GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 4, 2026

Rebecca Buchholz
Harbor House Ministries
919 44th Street
Jenison, MI 49428

RE: License #: AL700268722
Investigation #: 2026A0583018
Harbor House Beacon Place

Dear Ms. Buchholz:

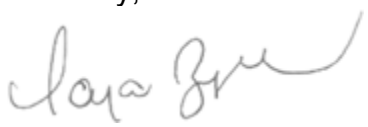
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL700268722
Investigation #:	2026A0583018
Complaint Receipt Date:	01/26/2026
Investigation Initiation Date:	01/26/2026
Report Due Date:	02/25/2026
Licensee Name:	Harbor House Ministries
Licensee Address:	919 44th Street Jenison, MI 49428
Licensee Telephone #:	(616) 797-9920
Administrator:	Rebecca Buchholz
Licensee Designee:	Rebecca Buchholz
Name of Facility:	Harbor House Beacon Place
Facility Address:	949 Forty-fourth Street Jenison, MI 49428-9193
Facility Telephone #:	(616) 797-9920
Original Issuance Date:	08/18/2005
License Status:	REGULAR
Effective Date:	03/07/2024
Expiration Date:	03/06/2026
Capacity:	13
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff Latoria Triggs slapped Resident A across the face.	Yes
Staff Latoria Triggs lacks required training.	Yes

III. METHODOLOGY

01/26/2026	Special Investigation Intake 2026A0583018
01/26/2026	Special Investigation Initiated - On Site
01/26/2026	Contact - Document Received Network 180 Aston Byrne
01/28/2026	APS Referral APS Emily Graves
02/04/2026	Exit Conference Licensee Designee Rebecca Buchholtz

ALLEGATION: Staff Latoria Triggs slapped Resident A across the face.

INVESTIGATION: On Monday 01/26/2026 I received an email drafted 01/24/2026 from license designee Rebecca Buccholtz. The email contained an Incident Report dated 01/24/2026, and stated the following: *"I was standing next to the dining room table. I saw (Resident A) sitting in his wheelchair next to the table. He seemed to want to change seat locations evident by him attempting to stand up. An agency worker Latoria was standing in front of him and attempted to keep him from standing up by placing a hand on his upper body to keep him from standing up. (Resident A) became upset and began hitting Latoria. I saw him hit her twice on the upper body near her head and arm/ shoulder area. Latoria blocked his hits and then slapped him with her right hand on the left side of his face. She immediately looked at me and tried to play it off as if nothing happened and stated it was a reflex. (Resident A) sat there and looked to have been taken back/ shocked. I went over to (Resident A) and removed him from being by Latoria and helped him transfer to laying on the couch and noticed he had red marks on the left side of his face. She repeatedly asked me not to tell anyone. Once Emily came back to being on a side and (Resident A) was with another HHM staff I went and got the lead Megan and notified her of what happened. Megan then called Julie Mesman our HR. Becky, the director was notified as well as the Home Supervisor and the police were called, and Michelle, (Resident A's) guardian was called. Latoria was asked to sit in the break room until the police could get there. (Resident A) was reassessed for injury, but the only injury noticed*

was the redness on the left side of his face. Latoria was ask to leave for the remainder of the shift after the police report was done".

On 01/26/2026 I reviewed a voicemail left from licensee designee Rebecca Buchholtz on 01/24/2026. Ms. Buchholtz stated that on that day Resident A was struck in the face by staff Latoria Triggs and law enforcement was immediately called to the facility. She stated that Ms. Triggs will no longer be allowed to work at the facility.

On 01/26/2026 I completed an unannounced onsite investigation at the facility and privately interviewed staff Kristen Booth and Emily Proeber.

Ms. Booth stated that on 01/24/2026 at approximately 10:30 AM she received a telephone call from staff Megan Burns who advised staff Latoria Triggs was observed by staff Nadeen West to have slapped Resident A across his face leaving a large red mark. Ms. Booth stated that she immediately telephoned licensee designee Rebecca Buccholtz and reported the incident. Ms. Booth stated that Ms. Buchholtz immediately reported the incident to law enforcement. Ms. Booth stated that she drove to the facility to assist with staffing and arrived at approximately 11:30 AM. Ms. Booth stated law enforcement was at the facility upon her arrival and Ms. Triggs was asked to leave the facility after speaking to law enforcement. Ms. Booth stated that she observed red marks on the left side of Resident A's face. Ms. Booth stated that Ms. Triggs has not worked at the facility since the event occurred. Ms. Booth stated that she has worked with Ms. Triggs in the past and observed her to be "impatient" with residents, but not abusive. Ms. Booth stated that Ms. Triggs received feedback appropriately.

Ms. Proeber stated that she worked on 01/24/2026 with Ms. Triggs, Ms. West, and Ms. Burns. She stated that at approximately 10:00 AM she was in the bathroom when Ms. Burns knocked on the door and requested that Ms. Proeber come to assist because Ms. Triggs had just slapped Resident A across the left side of his face. Ms. Proeber stated that she exited the bathroom and observed Resident A lying on the living room couch with a large red mark on the left side of face and neck. Ms. Proeber stated that Ms. West said she had just observed Ms. Triggs slap Resident A across the face. Ms. Proeber stated that Ms. Burns and Ms. Proeber stayed with Resident A until law enforcement arrived at the facility at approximately 11:00 AM. Ms. Proeber stated that she photographed the red marks on the left side of Resident A's face and neck that day at 10:46 AM. Ms. Proeber stated that Ms. Triggs spoke with law enforcement and was asked to leave the facility at the conclusion of their interview with her. She stated that she has worked with Ms. Triggs in the past and never observed Ms. Triggs mistreat residents.

