GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 3, 2026

Juliet Chowdhury
3538 144th Ave
Holland, MI 49424

RE: License #:	AS700403401
Investigation #:	2026A0356041
	Beechwood Hope Care

Dear Mrs. Chowdhury:

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:

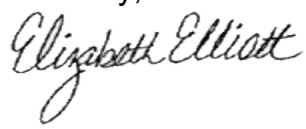
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS700403401
Investigation #:	2026A0356041
Complaint Receipt Date:	06/09/2026
Investigation Initiation Date:	06/11/2026
Report Due Date:	08/08/2026
Licensee Name:	Juliet Chowdhury
Licensee Address:	608 Beechwood St Holland, MI 49423
Licensee Telephone #:	(616) 994-2060
Administrator:	Juliet Chowdhury
Licensee Designee:	Juliet Chowdhury
Name of Facility:	Beechwood Hope Care
Facility Address:	608 Beechwood St. Holland, MI 49423
Facility Telephone #:	(616) 994-2060
Original Issuance Date:	03/27/2020
License Status:	REGULAR
Effective Date:	09/27/2024
Expiration Date:	09/26/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, ALZHEIMERS, DEVELOPMENTALLY DISABLED, MENTALLY ILL AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A died unexpectedly in the facility.	No
Additional Findings	Yes

III. METHODOLOGY

06/09/2026	Special Investigation Intake 2026A0356041
06/11/2026	Special Investigation Initiated - Telephone Natasha grew, licensing consultant.
06/11/2026	APS Referral
06/15/2026	Contact - Telephone call made Libby Huizenga, Lakeside Clubhouse supervisor.
06/15/2026	Contact - Telephone call made Leah Osterhaven, Ottawa County Community Mental Health, supports coordinator supervisor.
06/24/2026	Contact - Telephone call made Relative #1.
06/25/2026	Contact - Face to Face Resident B, Clubhouse.
06/25/2026	Inspection Completed On-site
06/25/2026	Contact - Face to Face Resident C and live in home manager, Keith Jackson.
06/25/2026	Contact - Telephone call made Licensee Designee, Juliet Chowdhury.
06/25/2026	Contact-Document received Certificate of Death.
06/26/2026	Contact - Telephone call received Juliet Chowdhury, Licensee.
06/29/2026	Contact - Document Received Facility documents received.

07/01/2026	Contact - Document Received Facility documents.
07/21/2026	Contact - Document sent Det. Dave Dewitt, Det. Ann Koster, Ottawa County Sheriff Office, re: police report.
07/27/2026	Contact-Telephone call made Det. Tyler VanDoeselaar, Ottawa County Sheriff Office, police report.
07/27/2026	Contact-Document received Briana Fowler, Ottawa CMH ORR and Matt Postema, Ottawa CMH, trainer. Det. A. Koster, police report.
07/27/2026	Contact-Document Sent J. Chowdhury.
07/29/2026	Contact-Telephone call made J. Chowdhury
07/29/2026	Contact-Document sent M. Postema, CMHOC
08/03/2026	Exit conference-Juliet Chowdhury, Licensee.

ALLEGATION: Resident A died unexpectedly in the facility.

INVESTIGATION: On 06/09/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported on 06/01/2026, Resident A, B and C were eating sandwiches, and Resident A started to choke. One of the residents went to get help, the home manager “Keith” called 911 but did not attempt CPR or the Heimlich maneuver and Resident A died.

On 06/15/2026, I interviewed Libby Huizenga, Lakeside Clubhouse supervisor via telephone. Ms. Huizenga stated Resident B witnessed the entire event at the facility. Ms. Huizenga stated Resident B reported that the residents were eating peanut butter and jelly sandwiches when Resident A began to choke. Resident A reportedly said she could still breathe. Resident C got the home manager Keith Jackson. Resident B reported when Resident A could no longer breathe, she went down to the floor and Mr. Jackson picked Resident A up and put her on the couch where she died. Ms. Huizenga stated Resident A had no history of swallowing issues that she was aware of but she had “embodied trauma” and was known to grab her throat and say she could not breathe even though she was breathing normally.

