



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 28, 2026

Meridee Watt
AH Holland Subtenant LLC
Ste 1600
1 Towne Sq
Southfield, MI 48076

RE: License #: AL700397734
Investigation #: 2026A0467033
AHSL Holland Lighthouse

Dear Mrs. Watt:

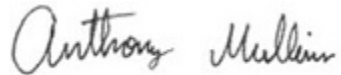
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 cursive script that reads "Anthony Mullins".

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 #:	AL700397734
Investigation #:	2026A0467033
Complaint Receipt Date:	04/23/2026
Investigation Initiation Date:	04/23/2026
Report Due Date:	06/22/2026
Licensee Name:	AH Holland Subtenant LLC
Licensee Address:	Ste 1600 1 Towne Sq Southfield, MI 48076
Licensee Telephone #:	(616) 283-9221
Administrator:	Meridee Watt
Licensee Designee:	Meridee Watt
Name of Facility:	AHSL Holland Lighthouse
Facility Address:	11905 James Street Holland, MI 49423
Facility Telephone #:	(616) 393-2174
Original Issuance Date:	03/21/2019
License Status:	REGULAR
Effective Date:	09/21/2025
Expiration Date:	09/20/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff member Amara Smith moved Resident A's call light out of reach, resulting in her falling out of bed on 4/22/26.	Yes

III. METHODOLOGY

04/23/2026	Special Investigation Intake 2026A0467033
04/23/2026	Special Investigation Initiated - Telephone
04/23/2026	APS Referral made via phone
04/27/2026	Inspection Completed On-site
04/27/2026	Exit conference with licensee designee, Meridee Watt

ALLEGATION: Staff member Amara Smith placed Resident A's call light out of reach, resulting in her falling out of bed on 4/22/26.

INVESTIGATION: On 4/23/26, I received a call from licensee designee Meridee Watt. She reported that staff member Amara Smith had moved Resident A's call light out of reach, which resulted in her falling out of bed on 4/22/26. Resident A did not sustain any marks, bruises, or injuries from the fall. Mrs. Watt stated that she collected written statements from staff members who were aware of the incident and would provide copies during my onsite visit.

On 4/27/26, I conducted an announced onsite investigation at the facility. Upon arrival, I met with licensee designee Meridee Watt and wellness director Brooke Marshall. They provided me with statements gathered during their internal investigation. According to Mrs. Marshall's statement, Ms. Smith called her around 6:00am on 4/22/26 to report Resident A's fall. During the call, Ms. Smith admitted that she had removed Resident A's call light earlier in the shift because she was "using it too much," approximately every 10 minutes. Ms. Smith acknowledged that she placed the call light out of Resident A's reach. Mrs. Marshall informed Ms. Smith that she is not permitted to do so, as the call light is Resident A's means of requesting assistance when needed. Ms. Smith responded, "I know." Mrs. Marshall had a different staff member work in the building with Resident A for the remainder of the shift.

Medication tech Kerrie Flores also provided a written statement regarding the incident. Ms. Flores reported that when she arrived for her shift on the morning of

4/22/26, she was approached by staff member Amara Smith. According to Ms. Flores, Ms. Smith was swearing and expressing frustration, complaining that Resident A had been pulling the light repeatedly throughout the shift. Ms. Smith allegedly stated that she “got sick of it” and removed the call light from Resident A’s reach. Ms. Flores reported that Ms. Smith told her that Resident A was on the floor, but she believed the fall was staged. Before leaving the building, Ms. Smith informed Ms. Flores that she planned to message management about the incident to share how she felt and that she “didn’t care” if she were to be terminated.

I also reviewed the statement completed by staff member Olivia Bissonette. Ms. Bissonette reported that Ms. Smith referred to Resident A as “petty” and asked Ms. Bissonette if she knew who the resident was. When Ms. Bissonette responded that she did not, Ms. Smith explained that Resident A had repeatedly pulled her call light during her shift, so she took the call light away. Ms. Bissonette stated that Ms. Smith showed her a photo of Resident A lying on the floor. When Ms. Bissonette asked whether she had notified the wellness director, Ms. Smith stated, “yes, and I told her I took her call light away.”

Prior to concluding my onsite investigation, Mrs. Marshall assisted me to Resident A’s room. I observed Resident A sitting in her recliner chair. When asked whether staff were taking good care of her, Resident A responded “no.” When prompted to explain, she stated that her reclining chair was not working. Resident A provided the chair remote to Mrs. Marhsall, who was able to operate it without issue, indicating that Resident A had been pressing the wrong button in her attempt to operate the chair. Mrs. Marshall assisted Resident A from the chair, and Resident A was able to walk to her bed. Resident A did not provide any additional information. She was free of any visible marks or bruises.

While onsite, I conducted an exit conference with Licensee Designee Meridee Watt and Wellness Director Brooke Marshall. Mrs. Watt confirmed that staff are not provided with company phones during their shift. Therefore, Ms. Smith took a picture of Resident A with her personal phone, which invaded her privacy. Mrs. Watt also confirmed that Ms. Smith was terminated on the morning of the incident (4/22/26) and provided documentation to verify this. Additionally, Mrs. Watt provided documentation showing that staff members completed an in-service training on the facility’s abuse and neglect policy following the incident. Mrs. Watt is aware that a corrective action plan (CAP) is due within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: (p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.

ANALYSIS:	Ms. Smith admitted to management and other staff members that she removed Resident A's call light from within reach because Resident A was using it repeatedly throughout her shift. This action may have resulted in Resident A falling out of bed. No marks, bruises, or injuries were observed as a result of the fall. Ms. Smith also took a picture of Resident A while she was lying on the floor, which invades her privacy. Based on the information obtained, there is a preponderance of evidence to support this applicable rule violation.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no changes to the current license status.

Anthony Mullins

04/28/2026

 Anthony Mullins
 Licensing Consultant

 Date

Approved By:

Jerry Hendrick

04/28/2026

 Jerry Hendrick
 Area Manager

 Date