GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 13, 2025

Larry Anderson
Overlook Home Inc.
12755 Overlook NE
Greenville, MI 48838

RE: License #: AM410070879
Investigation #: 2025A0583034
Overlook Home

Dear Mr. Anderson:

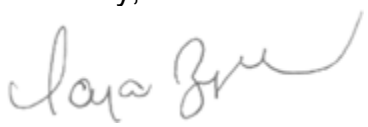
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM410070879
Investigation #:	2025A0583034
Complaint Receipt Date:	04/22/2025
Investigation Initiation Date:	04/25/2025
Report Due Date:	05/22/2025
Licensee Name:	Overlook Home Inc.
Licensee Address:	12755 Overlook NE Greenville, MI 48838
Licensee Telephone #:	(616) 691-7258
Administrator:	Larry Anderson
Licensee Designee:	Larry Anderson
Name of Facility:	Overlook Home
Facility Address:	12700 Overlook Drive Greenville, MI 48838
Facility Telephone #:	(616) 691-7258
Original Issuance Date:	03/01/1996
License Status:	REGULAR
Effective Date:	12/15/2024
Expiration Date:	12/14/2026
Capacity:	12
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff eaves drop on Resident A's conversations.	No
Staff go through Resident A's belongings without Resident A's permission.	No
On 04/18/2025, Resident A did not receive lunch.	No
Staff did not charge Resident A the agreed upon rental rate.	Yes

III. METHODOLOGY

04/22/2025	Special Investigation Intake 2025A0583034
04/25/2025	Special Investigation Initiated - On Site
04/25/2025	APS Referral
05/12/2025	Exit Conference Licensee Designee Larry Anderson

ALLEGATION: Staff eavesdrop on Resident A's conversations.

INVESTIGATION: On 04/21/2025 a complaint was received from the LARA-BCHS-Complaint online system. The complaint alleged that staff are "eavesdropping" on Resident A's conversations. The complaint further alleged that on 04/15/2025 the Ombudsman visited Resident A at the facility and staff were listening to the conversation.

On 04/24/2025 I completed an unannounced onsite investigation at the facility and privately interviewed licensee designee Larry Anderson, Resident A, Resident B, and Resident C. Licensee designee Larry Anderson stated that Resident A was admitted to the facility on 08/23/2024 and is unhappy to be residing in an Adult Foster Care Home. Mr. Anderson stated that Resident A was residing in homeless shelters with his mother, Relative 1 and preferred to reside with her. Mr. Anderson stated that while homeless, Resident A experienced a long-term hospitalization and was transitioned by hospital staff to the facility. Mr. Anderson stated that Adult Protective Services assisted Resident A with moving to the facility and secured the appointment of public guardian Veronica VanderMolen. Mr. Anderson stated that Resident A is unhappy to be residing away from Relative 1 and is unhappy to have a public guardian. Mr. Anderson stated that Resident A is afforded adequate privacy as established via Adult Foster Care licensing rules. Mr. Anderson stated that staff Stacey Bulthuis does not eaves drop on Resident A's phone calls and does not eaves drop on Resident A's personal visits. Mr. Anderson stated that all staff provide Resident A with adequate privacy.

Resident A stated that staff Stacey Bulthuis does not allow him to have private conversations while on the telephone and during visits from individuals such as Long-Term Care Ombudsman Angela Gates. Resident A stated that he utilizes his personal cell phone in his bedroom with his door open. Resident A stated that he purposefully doesn't shut his bedroom door because he is claustrophobic. Resident A stated that Ms. Bulthuis eavesdrops on his phone conversations because Ms. Bulthuis can hear him speaking on the telephone when his bedroom door is open. Resident A stated that he has not observed any staff member at his doorway or in his bedroom when he is on his cell phone. Resident A stated that he often has guests visit the facility and meets with his guests in the communal joint living/dining room areas. Resident A stated that Ms. Bulthuis often stays in the kitchen during Resident A's personal meetings, however she keeps the kitchen door open. Resident A stated that he wants Ms. Bulthuis to close the kitchen door when he is having private meetings in the communal living room area but acknowledged that Ms. Bulthuis may be keeping the door open to supervise other residents.

