GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 2, 2025

Jonathan Book
AH Jenison Subtenant LLC
Ste 1600
1 Towne Sq
Southfield, MI 48076

RE: License #: AL700397748
Investigation #: 2026A0467003
AHSL Jenison Sandalwood

Dear Mr. Book:

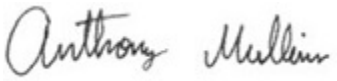
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL700397748
Investigation #:	2026A0467003
Complaint Receipt Date:	11/19/2025
Investigation Initiation Date:	11/19/2025
Report Due Date:	01/18/2026
Licensee Name:	AH Jenison Subtenant LLC
LicenseeAddress:	Ste 1600 1 Towne Sq Southfield, MI 48076
Licensee Telephone #:	(616) 432-2112
Administrator:	Jonathan Book
Licensee Designee:	Jonathan Book
Name of Facility:	AHSL Jenison Sandalwood
Facility Address:	861 Oak Crest Lane Jenison, MI 49428
Facility Telephone #:	(616) 457-3576
Original Issuance Date:	03/11/2019
License Status:	REGULAR
Effective Date:	09/11/2025
Expiration Date:	09/10/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A sustained injuries to her face and head after eloping from the facility and falling in a nearby community. There is concern regarding Resident A's supervision.	Yes

III. METHODOLOGY

11/19/2025	Special Investigation Intake 2026A0467003
11/19/2025	APS Referral Complaint received from Ottawa County APS.
11/19/2025	Special Investigation Initiated - On Site
11/19/2025	Exit conference completed onsite with licensee designee, Jonathan Book
11/19/2025	Contact – Document received Resident A's assessment plan received via email from licensee designee, Jonathan Book

ALLEGATION: Resident A sustained injuries to her face and head after eloping from the facility and falling in a nearby community. There is concern regarding Resident A's supervision.

INVESTIGATION: On 11/19/25, I received a LARA-BCHS online complaint stating that Resident A has been diagnosed with dementia and on 11/16/25, Resident A was able to elope from the facility and walk to a nearby community where she fell and sustained injuries to her face and head. Resident A was taken to a nearby hospital for treatment. The complaint alleged that the two staff members were preoccupied when Resident A left the facility. Staff at American House reported Resident A missing, but it is unknown how long she was gone before anyone noticed.

On 11/19/25, I made an unannounced onsite investigation at the facility. Upon arrival, I met with licensee designee, Jonathan Book in his office. Mr. Book confirmed that Resident A was able to elope from the facility on 11/16/25 at 1:50pm due to a door in the kitchen being propped open. Mr. Book confirmed that Resident A sustained injuries to her face after a fall while in the community. Per Mr. Book, Resident A's daughter confirmed that a CT scan was completed and the results were negative. Mr. Book shared that a second door in the kitchen that requires a keycode to exit wasn't shut all the way, which allowed Resident A to make exit

unnoticed. Mr. Book stated that despite passing a fire inspection recently with the Fire Marshal, the alarm on the door malfunctioned. Mr. Book was adamant that since this incident, the door has been fixed and a self-closing device has been added to the door to ensure a similar situation doesn't happen again. I was able to confirm this while on-site as well. I also observed Resident A sitting at the dining room table with some bruising to her face. Aside from the bruising, Resident A appeared to be doing well physically. She was not interviewed due to having a diagnosis of Alzheimer's disease.

On the day in question, Mr. Book shared that two staff members, Dannette Nordyke and Peyton Moore were working as the medication tech and the resident assistant. While working, Ms. Nordyke reportedly asked the culinary staff member, Alan Nordyke to keep an eye on the front door so that she and Mr. Moore could assist another resident. While Mr. Nordyke was sitting at the dining room table observing the front door, his back was facing the kitchen door. Resident A was able to sneak behind him and go through the kitchen. Due to the kitchen doors being propped open and not locked, Resident A was able to get outside at approximately 1:59pm. Staff noticed that Resident A was missing at approximately 2:06pm and began searching for her immediately. Resident A's family and 911 were called after staff were unable to locate Resident A. Mr. Book stated that Resident A typically uses a walker, but she did not have her assistive device with her when she left the facility. Resident A was able to walk approximately half a mile before falling and injuring herself. As a result of this incident, Mr. Book shared that the culinary staff member, Alan Nordyke was suspended immediately and all staff members working onsite on the day of the incident completed statements. Mr. Book shared that all staff were provided with education on missing residents/elopement procedures and signed off on it. He provided me with copies of this to confirm.

Prior to concluding this on-site investigation, I reviewed the statements from staff members working on the day of the incident, which confirmed that Mr. Nordyke left the kitchen door all the way open, leading to Resident A's elopement. It should be noted that the facility was adequately staffed based on licensing rules. Mr. Book confirmed that Resident A had only been at the facility for a few weeks and she is planning to discharge soon at the request of the family.

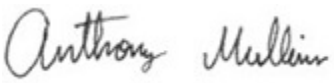
While onsite, I conducted an exit conference with licensee designee, Mr. Book. He was informed of the investigative findings and agreed to complete a corrective action plan.

On 11/19/25, I received a copy of Resident A's assessment plan from Mr. Book via email. I reviewed the assessment plan, which indicates Resident A has "moderate wandering: currently wanders within the residence of the facility. May wander outside; health or safety may be jeopardized, but participant does not resist redirection about returning to community."

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Resident A has a documented history of wandering within the facility, and her assessment plan notes a risk of elopement. Despite the known risk, staff at the facility did not implement the necessary safety measures to prevent this from occurring. As a result, Resident A exited the facility unsupervised and sustained injuries. Based on these findings, 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.



12/01/2025

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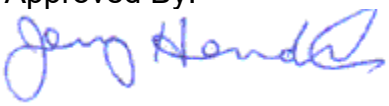
Anthony Mullins Date
Licensing Consultant

Approved By:



12/02/2025

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Jerry Hendrick Date
Area Manager