GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 29, 2026

Grandhaven Living Center LLC
Suite 200
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL330268975
Investigation #: 2026A0622013
Grandhaven Living Center 5 (Cottage)

Dear Ms. DelRaso:

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 feel free to 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 (517) 335-5985.

Sincerely,

Amanda Blasius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330268975
Investigation #:	2026A0622013
Complaint Receipt Date:	12/08/2025
Investigation Initiation Date:	12/09/2025
Report Due Date:	02/06/2026
Licensee Name:	Grandhaven Living Center LLC
Licensee Address:	Suite 200 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(517) 420-3898
Administrator:	Marie Jonzun
Licensee Designee:	Carol DelRaso
Name of Facility:	Grandhaven Living Center 5 (Cottage)
Facility Address:	3165 W. Mount Hope Avenue Lansing, MI 48911
Facility Telephone #:	(517) 485-5966
Original Issuance Date:	03/17/2005
License Status:	REGULAR
Effective Date:	12/23/2025
Expiration Date:	12/22/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
On 7/31/25, Resident A eloped the facility due to the doors and alarms malfunctioning.	Yes
On 1/16/25, staff failed to follow documented pre-surgical instructions for Resident A.	Yes
Resident A was given a 30-day discharge notice without an appropriate setting identified.	No
Additional Findings	Yes

III. METHODOLOGY

12/08/2025	Special Investigation Intake 2026A0622013
12/09/2025	Special Investigation Initiated – Telephone call to Guardian A1
12/16/2025	Inspection Completed On-site
01/02/2026	Contact - Document Received
01/09/2026	Contact - Telephone call made to direct care worker Susan Kuzmanov
01/13/2026	Contact- Email sent to administrator, Marie Jonzun
01/20/2026	Contact- Email sent to administrator, Marie Jonzun and licensee designee, Carol DelRaso. Email sent to Guardian A1
01/21/2026	Contact- phone call to administrator, Marie Jonzun. Documents received from direct care worker, Susan Kuzmanov
01/29/2026	Exit Conference with licensee designee, Carol DelRaso

ALLEGATION: On 7/31/25, Resident A eloped the facility due to the doors and alarms malfunctioning.

INVESTIGATION:
On 12/08/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, on 7/31/2025, Resident A eloped from the home. The complaint stated that on 8/1/2025, Guardian A1 was notified by phone that Resident A eloped due to all five doors in the Cottage unit malfunctioning and the alarms were not working.

On 12/09/2025, I interviewed Guardian A1 via email. Guardian A1 reported that on 8/1/2025, she received a phone call from Crystal Barclay stating that on 7/31/2025, the doors in the Cottage unit malfunctioned and the alarms were not working, which resulted in Resident A eloping from the home. Guardian A1 reported that she was told that Resident A was outside of the building for about 5-10 minutes. Guardian A1 reported that Crystal Barclay informed her that they would be completing hourly checks on residents and they had contacted a service company to fix the doors. According to Crystal Barclay the doors would be fixed by 6pm on 8/1/25.

On 12/10/2025, Guardian A1 provided me with a document titled, *General and Supplemental Fee Policy*. According to the *General and Supplemental Fee Policy*, it stated that it was effective 1/1/2025 for Resident A. The fee schedule stated that Resident A was charged the following:

- Essential Service Rate: $2,753
- Individual Service Plan Rate: $1,368
- Monthly Service Rate: $4,121

The *General and Supplemental Fee Policy* stated that Resident A's fee was under the memory care base rate and determined at the level of care II. The *General and Supplemental Fee Policy* stated that the essential services rate included the following services: Studio/one bedroom, 24/7 awake staff, life enrichment activities, housekeeping services, maintenance services, all meals, snacks & beverages, personal laundry and linen services and all utilities noted in section 2 of this policy.

The *General and Supplemental Fee Policy* stated that level of care charges, for the individual service plan rate, are in addition to the residents monthly base rate and represent additional cost of providing personalized care and assistance to the resident. The amount and type of personal care assistance needed is to be determined from the information provided by the resident's licensed health care professional and the evaluation that includes the individualized service plan.

On 12/16/2025, I completed an unannounced onsite investigation to Grandhaven Living Center 5 (Cottage). During the unannounced onsite investigation, I interviewed administrator, Marie Jonzun and reviewed documentation.

