GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 22, 2025

Jacklyn Stoltzfus
Covenant Enabling Res of MI Inc.
862 Forest Park Road
Muskegon, MI 49441

RE: License #:	AS410309175
Investigation #:	2025A0356051
	Faith House

Dear Ms. Stoltzfus:

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 #:	AS410309175
Investigation #:	2025A0356051
Complaint Receipt Date:	07/23/2025
Investigation Initiation Date:	07/25/2025
Report Due Date:	09/21/2025
Licensee Name:	Covenant Enabling Res of MI Inc.
Licensee Address:	862 Forest Park Road Muskegon, MI 49441
Licensee Telephone #:	(231) 288-5697
Administrator:	Jacklyn Stoltzfus
Licensee Designee:	Jacklyn Stoltzfus
Name of Facility:	Faith House
Facility Address:	340 Thornridge Dr. NW Grand Rapids, MI 49504
Facility Telephone #:	(231) 288-5697
Original Issuance Date:	02/07/2011
License Status:	REGULAR
Effective Date:	08/07/2025
Expiration Date:	08/06/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was left alone and unsupervised in the facility by staff.	Yes

III. METHODOLOGY

07/23/2025	Special Investigation Intake 2025A0356051
07/23/2025	APS Referral APS denied.
07/25/2025	Special Investigation Initiated - Telephone Jacki Stoltzfus, Licensee Designee.
08/01/2025	Contact - Telephone call made Jacki Stoltzfus, Licensee Designee.
08/01/2025	Inspection Completed On-site
08/01/2025	Contact - Face to Face Karen Chapman, home manager.
08/01/2025	Contact - Telephone call made Resident A.
08/14/2025	Contact - Telephone call made Kim Van Gessel, DCW. Said she would call me later, and did not return telephone call.
08/18/2025	Contact - Document Sent Karen Chapman, home manager.
08/18/2028	Contact - Telephone call made Relative #1 and Relative #2
08/18/2025	Contact-Telephone call made Amanda Erspamer, Network 180 supports coordinator.
08/22/2025	Exit conference-Jackie Stoltzfus, Licensee Designee.

ALLEGATION: Resident A was left alone and unsupervised in the facility by staff.

INVESTIGATION: On 07/23/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported Resident A has a diagnosis of mild intellectual disability, spectrum disorder and Fragile X syndrome. Resident A was left alone at the home by a staff member, on July 20, 2025. The complainant reported that staff thought Resident A was picked up by his parents, but he was left alone in his bedroom watching television. It is unknown how long Resident A was home alone, and he was later found in the home by a relative. There are concerns that Resident A was not properly supervised in his placement.

On 07/23/2025, I received an Office of Recipient Rights Complaint from Amanda Erspamer, Network 180 (Community Mental Health) supports coordinator dated 07/22/2025. The complaint documented the following information, *'On 07/21/2025, (Resident A's) (Relative #1/legal guardian) reported that when (Resident A's) (Relative #2) went to pick (Resident A) up on 07/20/2025, there were no staff in the home. It was discovered that the AFC staff, Angie, had left the AFC home as she thought (Resident A) had been picked up already, however, he was sitting in his bedroom watching TV. (Resident A) lacks the safety skills to be left alone for any amount of time.'*