On 06/24/2026, I interviewed Relative #1 via telephone. Relative #1 stated she received a telephone call from the police informing her of Resident A's death on 06/01/2026. Relative #1 stated according to Ms. Huizenga, staff at the facility did not perform any life saving measures to Resident A while she was choking on food. Relative #1 stated the home manager, Mr. Jackson, was at the facility but the Licensee, Juliet Chowdhury was not there. Relative #1 stated her experience with Mr. Jackson is that he stays in his room with the door closed much of the time. Relative #1 stated Resident A and Resident D are twin sisters. While neither are reliable witnesses, Resident B is and Resident B reported that Mr. Jackson did not attempt to perform the Heimlich maneuver when Resident A was choking.

Relative #1 stated Resident A often said she was going to die. She would say things like, "I can't breathe" and grab her throat or "my legs are broken." Relative #1 stated Resident A had no dietary restrictions and was able to eat peanut butter, which is the sandwich Resident A choked on. Relative #1 stated she heard that Resident A made her own sandwich on the day she choked and died but also that Mr. Jackson makes food for the residents and then retreats to his room and closes the door. Relative #1 stated Resident A required staff supervision while in the community and some staff supervision while in the home.

On 06/25/2026, I interviewed Resident B at a location away from the facility. Resident B stated it was lunchtime when she, Resident A and Resident C were at the home with Mr. Jackson. Resident B stated Resident D and E were not in the facility. Resident B stated Resident A was always "fidgeting, messing with her hair and edgy," she was "moving around a lot" and Resident B stated she told Resident A to "settle down." Resident B stated Resident A said she couldn't settle down and was going to "blow up", which Resident B stated was not out of the ordinary for Resident A to say something was going to happen to her. Resident B stated Resident C made Resident A and B peanut butter and jelly sandwiches and they had a glass of milk. Resident B stated Resident A "guzzled" her milk and "gobbled" her sandwich. She stated Resident A usually eats slow but on this day she ate fast. Resident B stated Mr. Jackson was in his room because she (Resident B) did not think that Mr. Jackson felt well that day and he had asked Resident C to make the sandwiches. Resident B stated Resident C does not normally make food. Resident B stated Mr. Jackson usually always makes lunch for the residents but on this occasion, he did not.

Resident B stated Resident A was taking big bites out of her sandwich and she told Resident A to "slow down." Resident B stated Resident A said she could not slow down; she was hungry and she "ate big bites and swallowed them." Resident B stated Resident A went into the bathroom located off the kitchen and began to push up on her throat and it would not come up. She tried to push down on her throat, and the stuck food would not go down. Resident B stated she got Resident A a glass of water, but the water came back up and during this time, Mr. Jackson was in his room. Resident B stated she went to Mr. Jackson's room and told him that Resident

A took too big of a bite of her sandwich and was choking. Resident B stated she knew Resident A was choking right from the beginning because she watched Resident A take a big bite from her sandwich and try to swallow it, and Resident A said “I’m choking” and was “gasping for air.” Resident B stated she told Mr. Jackson immediately that Resident A was choking and Mr. Jackson did not jump up and run out of his room but said he was sick and to try and “get it (the food) up or down”. Resident B stated Mr. Jackson came out and then went back into his room. Resident B stated Mr. Jackson came out of his room in a “short amount of time” and got Resident A to her chair at the dining room table and then called Ms. Chowdhury and 9-1-1. Resident B stated she heard Mr. Jackson talking to Ms. Chowdhury and Resident A’s twin sister, Resident D, who was with Ms. Chowdhury. Resident B stated this is when Resident A “slouched down” and the chair in the dining room tipped backwards onto the kitchen floor while Resident A was still sitting in the chair. Resident B stated Mr. Jackson then got Resident A off the kitchen floor and to the living room couch.

