GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 15, 2025

Jessica Kross
Pine Rest Christian Mental Health Services
300 68th Street SE
Grand Rapids, MI 49548

RE: License #: AM410008657
Investigation #: 2025A0340043
Pine Rest Westwood

Dear Mrs. Kross:

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,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM410008657
Investigation #:	2025A0340043
Complaint Receipt Date:	05/28/2025
Investigation Initiation Date:	05/28/2025
Report Due Date:	07/27/2025
Licensee Name:	Pine Rest Christian Mental Health Services
Licensee Address:	300 68th Street SE Grand Rapids, MI 49548
Licensee Telephone #:	(616) 455-5000
Administrator:	Candy McKenney
Licensee Designee:	Jessica Kross
Name of Facility:	Pine Rest Westwood
Facility Address:	7047 Madison Avenue SE Grand Rapids, MI 49508-7707
Facility Telephone #:	(616) 455-5000
Original Issuance Date:	06/23/1975
License Status:	REGULAR
Effective Date:	03/07/2024
Expiration Date:	03/06/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff Alexis Palacias did not puree Resident A's food which caused him to choke and require hospitalization.	Yes

III. METHODOLOGY

05/28/2025	Special Investigation Intake 2025A0340043
05/28/2025	APS Referral
05/28/2025	Special Investigation Initiated - Telephone Jessica Kross
06/03/2025	Inspection Completed On-site
07/14/2025	Contact - Telephone call made staff Catherine Palacias
07/14/2025	Contact - Telephone call made staff Ariane Lewis
07/14/2025	Contact - Telephone call made staff Alexis Palacias
07/14/2025	Exit Conference Designee Jessica Kross

ALLEGATION: Staff Alexis Palacias did not puree Resident A's food which caused him to choke and require hospitalization.

INVESTIGATION: On May 28, 2025, I was notified by Designee Jessica Kross that an incident occurred at the Westwood Home at Pine Rest. Ms. Kross received an Incident Report (IR) which she shared for my review. The IR was completed by staff Ariane Lewis. It was documented on the IR that on 5/24/25 at 12:15 PM, Resident A was making choking noises from his room. Staff members Catherine Palacias, Ariane Lewis and Alexis Palacias went to his room and observed him throwing up. Alexis Palacias called nursing staff Eric Lund and Resident A was sent to the ER.

Ms. Kross provided a copy of Resident A's Assessment Plan which was signed by her on 9/14/24 which stated under the heading, "Eating/Feeding", "Puree diet to a liquid consistency".

Ms. Kross informed me that it had been reported to her that Alexis Palacias had given Resident A goulash and did not puree the food before serving it to him. She has been terminated from Pine Rest employment.

On June 6, 2025, I conducted an unannounced home inspection. Resident A was not home as he was still hospitalized from the choking incident.

On July 14, 2025, I interviewed staff Catherine Palacias. I informed her of the complaint. She stated she remembers working that day as the med lead. Resident A likes to sleep and typically naps in the morning after breakfast. Sometimes he needs prompting to get up for lunch. Therefore, it was after all the other residents had eaten before Resident A got up and went to eat. She did remember hearing him cough at the table but nothing significant as Resident A coughs regularly. She began to pass medications to other residents when she heard him in his room, and it sounded like he was throwing up. Ms. Palacias went to his room and called for her two co-workers when she saw Resident A vomiting “lots of phlegm”. She called Pine Rest nurse Eric Lund. He advised to watch Resident A and if it doesn’t stop shortly to call him back. It did not stop so they called Mr. Lund back and Resident A was then sent to the hospital.

I asked Ms. Palacias if she knew what caused Resident A to vomit. She stated that she observed whole noodles in the vomit. She did not make or serve his lunch, but she knows Resident A is only supposed to be given pureed food. Resident A is non-verbal, so he is unable to say what happened. Resident A was admitted to the hospital where he remained for approximately two weeks. Ms. Palacias stated he has been doing well since his return to the home.

I asked Ms. Palacias who made lunch or served Resident A his meal that day and she stated it was Alexis Palacias. She told me that she asked Alexis Palacias about the whole noodle and Alexis Palacias told her she thought it was small enough and soft enough already, so she did not puree it. Ms. Palacias described the noodle as a macaroni noodle.

On July 14, 2025, I interviewed staff Ariane Lewis and informed her of the allegation. She confirmed she was working during the incident. She normally works at Interactions but had picked up a shift at Westwood. She had to be trained in food prep and learn the difference in puree, chopped, etc. and to know the difference to work in the home. Ms. Lewis remembered seeing Alexis Palacias serving the goulash without pureeing and said something to her about it not being appropriate for Resident A. Alexis Palacias responded to Ms. Lewis that “the noodles are soft so they didn’t need to be blended”. Ms. Lewis questioned her and suggested she puree them, but then went to help another resident when Resident A went to eat his lunch. Ms. Lewis remembered Ms. C. Palacias was passing medications when she heard her call for help in Resident A’s room. Ms. Lewis estimated the time this occurred to be not long after Resident A had lunch. When Ms. Lewis got to Resident A’s room, she saw he was vomiting up “a lot of saliva and seemed to be having a hard time

breathing". Nursing staff was called and then someone called for the ambulance a short time later and Resident A went to the hospital.

On July 14, 2025, I interviewed Alexis Palacias. She stated she no longer works for Pine Rest. She remembered the events which led to her termination. I asked her to recount those events. She stated she was serving goulash that day for lunch. She woke up Resident A for lunch. He took a bite of goulash and threw the rest of it away. He went to his room and began to cough. He started "spitting up" so someone called nursing who told staff to watch Resident A. He continued to cough so Alexis Palacias stated she brough him to Urgent Care and he was sent to the ER from there. She followed the ambulance to the hospital but it was getting toward the end of her shift so someone else from Pine Rest met her at the hospital and took over. Alexis Palacias then went home.

I asked Alexis Palacias if she had pureed his food and she stated she did not. I asked if she was supposed to. She stated she thought the noodles and tomatoes were soft enough. She stated she was not trying to hurt Resident A and acknowledged she "made a mistake".

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(b) Special diets.**
ANALYSIS:	The allegation was made that Staff Alexis Palacias did not puree Resident A's food which caused him to choke and require hospitalization. Resident A's Assessment Plan specifies that he requires a puree diet to a liquid consistency. Catherine Palacias and Ariane Lewis stated Resident A choked on noodles which were not pureed. This meal was provided to Resident A by Alexis Palacias. Alexis Palacias acknowledged that she made and served noodles to Resident A, which she did not puree. Upon eating a small portion of this meal, Resident A began vomiting and was transported to the hospital, where he was admitted.

	There is a preponderance of evidence to support a rule violation that Alexis Palacias neglected to follow Resident A's special dietary needs as specified in his Assessment Plan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On July 14, 2025, I conducted an exit conference with Designee Jessica Kross. We discussed the allegation and the evidence of a rule violation. She understood and agreed to send a Corrective Action Plan. Ms. Kross had no further questions.

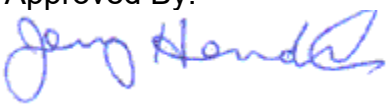
IV. RECOMMENDATION

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

July 15, 2025

Rebecca Piccard Date
Licensing Consultant

Approved By:



July 15, 2025

Jerry Hendrick Date
Area Manager