GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 9, 2026

Sandra and John Bishop
11705 Edgerton Rd
Cedar Springs, MI 49319

RE: License #: AF410094736
Investigation #: 2026A0357009
The Haven of Rest

Dear Sandra and John Bishop:

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,

Gene Coulter, Jr. Adult Foster Care Licensing Consultant, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 249.8479

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF410094736
Investigation #:	2026A0357009
Complaint Receipt Date:	12/02/2025
Investigation Initiation Date:	12/02/2025
Report Due Date:	01/31/2026
Licensee Name:	Sandra and John Bishop
Licensee Address:	11705 Edgerton Rd Cedar Springs, MI 49319
Licensee Telephone #:	(616) 866-7224
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	The Haven of Rest
Facility Address:	11705 Edgerton Road Cedar Springs, MI 49319
Facility Telephone #:	(616) 918-6224
Original Issuance Date:	09/21/2001
License Status:	REGULAR
Effective Date:	07/24/2024
Expiration Date:	07/23/2026
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's bedroom has an ongoing presence of bed bugs.	No
The home has unsanitary conditions.	No
On 11/24/2025, Resident A had no heat in her bedroom and it was not fixed until the following day.	No
The licensee threatened to turn off the electricity in Resident A's room because she left her lights on.	No
The licensees refuse to address concerns or communicate with Resident A's guardian, including the use of her medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/02/2025	Special Investigation Intake 2026A0357009
12/02/2025	Special Investigation Initiated - Telephone Licensing Consultant Toya Zylstra, telephoned Resident A's daughter to discuss the complaint.
12/04/2025	Contact - Document Received Document received from Sawyer T. Rozgowski, of Slot Law Group, PLLC.
01/16/2026	Contact - Document Received Document received from the Mr. and Mrs. Bishop's attorney.
01/26/2026	Inspection Completed On-site Unannounced inspection completed.
01/26/2026	Contact - Face to Face Interviewed the Licensee's Sandra and John Bishop, Residents B, C, D, and E.
01/26/2026	Contact - Document Sent Exchanged Emails with Resident A's daughter/guardian.
02/02/2026	Contact – Telephone call to co-license, Sandra Bishop.
02/09/2026	Telephone call with Exit Conference to Co-licensee, Sandra Bishop.

ALLEGATION: Resident A's bedroom has an ongoing presence of bed bugs.

INVESTIGATION: On 12/02/2025, Resident A's Daughter/Guardian stated that Resident A's bedroom has had continuous bed bugs even after the room had been treated several times by a pest control company. The Guardian specifically stated she had been in Resident A's bedroom on 11/23-24/2025 and observed bed bugs. She also reported that she had taken all of Resident A's clothes to the laundromat and washed them in hot water and dried them in the hot dryer to get rid of the bed bugs, but the guardian said it did not work. The bed bugs came back.

On 01/26/2026, I made an unannounced inspection of Resident A's bedroom. According to Mr. and Mrs. Bishop Resident A had moved out of the home on Friday the 16th of January/2026. The bed remained in the bedroom, and I checked the mattress, the drawers in the dresser, the carpet on the floor and in the closet and I did not find any bed bugs. Both licensees stated they hired a Pest Control company and had treated the home and Resident A's bedroom several times. They had also purchased a special light that the Pest Control staff had told them was good and would help, so they used it in Resident A's bedroom several times. Both Licensee's denied seeing any bed bugs in Resident A's bedroom. They also stated that they spent many dollars to have the home treated for bed bugs. They provided me with a signed statement from Grand Rapid Pest Control Inc., dated 03/21/2025. The statement read as follows: "Grand Rapids Pest Control performed bedbug treatment to the home of Sandra Bishop at (11705 Edgerton Cedar Springs, MI 49319), the initial of the most recent treatment was done on 09/06/2024 where a whole home treatment was completed. Retreats were done on 10/10/24, 11/15/24, and 12/27/24, reduced activity reported each time. On 02/14/25 due to a report of one live bedbug seen out of abundance of caution, a final retreat was done to the bedroom where the bedbug was reported, no activity seen at this time." Signed by Rachel Travis, Grand Rapids Pest Control.

On 01/26/2026, I interviewed Resident B, C, D, and E and they all stated they had not seen any bedbugs in their bedrooms, the living room, the bathroom, the laundry room, the hallway or the dining room.

On 02/09/2026, I conducted a telephone exit conference with Sandra Bishop, Co-licensee. We discussed the findings of this investigation. Sandra Bishop agreed with the findings.

APPLICABLE RULE	
R 400.645	**Environmental health.**
	(6) An insect, rodent, or pest control program must be maintained and carried out in a manner that continually protects the health of residents.