Resident B stated she knows what the Heimlich maneuver is and she did not see Mr. Jackson attempt to administer the Heimlich maneuver nor did she see Mr. Jackson perform CPR on Resident A. Resident B stated while Resident A was sitting on the couch in the living room, she was slouched but she was awake and trying to talk and said, “get it out, get it out.” Resident B stated the fire department came quickly and Mr. Jackson and the paramedics got Resident A onto the floor. Resident B stated she and Resident C told the paramedics that Resident A took a big bite of a PBJ sandwich, swallowed it and the food was stuck and they (the paramedics) asked how long it had been. Resident B stated she told the paramedics it had been “a few minutes, maybe 5 minutes.” Resident B stated she told the paramedics that she gave Resident A a glass of water and Resident A spit it back up. Resident B stated Resident A was holding her throat and trying to push the food up or down because she was having hard time breathing. Resident B stated the paramedics began chest compressions and attempted to clear her throat. Resident B stated the fire department “came right out quickly.” Resident B stated Resident A died on the floor by the couch in the living room.

On 06/25/2026, I conducted an unannounced inspection at the facility and interviewed Resident C. Resident C stated the incident occurred when it was lunch time and she was making PBJ sandwiches. She recalled that Resident A was “wound up” and her “anxiety was too much” on 06/01/2026. Resident C stated Resident A was acting like her normal self on that day. She was saying things like, “I’m going to break, I’m going to explode” and she said things like that all the time. Resident C stated she did not see Resident A take a large bite of her sandwich, she only saw Resident A on the floor in the kitchen. Resident C stated she had not yet sat down to eat when this happened and Resident B said to Resident C that Resident A took too big of a bite from her sandwich. Resident C stated that Resident A did not usually eat fast or take large bites of food. Resident B took Resident A to the bathroom and then came back to the kitchen where Resident A fell on the floor. Resident C stated Resident B said Resident A was turning blue and so she

(Resident C) went and got Mr. Jackson, who was in his room. Resident C stated she informed Mr. Jackson that Resident A was on the kitchen floor but did not know if she told Mr. Jackson that Resident A was choking and Mr. Jackson called Ms. Chowdhury. Resident C stated Ms. Chowdhury did not answer initially but she immediately called Mr. Jackson back and then Mr. Jackson called 9-1-1. Resident C stated Mr. Jackson then helped Resident A to the couch in the living room and then onto the floor when the fire department arrived. Resident C said the fire department arrived at the home quickly, but the ambulance took a longer time. Resident C stated Resident A died before the ambulance arrived. Resident C stated the paramedics performed CPR, but she did not see Mr. Jackson perform the Heimlich maneuver or CPR. Resident C stated the people in the home on 06/01/2026 included Resident A, B, Mr. Jackson and herself.

On 06/25/2026, I interviewed Mr. Jackson at the facility. Mr. Jackson stated he resides in the facility and was the only direct care staff on duty on 06/01/2026. Mr. Jackson stated before lunchtime, he got Resident A up from her room. Mr. Jackson stated he was checking rooms and Resident A went to the dining room table and then into the bathroom. Mr. Jackson stated it was at that time that Resident C came to him and said that Resident A was not acting right. Mr. Jackson stated he went to the kitchen and Resident A was sitting in a dining room chair with her “head down, gagging.” Mr. Jackson stated he thought Resident A was having an epileptic seizure and did not know Resident A was choking. He denied that Resident C had told him Resident A was choking. Mr. Jackson stated he got Resident A onto the living room couch. She was not responding or breathing, but he still thought she was having an epileptic seizure. Mr. Jackson stated he called 9-1-1 right away while they were still in the kitchen and the operator told him not to perform CPR because he reported that he thought Resident A was having a seizure. Mr. Jackson stated he was on the phone with the 9-1-1 operator when he moved Resident A to the living room couch to let her lay down. The operator then instructed him to move Resident A from the couch to the floor, which he did. He was instructed to tilt Resident A’s head back to keep her airway open and he did that and then the paramedics arrived.

