GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 15, 2026

Janae Mcclenton
Trinity AFC, LLC
143 Wall St
KALAMAZOO, MI 49001

RE: License #: AS390419074
Investigation #: 2026A0578035
Trinity AFC, LLC

Dear Janae Mcclenton:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390419074
Investigation #:	2026A0578035
Complaint Receipt Date:	07/13/2026
Investigation Initiation Date:	07/13/2026
Report Due Date:	09/11/2026
Licensee Name:	Trinity AFC, LLC
Licensee Address:	143 Wall St KALAMAZOO, MI 49001
Licensee Telephone #:	(269) 615-3000
Administrator:	Janae Mcclenton
Licensee Designee:	Janae Mcclenton
Name of Facility:	Trinity AFC, LLC
Facility Address:	143 Wall St Kalamazoo, MI 49001
Facility Telephone #:	(269) 615-3000
Original Issuance Date:	10/27/2025
License Status:	REGULAR
Effective Date:	04/27/2026
Expiration Date:	04/26/2028
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A is left in this facility alone and unsupervised.	Yes

III. METHODOLOGY

07/13/2026	Special Investigation Intake 2026A0578035
07/13/2026	Special Investigation Initiated - On Site
07/13/2026	APS Referral
07/13/2026	Special Investigation Completed On-site-Interview with Resident A.
07/13/2026	Contact-Telephone-Interview with Bridgeways case worker Andrea VanLaan.
07/13/2026	Contact-Telephone-Interview with licensee designee Janae Mcclenton.
07/13/2026	Exit Conference-With licensee designee Janae Mcclenton.

ALLEGATION:

Resident A is left in this facility alone and unsupervised.

INVESTIGATION:

On 07/13/2026, I received this complaint through LARA-BCHS-Complaints@michigan.gov. Complainant reported Resident A is diagnosed with bipolar affective disorder, major depressive disorder and recurrent episodes with psychotic features. Complainant reported Resident A is legally blind in one eye, has a history of stroke, issues with heart arterial/vein issues, and history of cocaine use. Complainant added that Resident A does not have a legal guardian and is able to complete all activities of daily living independently. Complainant reported Resident A has transportation and employment services. Complainant reported Resident A was previously employed; however, Resident A required reconstructive surgery on his foot after a work accident but is now capable of walking. Complainant reported licensee designee Janae Mcclenton works “down the road” from this facility. Complainant reported Resident A has Janae Mcclenton’s phone number and can

call her at any time and Janae Mcclenton is able to return to the facility. Complainant reported that Resident A knows in the event of any emergency situations, to call 911 for help. Complainant reported Resident A has a phone and is the only resident in the facility. Complainant alleged that Resident A is left alone in the facility daily.

On 07/13/2026, I completed an unannounced investigation onsite at this facility and interviewed Resident A regarding the allegations. Resident A reported living at this facility for the last two months. Resident A acknowledged being the only person present in this facility and denied that licensee designee Janae Mcclenton or any other direct care staff was present or available. Resident A reported this was because this facility was closing at the end of this month and he would be moving to a home across the street. Resident A reported that he would currently be living across the street, but there are people currently living at that home that are refusing to leave. Resident A reported the home across the street is also owned by Janae Mcclenton.

Resident A reported that Janae Mcclenton's relatives check on Resident A at this facility during the day while Janae Mcclenton is at work in Battle Creek, Michigan. Resident A reported these relatives provide him with breakfast and lunch as well as his medications. Resident A reported Janae Mcclenton usually returns to this facility around 7PM.

Resident A reported having independent community access while residing at this facility and reported feeling safe at this facility.

On 07/13/2026, I interviewed Bridgeways case manager Andrea VanLaan regarding the allegations. Andrea VanLaan clarified that she had just received Resident A for case management prior to Resident A being transferred by an adjacent county. Andrea VanLaan reported it was the expectation of her agency that Resident A would be provided with 24-hour staffing for supervision and protection. Andrea VanLaan confirmed that Resident A had been left unattended to at this facility on more than one occasion and clarified that on one occasion, licensee designee Janae Mcclenton was present at the facility and when Andrea VanLaan questioned Janae Mcclenton regarding staff not always being present, Janae Mcclenton informed Andrea VanLaan that she was one of Resident A's "chore providers." Andrea VanLaan expressed concerned about this response from Janae Mcclenton and reported that her organization had determined this facility was not a supportive placement for Resident A and a new placement for Resident A would be obtained.

On 07/13/2026, I interviewed licensee designee Janae Mcclenton regarding the allegation. Janae Mcclenton acknowledged that Resident A is alone at this facility without required staffing and stated the reason Resident A was alone at this facility was because Resident A is "his own person" and does not have a guardian. Janae Mcclenton reported staff will come to this facility and provide Resident A with meals and medications and that staff may spend at least two hours at this facility while providing Resident A with these services.

Janae Mcclenton denied this facility was closing and reported that she had not made a final decision to close this facility. Janae Mcclenton was provided with consultation regarding the staffing requirements for licensed adult foster care facilities and instructed to provide immediate staffing for Resident A, 24 hours a day. Janae Mcclenton agreed to comply with providing Resident A with immediate staffing 24 hours a day and reported she would make a determination on continuing as a licensed facility or providing a written request to close this license.

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: **(b) 12 residents for small group and family homes.**
ANALYSIS:	Based upon my investigation, which consisted of interviews with Resident A, Bridgeways case worker Andrea VanLaan, and licensee designee Janae Mcclenton, as well as observations made during an unannounced investigation on-site, sufficient direct care staff were not always on duty at this facility to provide for the supervision, personal care and protection of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Due to the quality of care violations cited in the report, an approved corrective action plan is required. Upon receipt of an acceptable corrective action plan, I recommend the issuance of a six month provisional license.

07/15/2026

Eli DeLeon Date
Licensing Consultant

Approved By:

07/15/2026

Dawn N. Timm Date
Area Manager