ANALYSIS:	It was alleged that Resident A's bedroom has had on-going presence of bed bugs. Residents B, C, D and E all denied seeing any bed bugs in the home. Both Mr. and Mrs. Bishop denied seeing any bedbugs in the home or in Resident A's bedroom. They provided a signed statement from Grand Rapids Pest Control on the dates they had treated the home including the final retreat completed on 02/14/2025 where no activity was seen at that time. I inspected Resident A's bedroom on 01/26/2026 and did not observe any live or dead bedbugs. There is insufficient evidence to establish a violation of the rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The home has unsanitary conditions.

INVESTIGATION: On 12/02/2026, Resident A's guardian stated that the resident rooms, bathroom, and common areas are unsanitary. Resident A is not allowed to use the kitchen sink to clean moldy thermos. Resident A's guardian stated that Resident A had "moldy cups," in her bedroom. She described the cups as not having been washed for a very long time. She stated that they needed to be washed with dish soap and have bleach used on them. She stated the cup Resident A was using was "disgusting." She stated that she asked Mrs. Bishop if she could come into the kitchen and wash the cup, but Mrs. Bishop refused to let her come into the kitchen due to their house rules. The drinking cup and thermos was the only identified unsanitary item by Resident A's guardian.

On 01/26/2026, I conducted an interview with Mr. and Mrs. Bishop. Mrs. Bishop stated that Resident A's guardian was in the home on 11/24/2025, and she yelled at Mrs. Bishop and told her that her home was deplorable and disgusting. Mrs. Bishop stated that she had not been aware of Resident A's use of a type of thermos to use for her drinking water. She said she had explained to all of the residents (including Resident A) that if they wanted any of their washable items to be cleaned all they had to do was let her know and she would run them through the dishwasher. She said several of the residents gave her their items to be washed several times. She explained that she had House Rules and one of the rules stated that only staff could be in the kitchen. Mr. Bishop stated that they have knives and other sharp items in the kitchen and they did not want anyone to be hurt.

On 01/26/2026, I observed the restroom and found it clean. I also observed each

resident bedroom and they were clean and orderly.

On 01/26/2026, I observed the carpet in the hallway which had some lint on it and needed to be vacuumed. I had noticed in the past that several pieces of furniture needed to be dusted but they were not unsanitary. I have noticed the large ceiling fan in Resident A's room need to be cleaned and dusted which I told Mrs. Bishop about during the most recent renewal inspection. When I have been in the home in the past, I have always found the kitchen to be clean including unannounced inspections. The home has always been picked up and neat. When I checked the refrigerator, it was clean and organized. Upon renewal inspections the restrooms were clean. In addition, all the exits were unobstructed each time I was in the home, and the residents could easily exit the home in the event of a fire, so their safety was provided. When I interviewed the residents in the past, including Resident A, each resident said they had no complaints and were happy to be living in this Adult Foster Care home and they all felt safe.

On 02/09/2026, I conducted a telephone exit conference with the Sandra Bishop, the co-Licensee. We discussed the findings of this investigation. Sandra Bishop agreed with the findings.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	It was alleged that the home has unsanitary conditions. Resident A's guardian reported that Resident A's drinking container was moldy. She reported that Mrs. Bishop would not let her wash it in the kitchen of the home. Mrs. Bishop denied having any knowledge of Resident A's drinking container. She advised Resident A and all the residents that if they had washable items, to provide them for her and she would wash it in the dishwasher. She reported several residents had given her their drinking containers to be washed. There is insufficient evidence to establish a violation to this rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: On 11/24/2025 Resident A had no heat in her bedroom, and it was not fixed until the following day.

INVESTIGATION: On 12/02/2025, Resident A's guardian stated that Resident A told her that her wall mounted heater was broken on 11/24/2025 and the homeowner didn't fix it until the next day. She reported that Resident A did not have heat in her bedroom from Monday afternoon at 4PM until 9AM on Tuesday morning. Mr. Bishop refused to look at the heater. Mrs. Bishop looked at it once when she returned to the home around 8:30 -9pm and said she will fix it the following day. Resident A's guardian stated she was with Resident A in her bedroom on 11/23/2025 and 11/24/2025.

On 01/26/2026, I conducted a face-to-face interview with Mr. and Mrs. Bishop. Mrs. Bishop stated that Resident A did not tell her that her heater was not working. She explained that Resident A's guardian was in the room that day and the day before cleaning with Resident A. She went on to say that as soon as Resident A told her that her room was cold, Mrs. Bishop when to her room and checked the wall mounted heater and found the cord was only half-way in. She said that she pushed the plug back in and the heater came on immediately. Both Mr. and Mrs. Bishop stated that they had not been made aware that Resident A's wall mounted heater was not working or they would have checked it immediately. They did not know what Resident A's room temperature was when they were notified that her heater was not working correctly. Both Mr. and Mrs. Bishop reported that Resident A is quite capable of letting then know that her heater was not working properly and when she did let them know. Mrs. Bishop fixed the heater immediately. Mr. Bishop denied that he refused to fix the heater.