Mr. Jackson stated no one said that Resident A was choking until after everything had already happened and it was at that point that he thinks Resident C might have said Resident A was choking. Mr. Jackson stated Resident B was not home when this incident occurred. She was at her day program and he thought it was only Resident A, Resident C and himself in the home at the time of this incident. Mr. Jackson stated he made Resident A’s sandwich and Resident C made her own sandwich. Mr. Jackson stated Resident A did not have any dietary restrictions and was able to have a PBJ sandwich. Mr. Jackson stated Resident A had no history of choking and she was not a fast eater. Mr. Jackson stated he was not in his room when this incident occurred, he was out and around the facility, and he is the one who called Resident A for lunch. Mr. Jackson stated he does not have to closely supervise the residents in the home and that the type of seizures Resident A had were the “staring” type of seizures and not the “jerking” type of seizures. Mr. Jackson stated that he had been trained in CPR and first aid but he did not perform CPR

or the Heimlich maneuver because he thought Resident A was having a seizure.

On 06/25/2026, I received and reviewed the Certificate of Death for Resident A. The document is dated 06/02/2026, signed by Dr. Matthew D. Carr, MD. The date of Resident A's death is 06/01/2026. The cause of death was documented as 'asphyxiation due to aspiration of food' and the manner of death was documented as an 'accident.' The interval between the onset and death of Resident A is documented as 'minutes.'

On 06/29/2026, I interviewed Juliet Chowdhury, licensee via telephone. Ms. Chowdhury stated she was not in the home when this incident occurred and when she arrived, the ambulance was there. Ms. Chowdhury stated Resident A, B and C were present at the home with Mr. Jackson. Ms. Chowdhury stated when she talked to Resident B, Resident B reported that Resident A was eating, coughing, and went to the bathroom holding her throat. Ms. Chowdhury stated Resident A frequently holds her throat and says that she is choking, not breathing, dying, her blood is coming out, and her leg is broken so this action is not out of the ordinary for Resident A. Ms. Chowdhury stated the residents got Mr. Jackson from his room. He was in his room because he was not feeling well, and Mr. Jackson took Resident A from the dining room to the living room. Ms. Chowdhury stated Resident A was still able to walk when Mr. Jackson assisted Resident A from the dining room to the living room couch. Ms. Chowdhury stated Mr. Jackson has been trained in CPR/first aid through Community Mental Health Ottawa County and knows how to perform the Heimlich maneuver. Ms. Chowdhury stated had Mr. Jackson known Resident A was choking, he would have done the Heimlich maneuver and performed CPR. Ms. Chowdhury stated Resident B and C did not tell Mr. Jackson that Resident A was choking and therefore, he did not know. Ms. Chowdhury stated Mr. Jackson called her and reported that Resident A was "not acting right" and that she was not feeling well. Ms. Chowdhury stated she told Mr. Jackson to hang up with her and call 9-1-1, which he did.

Ms. Chowdhury stated Mr. Jackson was not required to always be with the residents and the residents were allowed to make or get their own snacks. Ms. Chowdhury stated Resident A could eat peanut butter and did not have a special diet or any restrictions on food. Ms. Chowdhury also stated Resident A did not have a history of seizure activity.

On 06/29/2026, I received and reviewed an IR (Incident Report) dated 06/01/2026, 12:10p.m. written by Ms. Chowdhury, the IR documented Mr. Jackson, Resident B and C as witnesses to the incident. The documents stated, *'(Resident A) was eating with (Resident B) at the table, suddenly (Resident A) started coughing then (Resident B) told her to slow down. (Resident A) got up from the chair and went to the bathroom and coughed then she came back to the table. Then, she started to put her head down. Then (Resident B) called Keith and told him she's not feeling well. He (Mr. Jackson) asked (Resident A) are you ok? She looked at him, he saw*

she's having hard to breath. Nobody mentioned that she was eating. He called 9-1-1, they told him lay her on the floor, he did and they came and took over.'