Resident B and Resident C both stated that staff do not eavesdrop on Resident A's personal calls and personal meetings. Resident B and Resident C stated that Resident A often uses his personal cell phone in his bedroom with the door open. Resident B and Resident C both stated that Ms. Bulthuis goes into the kitchen during Resident A's personal meetings in the living room but keeps the door open in case a resident requires assistance. Resident B and Resident C stated that they are happy with the care provided at the facility.

On 04/25/2025 I completed an online complaint to Adult Protective Services.

On 04/29/2025 I interviewed staff Stacey Bulthuis via telephone. Ms. Bulthuis stated that she has never eavesdropped on Resident A's telephone calls or during his private visits. Ms. Bulthuis stated that Resident A has a personal cell phone and uses the device in his bedroom with his bedroom door open. Ms. Bulthuis stated that she has never purposefully listened to his telephone calls. Ms. Bulthuis stated that Resident A typically meets with his visitors in the communal living/dining area of the facility. Ms. Bulthuis stated that during Resident A's visits, Ms. Bulthuis attempts to stay in the kitchen but keeps the door open as a precaution to provide supervision to other residents. Ms. Bulthuis stated that Resident A never requested that she shut the kitchen door during the time in which he has visitors to the facility.

On 05/12/2025 I completed an Exit Conference via telephone with licensee designee Larry Anderson. Mr. Anderson stated that he agreed with the special investigation findings.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated

	representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(g) The right to associate and have private communications and consultations with his or her physician, attorney, or any other person of his or her choice.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Resident A stated that staff Stacey Bulthuis does not allow him to have private conversations while on the telephone and during visits he receives at the facility. Resident B and Resident C both stated that staff do not eavesdrop on Resident A's personal calls and personal meetings. Stacey Bulthuis stated that she has never eavesdropped on Resident A's telephone calls or during his private visits. A preponderance of evidence was not established during the special investigation to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff go through Resident A's belongings without Resident A's permission.

INVESTIGATION: On 04/21/2025 a complaint was received from the LARA-BCHS-Complaint online system. The complaint alleged that staff are going through Resident A's belongings and taking pictures in his bedroom without his consent.

On 04/24/2025 I completed an unannounced onsite investigation at the facility and privately interviewed licensee designee Larry Anderson, Resident A, Resident B, Resident C, and Sandy Warner. Licensee designee Larry Anderson stated that no staff and no visitors have gone through Resident A's personal belongings to his knowledge. Mr. Anderson stated that his "ex-wife" Sandy Warner visits the facility but is not allowed to provide resident care. He stated that Ms. Warner spends most of her time in the non-licensed private area of the facility while visiting and has minimal interactions with residents.

Resident A stated that Ms. Warner photographed his bedroom and personal items.

Resident A stated that he did not provide Ms. Warner with permission to enter his bedroom and asked her not to photograph his personal items. Resident A stated that he doesn't understand why she would photograph his bedroom.

Resident B and Resident C both stated that staff do not go into their bedrooms without permission and do not go through their personal items. Resident B and Resident C both stated that they have never observed staff rummage through or photograph Resident A' personal items.

Sandy Warner stated that she is not a staff member and does not provide resident care. Ms. Warner stated that she visits the facility to spend time with Mr. Anderson and rarely interacts with residents. Ms. Warner denied that she went into Resident A's bedroom. Ms. Warner denied that she went through his belongings and denied that she photographed any personal items.

On 05/12/2025 I completed an Exit Conference via telephone with licensee designee Larry Anderson. Mr. Anderson stated that he agreed with the special investigation findings.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Resident A stated that Ms. Warner photographed his bedroom and personal items. Resident A stated that he did not provide Ms. Warner with permission to enter his bedroom and asked her not to photograph his personal items. Resident A stated that he didn't understand why she would photograph his bedroom. Resident B and Resident C both stated that staff do not go into their bedrooms without permission and do not go through their personal items. Resident B and Resident C both stated that they have never observed staff rummage through Resident A's personal items or photograph them.

	Sandy Warner stated that she is not a staff member and does not provide resident care. Ms. Warner stated that she visits the facility to spend time with Mr. Anderson and rarely interacts with residents. Ms. Warner denied that she went into Resident A's bedroom, went through his belongings or photographed any personal items. A preponderance of evidence was not established during the special investigation to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: On 04/18/2025, Resident A did not receive lunch.