On 02/09/2026, I conducted a telephone exit conference with Sandra Bishop the Co-licensee. We discussed the findings of this investigation. Sandra Bishop agreed with the findings.

APPLICABLE RULE	
R 400.653	**Room temperature.**
	Resident-occupied rooms must be heated at no less than 68 degrees Fahrenheit. While air conditioning is not required, precautions must be taken to prevent prolonged resident exposure to noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations must be based on a resident's health care appraisal and addressed in the resident's assessment plan.
ANALYSIS:	It was alleged that Resident A had no heat in her bedroom, and it was not fixed until the next day. Resident A's guardian reported that Resident A told her on 11/24/2025, that her wall mounted heater was broken and the licensee did not fix it until the next day.

	Mr. and Mrs. Bishop both denied that they had been made aware of Resident A's wall mounted heater not working. Mrs. Bishop stated that as soon as Resident A told her, she checked the heater and found it half unplugged. She stated she pugged it in and it worked immediately. Both Mr. and Mrs. Bishop stated that Resident A could inform them that her heater was not working properly but she did not tell them until the next day. Mrs. Bishop fixed the heater immediately by plugging it in all the way and the heater worked. Mr. Bishop denied that he had refused to fix the heater. During this investigation there was insufficient evidence to establish a rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The licensee threatened to turn off the electricity in Resident A's room because she left her lights on.

INVESTIGATION: On 01/26/2026, I conducted a face-to-face interview with Co-licensee's Mr. and Mrs. Bishop. I asked them if they had verbally threatened Resident A that if she left her lights on, they would turn off the electricity in her bedroom. Both Licensees denied making any such threat to Resident A.

On 01/26/2026 I interviewed Residents B, C, D, and E. They all denied that they had heard either licensee verbally threatened Resident A that they would turn off the electricity in her bedroom.

On 02/09/2026, I conducted a telephone exit conference with Sandra Bishop the Co-licensee. We discussed the findings of this investigation. Sandra Bishop agreed with my findings.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(f) Subject a resident to any of the following:** **(iv) Threats.**
ANALYSIS:	Both Mr. and Mrs. Bishop denied that they had verbally threatened Resident A with turning off the electricity in her bedroom because she had left the lights on. Residents B, C, D, and E all denied hearing either licensee

	threaten Resident A with turning the electricity off in her room if she left the lights on. During this investigation there was insufficient evidence that Mr. or Mrs. Bishop verbally threatened Resident A with cutting the electricity in her bedroom if she left the lights on. A rule violation was not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The licensees refuse to address concerns or communicate with Resident A's guardian, including the use of her medications

INVESTIGATION: On 12/02/2025, Resident A's guardian stated that when she was with Resident A on 11/23 & 24/2025, in her bedroom she observed bed bugs. She stated that she had sent a text message to Mrs. Bishop and asked what the cleaning process for bedbugs entailed, but Mrs. Bishop never texted her back.

On 01/26/2026, I conducted a face-to-face interview with Mr. and Mrs. Bishop. Mrs. Bishop stated that they had secured and paid for removal of the bedbugs several times and the last time the pest control company was there on 02/14/2025, they found no activity of bed burgs. She was certain that Resident A and her guardian were aware of the times the pest control company had been there to spray for the bed bugs. She acknowledged that she did not communicate with Resident A's guardian about her question on how she was cleaning for the bed bugs and that she forgot to text her back.

On 12/02/2025, Resident A's guardian had explained that Resident A had been seen by a physician due to a herpes outbreak and was prescribed Valtrex. The guardian stated that she had sent a text message to Mrs. Bishop and asked her if she needed the medication, but Mrs. Bishop did not respond.

On 01/26/2026, I asked Ms. Bishop if the had responded to Resident A's guardian about the medications and she stated that she forgot to get back to her.