On 06/29/2026, I received and reviewed the assessment plan for AFC residents for Resident A dated 09/25/2025. The assessment plan documented Resident A did not require a special diet. Resident A also did not require assistance with eating or feeding herself and was independent in the community and did not require any level of heightened supervision by staff in the home. The assessment plan does not have any information documenting that Resident A had a history of seizures.

On 06/29/2026, I received and reviewed the psychosocial assessment for Resident A, completed on 07/01/2024 by Community Mental Health of Ottawa County. The assessment documented, *'(Resident A) is always unsure of herself stating, I hope I'm ok, I am worried about my body, worried she is going to explode inside, bleeding from the inside and worries about not being able to make it.' (Resident A) has been 'evaluated by the ER on a few occasions and they reported finding no medical cause for this. Judgement and insight are limited. Cognition is impaired by borderline cognitive functioning.'*

On 06/29/2026, I received and reviewed the health care appraisal (HCA) for Resident A dated 05/19/2025, signed by Jennifer Morrical, MD (medical doctor). Resident A's date of birth was 07/21/1980, her diagnosis was 'schizoaffective, bipolar type, unspecified anxiety, borderline intellectual functioning, continues with psychiatry. Resident A's past medical history includes, 'hypercholesteremia, mild intermittent asthma, uncomplicated and schizoaffective disorder. The HCA documented Resident A's current diet as 'eats a varied diet, not picky. Well balanced in fruits and veggies. Sometimes can be anxious in morning and not want to eat.' The HCA does not document that Resident A had seizures of any type.

On 07/27/2026, I received the Ottawa County Sheriff's Office report dated 06/01/2026, 12:35 (12:35p.m.), time of death, 13:26 (1:26p.m.). The report was written by Officer Anderson, Deputy Hartman. *'On 06/01/2026 at 13:08, I was dispatched to 608 Beechwood St. in Park Twp for a 45-year-old female originally dispatched as a difficulty breathing call. I arrived on scene making contact with AMR and Park Twp FD who were performing life saving efforts on (Resident A) who choked on a peanut butter and jelly sandwich which resulted in (Resident A) going into cardiac arrest. AMR advised contact was being made with a physician at HCH for a time of death as the resuscitation efforts were unsuccessful. AMR also advised when they attempted to insert an airway device, there was a significant amount of the peanut butter and jelly sandwich obstructing her airway that then dislodged when they re-attempted to place the airway device.*

I made contact with homeowner Juliet who runs the AFC home. Juliet stated she was taking (Resident A's) twin sister to an event center when another resident, Keith Jackson (this is an error, Mr. Jackson is staff) called and told her (Resident A) was

choking and she instructed Keith to call 9-1-1. Juliet stated the ambulance was already at the house doing CPR on (Resident A) when she arrived back home. Juliet stated (Resident A) makes her own decisions and does not have a power of attorney. (Resident A) is diagnosed with anxiety and schizophrenia. AMR advised Dr. Krozee at HCH provided time of death at 13:26.'
The supplemental report by Deputy Vriezema on 06/02/2026 documented, *'I made contact with (Resident B) in the kitchen of the home. (Resident B) advised that she was eating lunch with (Resident A) before she began choking. I asked (Resident B) to explain further what happened. (Resident B) stated that (Resident A) had a history of pretending to choke as well as saying that she was dying. (Resident B) advised that her and (Resident A) were eating peanut butter and jelly sandwiches when she began to choke. (Resident B) also advised that when (Resident A) eats she jerks her body back and forth. (Resident B) went on to say that (Resident A) began to grab at her throat and demonstrated the universal sign of choking. (Resident B) advised they attempted to rub (Resident A's) neck in hopes that was going to help. (Resident B) then stated that they walked to the bathroom before they walked out into the living room before (Resident A) went unconscious. (Resident B) advised they first placed the phone call to the operator of the home, who was not on scene at the time, who advised them to hang up and call 9-1-1. (Resident B) advised that was when 9-1-1 was contacted.'*