I viewed an incident report that was completed on 7/31/2025 at 4:15pm. According to the incident report, Resident A was found outside on community grounds by direct care worker, Susan Kuzmanov and was observed to be entering the building from an outside door. According to the incident report, staff immediately assisted Resident A back into the common area and performed a count to ensure all other residents were accounted. Staff performed a check of all exit doors to find that several exit doors are not locking as expected, and the alarm is not sounding. The report stated that leadership contacted Riverview to visit the community to assess the problem. According to the report, no injuries were observed on Resident A. Guardian A1 was notified on 8/1/25 at 8am.

On 12/16/2025, I interviewed administrator, Marie Jonzun in person. She confirmed that on 7/31/2025, the locked doors in the Cottage unit were not working, nor were the alarms working. Ms. Jonzun stated that the wiring in the doors ended up needing to be replaced. To provide more supervision while the doors and alarms were not working, Ms. Jonzun stated that they had four direct care workers on shift and were completing 15-minute checks on all residents, including Resident A.

On 01/09/2026, I interviewed direct care worker, Susan Kuzmanov via phone. DCW Kuzmanov confirmed that on 7/31/2025 that the locked doors in the Cottage malfunctioned and Resident A eloped from the home.

During the unannounced onsite investigation, I viewed three other incident reports regarding elopements for Resident A.

On 10/24/2024 at 7:22pm, Resident A eloped from the facility. According to the incident report completed by direct care worker Crystal Barclay door number 7 went off and alarmed the phones. The report stated that the supervisor went to the building to assist staff that were already in the process of looking for the resident. Staff located Resident A outside the building in the parking lot, eight minutes after the phone alarms went off. The incident report stated that Resident A was assisted and directed indoors, and an evaluation was completed to ensure he had no injuries. The report stated that Guardian A1 was notified, along with leadership. According to the incident report, increased supervision checks were set into place.

On 12/08/2024 at 2:45pm, Resident A eloped from the facility. According to the incident report completed by direct care worker, Crystal Barclay, Resident A was observed walking outside at the end of the lighthouse near the parking lot. The incident report stated that Resident A said he got out by himself and he doesn’t know where he is going. The incident report stated that Resident A was taken back to his apartment and team members and leadership were contacted. Guardian A1 was notified on 12/8/24 at 4pm.

On 04/29/2025 at 4:40pm, Resident A eloped from the facility. According to the incident report completed by direct care worker, Crystal Barclay Resident A eloped from the facility around 4:40pm and was found at 5:30pm in the apartments across the parking lot. According to the incident reports when Resident A eloped staff immediately started to look for Resident A. When staff could not locate him leadership and 911 was notified. The report also stated that Guardian A1 was also notified.

On 12/16/2025, an AFC Licensing Division incident/accident report was not available for review for Resident A’s elopements.

On 12/16/2025, an updated 2025 Assessment Plan for AFC Residents for Resident A was not available for review.

Based upon Resident A's *Assessment Plan for AFC Residents* signed 1/8/24, it stated the following for Resident A:

- Moves independently within the community- yes
- Communicates needs- yes
- Understands verbal communication- yes
- Alert to surroundings- yes
- Reads and writes- yes
- Follows instructions- yes
- Controls aggressive behavior- yes
- Gets along with others- yes
- Needs help with feeding, toileting, dressing, bathing- no
- Grooming- needs reminders
- Personal hygiene- needs reminders
- Needs help with walking/mobility- no
- Special diets, physical limitations, special equipment needed, other difficulties, suspectable to hypothermia and hyperthermia- no

On 01/21/2026, I received additional documents regarding Resident A from direct care worker, Susan Kuzmanov. Direct care worker Kuzmanov provided a document titled, *Service Plan Report*. The *Service Plan Report* for Resident A, which was created on 3/12/24 stated the following:

- Escort/mobility- Resident is independent with all tasks related to mobility
- Transfers- Resident is independent with all tasks related to mobility
- Assurance checks- Assurance checks provided every hour for safety
- Falls- Rounding during checks
- Bathing, dressing, grooming toileting- needs reminders and cueing
- Communication- requires assistance with communication, extra time, multiple approaches, cue cards, word findings
- Reasoning- care staff will report any changes in ability to reason
- Connection points (created on 8/4/25)- anticipate resident needs, pay close attention to face and body for cues. Approach resident from front, introduce self and explain why you are there. May need simple reminders and directions. Use gentle touch and soft voice with resident.
- Instrumental ADL's- Resident requires assistance with using phone, acquiring transportation, completing shopping, preparing own meals, performing housework and managing legal affairs.

