GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 4, 2025

Nigel Jordon
Above and Beyond Care, LLC
3287 Stormy Creek Dr., SE
Kentwood, MI 49512

RE: License #: AS410409367
Investigation #: 2025A0579048
Above & Beyond Care 2

Dear Mr. Jordon:

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,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W., Unit 13
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410409367
Investigation #:	2025A0579048
Complaint Receipt Date:	08/01/2025
Investigation Initiation Date:	08/01/2025
Report Due Date:	09/30/2025
Licensee Name:	Above and Beyond Care, LLC
Licensee Address:	3287 Stormy Creek Dr., SE Kentwood, MI 49512
Licensee Telephone #:	(508) 203-0654
Administrator:	Nigel Jordon
Licensee Designee:	Nigel Jordon
Name of Facility:	Above & Beyond Care 2
Facility Address:	2215 Bentbrook Ct SE Kentwood, MI 49508
Facility Telephone #:	(616) 246-1144
Original Issuance Date:	08/24/2021
License Status:	REGULAR
Effective Date:	02/24/2024
Expiration Date:	02/23/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED/ MENTALLY ILL/ DEVELOPMENTALLY DISABLED/AGED/ TRAUMATICALLY BRAIN INJURED/ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was given Resident B's medications and medical treatment was not sought for her.	Yes
Mr. Jordon recorded a conversation with Resident A and sent it to Relative A without Resident A knowing.	Yes

III. METHODOLOGY

08/01/2025	Special Investigation Intake 2025A0579048
08/01/2025	Special Investigation Initiated - Letter E-mail to Complainant
08/01/2025	Contact - Face to Face Christina Jordon, DCW
08/01/2025	Contact - Telephone call made Relative A
08/01/2025	Contact - Document Sent Nigel Jordon, Licensee Designee
08/01/2025	APS Referral
08/04/2025	Contact- Document Received Relative A Kelli Bandstra, Caseworker
09/03/2025	Exit Conference Nigel Jordon, Licensee Designee

ALLEGATION: Resident A was given Resident B's medications and medical treatment was not sought for her to ensure her safety.

INVESTIGATION: On 8/1/25, I received this referral which alleged Resident A was given Resident B's evening medication instead of her own, and follow-up was not made with a medical professional. Mr. Jordon reportedly advised the direct care worker ("DCW") on duty just to observe Resident A overnight. Resident A reported to

Relative A that she vomited throughout the night and was dizzy and lethargic for 24 hours.

On 8/1/25, I contacted the complainant to confirm receipt of the allegations. The complainant requested I contact Relative A for more information.

On 8/1/25, I completed an unannounced on-site investigation at the home. It was reported Resident A was not present and Ms. Fuller, who was the DCW involved in the incident, was on an outing and not present in the home. Present was DCW Christina Jordon who reported she had knowledge of the incident and agreed to be interviewed.

Ms. Jordon reported Resident A does not take her medication at the counter near the medication cabinet, she prefers DCWs bring it to her. She stated that on the day of the incident, Ms. Fuller walked the medications to Resident A, Resident A took them, and Ms. Fuller then realized she had brought Resident B's medication to Resident A and Resident A had taken the wrong medications. Ms. Fuller immediately reported this to her and Mr. Jordon. She stated the medications Resident A took that were not her own were primarily vitamins. She stated Resident A did not show altered behavior, so she and Mr. Jordon advised Ms. Fuller to hold Resident A's medications, continuously observe Resident A overnight, and seek medical treatment if her condition changed. She stated Resident A did not vomit or show any concern for her health and she successfully attended her day program the next day, so she does not believe the medications impacted Resident A.

I reviewed the medications. Resident A's evening medications are: Buspirone 10MG, Famotidine 20MG, Pilocarpine 5MG, Midodrine 5MG, Gabapentin 600MG, Allopurinol 300MG, Atorvastatin 40MG, Furosemide 40MG, Levetiracetam 500MG, Potassium Chloride Tab, Solifenacin 5MG, and Trazadone 100MG, On the day of the incident, Resident A was given Resident B's medication which included Cyclobenzaprine 10MG, Gabapentin 100MG, Eliquis 5MG, Famotidine 20MG, Caplyta 42MG, Melatonin 10MG, Vitamin D3 125 MCG, Fish Oil 500MG, and Cyclobenzaprine 10MG.

I provided consultation that medical treatment such as phone call to Resident A's primary physician's office, Poison Control, and/or taking Resident A to urgent care or an emergency department should occur any time a resident ingests a medication that is not prescribed to them. Ms. Jordon stated since Resident A primarily only received vitamins that were not prescribed to her and did not show symptoms, it was not believed that she needed medical attention. I advised that even if she only consumed vitamins, a health care professional should make the determination whether vitamins negatively interact with Resident A's current medications, and it is not the discretion of DCWs or Mr. Jordon. Ms. Jordon expressed understanding. She stated since the incident, all residents must come to the counter to receive their medication to prevent this from occurring again.