Attached to the police report was an APS (Adult Protective Services) law enforcement notification sent from the Ottawa Co. Sheriff's Office to Centralized Intake dated 06/09/2026. The referral documented the following information, *'On 06/01/2026, (Resident A and Resident B) and another unknown individual were eating peanut butter sandwiches when (Resident A) began to choke. (Resident A) was initially able to breathe, was asking for help, and stating she did not want to die. The unknown individual went to get Keith and by the time they got back, the food had lodged further and (Resident A) could no longer breathe. Keither did not perform the Heimlich maneuver or take any life saving measures and (Resident A) died. It is unknown what staff are required to do in this situation and there is concern for neglect.'*

The APS referral continued, *'On 06/11/2026 at approx. 9:53a.m., I (Deputy Hartman) followed up with Juliet and Keith at the residence. I made contact with Juliet and asked her if there were any known conflicts or issues between any of the residents with (Resident A). Juliet stated there are no known issues between any residents, when (Resident A) would have episodes or seizures, they would comfort her. I then made contact with Keith about his recollection of the incident. Keith stated that it was lunchtime and (Resident A) was at the table but he went to get something, so he was not in there the whole time. Keith stated (Resident B) came to him and said, "(Resident A) is acting weird. So, I went back to the table and could tell something was wrong, she was still responding a little bit, something was wrong." Keith stated he got on the phone with the operator and they told him to see if she could walk to the sofa, and he said, "I don't think she was able to walk, so she said, well pick her up and carry her to the sofa. I wrapped my arm (around Resident A) and took her to*

the sofa." Keith stated (Resident A) did not make any indications that she was choking. Keith said (Resident A) would have seizures, so he was not sure if she might have already had one while he was out of the room because she would be lethargic like that afterwards and she would go to the hospital for those. Keith stated (Resident A) wasn't really responding anymore and her lips were turning purple, so the operator told him to lay her down on the floor then gave him instructions. Keith said there was so much chaos and the clients were upset so he was trying to calm them because they take care of her too.

I asked Keith about when (Resident A) was sitting at the table if there were any indications that she was choking, and he stated, "no." I asked Keith if it appeared similar to her usual episodes or seizures and he stated, "at first it did, but sometimes it's hard to tell." Keith stated the residents said they thought (Resident A) had a seizure, but he didn't think she had one.'

On 07/27/2026, I contacted Ms. Chowdhury via email and asked if Resident A has a history of seizures or a seizure disorder. Ms. Chowdhury responded and said "no."

On 08/03/2026, I conducted an exit conference with Licensee, Juliet Chowdhury via telephone. Ms. Chowdhury stated Mr. Jackson did not know Resident A was choking and thought she was having some type of seizure. Ms. Chowdhury stated the residents did not tell Mr. Jackson that Resident A was choking because they (the residents) did not know themselves that Resident A was choking. Ms. Chowdhury stated Mr. Jackson knows to immediately call 9-1-1 if a resident was choking. Ms. Chowdhury stated she understands the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	The complainant reported on 06/01/2026, Resident A, choked on a sandwich, the home manager called 911 but did not attempt CPR or the Heimlich maneuver and Resident A died. The IR documented the time of the incident as 12:10p.m. The Ottawa County Sheriff's Office report documented the call came in at 12:35 (p.m.). Resident C reported Mr. Jackson called Ms. Chowdhury before calling 9-1-1 but Resident B reported Mr. Jackson called 9-1-1 and then Ms. Chowdhury.