After reviewing the *Service Plan Report* for Resident A, no updates were completed for Resident A, besides the connection points which was updated on 8/4/25.

On 01/21/2026, I received documents regarding Resident A's elopement risk. According to the documents an elopement risk was completed on 12/16/2024, 5/12/2025 and 8/1/2025. All three elopement risk assessments had a score of 36 which, according to the document falls under at risk; "resident is placed on a wander system management system or routine assurance check protocol by the community.

The resident's whereabouts should be verified routinely throughout the day and night. Ensure the resident is maintained in sight during programs/activities."

On 01/21/2026, DCW Susan Kuzmanov reported that on 4/27/2025, staffing in the Cottage building increased to three direct care workers during the daytime shifts and two direct care workers during the sleeping hours and continued at this ratio until Resident A was discharged.

On 01/23/2026, I received a copy of an elopement document dated 11/15/2025. According to Administrator, Marie Jonzun this elopement prompted a request for Guardian A1 to provide 1:1 supervision for Resident A until he could find a new placement. The elopement document stated the following: "Staff responded to door 11 sounding and observed [Resident A] about 10 feet away. Resident was redirected indoors to the facility. Leadership and Guardian A1 were notified of the incident." No additional details were provided on the elopement document.

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:	After interviews and review of documentation for Resident A it has been determined that Grandhaven Living Center 5 (Cottage) was not properly providing supervision and protection to Resident A on 7/31/25, as the locked doors in the unit malfunctioned and allowed Resident A to elope from the building. According to the interviews and documentation, Resident A was to have hourly checks and three direct care workers were on staff yet he still eloped. Direct care workers shall be providing the supervision and should not rely solely on the alarms and locked doors of the unit to prevent Resident A from eloping from the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 1/16/25, staff failed to follow documented pre-surgical instructions for Resident A.

INVESTIGATION:
On 12/08/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, on 01/14/2025 direct care worker Susan Kuzmanov (wellness director) was given

written notification that Resident A had surgery on 1/16/25 and pre-surgical instructions were given in writing. The complaint stated that the instructions stated that Resident A needed to be showered on the evening of 1/15/2025 and nothing should be consumed by mouth for Resident A after midnight on 1/15/25. According to the complaint, Guardian A1 arrived on the morning of 1/16/25 to transport Resident A to his surgery and he had been given breakfast and the caregivers on shift were unaware of any pre-surgical instructions that should have been followed. The complaint stated that Resident A's surgery needed to be rescheduled.

On 12/09/2025, I interviewed Guardian A1 via email. Guardian A1 provided copies of her emails between herself and DCW Susan Kuzmanov. The email sent to DCW Susan Kuzmanov on 1/14/25 at 3:45pm stated the following:

"Hello Susan, [Resident A's] second eye surgery is coming up this Thursday, January 16th. He will follow the same regimen as last week, including shower Wednesday night, nothing to consume after midnight and hold the same medications. I will pick him up around 10:45am Thursday."

On 01/09/2026, I interviewed direct care worker Susan Kuzmanov via phone. She reported that she does remember the appointment for Resident A from January 2025. DCW Kuzmanov reported that she did receive the communication regarding Resident A's surgery for 1/16/25 via email and the email stated that he needed to be showered the night prior and he should not eat anything after midnight. DCW Kuzmanov stated that she was unable to get the communication out to the direct care workers on the floor for 1/15/25 and 1/16/25, therefore the orders were not followed. DCW Kuzmanov reported that she communicated with Guardian A1 and apologized for the inconvenience and for not passing on the pre-surgical orders to the direct care workers on the floor. DCW Kuzmanov confirmed that the surgery was re-scheduled.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	Based upon the documentation received and interviews with direct care worker, Susan Kuzmanov it can be determined that Resident A's pre-surgical orders were not followed on 1/15/25 and 1/16/25. Pre-surgical instructions were provided to DCW Kuzmanov via email on 1/14/25 and during an interview with DCW Kuzmanov she confirmed that she did not inform the direct care workers working on 1/15/25 and 1/16/25, that Resident A needed to be showered and he should not be given breakfast due to his pre-surgical orders. DCW Kuzmanov reported that she did not send out the orders to the other direct care workers and also confirmed that Resident A had to have his surgery rescheduled due to not following the pre-surgical orders.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was given a 30-day discharge notice without an appropriate setting identified.

