



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 11, 2026

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

RE: License #: AS390419164
Investigation #: 2026A0578037
CenterPointe Recovery Center

Dear Jessica 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 feel free to 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 (517) 335-5985.

Sincerely,

A handwritten signature in black ink, appearing to read 'Eli DeLeon', with a stylized, flowing script.

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390419164
Investigation #:	2026A0578037
Complaint Receipt Date:	07/22/2026
Investigation Initiation Date:	07/23/2026
Report Due Date:	09/20/2026
Licensee Name:	Pine Rest Christian Mental Health Services
Licensee Address:	300 68th Street SE Grand Rapids, MI 49548
Licensee Telephone #:	(616) 455-5000
Administrator:	Jessica Kross
Licensee Designee:	Jessica Kross
Name of Facility:	CenterPointe Recovery Center
Facility Address:	1701 Olmstead Road Kalamazoo, MI 49048
Facility Telephone #:	(269) 382-3865
Original Issuance Date:	07/31/2025
License Status:	REGULAR
Effective Date:	01/31/2026
Expiration Date:	01/30/2028
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A required the use of a CPAP machine that was only operable with an unsafe extension cord.	Yes
Resident A was not provided with the treatment needed for a documented and worsening infection.	No
Resident A was denied the use of his CPAP machine during the day.	Yes
Resident A was denied personal clothing as this clothing was provided to another resident.	No
Resident A was forced to leave this facility without appropriate discharge planning.	Yes
Resident A was provided with access to resident protected health information.	No
A part of Resident A's record was destroyed instead of being appropriately retained.	No

III. METHODOLOGY

07/22/2026	Special Investigation Intake 2026A0578037
07/22/2026	APS Referral
07/23/2026	Special Investigation Initiated - Telephone
07/23/2026	Additional Allegations Received.
07/23/2026	Contact-Telephone-Interview with Resident A.
07/27/2026	Special Investigation Completed On-site-With Integrated Services of Kalamazoo recipient right officer Kate Koyak, interview of administrator Candy McKenney, interview with direct care staff Jonny Gettle, interview of direct care staff Amanda Oliver, interview of direct care staff Hayden Edelberg, interview of direct care staff Samara Trout.
07/27/2026	Contact-Documentation Reviewed- <i>Hospital Psychosocial Admission Assessment</i> for Resident A, dated 07/18/2026.
07/27/2026	Contact-Documentation Reviewed- <i>Centerpointe CRS Adult Psychiatric Admission Evaluation</i> for Resident A, dated 07/18/2026.

07/27/2026	Contact-Documentation Reviewed- <i>Floor Plan</i> .
07/27/2026	Contact-Documentation Reviewed- <i>Medication Administrations</i> for Resident A.
07/27/2026	Contact-Documentation Reviewed- <i>Residential Nursing Assessment</i> for Resident A, dated 07/18/2026.
07/27/2026	Contact-Documentation Reviewed- <i>Centerpointe CRS Adult Psychiatric Admission Evaluation</i> for Resident A, dated 07/18/2026.
07/27/2026	Contact-Documentation Reviewed- <i>CRS Care Provider Progress Notes</i> , 07/19/2026 and 07/20/2026.
09/08/2026	Contact-Telephone-Interview with Case Manager A.
09/09/2026	Contact-Documentation Reviewed- MP4 recording associated with Incident Number 2026-00011784.
09/09/2026	Exit Conference-Message left for licensee designee Jessica Kross.

ALLEGATION:

Resident A required the use of a CPAP machine that was only operable with an unsafe extension cord.

INVESTIGATION:

On 07/22/2026, I received this complaint through LARA-BCHS-Complaints@michigan.gov. Complainant reported Resident A experienced a mental health crisis and was admitted to this facility. Complainant reported Resident A is dependent on a continuous positive airway pressure (CPAP) machine at night. Complainant reported that electrical outlets were not available in the bedroom provided to Resident A and Resident A's CPAP machine had to be plugged into an electrical outlet in another room with the use of an extension cord.

