



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 23, 2026

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

RE: License #: AL700397734
Investigation #: 2026A0579027
AHSL Holland Lighthouse

Dear Meridee Watt:

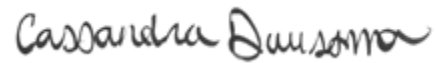
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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

License #:	AL700397734
Investigation #:	2026A0579027
Complaint Receipt Date:	03/12/2026
Investigation Initiation Date:	03/17/2026
Report Due Date:	05/11/2026
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/ ALZHEIMERS/ AGED

II. ALLEGATION(S)

	Violation Established?
The facility is insufficiently staffed from 6:45 p.m. to 7:00 a.m.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/12/2026	Special Investigation Intake 2026A0579027
03/17/2026	Special Investigation Initiated - Face to Face Kerrie Flores, Direct Care Worker Meridee Watt, Direct Care Worker Phil Tyson, Maintenance Worker
03/17/2026	Contact - Telephone call made Te'a Valentine, Direct Care Worker
04/20/2026	Contact- Telephone call made Angela Finney, Direct Care Worker
04/20/2026	Contact- Telephone call made Diana Baldwin, Direct Care Worker
04/20/2026	Contact- Telephone call made Brisa Martinez, Direct Care Worker
04/20/2026	Contact- Telephone call made Brandy Ramirez, Direct Care Worker
04/20/2026	Contact- Telephone call made Brent Essink, Direct Care Worker
04/20/2026	Contact- Document sent Meridee Watt, Licensee Designee
04/20/2026	Contact- Telephone call made Angela Finney, Direct Care Worker
04/20/2026	Contact- Telephone call made Brandy Ramirez, Direct Care Worker
04/22/2026	Exit Conference Meridee Watt, Licensee Designee

ALLEGATION: The facility is insufficiently staffed from 6:45 p.m. to 7:00 a.m.

INVESTIGATION: On 3/12/26, I received this referral which alleged this home is a memory care unit and there are 18 residents to one direct care worker (DCW) during the overnight shift which begins at 6:45 p.m. and goes until 7:00 a.m. Residents are awake from 7:00 p.m. to 11:00 p.m. Residents are woken up starting at 5:00 a.m. There are residents who are at risk for falls and use a call light. Sometimes the call light rings for 15 minutes or more. Not all DCWs who work alone are trained to pass medication. When a DCW working alone isn't trained on medications and a resident needs medication, a DCW from another home on this campus must come from that home to pass and sign for medication in this home. There are checks and changes every two hours when residents are sleeping. There are several residents who require the assistance from two DCWs for transferring. With only one DCW in the home, medication, care, and showers are not being provided appropriately. It was reported "the Memory Care Coordinator" is aware of these concerns and they have not been resolved. The complainant did not provide their name or contact information so additional, specific information could not be obtained.

On 3/17/26, I completed an unannounced on-site investigation at the home. I spoke to DCW Kerrie Flores who stated she works the dayshift in this home. She reported that all residents in the home have cognitive impairments that would prevent them from being successfully interviewed.

I observed five residents in the common area of the home. They appeared neat, clean, appropriately dressed, and active. Two residents spoke to me but did not engage in interviewing.

Ms. Flores informed me that the Memory Care Coordinator in this home is Te'a Valentine. She called Ms. Valentine while I was present. Ms. Valentine advised she was not available in person and suggested I speak to Licensee Designee Meridee Watt.

I completed an interview with Ms. Watt at another building on this campus. Ms. Watt reported she understands that AFC facilities must have one DCW to 15 residents during awake hours and one DCW to 20 residents during sleeping hours. She stated she is also aware that if a resident requires the assistance of two or more DCWs, more than one DCW must always be in the home. She denied that she uses "roaming or floating" staff and DCWs who are scheduled and needed in one home do not leave to go to another home to provide care. She stated there is a home on this campus that is staffed with two DCWs and one can leave to assist in other homes because per resident assessment plans, two DCWs are not needed in that home overnight, although that home is high acuity as well.

Ms. Watt stated the census for this home has increased significantly since the fall of 2025. She stated at that time, there were approximately 10 residents in the home and now the home is at capacity with 20 residents. She stated at one time, this

home was the highest acuity and therefore had the greatest staffing needs, however now the home with the highest acuity has two DCWs scheduled, with one being allowed to leave to cover breaks and pass medications as needed. Ms. Watt stated none of the residents in this home require the assistance of two DCWs for mobility, transferring, or toileting. She stated due to this; she is following the requirements of having two DCWs during awake hours which is considered 6:45 a.m. to 7:00 p.m. in this home and one DCW during overnight hours which is considered 6:45 p.m. to 7:00 a.m. at this home. She stated residents typically go to bed following their medication pass at 8:00 p.m. She stated she tries to have additional staff available until 11:00 p.m. but with rebuilding the census of the home, she is also rebuilding the staffing for the home too so that is not always possible. She stated overnight staff also will start waking residents up for the day during their shift.

