



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 23, 2026

James Saintz
Agnus Dei AFC Home Inc.
1307 42nd St.
Allegan, MI 49010

RE: License #: AM120413630
Investigation #: 2026A1032022
Agnus Dei AFC Home IV

Dear James Saintz:

Attached is the Special Investigation Report for the above-referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If 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, appearing to read "Dwight Forde".

Dwight Forde, 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 #:	AM120413630
Investigation #:	2026A1032022
Complaint Receipt Date:	03/02/2026
Investigation Initiation Date:	03/05/2026
Report Due Date:	05/01/2026
Licensee Name:	Agnus Dei AFC Home Inc.
Licensee Address:	1307 42nd St., Allegan, MI 49010
Licensee Telephone #:	(269) 686-8212
Administrator:	James Saintz
Licensee Designee:	James Saintz
Name of Facility:	Agnus Dei AFC Home IV
Facility Address:	738 East Grant, Bronson, MI 49028
Facility Telephone #:	(517) 858-1027
Original Issuance Date:	05/05/2023
License Status:	REGULAR
Effective Date:	11/05/2025
Expiration Date:	11/04/2027
Capacity:	8
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was left stranded at the hospital.	No

III. METHODOLOGY

03/02/2026	Special Investigation Intake 2026A1032022
03/05/2026	Contact - Document Sent Email sent to the source
03/05/2026	Special Investigation Initiated - Letter Email received from the source.
03/16/2026	Inspection Completed On-site Interview with Home Manager Patricia Torres and Resident A
03/17/2026	Contact - Document Sent Requested IR, and assessment plan
04/21/2026	Contact - Document Received Received IR and assessment plan
04/23/2026	Exit Conference

ALLEGATION:

Resident A was left stranded at the hospital.

INVESTIGATION:

On 3/5/26, I received an email from the source verifying the accuracy of the complaint information

On 3/16/26, I interviewed Resident A in the facility. Resident A stated that on the night in question, she had expressed suicide ideation and asked to be taken to the hospital. She stated that when she was finally seen, she was greeted harshly by the attending physician, who declined to properly assess her. She stated that she was

expelled to the waiting room where she fell asleep briefly. When she awoke, and realized that she was without transportation, she wandered around the hospital then left to make her way to a friend's house nearby. She stated that her case manager soon found her and arrangements were made for her to return to the facility. She expressed surprise and consternation that she was not admitted to a behavioral health unit at the hospital.

I interviewed home manger Patricia Torres in the facility. Ms. Torres advised that Resident A left the facility at night, when there was one member of staff working. She stated that the midnight staff tried to communicate to the doctor that arrangements would be made early in the morning since more staff were available to retrieve Resident A from the hospital. Ms. Torres advised that when she arrived and did not see Resident A, she alerted Resident A's case manager about her disappearance. The case manager soon located Resident A around familiar haunts. Ms. Torres ultimately transported Resident A back to the facility.

On 3/17/26, I requested copies of Resident A's assessment plan and the incident report that sparked her trip to the hospital.

On 4/21/26, I received and reviewed the incident report and Resident A's assessment plan. The incident report details Resident A being transported by ambulance to the hospital for suicide ideation around 9:30 PM. The assessment plan indicates that she does not exhibit self-injurious behavior.

APPLICABLE RULE	
R 400.697	Resident transportation.
	(1) A licensee shall ensure the availability of transportation services as provided for in a resident care agreement. A licensee shall provide or arrange transportation for residents in a certified facility.
ANALYSIS:	Based on the time and manner in which Resident A was taken to the hospital, as well as attempts to communicate the need for more time to be provided due to staffing patterns, there is insufficient evidence to establish a violation. The hospital received Resident A through community transportation, making it somewhat difficult, given the hour, to impose a demand for immediate pick-up.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 4/23/26, I shared my findings with licensee designee James Saintz.

IV. RECOMMENDATION

I recommend no change to the status of this license.

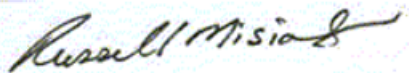


4/23/26

Dwight Forde
Licensing Consultant

Date

Approved By:



4/23/26

Russell B. Misiak
Area Manager

Date