INVESTIGATION: On 04/21/2025 a complaint was received from the LARA-BCHS-Complaint online system. The complaint alleged that Resident A didn't get lunch on 4/18/25.

On 04/24/2025 I completed an unannounced onsite investigation at the facility and privately interviewed licensee designee Larry Anderson, Resident A, Resident B, and Resident C. Mr. Anderson stated that staff provide three nutritious meals plus snacks daily. Mr. Anderson stated that Resident A was provided lunch on 04/18/2025 but may have chosen not to finish the meal.

Resident A stated that on 04/18/2025 he was served lunch but did not eat the meal because Resident B was "picking on me" during the meal. Resident A stated that his verbal argument with Resident B caused Resident A to lose his "appetite".

Resident B and Resident C both stated that staff provide three nutritious meals daily. They both stated that they have no knowledge of Resident A not receiving a meal on 04/18/2025.

On 05/12/2025 I completed an Exit Conference via telephone with licensee designee Larry Anderson. Mr. Anderson stated that he agreed with the special investigation findings.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	Licensee designee Larry Anderson stated that staff provide three nutritious meals plus snacks daily. Mr. Anderson stated that Resident A was provided lunch on 04/18/2025 but may have chosen not to finish the meal. Resident A stated that on 04/18/2025 he was served lunch but did not eat his meal because Resident B was "picking on me" during the meal. Resident A stated that his verbal argument with Resident B caused Resident A to lose his "appetite". A preponderance of evidence was not established during the special investigation to substantiate a violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff did not charge Resident A the agreed upon rental rate.

INVESTIGATION: On 04/21/2025 a complaint was received from the LARA-BCHS-Complaint online system. The complaint alleged that staff received money from Medicaid and from Relative 1, which led to a double payment of Resident A's rent.

On 04/24/2025 I completed an unannounced onsite investigation at the facility and interviewed licensee designee Larry Anderson and Resident A each privately. Licensee designee Larry Anderson stated that Resident A was admitted to the facility on 08/23/2024. Mr. Anderson stated that at the time of his admission, Relative 1 controlled Resident A's finances, but did not have official guardianship in place. Mr. Anderson stated that Adult Protective Services staff Kevin Souser was also involved at the time of Resident A's admission due to Relative 1 mishandling Resident A's finances. Mr. Anderson stated that from 08/23/2024 until 10/01/2024, Relative 1 paid no rent for Resident A. Mr. Anderson stated that during November 2024, December 2024, and January 2025; Relative 1 paid $500.00 for each of the three months for a total of $1500.00. Mr. Anderson stated that in February 2025, Mr. Souser secured the appointment of public guardian, Veronica VanderMolen, for Resident A. Mr. Anderson stated that on 01/28/2025, Mr. Souser secured Adult Protective Services state funding to pay $3265.46 in back rent and on 02/07/2025 Mr. Souser secured Adult Protective Services state funding to pay $1000.00 back rent. Mr. Anderson stated that in March public guardian Veronica gained full control of Resident A's finances and began paying his rent in full monthly. Mr. Anderson denied that he was "double paid" rental fees by Adult Protective Services and Relative 1.

Resident A stated that Relative 1 was previously in change of Resident A's finances. Resident A denied that Relative 1 did not pay the first three months of Resident A's rent. Resident A denied that Adult Protective Services paid his rent and instead

stated that the Department of Human Services assisted with rental payments. Resident A stated that he was not aware that that Adult Protective Services is a branch of the Department of Human Services but continued to state Mr. Anderson was “double paid”.

While onsite I observed Resident A’s Funds Part II form which indicated that on 11/05/2024 Resident A paid $500 in rent, on 12/02/2024 Resident A paid $500 in rent, and on 01/02/2025 Resident A paid $500 in rent. I observed that on 01/28/2025 Adult Protective Services paid $3265.46 in rent and on 02/07/2025 Adult Protective Services paid $1000 in rent.

While onsite I observed Resident A’s Resident Agreement, signed 08/23/2025. I observed that Resident A is charged $1000.00 monthly as the agreed upon rate of services.