Ms. Watt stated that when residents are sleeping, DCWs are expected to be checking on and toileting residents every two hours per home policy, unless increased care needs are noted in their assessment plan. She stated in the evening, DCWs may also shower a few residents on a rotating schedule, do the personal laundry of a few residents on a rotating schedule, and do some general cleaning. She stated facility laundry and cleaning is done by housekeeping staff and meal preparation is done in the commercial kitchen on the property. She stated she has heard concerns, primarily from one DCW working in this home, that the staffing level is not sufficient. She stated based on the State of Michigan requirements and the resident's assessment plans, there is sufficient staffing in the home, although DCWs may not have time to "sit and be on their phones" like when the census was lower.

Ms. Watt stated not every DCW who works alone is trained to pass medications. She stated there is always someone on this campus who is trained to pass medications who comes to the homes to pass 8:00 p.m. medications if a medication trained DCW is not in the home. She stated if a resident wakes up during the night and needs a PRN medication, that same individual could be called to come pass the PRN medication. She stated she does not believe that residents in this home ask for PRN medication overnight.

Ms. Watt expressed her opinion that having a DCW come from another home to pass resident medications should not be considered using roaming or floating staff, stating although the DCW is working in another home, the resident assessment plans confirm only one DCW is needed in that home. She stated due to the higher acuity of the residents in that home though, they choose to have two DCWs in that home overnight. I later referred to the second person in the home as "extra staff" and Ms. Watt said, "Your words not mine." She explained they are needed in the home based the residents in the home having the "highest acuity", however resident assessment plans were completed and there is no one who requires the assistance of two DCWs per their assessment plan. She stated due to that, the second worker may briefly leave the home to assist in other homes. She acknowledged that the DCW leaving their assigned home and coming into this home to pass medications is not documented on the staff schedule when it occurs.

Ms. Watt reported DCWs also receive mandatory breaks throughout their shifts. She stated during the day shift, there are extra support staff, including herself, who cover meals and breaks for DCWs. She stated overnight, she is not certain how meals and breaks are managed, but likely by the second DCW from the higher acuity home. She acknowledged that break coverage is not documented on the staff schedule. She also reported that the staff schedule is not an accurate reflection of who worked in the home because changes to the schedule are not documented on the schedule. She stated staff timesheets would confirm who worked, however the timesheets do not list which home the DCW worked in just what time they were on the campus.

I requested the staff schedule for this home for the last month. Ms. Watt informed me there was a schedule maintained for this campus but not specifically for this home. I received and reviewed the campus schedule.

I found that from the hours of 6:45 a.m.-7:00 p.m. there were always two or more DCWs in this home. I found that from the hours of 6:45 p.m. to 7:00 a.m. there was one DCW in the home on 2/15/26-2/21/26, 2/23/26, 2/24/26, 2/28/26, 3/1/26-3/3/26, 3/8/26, 3/12/26, 3/14/26-3/17/26. The additional days, a second DCW was available in the home at some time or the entire time between 7:00 p.m. to 11:00 p.m.

I reviewed the assessment plans of the 20 residents in the home. I found 10 residents were independent in both transferring and mobility. One resident was independent in mobility and needed verbal prompts from DCWs for transferring. Three residents were independent in transferring but required verbal prompts for mobility. Three residents required verbal prompts for transferring and mobility. Two residents required verbal prompts for mobility but required standby assistance from a DCW with transferring. One resident required verbal prompts for mobility and hands-on assistance from one DCW for transferring. Based on the assessment plans, 10 residents require some type of verbal prompt, standby assistance, or hands-on assistance with mobility and/or transferring.

I interviewed maintenance staff, Phil Tyson, regarding the fire drills in the home. He reported he is present for all fire drills and participates by setting off the alarm and noting the evacuation times when everyone is evacuated. He stated the evacuation times for this home are typically around 5 minutes, even with one worker present.

I reviewed the fire drill records for the home. A drill was documented as conducted at 12:00 p.m. on 1/29/26 with the assistance of four DCWs and an evacuation time of five minutes and thirty seconds. A drill was documented as conducted at 5:00 p.m. on 1/19/26 with the assistance of four DCWs with an evacuation time of five minutes and fifteen seconds. A drill was documented as completed on 1/20/26 at 3:00 a.m. with the assistance of three DCWs with an evacuation time that was hard to read but appeared to be five minutes zero seconds. The staff schedule did not align with regularly having this many DCWs in the home, especially during overnight hours.

