



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 19, 2025

Michael Townsend
61 Diamond Avenue NE
Grand Rapids, MI 49503

RE: License #: AS410418699
Investigation #: 2026A0579009
Michael's Refuge

Dear Michael Townsend:

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,

A handwritten signature in black ink that reads "Cassandra Duursma". The signature is written in a cursive, flowing style.

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

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|---------------------------------------|---|
| License #: | AS410418699 |
| Investigation #: | 2026A0579009 |
| Complaint Receipt Date: | 11/19/2025 |
| Investigation Initiation Date: | 11/20/2025 |
| Report Due Date: | 01/18/2026 |
| LicenseeName: | Michael Townsend |
| Licensee Address: | 61 Diamond Avenue NE. Grand Rapids, MI 49503 |
| Licensee Telephone #: | (616) 516-6621 |
| Administrator: | Michael Townsend |
| Licensee Designee: | Michael Townsend |
| Name of Facility: | Michael's Refuge |
| Facility Address: | 722 Eastern Avenue SE. Grand Rapids, MI 49507 |
| Facility Telephone #: | (616) 481-2423 |
| Original Issuance Date: | 03/03/2025 |
| License Status: | REGULAR |
| Effective Date: | 09/03/2025 |
| Expiration Date: | 09/02/2027 |
| Capacity: | 5 |
| Program Type: | PHYSICALLY HANDICAPPED/ MENTALLY ILL/ DEVELOPMENTALLY DISABLED/ AGED |

II. ALLEGATION(S)

| | Violation Established? |
|---|-----------------------------------|
| Resident A does not receive adequate supervision. | No |
| Resident A was not provided with transportation to a medical appointment. | No |
| Additional Findings | Yes |

III. METHODOLOGY

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| 11/19/2025 | Special Investigation Intake 2026A0579009 |
| 11/20/2025 | Special Investigation Initiated - Face to Face Resident A Mark Townsend, Direct Care Worker |
| 11/20/2025 | APS Referral Denied |
| 11/20/2025 | Contact- Documentation Sent Michael Townsend, Licensee Designee |
| 12/05/2025 | Contact- Documentation Sent Michael Townsend, Licensee Designee |
| 12/10/2025 | Contact- Documentation Received Michael Townsend, Licensee Designee |
| 12/12/2025 | Contact- Documentation Received Michael Townsend, Licensee Designee |
| 12/17/2025 | Exit Conference Michael Townsend, Licensee Designee |

ALLEGATION: Resident A does not receive adequate supervision.

INVESTIGATION: On 11/19/25, I received this referral which alleged there is concern that Resident A “comes and goes as he pleases” without supervision although he needs some type of supervision when in the community. People have reportedly stolen money from Resident A, assaulted him, and Resident A went to jail for defending himself. It is unknown if the AFC home staff are aware that this occurred. It is unknown when this happened but “it sounds like it was a few weeks or months ago.”

On 11/20/25, I completed an unannounced on-site investigation. Resident A and direct care worker (DCW) Mark Townsend were present. I spoke to Resident A but due to his limited use of English and speaking primarily in Spanish, he could not engage in interviewing.

Mr. Townsend reported there have been challenges with Resident A's guardianship since he arrived at the home. He stated Resident A previously had a very unresponsive guardian, Guardian A1, who did not assist with completing Resident A's required documentation correctly even though Mr. Michael Townsend attempted to have it completed multiple times. He stated Resident A's overall functioning has been increasing since he arrived at the home because he arrived at the home very ill. He stated Resident A was recently appointed a new guardian, Guardian A2, so he believes Resident A assessment plan will be updated, completed correctly, and he will be given more freedom of movement.

Mr. Townsend stated currently Resident A does not go into the community without supervision. He stated Resident A has permission to take the GoBus to English classes and doctor's appointments and he visits Relative A and has a relative who lives near the home who will take him on visits as well. He stated the GoBus tickets are provided by his guardian. He stated he was aware that several years ago, while living independently, Resident A was assaulted and robbed and then sentenced and incarcerated for defending himself with a knife. He stated this occurred prior to Resident A moving into this home.

On 11/20/25, I contacted Mr. Michael Townsend. I was made aware in July 2025 when completing an on-site inspection that Mr. Michael Townsend was having challenges with Guardian A1 completing Resident A's assessment plan correctly. I requested a copy of any assessment plan completed for Resident A, any communication with Guardian A1 about the assessment plan, and any updated assessment plan that was or will be completed during this investigation with Guardian A2.

