GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 12, 2025

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

RE: License #:	AS410417567
Investigation #:	2025A0356037
	JC Assisted Living II

Dear Ms. Sanders:

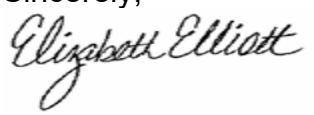
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2025A0356037
Complaint Receipt Date:	04/21/2025
Investigation Initiation Date:	04/21/2025
Report Due Date:	06/20/2025
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?
Facility staff are not adequately supervising Resident A.	Yes
Resident A is being locked in his room.	No

III. METHODOLOGY

04/21/2025	Special Investigation Intake 2025A0356037
04/21/2025	Special Investigation Initiated - Telephone Michael Kuik, Network 180, Office of Recipient Rights Officer.
04/21/2025	APS Referral Centralized Intake referral made.
04/24/2025	Inspection Completed On-site
04/24/2025	Contact - Face to Face Christina Sanders, Licensee, Jeannie Haff, ORR, Network 180, Michael Kuik, ORR, Network 180.
04/24/2025	Contact - Face to Face Kaylee Noffsinger, DCW.
05/29/2025	Inspection Completed On-site Contact-Face to Face DCW, Kaylee Noffsinger, Resident A.
06/05/2025	Contact-Telephone call made Relative #1 and Paul Heemstra, school special education provider.
06/05/2025	Contact-Telephone call made Christina Sanders, Licensee Designee.
06/09/2025	Contact-Telephone call received Relative #1, Jodie Hopewell, supports coordinator, Network 180.
06/11/2025	Contact-Telephone call made Paul Heemstra-not able to get through on the cell number provided to me by the school.
06/12/2025	Exit conference-Christina Sanders, Licensee Designee.

06/16/2025	

ALLEGATION: Facility staff are not adequately supervising Resident A.

INVESTIGATION: On 04/21/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported that the school bus arrived in the morning on Friday, March 28, 2025, to pick Resident A up and staff was sitting outside the facility. Staff reported they could not get in because the Licensee, Christina Sanders was inside sleeping.

On 04/21/2025, I initiated contact with Michael Kuik, Network 180, Office of Recipient Rights Officer. I was provided a copy of the ORR complaint and the complainant reported on a report written Friday, March 28, 2025, *'The school bus arrived to pick (Resident A) up this morning. The caregiver was sitting outside the home, unable to get inside to begin her scheduled shift. There are concerns for (Resident A) not getting appropriate care/supervision as they should be. The teacher contacted the caregiver in charge of the home, and she reported she was inside sleeping.'* Mr. Kuik and I coordinated an onsite inspection.

On 04/23/2025, I received additional information from Mr. Kuik from interviews he conducted. Mr. Kuik documented that he interviewed Paul Heemstra, special education provider at Lincoln School on 04/22/2025. Mr. Kuik documented that Mr. Heemstra reported Resident A's school schedule is Monday-Friday, 7:50a.m.-2:20p.m. Mr. Heemstra reported bus team members informed him that staff at the facility, most likely Ms. Sanders, because she lives at the facility, was asleep and unable to let staff into the facility or get (Resident A) ready to go to school on 03/28/2025. Mr. Heemstra reported he contacted Relative #1 and asked if Resident A had an appointment or something causing him to miss school. Relative #1 did not know so Mr. Heemstra contacted Ms. Sanders at 8:21a.m. on 03/28/2025 via text message and asked if Resident A was sick and Ms. Sanders reported "yes" but also that staff did not show up to work, that she (Ms. Sanders) slept through until a half hour ago and did not know Resident A was not on the bus. Mr. Heemstra reported to Mr. Kuik that there may have been one other case when staff overslept and Resident A missed the bus but mainly when Resident A misses school, it is due to medical issues. Mr. Heemstra reported when Resident A lived at home with family, he would miss school 2-3 times per year, now it is more like 2-3 times in a month, but again, mostly due to medical issues.

