GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 4, 2026

Dawn Noordijk
Heritage Homes Inc
Bldg 200, Suite 205
400 136th Avenue
Holland, MI 49424

RE: License #: AS700012884
Investigation #: 2026A0579047
Oak Lane AFC Home

Dear Ms. Noordijk:

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 #:	AS700012884
Investigation #:	2026A0579047
Complaint Receipt Date:	07/23/2026
Investigation Initiation Date:	07/23/2026
Report Due Date:	09/21/2026
Licensee Name:	Heritage Homes Inc
Licensee Address:	Bldg 200, Suite 205, 400 136th Avenue, Holland, MI 49424
Licensee Telephone #:	(616) 395-9311
Administrator:	Dawn Noordijk, Designee
Licensee Designee:	Dawn Noordijk, Designee
Name of Facility:	Oak Lane AFC Home
Facility Address:	15269 161st Avenue, Grand Haven, MI 49417
Facility Telephone #:	(616) 842-6021
Original Issuance Date:	01/01/1992
License Status:	REGULAR
Effective Date:	07/07/2026
Expiration Date:	07/06/2028
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
A third shift direct care worker was found asleep in the home.	Yes

III. METHODOLOGY

07/23/2026	Special Investigation Intake 2026A0579047
07/20/2026	Special Investigation Initiated - Letter Briana Fowler, Office of Recipient Rights
07/21/2026	Contact - Telephone call received Elizabeth Wills, Direct Care Worker
07/21/2026	Contact - Document Received Briana Fowler, Office of Recipient Rights
07/23/2026	Contact - Document Received Elizabeth Wills, Direct Care Worker
07/27/2026	Contact- Telephone call made Lillian Chatman, Former Direct Care Worker
07/28/2026	Contact- Face to Face Resident A Evangelina Nunez, Direct Care Worker
08/03/2026	Exit Conference Dawn Noordijk, Licensee Designee

ALLEGATION: A third shift direct care worker was found asleep in the home.

INVESTIGATION: On 7/23/26, I entered this referral after being informed on 7/20/26 by Briana Fowler from the Office of Recipient Rights that an incident report alleging a third-shift direct care worker (DCW) was found sleeping was expected to be received by LARA soon. Ms. Fowler stated residents require awake overnight staff and she confirmed this through the residents' evacuation scores (e-scores).

On 7/20/26, Ms. Fowler forwarded the e-scores to me. I reviewed them and noted Residents A-F had a combined evacuation assistance score of 86. One staff was listed as "immediately available," resulting in a staff promptness score of 20. The calculated e-score was 3.44, indicating a slow response time. These scores were calculated on 7/20/26.

On 7/21/26, I received a voicemail message from DCW Elizabeth Wills. I returned her call. She reported that the program supervisor arrived during the overnight shift the previous week and found Resident A's motion sensor device placed outside near a car tire at the end of the driveway. She stated an overnight DCW removed the device from Resident A's room and appeared to be waking up when the supervisor entered, suggesting the device was placed outside as a warning system so the DCW could sleep even though DCWs are required to be awake overnight.

On 7/21/26, I received written statements collected by Ms. Fowler. Program Supervisor Evangelina Nunez reported that around 5:00 a.m. on 7/17/26, she found Resident A's motion detector in the driveway of the home by a vehicle tire. Inside, she observed DCW Lillian Chatman lying on the living room couch with a blanket and pillow, and DCW Arielle German cooking in the kitchen. Ms. Chatman reported she had a headache and acknowledged placing the monitor outside. Ms. German said she was unaware of this, which Ms. Chatman confirmed. Ms. Nunez immediately required Ms. Chatman to check on Resident A who was in his room unattended and believed to be asleep. Ms. Nunez explained the serious safety risks of removing the assistive device.

Ms. Chatman wrote that she arrived at 9:52 p.m. on 7/16/26 and completed routine tasks and resident checks throughout the night. She reported developing a migraine after cleaning the garage around 4:00 a.m. She stated she checked and toileted Resident A shortly before 5:00 a.m., returned him to his room unattended, and then lay down on a couch in the living room. She claimed the motion sensor was moved outside due to "physical disorientation caused by the migraine," with no intent to harm Resident A. She said Ms. Nunez arrived around 5:15 a.m., she completed requested tasks, including checking on Resident A to ensure he remained safe while unattended in his room, and she discussed what occurred overnight with Ms. Nunez.

On 7/23/26, I requested the e-score report in place at the time of the incident. Ms. Wills provided an e-score dated 3/28/26 with the same resident evacuation assistance total. Two staff were listed as "immediately available," resulting in a staff promptness score of 40 and a calculated score of 1.72, indicating a slow response. Ms. Wills stated there are always two DCWs overnight and both are expected to be awake.

I also requested and was provided with Resident A's assessment plan, which indicated he uses an Ideal Security Motion Sensing Alarm placed across from where he is while in his room unattended, with the receiver kept in the common area so staff can respond promptly.

Ms. Wills reported Ms. Chatman is no longer employed at Heritage Homes Inc.

On 7/27/26, I interviewed Ms. Chatman by phone. She confirmed her written statement, saying she performed her duties until developing a migraine around 4:30 a.m. She stated she toileted Resident A, placed him back in his room unattended,

removed the motion sensor, placed it at the end of the driveway, and laid down on the couch. She said she does not fully understand why she removed the device and believes medical distress impaired her judgment. She stated she was not sleeping, though Ms. Nunez believed she was, and said she had laid down for about five minutes before Ms. Nunez arrived.

On 7/28/26, I completed an unannounced on-site investigation. Resident A was observed eating lunch and appeared without visible concerns. He could not be interviewed due to being nonverbal. His motion sensor was properly positioned in his room, and the alarm in the common area sounded appropriately when activated.

Ms. Nunez stated she arrived early on 7/17/26 and found the motion sensor outside by a vehicle tire at the end of the driveway. She reported entering the home and seeing Ms. Chatman lying on the couch. She said her primary concern was not whether Ms. Chatman was asleep because Ms. German was awake in the home, it was the removal of Resident A's assistive device while he was asleep and unattended, due to the risk of falls and injury. She immediately directed Ms. Chatman to check on Resident A, ensuring his safety, and then had a discussion with Ms. Chatman, reiterating the seriousness of the safety risk to Resident A from the device being removed.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Resident A's assessment plan noted he requires the use of Ideal Security Motion Sensing Alarm when he is unsupervised in his room. Ms. Nunez and Ms. Chatman confirmed the device was removed from Resident A's room while he was asleep in his room unsupervised and placed in the driveway of the home. Based on the interviews completed and documentation reviewed there is sufficient evidence that Resident A was not provided with the supervision or protection specified in his assessment plan when his assistive device was removed from his room.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/3/26, I completed an exit conference with licensee designee Dawn Noordijk who did not dispute my findings at the time of the completion of this report.

IV. RECOMMENDATION

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

08/05/2026

Cassandra Duursma Date
Licensing Consultant

Approved By:

08/05/2026

Jerry Hendrick Date
Area Manager