On 07/23/2026, Complainant provided several addendums to the allegations submitted on 07/22/2026. The addendums to the allegations were not investigated by this department as they are not rule or statute related.

On 07/23/2026, I interviewed Resident A regarding this allegation. Resident A confirmed the allegations as reported and clarified that he did not previously know

that an electrical outlet would not be available in his bedroom. Resident A reported that he had to resort to using an online delivery service to purchase and obtain an extension cord to plug his CPAP machine into an electrical outlet across the hallway from his bedroom. Resident A reported a direct care staff taped this electrical cord to the floor. Resident A reported understanding having this electrical cord in a hallway that forms part of the egress for this facility violated licensing rules and fire safety regulations. Resident A reported that anyone in this main hallway could have tripped on this extension cord, and had his door been shut, this might have caused his CPAP machine to be unknowingly unplugged while he was asleep. Resident A reported that if his CPAP machine had been unplugged while he was sleeping, this could have dropped his oxygen saturation.

On 07/27/2026, Integrated Services of Kalamazoo recipient right officer Kate Koyak and I interviewed direct care staff Jonny Gettle regarding the allegations. Administrator Candy McKenney was present. Jonny Gettle identified serving as the program supervisor for this facility. Jonny Gettle reported being aware of the allegations and confirmed that no electrical outlet was available in Resident A's bedroom during his time at this facility. Jonny Gettle added that in response to the allegations, electrical outlets were being added to every resident bedroom in the facility. Jonny Gettle reported he was not present when Resident A was staying at this facility but did not deny that an electrical cord covered by duct tape needed to be extended across a main hallway to facilitate Resident A using his CPAP machine.

On 07/27/2026, I reviewed the *Hospital Psychosocial Admission Assessment* for Resident A, dated 07/18/2026. The *Hospital Psychosocial Admission Assessment* for Resident A documented that Resident A's "health status and behaviors" confirmed sleep apnea as a medical diagnosis.

On 07/27/2026, I reviewed the *Centerpointe CRS Adult Psychiatric Admission Evaluation* for Resident A, dated 07/18/2026. The *Centerpointe CRS Adult Psychiatric Admission Evaluation* for Resident A documented that Resident A identified being recently diagnosed with obstructive sleep apnea and instructed to use a CPAP.

On 07/27/2026, I reviewed the *Floor Plan* for this facility. I noted the *Floor Plan* for this facility documented the main hallway of this facility is lined with resident bedrooms and is the only method of passage for egress exits at this facility.

APPLICABLE RULE	
R 400.685	R 400.685 Resident admission; resident assessment plan; resident care agreement; health care appraisal.
	(2) A licensee shall not accept or care for a resident until a written assessment has been completed. A written assessment plan must include all of the following: (b) The services, skills, and physical accommodations required by the resident that are available at the facility.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Resident A and direct care staff Jonny Gettle, as well as a review of pertinent documentation relevant to this investigation, Resident A was admitted and accepted to this facility with a diagnosis of sleep apnea and the need for a CPAP machine. The physical accommodation required for Resident A to safely utilize his CPAP machine was not available in this facility.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.725	Means of egress.
	(1) A means of egress must be considered the entire way and method of passage through the facility and out an exit door to free and safe ground outside the facility and must be arranged and maintained to provide free and unobstructed egress from all parts of the facility.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Resident A and direct care staff Jonny Gettle, as well as a review of pertinent documentation relevant to this investigation, the only alternative for providing Resident A with an electric outlet to use his needed CPAP machine involved using an extension cord in the main hallway of this facility and covering this extension cord with duct tape. As such, the only method of passage to any means of egress in this facility was not maintained to provide free and unobstructed egress from all parts of this facility.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

- **Resident A was not provided with needed treatment for a documented and worsening infection.**
- **Resident A was denied the use of his CPAP machine during the day.**

INVESTIGATION:

On 07/23/2026, Complainant provided an additional allegation that Resident A was admitted to this facility with an active infection in his armpit. Complainant reported that Resident A was prescribed Lotrimin cream for this active infection and alleged that staff at this facility refused to provide Resident A with this needed medication.

