact – telephone call made to AFC staff member, Briendon Stevens
05/01/2025	Contact – telephone call made to Detective Dewitt with the Ottawa County Sheriff's Department
05/07/2025	Contact – telephone call made to AFC staff member, Gabe Nanney
06/26/2025	Exit conference with Jess Engstrom, Chief Operations Officer on behalf of licensee designee, Steve Gerdeman.

ALLEGATION: On 4/25/25 at approximately 2:40am, Resident A was reportedly hit by a vehicle. It is unknown if staff knew of his whereabouts.

INVESTIGATION: On 4/28/25, I received a complaint from Ottawa County Adult Protective Services (APS) worker, Emily Fewless. The complaint alleged that on 4/25/25 at approximately 2:40am, Resident A was found lying down on the side of highway I-96 near exit 24 in Marne. Resident A reported that he was hit by a vehicle

while walking back from the gas station to buy cigarettes and soda for another resident. It is unknown if home staff knew of his whereabouts.

On 4/28/25, I spoke to Ms. Fewless with Ottawa County APS via email. Ms. Fewless stated that she spoke to Resident A at the hospital and he stated that he was "whacked" by a vehicle while returning to the home from the gas station. Ms. Fewless emailed me police reports regarding this incident. The initial report stated that law enforcement was dispatched at approximately 2:40am to reports of a male moving an object around on the highway. Police arrived and noticed a male on the shoulder of the roadway, who was identified as Resident A. Resident A disclosed to police that he was hit by a vehicle while trying to get home. Resident A expressed some pain in his back and he was transported to Trinity Health Hospital in Grand Rapids. The police report indicated that Resident A informed law enforcement that another resident asked him to go buy cigarettes and a soda from the gas station. Law enforcement conducted a search of the area and did not find any evidence of Resident A being struck by a vehicle. The police report indicated that the way Resident A's property (wallet) was set down, "it appears that he may have gotten tired from walking and laid down to take a rest."

A supplemental report was completed by Ottawa County Sheriff's Department on the same day, indicating that law enforcement interviewed a nurse at Trinity Health Hospital. The nurse stated that Resident A "has significant rash/abrasions from a vehicle" on his body. The nurse informed law enforcement that she believed Resident A was hit by a "significant force." The nurse also stated that Resident A has internal bleeding and it is possible he could have died if no one had found him.

On 4/28/25, I spoke to Robert Thorndill, guardian for Resident A. Mr. Thorndill confirmed that Resident A is his ward and he is aware of the recent incident involving Resident A being out of the home in the middle of the night, resulting in Resident A reportedly being hit by a vehicle. Mr. Thorndill stated that he is concerned because he was told by staff members that residents have a 9:00pm curfew that coordinate with staff completing bed checks on residents. Despite this, Resident A was able to get out of the home to walk to the local gas station. Mr. Thorndill stated that after being informed that Resident A was hit by a vehicle, he visited him at the Trinity Health Hospital and "nothing was broken, but he was bruised and shaken up" from the incident. Mr. Thorndill stated that Resident A informed him that he left the home to go to the gas station in the middle of the morning because "he was bribed" by another resident to go purchase soda and cigarettes. Mr. Thorndill stated that he told Resident A that he has the right to tell other residents no and he isn't forced to go anywhere or do anything for anyone. Mr. Thorndill stated that the owner, Steve Gerdeman informed him that staff are prohibited from locking the doors. I confirmed this with Mr. Thorndill and explained that adult foster care homes are structured as a least restrictive environment. Therefore, residents can leave the home when they want. I informed Mr. Thorndill that from the initial police report, law enforcement has not been able to find any

evidence of an accident occurring. At this time, it is unknown exactly what occurred, but law enforcement is still investigating.

At the time of this call, Mr. Thorndill shared that Resident A remains in the hospital and the medical team is working to determine if Resident A will return to the home or if he will need to be admitted to a rehab facility first. Mr. Thorndill confirmed that prior to this incident, he has not had any restrictions on Resident A being able to move throughout the community. Mr. Thorndill is reconsidering this although Resident A has been at the home for years without an incident. Mr. Thorndill stated that staff at Serenity Homes – North informed him that they would be conducting an internal investigation as well, including having a meeting with all residents to encourage them to not force or bribe other residents to go to the store for them in the middle of the morning. Mr. Thorndill stated that he will also continue to provide this education to Resident A.