Mr. Kuik reported that he interviewed Relative #1 by phone on 4/22/25. Mr. Kuik documented that Relative #1 was contacted by Resident A's teacher via text that the bus attempted to pick Resident A up and the bus aide and bus driver observed staff for the facility standing outside, trying to get in. Mr. Kuik documented that Relative #1 reported the bus aide spoke to the employee who explained no one was coming to the door and she had no way to get in. Relative #1 reported Resident A's teacher texted Ms. Sanders on 03/28/2025 and asked if everything was okay and Ms. Sanders reported that an employee didn't show up. Relative #1 reported he thinks

Ms. Sanders ‘works during the day and sleeps at night,’ and there have been times in the past when Resident A was taken to the ER late at night, and Ms. Sanders requested Relative #1 call her because whomever is working might be in the basement and not hear the phone ring.

Mr. Kuik reported that Relative #1 was told that Resident A would have staff supervision with staff that is awake at night. Mr. Kuik stated Relative #1 reported that Resident A has PICA (an eating disorder in which a person compulsively eats or craves nonfood items) and will wander at night. Relative #1 reported that Resident A, while he lived at home with Relative #1, would get up at night, knock things down, dropping items to the ground, if there was anything breakable, he would try to stick pieces of it in his mouth, and for example, if there were batteries in anything, he would try to stick the batteries in his mouth. Mr. Kuik stated that Relative #1 reported Resident A has a J-tube that must be plugged in and runs 20 hours a day. Relative #1 reported that Resident A requires 24-hour care and supervision with awake staff due to his severe disabilities and complicated medical needs. Mr. Kuik stated it has been an ongoing issue of Resident A missing school. Mr. Kuik reported Resident A rarely missed school prior to this placement and there have been many times Resident A has not shown up for school and the school is not notified.

On 04/24/2025, I conducted an unannounced inspection at the facility and met with Mr. Kuik, Jeannie Haff, Network 180 Office of Recipient Rights officers, and Licensee, Christina Sanders. Ms. Sanders stated she was staff on duty at the time of this incident (03/28) and she was sleeping on the couch in the living room when the new staff, Kaylee Noffsinger arrived for her shift and could not get into the facility. Ms. Sanders stated Resident A ended up staying home from school that day because she had failed to get up and get Resident A ready on time. Ms. Sanders stated she sets her alarm for every 2 hours to check on Resident A throughout the nighttime/sleeping hours. Ms. Sanders stated she does that on her own as there is nothing in writing that documents Resident A needs to be checked on throughout the night. Ms. Sanders stated Resident A’s IPOS documented Resident A needs to be checked on every 15 minutes through the daytime when he is not in school, and Resident A is always with staff during waking hours and supervised. Ms. Sanders stated she does not document Resident A’s checks during the night but checks on him on her own to make sure he is supervised. Ms. Sanders stated at this time, she lives in the facility and when she is not working and other staff are at the facility, she keeps the door that leads upstairs to her room open, so she is available if needed. Ms. Sanders stated when she is working, she sleeps downstairs in the living room on the couch. Ms. Sanders stated that none of the other residents were up on the morning of 03/28/2025 and none of the residents were left unsupervised as everyone was sleeping. Ms. Sanders stated Resident A has lived in this facility since 11/2024 and goes to school 5 days a week. Ms. Sanders stated this is the first time this has happened and is not something that has occurred more than this one time. The only times Resident A misses school is when he stays home to meet with the in-house doctor, other than that, he has not missed school except for this time. Ms. Sanders acknowledged it was a mistake she made by oversleeping. Ms. Sanders

stated that none of the residents were harmed, none of them missed a meal or wandered about the facility or outside unattended.
On 04/24/2025, Mr. Kuik, Ms. Haff and I interviewed DCW (direct care worker) Kaylee Noffsinger at the facility. Ms. Noffsinger stated she was the staff that arrived for her shift on the morning of 03/28/2025. Ms. Noffsinger stated she arrived at 7:15a.m. and could not get in. Ms. Noffsinger stated she thought the door was locked but it was stuck, when the bus arrived, she sent them on their way because Resident A was not up and ready to go to school. Ms. Noffsinger stated Ms. Sanders got up and let her in the door and she worked her shift.