On 8/1/25, I completed a telephone interview with Relative A. She stated Resident A does not have a guardian. She stated she is Relative A's next of kin. She stated Mr. Jordon did not report the incident to her and has not provided an incident report that she requested so she is not aware of the medications Resident A was given. She stated the day after the incident Resident A reported to her that she was given the wrong evening medication and spent the evening vomiting and was tired and dizzy the next day. She stated Ms. Fuller and Mr. Jordon did not seek medical treatment for Resident A. She stated she has advised Resident A she needs to cooperate with taking her medications at the medication counter upstairs because it is true that Resident A prefers the medication be brought to her which is what likely was a part of why this error occurred. I agreed to contact Mr. Jordon and Resident A's caseworker about the incident report.

On 8/4/25, I received an email from Relative A connecting me to Kelli Bandstra who is Resident A's case worker. Ms. Bandstra reported she is also investigating the allegations and did not receive an incident report regarding the incident.

On 8/4/25, I received an incident report completed and signed by Ms. Fuller. It stated that on 7/23/25, at approximately 8:00 p.m., Ms. Fuller gave Resident A the wrong medications. Ms. Fuller reported the incident to Resident A and Mr. Jordon. Mr. Jordon advised Ms. Fuller to watch Resident A closely throughout the night and to call an ambulance immediately if there was any change in her behavior. Ms. Fuller reported she observed Resident A closely throughout the night. Resident A slept, and there was no change in her behavior. Resident A awoke the next morning, did not report feeling ill, and attended her day program. Resident A did not report feeling ill that day.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	Ms. Jordon, Relative A, and the incident report completed by Ms. Fuller all reported Ms. Fuller accidentally gave Resident A the evening medication prescribed to Resident B. Ms. Fuller was advised by Ms. Jordon and Mr. Jordon to observe Resident A throughout the night. Contact was not made with an appropriate health care professional to ensure Resident A's safety.

	Based on the interviews completed and documentation observed there is sufficient evidence that contact with an appropriate health care professional was not obtained after Resident A consumed medication not prescribed to her.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Mr. Jordon recorded a conversation with Resident A and sent it to Relative A without Resident A knowing.

INVESTIGATION: On 8/1/25, Relative A requested to send me a recording. She stated after the incident, Mr. Jordon and Ms. Fuller recorded a conversation they had with Resident A. She stated Resident A did not have knowledge of the recording being sent to her. She stated she felt the tone of the conversation was not appropriate and requested I listen to the recording as well.

On 8/1/25, I listened to the recording Relative A sent to me. On the recording were the voices of Mr. Jordon, Ms. Fuller, and Resident A. Mr. Jordon was heard asking Resident A leading questions about the incident and appeared to be attempting to influence Resident A's responses. Resident A reported that she vomited and felt unwell after receiving the wrong medication and Mr. Jordon and Ms. Fuller dismissed this and continued with their narrative of what occurred. The tone of the conversation was uncomfortable and Resident A sounded upset at times.

On 9/3/25, I provided consultation to Mr. Jordon regarding obtaining Resident A's consent to record and share her conversations and suggested scheduling video or telephone conferences with Relative A and her supports coordinator to openly discuss concerns in the future, instead of privately recording and sharing conversations with Resident A. I also discussed the tone of the conversation and how the leading questions and dismissing Resident A were not appropriate.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**

	(2) A licensee shall provide the resident and the resident's designated representative with a written copy of the rights outlined in subrule (1) of this rule upon a resident's admission to the home.
ANALYSIS:	Relative A expressed concern that a recording of a conversation involving Mr. Jordon, Ms. Fuller, and Resident A was sent to her without Resident A's knowledge and expressed that the tone of the conversation was concerning. I listened to the recording and heard Mr. Jordon, Ms. Fuller, and Resident A discussing the incident where Resident A was given incorrect medication. Resident A reported feeling unwell and Mr. Jordon and Ms. Fuller dismissed this. Mr. Jordon asked Resident A leading questions and appeared to attempt to influence her responses. Resident A sounded upset at times. Based on the interview and recording, there is sufficient evidence that Resident A was not treated with dignity and respect, and her privacy was not respected during the recorded conversation I heard.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/3/25, I completed an exit conference with Mr. Jordon. I provided the same consultation I had with Ms. Jordon regarding consulting health care professionals after medication errors. I provided consultation regarding appropriate communication with residents and their supports. Mr. Jordon did not dispute my findings or recommendations at the time of report disposition.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

Cassandra Duursma 09/04/2025

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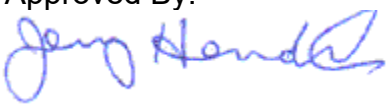
Cassandra Duursma Date
Licensing Consultant

Approved By:



09/04/2025

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Jerry Hendrick Date
Area Manager