While onsite I observed Resident A lying on a couch in the living room of the facility. Resident A presented as non-verbal and developmentally delayed. He was appropriately dressed and groomed. I observed small red marks on the left side of Resident A's neck.

On 01/30/2026 I interviewed staff Nadeen West via telephone. Ms. West stated that she worked at the facility on 01/24/2026 and at approximately 10:00 AM she observed Resident A sitting in his wheelchair located in the dining room. Ms. West stated that Resident A appeared agitated and was hitting Ms. Triggs in the chest. Ms. West stated that she observed Ms. West use her right open hand to slap Resident A across the left side of his face leaving a large red area on his face and neck. Ms. West stated she was “shocked and stunned” by observing Ms. Triggs slap Resident A and Ms. West immediately went to assist Resident A. Ms. West stated that she moved Resident A from the dining room to the living room and transferred him onto the couch. Ms. West stated that Ms. Triggs then stated that Resident A hit people because he “doesn’t understand consequences” and thinks it’s okay to hit people because no one tells him he can’t. Ms. West stated that she stayed with Resident A for approximately ten minutes until Ms. Burns arrived at the area. Ms. West stated that she informed Ms. Burns that Ms. West had slapped Resident A and Ms. Burns immediately contacted administration and law enforcement. Ms. West stated that Ms. Triggs stayed at the facility in a separate room until law enforcement arrived, interviewed, and escorted her off the premises. Ms. West stated that she has never worked with Ms. Triggs in the past.

On 01/30/2026 I interviewed staff Megan Burns via telephone. Ms. Burns stated that on 01/24/2026 at approximately 10:00 AM she was informed by Ms. West that Ms. Triggs had just slapped Resident A across the face. Ms. Burns stated that she immediately directed Ms. Triggs to leave the facility and wait in the break room. Ms. West said that Ms. Triggs denied slapping Resident A but acknowledged that she had tried to move his hand to prevent Resident A from striking her. Ms. Burns stated that she observed a reddened area on Resident A’s face consistent with being slapped. Ms. Burns stated that she reported the incident immediately to “administration” and law enforcement was contacted. She stated Ms. Triggs was interviewed by law enforcement and escorted out of the facility. She stated that she had worked with Ms. Triggs in the past and never observed any concerning regarding her interactions with residents.

On 02/02/2026 I telephoned staff Latoria Triggs who did not answer. Her voicemail box was full; therefore, no message was left.

On 02/02/2026 I text messaged staff Latoria Triggs and requested that she return my telephone call.

On 02/03/2026 I telephoned staff Latoria Triggs who did not answer. A voicemail message was left requesting that she return my telephone call.

On 02/04/2026 I completed an in-person exit conference with licensee designee Rebecca Buchholtz. She stated that she did not dispute the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	Staff Nadeen West stated that on 01/24/2026 she observed staff Latoria Triggs slap Resident A across the left side of his face leaving a large red mark on his face and neck. I observed photographs taken on 01/24/2025 by staff Emily Proeber which display a large red area on the left side of Resident A's face and neck. On 01/26/2026, I observed small red marks on the left side of Resident A's neck. Staff Latoria Triggs failed to return a phone call, voicemail, and text message requesting an interview. Based upon my investigation, which consisted of multiple interviews and a review of pertinent documentation relevant to this investigation, it has been established that staff Latoria Triggs slapped Resident A across the left side of his face and neck.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Staff Latoria Triggs lacks required training.

INVESTIGATION: On 01/26/2026 I emailed Ms. Buchholz and requested verification of Ms. Triggs' required training.

On 01/27/2026 I received an email from Ms. Buchholz which contained verification that Ms. Triggs completed CPR and prevention and containment of communicable diseases.

On 02/02/2026 I received an email from Ms. Buchholz. She confirmed that she does not have verification that Ms. Triggs completed the required training in the areas of reporting requirements, first aid, personal care, supervision, and protection, resident rights, safety and fire prevention, food safety, and nutrition and special diets.

On 02/04/2026 I completed an in-person exit conference with licensee designee

Rebecca Buchholtz. She stated that she did not dispute the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(5) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be trained and competent in all of the following areas before performing assigned tasks independently: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation, which includes a hands-on demonstration as part of the training.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases including recognizing signs of illness.** **(h) Food safety, which includes food storage, preparation, distribution, and serving in a safe manner.** **(i) Nutrition and special diets.**
ANALYSIS:	Licensee Designee Rebecca Buccholz confirmed that staff Latoria Triggs works at the facility via a staffing agency and the facility does not have verification that Ms. Triggs completed required training in the areas of first aid, personal care, supervision, and protection, resident rights, safety and fire prevention, food safety, and nutrition and special diets. Based upon my investigation, which consisted of multiple interviews and a review of pertinent documentation relevant to this investigation, it has been established that staff Latoria Triggs lacks the required trainings.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

02/04/2026

Toya Zylstra Date
Licensing Consultant

Approved By:

02/04/2026

Jerry Hendrick Date
Area Manager