On 08/01/2025, I conducted an unannounced inspection at the facility and interviewed home manager, Karen Chapman. Ms. Chapman was leaving on an outing with all the residents, so we agreed to continue our interview via telephone when she returned. Ms. Chapman called me and confirmed the information in the complaint allegation did occur. Ms. Chapman stated the staff was Kim Van Gessel and not Angie, and Resident A was accidentally left alone in the facility on 07/20/2025 when Ms. Van Gessel took the other residents to the Speedway gas station. Ms. Chapman stated Ms. Van Gessel, and the residents went to church and then came home. Resident A was scheduled to be picked up by Relative #2 and was in his room watching TV and waiting for Relative #2 to arrive. Ms. Chapman stated Ms. Van Gessel went to the bathroom and when she came out, she asked the residents in the living room if Resident A had left and they told her yes, he had been picked up. Ms. Chapman stated Ms. Van Gessel took the residents to the Speedway gas station and Resident A was still in his room watching NASCAR. Ms. Chapman stated Resident A did not know he was alone and Relative #2 came in and found Resident A alone in his room. Ms. Chapman stated nothing happened to Resident A, and he did not know he was alone in the facility. Ms. Chapman stated Resident A would tell me that he was afraid but until he was told he was alone in the facility, he did not know he was alone. Ms. Chapman stated Ms. Van Gessel called her immediately and told her what happened. Ms. Chapman stated she called Relative #1 and Network 180 to report. Ms. Chapman stated Ms. Van Gessel always checks the residents' rooms before she leaves the facility and reported that she does not know why she did not check all the rooms this time. Ms. Chapman stated Relative #2 stayed with Resident A until Ms. Van Gessel and the other residents came back to the facility. Ms. Chapman stated protocols are being put in place to prevent this from happening in the future. Ms. Chapman stated Ms. Van Gessel is a long-time

employee, has worked at this facility since 2017 and nothing like this has ever happened before.

On 08/01/2025, I interviewed Resident A via telephone, and he said he was left alone in the facility, and he was scared. Resident A stated he “didn’t know what he was doing” but that he was in his room watching NASCAR when Relative #2 “came here, knocked on my door and scared me.” Resident A stated he waited in his room with Relative #2 for Ms. Van Gessel to come back and then went to Relative #1 & #2’s house.

On 08/18/2025, I interviewed Relative #2 via telephone. Relative #2 stated that Resident A did not realize that he was alone in the facility and he does not seem to be negatively affected by the incident. Relative #2 stated he arrived at the facility on Sunday, 07/20/2025, knocked on the door, there was no answer. Relative #2 stated he stepped into the facility and yelled, “anybody here?” and there was no answer. Relative #2 stated he went to Resident A’s room and went in. Resident A had no idea everyone in the facility was gone. Relative #2 stated once Resident A knew he was alone; he told Relative #2 that everyone had gone for a walk or a bike ride. Relative #2 stated there was no vehicle in the driveway so he figured they had left to go somewhere other than walking or for bike rides. He called Relative #1, and she called Ms. Van Gessel to ask where she was. Relative #2 stated he needed to get Resident A’s medications and that’s why he was waiting at the facility for Ms. Van Gessel to return. Relative #2 stated Ms. Van Gessel reported that she had asked the other residents if Resident A had left and they told her he had so she took them to the gas station. Relative #2 stated Resident A did not seem afraid. He was in his room watching NASCAR, waiting for Relative #2 to arrive and Resident A did not know he was alone. Relative #2 stated on Sundays, he usually waits approximately 20 minutes after they get home from church and then goes to the facility to pick Resident A up. Relative #2 stated he does not know how long Ms. Van Gessel and the other residents were gone and Resident A was alone.

On 08/22/2025, I conducted an exit conference with Ms. Stoltzfus, Licensee Designee via telephone. Ms. Stoltzfus stated she understood and agreed with the information, analysis, and conclusion of this applicable rule. Ms. Stoltzfus stated she will submit an acceptable corrective action plan and that they have already put new protocols in place to prevent this from happening in the future.

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. The complainant reported on 07/20/2025, Resident A was left

ANALYSIS:	alone in the facility without staff supervision for an unknown amount of time. Based on investigative findings, on 07/20/2025, Resident A was left unsupervised in the facility by staff, Kim Van Gessel for an unknown amount of time. Resident A's protection and safety were not being attended to while he was alone in the facility and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

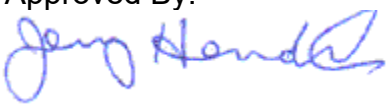
IV. RECOMMENDATION

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

08/22/2025

Elizabeth Elliott — Date
Licensing Consultant

Approved By:



08/22/2025

Jerry Hendrick — Date
Area Manager