I reviewed the drills for 2025 and observed they were all completed with at least three DCWs present, including overnight, and always took between five and six minutes.

On 3/17/26, I completed a telephone interview with Ms. Valentine. She stated she has heard complaints from several overnight DCWs that there isn't sufficient staffing in the home overnight. She stated she has discussed these concerns with management and has been advised that there can be one DCW to 20 residents overnight in this home because residents do not require the assistance of two or more DCWs with care needs. She denied that the current staffing level has impacted resident care needs based on what she has observed. She acknowledged that overnight shifts can be challenging for the DCWs working by themselves based on what they have reported to her. She stated she could not answer questions regarding medication passing as that is something the nursing staff would have more information on.

On 4/20/26, I attempted telephone interviews with every DCW noted as working overnight on the schedule I received. A voicemail message requesting a return phone call was left for Diana Baldwin and Brisa Martinez. An individual answered the phone of Angela Finney and agreed she would call me back. A return phone call was not received from these DCWs by the time of report disposition.

On 4/20/26, I completed a telephone interview with DCW Brent Essink who reported he occasionally works in the home overnight. He stated previously the home had a lower capacity and one DCW was sufficient to meet resident care needs. He stated recently the home is at full capacity and there are residents with a lot of overnight care needs. He stated it "depends on the night" whether one DCW can complete the tasks required and meet resident care needs in the home by themselves.

Mr. Essink estimated that approximately 25% of the time there will be minimal incidents of residents getting up during sleeping hours and needing DCW assistance outside of two-hour checks. He stated on those nights, one DCW is adequate. He stated 75% of the time now, one or multiple residents wake up during the night having behaviors that require DCW response. He stated one resident is often awake, "whiney," and demands the attention of DCWs. He stated another resident is often awake and wandering so DCWs must attempt to keep that resident from going into other's rooms. He stated another resident regularly pulls their call light for assistance. He stated when that occurs, it is hard to meet all resident care needs and the tasks expected of overnight DCWs. He stated residents begin going to bed after 8:00 p.m. medication passes but the time that everyone is asleep varies and they are typically awake until 8:00 p.m. at least.

Mr. Essink stated that although no residents require the assistance of two DCWs with transferring or mobility at this time, most of them need guidance or prompting and one DCW cannot safely do that for all the residents who need assistance should there be an emergency. He stated he believes that he participated in one fire drill at

this home; however, he does not think he was scheduled at this home at that time. He stated he believes he came over from another home to assist but he is not certain so he could not confidently discuss how fire drills occur in this home.

On 4/20/26, I contacted Ms. Watt to request correct phone numbers for Angela Finney, Tameeka Davis, Debbi Johnson, and Brandy Ramirez. Ms. Watt provided the contact information for Ms. Finney and Ms. Ramirez. She reported Ms. Davis and Ms. Johnson no longer are employed at American House Senior Living.

On 4/20/26, I completed a telephone interview with Ms. Ramirez who stated she has been told that only one DCW is needed for 20 residents at this home because they do not require the assistance of two DCWs for transferring and mobility. She stated although the home "is not heavy lifting-wise, it is heavy with behaviors" due to the residents all having diagnoses of dementia. She stated it can be "overwhelming" caring for the residents in this home without another DCW present.

Ms. Ramirez stated this home was the highest acuity home until the capacity was lowered. She stated when the capacity was lower in the fall of 2025 until recently, it was not challenging working with one DCW. She stated since the home is at full capacity again, it is likely the highest acuity again, and the staffing does not reflect that yet. She stated she understands that management is trying to hire additional staff, however due to turnover, it is hard to maintain staff ratios. She stated during day shift, management provides direct care in the homes, so they are trying to provide their support, however they are not present overnight.

Ms. Ramirez stated management tries to schedule someone to be present in the home from 7:00 p.m. to 11:00 p.m., however that is not guaranteed. She stated on nights when there is no assistance from 7:00 p.m. to 11:00 p.m., it is "impossible" to get her assigned tasks and resident care needs met. She stated during that time she is expected to shower certain residents and do the laundry of certain residents, however there are residents who wander into each other's rooms, or become confused and agitated, or repeatedly pull their call button so she cannot be in the bathroom or the laundry room and not be in sight of the residents. She stated she is trained to pass medications so when she works alone, she also must pass resident medications in the evening and it is challenging to pass the medications on time.