Mr. Michael Townsend responded, including Guardian A2 and Resident A's caseworker. He stated he wanted to express concern about Resident A's supervision. He stated that since Resident A's health and cognition have improved while living in the home, Resident A has begun attempting to leave the home without supervision to purchase cigarettes. He stated this was not allowed by DCWs at the home and was immediately addressed. He stated Resident A often waits until DCWs are preparing meals and attempts to leave unnoticed. DCWs respond by redirecting Resident A back to the home, discussing his supervision expectations with him, and notifying his guardian. He confirmed that Resident A leaving the home unsupervised was discussed with him at a meeting with an interpreter present so Resident A is aware he can only leave the home with DCWs or guardian permission. He noted a 30-day notice was discussed if Resident A's elopement continued and Guardian A2 approved Relative A placing an AirTag in Resident A's jacket to locate him quickly if he elopes from the home. He reported none of Resident A's stolen money or legal

involvement occurred while he resided at Michael's Refuge. He reported both of Resident A's guardians have given him GoBus tickets to move independently within the community.

Mr. Michael Townsend provided communication between him and Guardian A1 from 7/14/25 when he asked Guardian A1 to complete Resident A's required AFC documents, which he attached. She responded that she does not complete the forms, she only signs them.

I received Resident A's assessment plan completed by Guardian A1 and dated 7/16/25. Regarding moving independently within the community, the 'No' box was checked and the comment line stated "No." No additional details were included.

On 12/5/25, I contacted Mr. Michael Townsend to inquire if Guardian A2 was able to complete an updated assessment plan for Resident A. I provided examples of appropriate responses regarding supervision. I attached an example of an acceptable assessment plan that I completed for training purposes. I requested a copy of appropriate documentation by 12/12/25 if it is available.

On 12/10/25, Mr. Townsend reported he was updating the assessment plan with Guardian A2 at the home today and would provide an updated copy.

On 12/12/25, I received an updated assessment plan completed by Guardian A2. Regarding supervision. It was noted Resident A moves independently within the community but must make DCWs aware of where he is going.

| APPLICABLE RULE | |
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| 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: | Mr. Mark Townsend and Mr. Michael Townsend reported that it was known from previous on-site contact, and documentation confirmed that Guardian A1 was not responsive with completing Resident A's assessment plan correctly. The assessment plan initially stated Resident A does not move independently within the community and did not provide further details. It was reported Guardian A1 and Guardian A2 provided Resident A GoBus passes for Resident A to go into the community, although his assessment plan stated he did not go in the community independently. |

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| | <p>Mr. Michael Townsend and Guardian A2 updated Resident A's assessment plan during this investigation to reflect Resident A's current supervision needs. It was confirmed Resident A may go into the community independently if he reports his whereabouts.</p> <p>Based on the interviews completed and documentation reviewed there is insufficient evidence that Resident A did not receive supervision as specified in his assessment plan.</p> |
| CONCLUSION: | VIOLATION NOT ESTABLISHED |

ALLEGATION: Resident A was not provided with transportation to a medical appointment.

INVESTIGATION: On 11/19/25, I reviewed the referral which alleged Relative A brought Resident A to a doctor's appointment because AFC staff called Relative A and said they could not transport Resident A to the appointment even though staff confirmed the appointment. The physician had difficulty contacting Guardian A2 to allow Relative A to attend the appointment with Resident A since she is not his guardian.

On 11/20/25, Mr. Townsend reported Resident A ran out of GoBus passes, did not want to attend his appointment, and would not get up when he was prompting Resident A that he needed to get ready for his appointment. He stated GoBus tickets are provided by Resident A's guardians. He stated Relative A called to report she was heading to the appointment and would meet Resident A there. He stated he explained to Relative A that Resident A did not have GoBus passes and was not willing to get out of bed and she agreed she would come to the home. She stated Resident A agreed to attend the appointment with Relative A. He stated he did not call Relative A or ask her to transport Resident A or refuse to transport Resident A. She offered to assist Resident A with attending the appointment since she was already going to the appointment.