INVESTIGATION:
On 12/08/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, on 11/06/2025, Guardian A1 met with administrator, Marie Jonzun and was provided with a 30-day discharge notice for Resident A. The complaint stated that Guardian A1 asked if there would be any options for extending the deadline to find an adequate home and she was told "no" by administrator Marie Jonzun. According to the complaint, Guardian A1 asked what would happen if she could not find an acceptable home and she was told that she would have to take Resident A to her personal home.

On 12/09/2025, I interviewed Guardian A1 via email. She provided a copy of her written discharge notice and explained that she was forced to pay for a one-on-one staff member to supervise Resident A as of 11/15/25. She reported that Resident A eloped again on 11/15/2025. Guardian A1 explained that she was able to find a new adult foster home for Resident A on 11/18/25. She stated that she felt forced to find a new home ASAP due to the amount she was paying for his one-on-one care.

On 12/09/2025, I reviewed the written discharge notice for Resident A dated 11/06/2025. The discharge notice stated the following: "[Resident A's] frequent exit seeking and elopement behaviors present a substantial safety risk to himself, other residents and staff. It was determined that [Resident A] would require one-on-one supervision. His current needs are beyond our ability to provide the safety, protection and supervision he requires and all interventions that have been attempted have been unsuccessful. Therefore, according to the licensing rule and in accordance with the discharge policy that was signed at admission, I must exercise my duty to provide you with 30-days written notice to discharge [Resident A] from Grandhaven Living Center. [Resident A] had fifteen incidents of exit seeking from

2024-2025 and received increased supervision four times from 2024-2025 due to excessive exit seeking. It is documented that [Resident A] eloped on 6/7/24, 4/9/25, 7/31/25 and 10/24/2025."

On 12/16/2025, I completed an unannounced onsite investigation. During the unannounced onsite investigation, I interviewed administrator, Marie Jonzun in person. She reported that a discharge notice was given to Guardian A1 in person on 11/6/25 due to Resident A having frequent exit seeking behavior. Administrator Jonzun stated that they felt they could no longer provide Resident A with the needed supervision and were unable to provide one-on-one care for Resident A, therefore they issued the 30-day notice. Administrator Jonzun confirmed that Resident A was moved out by Guardian A1 on 11/18/2025.

APPLICABLE RULE	
R 400.687	**Resident admission and discharge policy; house rules; change of residency; provision of resident records.**
	(6) A licensee shall take all of the following steps before discharging a resident under subrule (5) of this rule: **(c) A resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.**
ANALYSIS:	Based upon the interview with Guardian A1 and reviewing the 30-day discharge notice, it was determined that Guardian A1 found an additional appropriate placement for Resident A before the end of the thirty-day notice. Resident A was given a thirty day discharge notice on 11/06/2025 and was moved to another AFC on 11/18/2025, therefore a violation was not established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 12/16/2025, I completed an unannounced onsite investigation to Grandhaven Living Center 5 (Cottage). I requested to review Resident A's current *Assessment Plan for AFC Residents.* At the time of the unannounced onsite investigation, Resident A's *Assessment Plan for AFC Residents* for the current year, 2025, was unavailable. I was provided with an *Assessment Plan for AFC Residents* that was signed on 1/8/24 for Resident A. Based upon an email from administrator, Marie Jonzun on 12/17/25, she confirmed that a signed *Assessment Plan for AFC Residents* for Resident A was unavailable.

On 12/16/2025, I completed an unannounced onsite investigation to Grandhaven Living Center 5 (Cottage). I interviewed administrator, Marie Jonzun in person. During the interview, administrator Jonzun reported that over the last year they have

increased Resident A's supervision due to his elopements. She reported that they have tried adding three staff to the Cottage to assist with providing more adequate supervision for Resident A. Administrator Jonzun reported that on 11/15/25, Resident A eloped from the home and made it to a nearby bluff that contained brush and wildlife. She stated that staff were running around looking for him for about 10 minutes. She also confirmed that once staff found him, they struggled to get him back inside as it was difficult to redirect him. Administrator Jonzun stated that they then requested that Guardian A1 find one on one supervision for Resident A until she could find a more appropriate placement for Resident A.