On 4/28/25, I made an unannounced visit to Trinity Health Hospital in downtown Grand Rapids. Upon arrival, staff assisted me to Resident A's room and introductions were made. Resident A confirmed that on or around 4/25/25, he walked to the local gas station sometime after 2:00am to purchase soda and cigarettes for his peers. While walking home from the gas station, Resident A stated that he walked on the entrance ramp of the freeway. This was unintentional but it was dark, making it hard for him to see exactly where he was going. While on the ramp, Resident A stated, "I got whacked by a truck." Resident A was adamant that part of a vehicle hit him while on the ramp. Resident A stated that he couldn't walk anymore, which led to him waving for help. Resident A stated that he had his phone with him and attempted to call for a ride. However, this was unsuccessful because his phone could not get through to anyone. Resident A stated that he even attempted to call 911, "but I got a funny message." Resident A did not elaborate on this further but he did state that someone was able to get him an ambulance.

Resident A confirmed that he did not ask or tell staff he was leaving the home and he knows that he shouldn't have been walking to the gas station at that time of the morning. Resident A was adamant that he will not leave the home in the dark as he knows his safety would be at risk again. As a result of the incident, Resident A stated that he sustained internal and external bleeding, with bruises to his buttocks, legs and part of his back. It should be noted that aside from this incident, Resident A spoke highly of his time at the home. Resident A made it known that this incident was a result of him being bribed by his peers to go to the store. Prior to concluding my visit at the hospital, Resident A gave consent for nurse Brandon (last name unknown) to provide me with a medical update on him. The nurse stated that Resident A does not have any fractures but he does have a hematoma on his left lower extremity and bilateral kidney laceration. At this time, there are no surgical interventions needed and the medical team continues to monitor him while he receives rehab (Physical therapy/occupation therapy) at the hospital.

On 4/28/25, I made an unannounced onsite investigation at the AFC facility. Upon

arrival, introductions were made with staff member, Amber Palmer and she agreed to discuss the case. Ms. Palmer stated that on the day of the incident, manager Briendon Stevens texted her at approximately 3:54am stating that an Ottawa County Sheriff Deputy found Resident A on the freeway after he was reportedly hit by a vehicle. Ms. Palmer stated that staff member, Gabe Nanny was working on the day in question. Ms. Palmer stated that Resident A does not typically leave the home at night. Ms. Palmer stated that this incident stems from Resident B and C waking Resident A up in the middle of the night to ask him to go to the store to get cigarettes and soda. Ms. Palmer stated that Resident B is banned from the gas station due to stealing and Resident C uses a walker and is unable to make it to the gas station on his own. Therefore, Resident B and C essentially "forced" Resident A to go to the gas station for them despite it being nearly 3:00am. Since this incident occurred, Ms. Palmer sated that she had a house meeting the following morning and told Resident B and C to stop waking Resident A up to make him go to the gas station. Ms. Palmer stated that Resident B initially denied the incident. However, Resident C disclosed the truth to her. Ms. Palmer stated that staff member Gabe Nanney checked on Resident A just before the incident. Sometime after, police arrived at the home to talk to Mr. Nanney.

After speaking to Ms. Palmer, I spoke to staff member, Adrianna Hart. Ms. Hart stated that she was not working on the day of the incident. Therefore, she does not have any information to add aside from what Ms. Palmer already shared. While onsite, I reviewed Resident A's assessment plan, which indicated that he has independent community access and likes to take walks for exercise.