On 04/29/2025 I interviewed Adult Protective Services staff Kevin Souser via telephone. Mr. Souser stated that Resident A was previously his own legal decision maker even though Relative 1 was in control of Resident A’s finances. Mr. Souser stated that Resident A was often homeless and resided with Relative 1 until Resident A was admitted to the facility on 08/23/2025. Mr. Souser stated that Relative 1 did not pay Resident A’s rent for the first three months of his admission and then paid approximately $500.00 of the monthly agreed upon rate the next three months thereafter. Mr. Souser stated that Adult Protective Services secured funds to assist Resident A with the payment of back rent, assisted Resident A with securing the SSI board and care rate, and secured the appointment of a public guardian.

On 05/02/2025 I interviewed staff Amanda Anderson. Ms. Anderson stated that she was the bookkeeper of the facility and is tasked with keeping track of residents’ rent and other documentation. Ms. Anderson stated that Resident A was admitted to the facility on 08/23/2024 from the hospital and Relative 1 oversaw Resident A’s finances. Ms. Anderosn stated that Relative 1 and Resident A agreed to pay the “SSI rate” of “$1096.50” monthly. Ms. Anderson stated that Resident A’s August 2024 rent was pro-rated for eight days at $35.37 for a total of $282.50 owed. Ms. Anderson stated that Resident A then owed $1096.50 for September 2024 and $1096.50 for October 2024; but the facility received no rent during said months. Ms. Anderson stated that in November 2024 the facility received $500 of the agreed upon $1096.50, leaving a balance of $596.50. Ms. Anderson stated that in December 2024 the facility received $500 of the agreed $1096.50, leaving a balance of $596.50. Ms. Anderson stated that in January 2025 the facility received $500 of the agreed upon $1096.50, leaving a balance of $596.50. Ms. Anderson stated that between 08/23/2024 and January 2025, Resident A owed a total balance of $4265.46 which is what Adult Protective Services paid in full. Ms. Anderson acknowledged that the Resident A’s Resident Care Agreement was not properly completed to reflect the “SSI rate”.

On 05/12/2025 I completed an Exit Conference via telephone with licensee designee Larry Anderson. Mr. Anderson stated that he agreed with the special investigation findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(12) Charges against the resident's account shall not exceed the agreed price for the services rendered and goods furnished or made available by the home to the resident.
ANALYSIS:	While onsite I observed Resident A's Funds Part II form which indicated that on 11/05/2024 Resident A paid $500 in rent, on 12/02/2024 Resident A paid $500 in rent, and on 01/02/2025 Resident A paid $500 in rent. I observed that on 01/28/2025 Adult Protective Services paid $3265.46 in rent and on 02/07/2025 Adult Protective Services paid $1000 in rent. While onsite I observed Resident A's Resident Agreement, signed 08/23/2025. This form indicated Resident A is charged $1000.00 monthly as the agreed upon rate of services. Staff Amanda Anderson stated that Resident A's August 2024 rent was pro-rated for eight days at $35.37 for a total of $282.50 owed. Ms. Anderson stated that Resident A then owed $1096.50 for September 2024 and $1096.50 for October 2024; but the facility received no rent during those months. Ms. Anderson stated that in November 2024 the facility received $500 of the agreed upon $1096.50, leaving a balance of $596.50. Ms. Anderson stated that in December 2024 the facility received $500 of the agreed upon $1096.50, leaving a balance of $596.50. Ms. Anderson stated that in January 2025 the facility received $500 of the agreed upon $1096.50, leaving a balance of $596.50. Ms. Anderson stated that between 08/23/2024 and January 2025, Resident A owed a total balance of $4265.46 which is what Adult Protective Services paid in full. Ms. Anderson acknowledged that the Resident A's Resident Care Agreement was not properly completed to reflect the "SSI rate". A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. Resident A signed a Resident Care Agreement on 08/23/2025 which stated that the agreed upon rate for service was $1000 monthly. Licensee designee Larry Anderson charged Resident

	A the “SSI” rate of $1096.50 monthly. Licensee designee Larry Anderson charged Resident A more than the agreed upon rate for services.
CONCLUSION:	**VIOLATION ESTABLISHED**

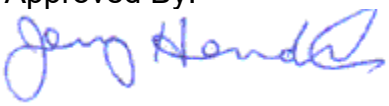
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license.

05/12/2025

Toya Zylstra Date
Licensing Consultant

Approved By:



05/13/2025

Jerry Hendrick Date
Area Manager