On 01/26/2026, I emailed Resident A's guardian about the medication, and she sent a text message back that read: "*The Meijer pharmacy is still on her account through corewell in case she needs medication same day so we probably just didn't confirm when they sent the refill out at the appointment."* I responded and asked if this was in September or November of 2025? She responded: *"On MyChart I have documentation that it was refilled/sent to a pharmacy prescribed in September (15 tablets). For the original flair up. She saw the gynecologist in November to follow up with a specialist and was asked to continue taking the medication. I had guessed that she still had medication in the home based on how many were prescribed/ what was actually needed to take. But no communication came from Sandra when I*

inquired about the medication twice, I see now looking back that the additional refill was sent to the Meijer Rockford pharmacy instead of LTC (the homes pharmacy) But it was still negligent to not communicate back to me about the medication, correct?" Resident A's guardian sent me the text message that she had sent to Ms. Bishop and only parts of it were readable, with the date October 4 and 10/06 with no year. She also wrote that she was not remembering about the med and she went back though her text messages. She wrote, "*I guess I did notice that it was sent to Meijer and picked it up and brought it to the home. Sandra confirmed this and said that she gave it to her (Resident A) in September."*

On 01/26/2026, I reviewed all of Resident A's Medication Administration Records (MAR) since her admission to the home on 10/09/2023 and I did not find the medication Valtrex listed on any medication sheet. Ms. Bishop stated that she failed to write it on Resident A's MAR. She stated that she remembers giving it to Resident A. She also acknowledged that she forgot to get back to Resident A's guardian about the medication question that was sent to her by text message.

On 02/03/ 2026, I asked Mrs. Bishop to call the pharmacy she uses, LTC to see if they had sent it to her. She called me back and said they reported they had not sent the medications to her home for Resident A. She also called Meijer's pharmacy, and they refused to give her any information.

On 02/09/2026, I conducted a telephone exit conference with Sandra Bishop, the Co-licensee. We discussed the findings on this investigation and Sanda Bishop agreed with the findings.

APPLICABLE RULE	
R 400.623	**Applicant, licensee and administrator qualifications; licensee, administrator and staff requirements; parole or probation or convicted of felony.**
	(6) A licensee, administrator, and staff shall cooperate with a resident, resident's family as appropriate, designated representative of a resident, and the responsible agency.
ANALYSIS	It was alleged that the licensees refuse to address concerns or communicate with Resident A's guardian, including the use of her medications. Resident A's guardian reported continuous bed bugs in Resident A's bedroom and on 11/23-24/2026 even after the room had been treated several times by a pest control company. She reported she had sent a text message to Mrs. Bishop and asked her what cleaning process she used for the bedbugs. She stated Mrs. Bishop never retuned the text message.

	Mrs. Bishop said she forgot to respond to Resident A's guardian. Resident A 's guardian stated that she had sent a text message to Mrs. Bishop with her concerns regarding Resident A's medication Valtrex if she needed more, but Mrs. Bishop did not return her text message. Mrs. Bishop acknowledged that she forgot to get back to Resident A's guardian about Resident A's medication concern. During this investigation there was evidence that Mrs. Bishop the co-licensee did not communicate with Resident A 's guardian on the occasions noted above. In addition, Mrs. Bishop failed to respond to Resident A's guardian when she asked her by text message if Resident A needed more of her medication Valtrex. Therefore, there is a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITONAL FINDINGS:

INVESTIGATION: On 12/02/2026, Resident A's guardian had confirmed that Resident A had been prescribed Valtrex and that she had picked the medication up and brought it to the home.

On 01/26/2026, I reviewed all of Resident A's MAR's since Resident A's admission, to confirm that Resident A's prescribed Valtrex had been administered and recorded. Mrs. Bishop stated that she had administered the medication, but she had not added the medication name or information to Resident A's MAR and had not initialed the MAR when she had in fact administered the prescribed medication with the time given. She explained that the pharmacy she uses (LTC) puts all of Resident A's medication on her MAR, but since the medication came from the Meijer pharmacy and brought to the home by Resident A's guardian it was not on Resident A's MAR, and Mrs. Bishop forgot to add the medication.

On 02/09/2026, I conducted a telephone exit conference with Sandra Bishop the Co-licensee. We discussed the findings of this investigation. Sandra Bishop agreed with the findings.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) (b) Complete an individual medication log that contains all of the following:

	(i) Medication name. **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) Initial's of the individual who administered the medication at the time given.**
ANALYSIS:	According to Resident A's guardian, she had brought Resident A's medication, Valtrex, from Meijer's pharmacy to the home. On 01/26/2026, I reviewed all of Resident A's MARs since her admission to the home and I did not find the medication Valtrex listed on any of Resident A's Medication Administration Records. Mrs. Bishop acknowledged she had administered the Valtrex to Resident A but had not completed Resident A's medication log. During this investigation there was evidence found that Co-licensee, Shandra Bishop had not completed Resident A's individual medication log. Therefore, there is a violation of the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the Co-licensee's submit and acceptable plan of correction and the complaint be closed.

Arlene B. Smith 02/09/2026

Arlene B. Smith Date
Licensing Consultant

Approved By:

Jerry Hendrick 02/09/2026

Jerry Hendrick Date
Area Manager