Ms. Ramirez stated from 11:00 p.m. to 7:00 a.m. it is more manageable to work alone, however approximately 75% of the time, residents are awake throughout the night and multiple residents may be up having behaviors that are hard to manage alone. She stated this varies day by day and 25% of the time, it is not challenging to work alone. She stated she has witnessed that resident care has been negatively affected by the lack of staffing in the home and residents are not receiving showers as scheduled, their laundry is not being washed as scheduled, and she cannot immediately respond to residents having behaviors when working alone. She stated residents do not start going to bed until after their 8:00 p.m. medication pass but

they all have varying times when they go to sleep. She stated a few begin waking up during the overnight shift as well.

Ms. Ramirez stated although residents may not require physical assistance, due to their behaviors and confusion, most residents require staff guidance to safely evacuate during a fire. She stated that it is not possible for one DCW to safely evacuate the 20 residents currently living in this home by themselves.

APPLICABLE RULE	
R 400.633	Staffing requirements.
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: (a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.
ANALYSIS:	<p>Fire drill records show that fire drills are being conducted with multiple additional staff members that exceed the home's regular staffing ratio. Even with the extra staff assisting with the fire drills, evacuation times of five to six minutes are being recorded. Direct care workers, Mr. Essink and Ms. Ramirez expressed concern regarding staff's' ability to safely evacuate residents with only one staff working in the home.</p> <p>Resident assessment plans noted 10 residents require some type of assistance from a direct care worker with transferring and/or mobility.</p> <p>Mr. Essink and Ms. Ramirez reported that with the home's current census, 75% of the time one direct care worker working alone overnight cannot meet the care needs of the residents and respond to resident behaviors.</p> <p>It was noted the overnight shift begins at 6:45 PM. Ms. Watt, Ms. Ramirez, and Mr. Essink reported residents are typically awake until after their 8:00 p.m. medication pass. Ms. Ramirez and Mr. Essink reported the sleeping hours for residents varies and some residents are regularly awake throughout the night.</p> <p>The staff schedule indicated that out of 31 days reviewed, 19</p>

	<p>days reportedly had direct care workers working alone from 7:00 p.m. to 6:45 a.m.</p> <p>Ms. Watt reported using DCWs from another home, who are not on this home's schedule, to meet resident care needs at times.</p> <p>Based on the interviews completed and documentation reviewed, there is sufficient evidence that there is not always sufficient staff on duty to provide adequate supervision, protection, and care and that a ratio of 1 direct care worker to 15 residents was not maintained while residents are awake from 7:00 p.m. to their medication pass time at 8:00 p.m. as reported by the individuals interviewed.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDING

During this investigation I found that there is not a schedule specific to this home. The schedule that is used includes all the homes on this campus.

No one was noted as working in the home from 7:00 p.m. to 8:45 p.m. on 2/21/26 or from 6:45 p.m. to 7:00 a.m. on 3/13/26.

Ms. Watt acknowledged that there is not a schedule specific to this home and reported there is a schedule maintained for the entire campus. She acknowledged that when a DCW comes to this home to pass a medication or cover a DCW's break it is not documented on the staff schedule.

Ms. Watt reported the staff schedule is not an accurate reflection of who worked in the home because changes to the schedule are not documented on the schedule. She stated staff timesheets would confirm who worked, however the timesheets do not list which home the DCW worked in.

APPLICABLE RULE	
R 400.639	Staff records.
	<p>(3) A licensee shall maintain for 90 days a daily work schedule and assignments that includes all of the following:</p> <p>(a) Names of staff on duty.</p> <p>(b) Job titles.</p> <p>(c) Hours or shifts worked.</p> <p>(d) Date of schedule.</p> <p>(e) Scheduling changes when made.</p>

ANALYSIS:	<p>The staff schedule does not indicate who worked in the home from 7:00 p.m. to 8:45 p.m. on 2/21/26 and does not list anyone working overnight on 3/13/26.</p> <p>Ms. Watt reported the staff schedule does not reflect who worked because changes are not documented. She also reported when a DCW comes from another home to pass medication or cover a break, this is not documented as well.</p> <p>Based on the interview completed and documentation reviewed there is sufficient evidence that a schedule in compliance with the requirements of the rule is not maintained in the home.</p>
CONCLUSION:	VIOLATION ESTABLISHED

On 4/22/26, I attempted an exit conference with Ms. Watt via telephone. A brief voicemail message was left requesting a return phone call if Ms. Watt would like to discuss the findings of the investigation via telephone. A follow-up email was sent to Ms. Watt discussing the findings of the investigation. As of the date of this report, Ms. Watt has not disputed or requested additional information regarding my findings.

IV. RECOMMENDATION

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

Cassandra Duursma

04/23/2026

Cassandra Duursma
Licensing Consultant

Date

Approved By:

Jerry Hendrick

04/23/2026

Jerry Hendrick
Area Manager

Date