On 4/28/25, I spoke to house manager, Briendon Stevens via phone regarding the incident. Ms. Stevens stated that on 4/25/25 she received a call from Ottawa County Sheriff's Department and AFC staff member, Gabe Nanney at 3:30am. Ms. Stevens stated that law enforcement indicated they found Resident A laying down on the highway after going to the gas station to get soda and cigarettes for residents. Ms. Stevens stated that it is unusual for Resident A to leave the facility in the middle of night. Ms. Stevens confirmed that her colleague, Amber Palmer had a meeting with residents on the morning of 4/25/25 to encourage them to not wake residents up during the night to go the gas station for them. Ms. Stevens shared that Resident A has been in the home for years and this is the first time that any incident like this has occurred. Ms. Stevens shared that when staff member Mr. Nanney did rounds at 2:00am, Resident A was in his room. Per Ms. Stevens, Mr. Nanney shared that he hadn't got to his next set of rounds (3:00am) before law enforcement called and/or showed up to the home to share the incident regarding Resident A. Ms. Stevens confirmed that Resident A is allowed independent community access per his guardian. Ms. Stevens confirmed that Resident A remains at Trinity Health Hospital at this time and the medical team is working to determine if Resident A will be able to return home or if he will need to be admitted to a rehab facility for additional care.

On 5/1/25, I spoke to detective Dave Dewitt with the Ottawa County Sheriff's Department via phone. Detective Dewitt asked if there was any indication that

something happened to Resident A prior to leaving the home on the morning of 4/25/25. I informed Detective Dewitt that at this time, I do not have any evidence to indicate this. Mr. Dewitt is aware that due to AFC homes typically operating as a least restrictive environment, residents can come and go as they please, regardless of the time of day. I informed Detective Dewitt that AFC staff member, Gabe Nanney reportedly did rounds on the morning in question. In addition, Resident A disclosed that he knows he shouldn't leave the home without informing staff, but he did so anyway. As a result of Resident A leaving the home, he was allegedly struck by a vehicle while walking back to the facility. I informed Detective Dewitt that I still need to speak with Mr. Nanney. However, based on the information I've gathered so far, it appears that this incident was an accident. Detective Dewitt plans to look further into his caseload as he was under the impression that similar incidents have happened in the past with residents at this home. Mr. Dewitt stated that he was told that Resident A was suffering from sepsis, which made him wonder if any of the injuries were old. I informed Detective Dewitt that this I was not aware of this, and Resident A and the nurse at bedside did not disclose this as a concern. Detective Dewitt will attempt to obtain Resident A's medical records to find out additional information regarding this.

On the same day, I received an email from Detective Dewitt with another supplemental police report, which was completed on 4/29/25 by Deputy Jones. The report had an interview authored by Emily Fewless with APS and indicated that the hospital social worker noted bed bugs on Resident A's clothing and he was found to have sepsis, indicating that he may have been sick prior to being admitted to the hospital.

On 5/7/25, I spoke to AFC staff member, Gabe Nanney via phone. Mr. Nanney confirmed that he was working 3rd shift on Thursday 4/24/25 starting at 7:00pm, into the morning of Friday, 4/25/25 at 7:00am. Mr. Nanney confirmed that he did rounds during the night/morning of 4/25/25 while working at the home. Mr. Nanney confirmed that he completed his 2:00am rounds and Resident A was awake sitting on his bed and he closed his bedroom window per Resident A's request. Mr. Nanney stated that he was a little late for his 3:00am rounds due to cleaning. Prior to completing his 3:00am rounds, he received a call from law enforcement stating that they found Resident A by the highway. Police initially told Mr. Nanney that Resident A was hit by a car. Law enforcement then stated that they didn't know for sure as they also believed that he may have gotten tired while walking home and sat down. When law enforcement arrived at the home, Mr. Nanney stated the police "asked me some questions and I explained things to them the best I could." Mr. Nanney stated that Resident A has never left the home during the night. Mr. Nanney also shared that he called his manager, Briendon Stevens and she spoke to law enforcement and explained the situation to them.

On 5/7/25, I received a text message from Amber Palmer with a round chart initialed by Mr. Nanney to confirm that he was completing hourly rounding on residents on the day in question.

On 06/26/25, I conducted an exit conference with Jess Engstrom, Chief Operations Officer on behalf of licensee designee, Steve Gerdeman. She was informed of the investigative findings and denied having any questions.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A left the home during the night without letting staff know he was leaving. While away from the home, he was apparently struck by a vehicle and sustained injuries, which resulted in his hospitalization. The facility is not locked, and Resident A does not have a history of leaving or attempting to leave the home during the night. In addition, Resident A's assessment plan indicates that he has independent community access. Therefore, there is not a preponderance of evidence to support a violation of this rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: While investigating the allegation listed above, I was informed by Detective Dewitt from the Ottawa County Sheriff's Department that there was a report of bedbugs on Resident A's person while in the hospital.