Based upon Resident A's *Assessment Plan for AFC Residents* signed 1/8/24, it stated the following for Resident A:

- Moves independently within the community- yes
- Communicates needs- yes
- Understands verbal communication- yes
- Alert to surroundings- yes
- Reads and writes- yes
- Follows instructions- yes
- Controls aggressive behavior- yes
- Gets along with others- yes
- Needs help with feeding, toileting, dressing, bathing- no
- Grooming- needs reminders
- Personal hygiene- needs reminders
- Needs help with walking/mobility- no
- Special diets, physical limitations, special equipment needed, other difficulties, suspectable to hypothermia and hyperthermia- no

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.

ANALYSIS:	Based upon my interview with administrator, Marie Jonzun and review of documentation it was determined that Grandhaven Living Center 5 (Cottage) did not complete an updated *Assessment Plan for AFC Residents* for Resident A annually. The last completed assessment for review was signed 1/8/24 and according to the interview with administrator Marie Jonzun, Resident A's personal care and supervision needs changed throughout the last two years. Due to no current signed and updated *Assessment Plan for AFC Residents* for Resident A a violation was established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 12/16/2025, I completed an unannounced onsite investigation to Grandhaven Living Center 5 (Cottage). I requested to review incident reports for Resident A regarding his elopements. During the unannounced onsite investigation, I was given a computer document that stated elopement at the top of the page. I was given four elopement reports for Resident A, all completed on the same document from a computer system. Upon review of the form, the document was missing the same information that is contained in the *AFC Licensing Division incident/accident report*. The form that the facility is using is missing pertinent information which included the names and contact information the person directly involved in the incidents, any witnesses and signatures of the person completing the report and the signature of the licensee designee.

On 01/13/2026, no documentation was found regarding Grandhaven Living Center 5 having approval to use another form or of a licensing consultant approving the current form they provided to me on 12/16/2025.

APPLICABLE RULE	
R 400.693	**Incident notification, incident records**
	(3) An incident must be recorded on a department-approved form, or a facility form that contains the same information, and retained in the facility for 2 years.

ANALYSIS:	During an unannounced onsite investigation, it was determined that Grandhaven Living Cener 5 is not using a department-approved form, or a facility form that contains the same information to record incidents. After reviewing the incident reports that Grandhaven Living Center 5 is using for Resident A's elopements, it was determined that their form is missing pertinent information which included the names and contact information the person directly involved in the incidents, any witnesses and signatures of the person completing the report, along with the licensee designee, therefore a violation was established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 01/09/2026, I requested Resident A's *Health Care Appraisal* to determine his need for supervision within the home and after reviewing the Resident A's General and Supplemental Fee Policy, it stated that the amount and type of personal care assistance needed is determined from the information provided by the residents licensed health care professional and the evaluation that includes the individualized service plan. On 01/13/2026, I followed up with administrator Marie Jonzun and licensee designee, Carol DelRaso regarding the health care appraisal as it had yet to be received. On 01/21/2026, I requested the *health care appraisal* again via email. On 01/23/2026, I received a copy of Resident A's health care appraisal via email. The health care appraisal received for Resident A was dated 5/5/2022 by Dr. Cynthia Buchwetz. According to the health care appraisal for Resident A, it stated that Resident A is fully ambulatory, has a cognitive impairment and needs supervision.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(10) A resident or resident's designated representative shall provide a written health care appraisal or a medical discharge summary by an appropriate health care professional that is completed within the 90-day period before admission. A written health care appraisal must be completed at least annually thereafter. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be completed no later than 30 days after admission.

ANALYSIS:	During the investigation, I requested the most recent copy of Resident A's *Health Care Appraisal.* I was provided with a copy of Resident A's *Health Care Appraisal*, which was dated 5/5/2022. A violation was established as Resident A's health care appraisal was not updated annually since 2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/22/2026

Amanda Blasius — Date
Licensing Consultant

Approved By:

01/29/2026

Dawn N. Timm — Date
Area Manager