On 04/24/2025, I reviewed the Original Licensing Study Report (OLSR) dated 09/07/2023, which documented there will not be awake staff during sleeping hours.

On 04/24/2025, I reviewed the assessment plan for AFC residents for Resident A. The assessment plan was dated 11/08/2024, signed by Ms. Sanders and Resident A's legal guardian, Relative #1. The assessment plan documented that Resident A is not alert to his surroundings and described his needs as, 'constant supervision (24 hour awake staff).'

On 04/24/2025, I reviewed Resident A's IPOS (individual plan of service) through Network 180. The IPOS is signed by Aubrie Allen, CTRS, QIDP with Network 180 on 11/20/2024. The IPOS documented, *'(Resident A's) family also use a baby gate in his bedroom doorway at night as (Resident A) tends to be awake during the night and family does not want him wandering the house and eating things while they are asleep. The AFC home will have 24/7 awake staff and will be able to monitor and redirect (Resident A) as needed if he comes out of his room.'*

The IPOS documented, *'Staff also need to monitor (Resident A) within the home due to his PICA, as he will often get up during the night and wander about. (Resident A) needs 15-minute checks at all times of the day to ensure his safety.'*

On 04/24/2025, Resident A is not available for an interview on this date as he is not in the facility. Resident A is nonverbal and according to Ms. Haff, Mr. Kuik and Ms. Sanders, he is not able to provide pertinent information for this investigation due to cognitive deficits.

On 06/09/2025, I interviewed Relative #1 via telephone. Relative #1 reiterated the information provided to Mr. Kuik and expressed concern regarding the level of supervision Resident A is receiving in the facility during nighttime hours.

On 06/12/2025, I conducted an exit conference with Ms. Sanders via telephone messages and texts. Ms. Sanders reported staff is awake during sleeping hours and Resident A is checked on during night hours. Ms. Sanders will review with staff the importance of maintaining the supervision of Resident A and will write a plan of correction.

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 that the school bus arrived on the morning of Friday, March 28, 2025, to pick Resident A up for school, staff was sitting outside the facility, they could not get in because the Licensee, Christina Sanders was inside sleeping. Resident A's assessment plan and IPOS document Resident A requires awake staff that can provide 24-hour supervision for safety reasons. Ms. Sanders acknowledged during an interview that she was sleeping in the facility on 03/08/2025 when the bus arrived to pick Resident A up for school. As a result, Resident A missed school. Relative #1 reported concern regarding the level of supervision Resident A received especially during sleeping hours. Investigative findings show that Resident A requires staff that is awake due to supervision and protection reasons. On 03/08/2025, Resident A missed the bus for school because staff, Ms. Sanders was asleep in the facility and failed to provide the supervision Resident A required. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A is being locked in his room.

INVESTIGATION: On 04/21/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported concern that Resident A is locked in his bedroom at night.

On 04/21/2025, I initiated contact with Michael Kuik, Network 180, Office of Recipient Rights Officer. I was provided a copy of the ORR complaint and the complainant reported on the report written Friday, March 28, 2025, concern that Resident A is locked in his bedroom at night while staff sleep.

On 04/23/2025, Mr. Kuik reported that he interviewed Relative #1 by phone on 4/22/25. Mr. Kuik documented that Relative #1 reported when Resident A was living with Relative #1, they had a baby gate in his room to maintain safety from wandering. Relative #1 reported to Mr. Kuik that there is no indication of staff locking Resident A in his room however, if staff are sleeping at night, he wonders what Resident A is doing as he tends to wander at night. Relative #1 reported to Mr. Kuik that he preferred Resident A stays in his room rather than wander around as he has PICA and puts anything in his mouth.