On 5/5/25, I made an unannounced onsite visit to the facility and spoke to staff members Morgan Bailey and Briendon Stevens. I immediately noticed 4 or 5 mattresses and box springs on the porch. Ms. Stevens and Ms. Bailey confirmed that the beds are being treated for bedbugs. Ms. Stevens confirmed that Resident A's mattress was impacted by this, as well as 3 other mattresses. Ms. Stevens was adamant that all the mattresses are being replaced. Ms. Bailey herself and other staff members were present to assist with this. Ms. Stevens confirmed that she noticed bedbugs in Resident A's room on Thursday, 4/24/25, which was the night prior to him leaving the facility to go to the gas station. Ms. Stevens stated that Rose Pest Professional has come to the facility at least 5 times in the past. Despite this, staff were treating the bedbugs themselves with Ecovenger bed bug killer spray. Ms. Stevens is aware that the home will need to be treated again by a professional company.

On 5/29/25, I received an email from Jess Engstrom, Chief Operations Officer for the company. The email included a receipt from Rose Pest Solution, dated 5/20/25. The

receipt indicated that all furniture was treated, including beds, baseboards in bedrooms, living room and hallways. The report indicated that bedrooms 4, 5 and 6 all had bedbug activity present and room 4 had “50+ bedbugs on the mattress.” This service includes one follow-up treatment.

On 6/26/25, I conducted an exit conference with Jess Engstrom, Chief Operations Officer on behalf of licensee designee, Steve Gerdeman. She was informed of the investigative findings and aware that professional treatments need to be used for all future issues to protect the residents. She agreed to submit a corrective action plan within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	The facility had a known bedbug issue and this was initially being treated by staff with Ecovenger Bedbug Spray. The issue was not rectified, and the facility eventually received a professional treatment on 5/20/25 by Rose Pest Solutions. There is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegations listed above, I reviewed a police report authored by Ottawa County Sheriff’s Department on 4/25/25. The police report indicated that AFC staff member, Gabe Nanney was working on the night in question and he is “cognitively impaired” and had trouble understanding what was asked of him.

On 4/28/25, staff member Amber Palmer shared that staff member, Gabe Nanney has high functioning autism, but he does everything necessary to ensure that residents’ needs are met. On the same day, home manager Briendon Stevens also confirmed that Mr. Nanney has high functioning autism and he has been cleared by his doctor to work with the AFC population. Ms. Stevens agreed to send me proof of this medical clearance.

On 5/5/25, I made an unannounced onsite visit to the facility. Upon arrival, I spoke to home manager, Briendon Stevens. Ms. Stevens stated she thought she sent the medical clearance for Mr. Nanney as previously requested. However, upon checking her email, she realized that it was never sent. Ms. Stevens then forwarded me what she believed to be Mr. Nanney’s medical clearance. Instead, the email included Mr.

Naney's TB test that was completed on 4/19/24. Ms. Stevens did not have a medical clearance form on file for Mr. Nanney.

On 5/7/25, I spoke to Mr. Nanney via phone regarding the noted concern by law enforcement. Mr. Nanney confirmed that he had a hard time understanding questions from law enforcement on the night of the incident until the questions were explained better. Mr. Nanney confirmed that he has a developmental disorder known as autism. However, he denied his diagnosis presents any challenges while working with the AFC population. Mr. Nanney was thanked for his time as this call concluded.

06/26/25, I conducted an exit conference with Jess Engstrom, Chief Operations Officer on behalf of licensee designee, Steve Gerdeman. She was informed of the investigative findings and agreed to complete a corrective action plan within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.15204	Direct care staff; qualifications and training.
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.** **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	The licensee was unable to provide documentation to confirm that Gabe Nanney has been medically cleared by his physician to work with this population. 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.

Anthony Mullins

06/26/2025

_____

Anthony Mullins Date
Licensing Consultant

Approved By:

06/26/2025

_____

Jerry Hendrick Date
Area Manager