On 11/20/25, Mr. Michael Townsend provided a resident care agreement completed by Guardian A1 that was not consistent with the department Resident Care Agreement form and was missing information. It noted transportation will be provided to medical appointments as needed. I inquired if an updated resident care agreement, in compliance with licensing rules, was available for Resident A.

Mr. Michael Townsend provided communication between him and Guardian A1 from 7/14/25 when he asked Guardian A1 to complete Resident A's required AFC documents, which he attached. She responded that she does not complete the forms, she only signs them.

Mr. Michael Townsend reported Relative A does not have restrictions on visiting with or transporting Resident A and she is allowed to attend his medical appointments. He stated on the morning of the appointment that Relative A transported Resident A to, Resident A refused to get out of bed and missed his scheduled transportation. To ensure Resident A did not miss the appointment, Relative A was contacted and assisted with transporting Resident A. He reported Resident A is out of GoBus tickets and noted Guardian A2 had addressed obtaining the next packet.

On 12/5/25, I contacted Mr. Michael Townsend to inquire if Guardian A2 was able to complete an updated resident care agreement for Resident A. Consultation was provided regarding appropriately completing the care agreement.

On 12/10/25, Mr. Townsend reported he was updating the Resident Care Agreement with Guardian A2 at the home today and would provide an updated copy.

On 12/12/25, I received an updated Resident Care Agreement form completed by Guardian A2. The section regarding transportation was not complete. Resident A's assessment plan dated 12/10/25 was also received and noted the AFC home will arrange transportation for Resident A.

| APPLICABLE RULE | |
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| R 400.685 | Resident admission; resident assessment plan; resident care agreement; health care appraisal. |
| | <p>(6) A licensee shall complete a written resident care agreement at the time of a resident's admission that includes all of the following:</p> <p>(i) An agreement by the licensee to provide care, supervision, and protection to the resident and to ensure transportation services as indicated in the resident's assessment plan and resident care agreement.</p> |
| ANALYSIS: | <p>Mr. Mark Townsend and Mr. Michael Townsend reported Resident A uses GoBus services for transportation. They reported on the day Relative A brought him to his appointment; he missed his transportation and Relative A's assistance was requested.</p> <p>Resident A's initial resident care agreement noted transportation was provided to medical appointments as needed. Resident A's updated Resident Care Agreement had the section regarding transportation incomplete. Resident A's updated assessment plan noted the AFC will arrange transportation for Resident A.</p> <p>Based on the interviews completed and documentation</p> |

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| | reviewed, there is insufficient evidence that transportation was not provided as specified in Resident A's assessment plan and care agreement, with the most updated documentation noting the AFC will arrange transportation for Resident A. |
| CONCLUSION: | VIOLATION NOT ESTABLISHED |

ADDITIONAL FINDING:

On 11/20/25, I observed that Resident A's current resident care agreement was not consistent with the department Resident Care Agreement form. I provided consultation on completing an acceptable resident care agreement.

On 12/5/25, I provided consultation regarding documentation. I advised any documentation not received correctly by 12/12/25, would be cited and a request would be made for a corrective action plan.

On 12/12/25, I received an updated Resident Care Agreement form where the section regarding transportation was not completed.

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| APPLICABLE RULE | |
| R 400.685 | Resident admission; resident assessment plan; resident care agreement; health care appraisal. |
| | (6) A licensee shall complete a written resident care agreement at the time of a resident's admission that includes all of the following: (f) Transportation services provided for a basic fee and services that are provided at an extra cost. |
| ANALYSIS: | Resident A's initial Resident Care Agreement form was not consistent with the department form. Consultation was provided on two occasions regarding completing acceptable Resident Care Agreement forms. Resident A's current Resident Care Agreement dated 12/10/25, did not have the section regarding transportation completed. Based on the documentation observed, there is sufficient evidence that Resident A's Resident Care Agreement did not include transportation services provided. |
| CONCLUSION: | VIOLATION ESTABLISHED |

On 12/17/25, I completed an exit conference with Mr. Michael Townsend who did not dispute my findings or recommendations at the time of report disposition. He reported leaving the transportation section incomplete on the Resident Care Agreement was an accidental oversight and would be corrected.

IV. RECOMMENDATION

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

Cassandra Duursma

12/18/2025

Cassandra Duursma
Licensing Consultant

Date

Approved By:

Jerry Hendrick

12/19/2025

Jerry Hendrick
Area Manager

Date