	Mr. Jackson reported that he called 9-1-1 immediately when he saw Resident A was in distress. Based on investigative findings, there is not a preponderance of evidence to show that Mr. Jackson failed to call 9-1-1 on 06/01/2026 immediately to obtain emergency care for Resident A when he realized Resident A was in distress. Therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING

INVESTIGATION: On 06/29/2026, I received and reviewed the training record for Mr. Jackson as documented by Ms. Chowdhury. On 03/11/2026, Ms. Chowdhury documented on a facility form that she reviewed CPR training with Mr. Jackson and Ms. Chowdhury signed the document. Ms. Chowdhury documented on 03/18/2026 that she reviewed First Aid training with Mr. Jackson and Ms. Chowdhury signed the document.

On 06/29/2026, I received and reviewed the Certificate of Completion for Mr. Jackson for Knowledge of First Aid 2026 through Lakeshore Regional Entity.

On 07/01/2026, I asked Ms. Chowdhury via email if Mr. Jackson had proof of CPR/First Aid in the form of the official CPR card. Ms. Chowdhury replied via email that Mr. Jackson had lost the CPR card.

On 07/01/2026, I received the transcript of training from Ms. Chowdhury through CMH of Ottawa County. The transcript documented as of 07/17/2026, Mr. Jackson had completed Knowledge of First Aid 2026 and is signed up for Ottawa-hybrid First Aid/CPR/AED on 08/21/2026.

On 07/27/2026, I emailed Briana Fowler, Office of Recipient Rights and requested clarification on whether Mr. Jackson was trained in CPR prior to 06/01/2026. Ms. Fowler and Matt Postema, Ottawa County CMH trainer, responded, *'Keith is registered for Ottawa – Hybrid FA/CPR/AED" on August 12 (*2026*). That's the in-person portion of the course. Shortly after he registered for the course, he was emailed the online portion of the course*.'

On 07/27/2026, Mr. Postema emailed me the following, *'I told Juliet I (Mr. Postema) did not have any proof that he (Mr. Jackson) took the class with me/CMHOC. I asked her to see if she could find anything indicating he came to a class and I've not heard back.'*

On 07/29/2026, I interviewed Ms. Chowdhury via telephone, and she stated that Mr. Jackson was training in CPR through CMHOC.

On 07/29/2026, I corresponded with Mr. Postema via email. Mr. Postema stated he had not found any documentation showing Mr. Jackson had CPR training.

On 08/03/2026, I conducted an exit conference with Licensee, Juliet Chowdhury via telephone. Ms. Chowdhury stated Mr. Jackson was trained in CPR through CMHOC and is going to check with Matt Postema at CMHOC again to see if they can find the records. Ms. Chowdhury stated she will provide a corrective action plan and accept the provisional license unless she is able to provide verification that Mr. Jackson was trained in CPR.

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: (c) Cardiopulmonary resuscitation, which includes a hands-on demonstration as part of the training.
ANALYSIS:	I requested verification of first aid and CPR training from Ms. Chowdhury for Mr. Jackson. Ms. Chowdhury provided proof that Mr. Jackson was trained in first aid but was unable to provide proof that Mr. Jackson was trained in CPR other than an in-facility document written by Ms. Chowdhury stating she reviewed CPR with Mr. Jackson. Mr. Postema stated Mr. Jackson is signed up for CPR training in August 2026 but he does not have verification that Mr. Jackson had been trained in CPR prior to this. Ms. Chowdhury stated Mr. Jackson is trained in CPR through CMHOC but cannot provide training verification. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE

R 400.629	**Direct care staff; qualifications and training.**
	(4) Direct care staff shall possess all of the following qualifications before working independently: (b) Be capable of appropriately handling emergency situations.
ANALYSIS:	Ms. Chowdhury is unable to show that Mr. Jackson is trained and competent in CPR and Mr. Jackson was the only staff on duty and working independently without verification that he had been trained in CPR. Therefore, Ms. Chowdhury is unable to demonstrate that Mr. Jackson was capable of appropriately handling emergency situations. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license be changed to provisional due to the above-cited quality-of-care violations.

Elizabeth Elliott

08/03/2026

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

Jerry Hendrick

08/03/2026

Jerry Hendrick — Date
Area Manager