On 04/24/2025, I conducted an unannounced inspection at the facility and met with Mr. Kuik, Jeannie Haff, Network 180 Office of Recipient Rights officers, and Licensee, Christina Sanders. Ms. Sanders stated they do not lock Resident A in his room and if the door is closed and Resident A is in his room, he is able to turn the knob and open the door on his own. Ms. Sanders stated she had been told Resident A is not able to open doors, but she has seen it and Resident A can turn the doorknob and open his own bedroom door. Ms. Sanders reiterated that they do not lock Resident A is his room.

On 04/24/2025, Mr. Kuik, Ms. Haff and I interviewed DCW (direct care worker) Kaylee Noffsinger at the facility. Ms. Noffsinger stated if Resident A is in his room and the door is closed, he can open the door on his own, she has witnessed him do it. Ms. Noffsinger stated she does not lock Resident A in his room.

On 04/24/2025, I inspected the door in Resident A's room. The door is equipped with a lock and the lock is nonlocking against egress per licensing rules. The door opens without struggle, if the door is closed and locked, the door opens with the twist of the doorknob. The doorknob is a round knob.

On 05/29/2025, I conducted an unannounced inspection at the facility and observed the bus arrive, Resident A getting off the bus, Ms. Noffsinger met Resident A at the door of the bus and escorted Resident A into the facility. I went into the facility and observed Resident A and Ms. Noffsinger. Resident A was walking around the facility and then he laid on the living room floor where Ms. Noffsinger could see him. Ms. Noffsinger stated she lives in the facility and again stated does not lock Resident A in his room. Ms. Noffsinger stated Resident A can turn the knob on the door of his room and open the door on his own.

On 05/29/2025, Resident A is not capable of providing pertinent information to this investigation due to cognitive deficits.

On 06/09/2025, I interviewed Relative #1 via telephone. Relative #1 stated he does not think Ms. Sanders or staff are "locking" Resident A in his room or preventing him from being outside his room. However, Relative #1 stated there is no way Resident A can open a doorknob that is round that needs to be gripped and turned. Relative #1 stated he raised Resident A and has never seen Resident A open a door unless it was a straight lever type doorknob, and Resident A happened to hit the lever just

right and it came open but that was not a common occurrence. Relative #1 stated the doorknobs at the facility are round doorknobs. Relative #1 stated staff at school have reported the same, that Resident A is not able to open doorknobs himself.

On 06/09/2025, I interviewed Jodi Hopewell, Network 180 supports coordinator via telephone. Ms. Hopewell stated during scheduled home visits; she has never seen Resident A confined to his room or open a door on his own.

On 06/12/2025, I conducted an exit conference with Ms. Sanders via telephone voicemail and text. Ms. Sanders reported in her interview statement, that Resident A is never locked in his room, he is capable of opening the door on his own and accepts the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(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: (d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.
ANALYSIS:	The complainant reported concern that Resident A is locked in his bedroom at night. Relative #1 and Ms. Hopewell reported there is no indication of staff locking Resident A in his room. Ms. Sanders and Ms. Noffsinger stated they do not lock Resident A in his room and if the door is closed and Resident A is in his room, he is able to turn the knob and open the door on his own. Resident A's door is equipped with a lock and the lock is nonlocking against egress, the door opens with the twist of the doorknob. The doorknob is a round knob. During an unannounced inspection at the facility, I observed Resident A walking around the facility and laying on the living room floor. Resident A was not locked in his room. Based on investigative findings, there is not a preponderance of evidence to show that Resident A is being confined or locked in his room by staff at the facility. Therefore, a violation

	of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

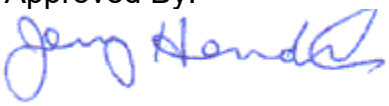
IV. RECOMMENDATION

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

06/12/2025

Elizabeth Elliott Date
Licensing Consultant

Approved By:



06/12/2025

Jerry Hendrick Date
Area Manager