GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 9, 2026

Nigel Jordon
Above and Beyond Care, LLC
3287 Stormy Creek Dr., SE
Kentwood, MI 49512

RE: License #: AS410409367
Investigation #: 2026A0579040
Above & Beyond Care 2

Dear Mr. Jordon:

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,

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 #:	AS410409367
Investigation #:	2026A0579040
Complaint Receipt Date:	05/20/2026
Investigation Initiation Date:	05/20/2026
Report Due Date:	07/19/2026
Licensee Name:	Above and Beyond Care, LLC
Licensee Address:	3287 Stormy Creek Dr., SE, Kentwood, MI 49512
Licensee Telephone #:	(508) 203-0654
Administrator:	Nigel Jordon
Licensee Designee:	Nigel Jordon
Name of Facility:	Above & Beyond Care 2
Facility Address:	2215 Bentbrook Ct SE, Kentwood, MI 49508
Facility Telephone #:	(616) 246-1144
Original Issuance Date:	08/24/2021
License Status:	REGULAR
Effective Date:	02/24/2026
Expiration Date:	02/23/2028
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED/ MENTALLY ILL/ DEVELOPMENTALLY DISABLED/ALZHEIMERS/ AGED/ TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was injured due to a wheelchair ramp being in disrepair.	Yes

III. METHODOLOGY

05/20/2026	Special Investigation Intake 2026A0579040
05/20/2026	Special Investigation Initiated - Letter Complainant
05/20/2026	APS Referral
05/21/2026	Contact- Face to Face Nigel Jordon, Licensee Designee
05/29/2026	Contact- Document received Complainant
06/09/2026	Exit Conference Nigel Jordon, License Designee

ALLEGATION: Resident A was injured due to a wheelchair ramp being in disrepair.

INVESTIGATION: On 5/20/26, I received this referral which alleged that on 5/18/26 Resident A was woken up because a repair person came to repair her motorized wheelchair which she uses for greater distances. The repair person was waiting in the garage. Resident A went to the exit door she typically uses that leads to the garage. The wheelchair ramp at that exit was removed without Resident A's knowledge so she fell onto the garage floor as she was exiting. She has a broken left wrist, a possible broken pinky, a broken nose, eight stitches to her right eyebrow, a concussion, and scraped knees. There was not a "do not enter" or "caution" sign placed or anything preventing anyone from using that exit. Mr. Jordon acknowledged that the removal of the ramp led to Resident A's fall.

On 5/21/26, I completed an unannounced on-site investigation. An interview was completed with Mr. Jordon. He reported Resident A was not present in the home for interview. Mr. Jordon reported Resident A was injured while exiting the building due to an accident. He stated the home is not considered barrier free or accessible and Resident A does not utilize her electric wheelchair in the home, nor does any other

resident utilize a wheelchair in the home. He reported the ramps are for ease of access but not required or approved by licensing.

Mr. Jordon stated on the day of Resident A's fall, he was having repair work done on the ramp at the exit door that goes into the garage, which is the exit only Resident A primarily uses. He stated a board on the ramp was being replaced and a railing was being added. He stated Resident A was not scheduled to leave the home that day and the other residents of the home typically do not use that exit so he did not put any barriers in place to block the exit. He stated he did not verbally have a chance to tell Resident A the ramp was being repaired and not to use that exit because she was sleeping when the repair work began. He stated he expected to tell her when she woke up.

Mr. Jordon stated while he and the person repairing the ramp were in another area, another repair person came to repair Resident A's motorized wheelchair which was in the garage. He stated that repair person did not call him, instead the repair person called Resident A directly which woke her up. He stated he thinks due to Resident A just waking up and moving quickly to meet the repair person, she did not notice a board missing from the ramp and was not observing her surroundings which led to her falling. He stated Resident A was taken for medical treatment and he believes she was diagnosed with a broken wrist. He stated it was an unfortunate accident that happened very quickly.

On 5/29/26, the complainant contacted me inquiring about the status of my investigation and reporting Resident A has been hospitalized for the last week and will be discharging to a rehabilitation facility.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Mr. Jordon reported Resident A's fall that led to her injuries was an accident. He reported a barrier was not put in placed due to Resident A typically being the only resident who uses that exit and the expectation that she would not be leaving the home that day. He reported he did not verbally advise her not to use the exit because she was asleep when repairs began. The complainant reported Resident A received significant injuries, was hospitalized for a week, and discharged to a rehabilitation setting due to her falling on the ramp that was in disrepair. Based on the interviews completed, there is sufficient evidence

	that proper precautions were not taken to prevent Resident A from falling by either blocking the exit, verbally advising Resident A not to use the exit, or having someone present to stop Resident A from using the exit while the ramp was in disrepair.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/9/26, I completed an exit conference with Mr. Jordon who did not dispute my findings or recommendations. He presented the start of an acceptable plan of corrective action that he reported he had already implemented in response to this incident.

IV. RECOMMENDATION

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

Cassandra Duursma 06/09/2026

Cassandra Duursma Date
Licensing Consultant

Approved By:

Jerry Hendrick 06/09/2026

Jerry Hendrick Date
Area Manager