On 07/23/2026, Complainant provided an additional allegation that the extension cord Resident A used to plug in his CPAP machine was not available during the day and this denied Resident A of the use of his CPAP machine while sleeping during the day.

On 07/23/2026, I interviewed Resident A regarding the allegations. Resident A confirmed the allegations as reported and added that prior to his admission to this facility, he presented with an infection in his arm pit from heat associated with the weather. Resident A reported he was medically cleared regarding this infection but was prescribed Lotrimin cream to use every 24 hours. Resident A reported he was not provided with this Lotrimin cream despite being uncomfortable and requesting this cream on 07/19/2027. Resident A reported he requested this Lotrimin cream from direct care staff Annie Norman.

Resident A reported never actually seeing his prescription for the use of his CPAP machine but reported that he is to use his CPAP machine any time he is sleeping. Resident A clarified this meant if he were to take a nap during the day, he should also have the use of his CPAP machine. Resident A reported the electrical cord for his CPAP machine was removed from the hallway and he was not allowed to use his CPAP during the day on Sunday 07/19/2026 due to a concern expressed by direct care staff about the extension cord for his CPAP machine being a trip hazard. Resident A reported that without the use of his CPAP machine his oxygen saturation can drop to 70%.

On 07/27/2026, Integrated Services of Kalamazoo recipient right officer Kate Koyak and I interviewed direct care staff Jonny Gettle regarding the allegations. Jonny Gettle reported Resident A's Lotrimin cream was an over-the-counter medication and was not added or documented in the *Medication Administration Records* for Resident A. Jonny Gettle reported assuming Resident A's Lotrimin cream was not added to his *Medication Administration Records* for Resident A as Resident A did not ask for this medication. Jonny Gettle reported being informed later that Resident A reported requesting this medication from the facility nurse without success. Jonny

Gettle denied being aware of any requests Resident A made to use his CPAP machine during the day and denied being aware of any direct care staff that did not respond to or denied this request.

On 07/27/2026, Integrated Services of Kalamazoo recipient right officer Kate Koyak and I interviewed direct care staff Amanda Oliver regarding the allegations. Amanda Oliver reported working at this facility for over a year. Amanda Oliver reported being the nurse for this facility but not working at the facility for most of Resident A's stay at this facility. Amanda Oliver reported being aware of Resident A's skin rash and aware that Resident A arrived at this facility with Lotrimin cream. Amanda Oliver reported there was no documentation that Resident A had requested any medication or Lotrimin cream from direct care staff. Amanda Oliver reported during the admission process, direct care staff had asked Resident A if he wanted Lotrimin cream to be available to him and Resident A acknowledged this and as a result, direct care staff obtained a physician's order for Resident A's Lotrimin cream. Amanda Oliver reported a verbal order was obtained for Resident A's Lotrimin cream the next day.

Amanda Oliver acknowledged that Resident A required the use of a CPAP machine but denied having a prescription for the appropriate use of Resident A's CPAP machine.

On 07/27/2026, Integrated Services of Kalamazoo recipient right officer Kate Koyak and I interviewed direct care staff Hayden Edelberg regarding the allegations. Hayden Edelberg reported that 07/20/2026 was his first day working at this facility. Hayden Edelberg denied being asked or being aware of Resident A asking for Lotrimin cream for the treatment of a rash. Hayden Edelberg denied being asked by Resident A to use his CPAP machine during the day.

On 07/27/2026, Integrated Services of Kalamazoo recipient right officer Kate Koyak and I interviewed direct care staff Samara Trout regarding the allegations. Samara Trout denied being asked or being aware of Resident A asking for Lotrimin cream for the treatment of a rash. Samara Trout denied being asked by Resident A to use his CPAP machine during the day.

On 07/27/2026, I reviewed the *Hospital Psychosocial Admission Assessment* for Resident A, dated 07/18/2026. The *Hospital Psychosocial Admission Assessment* for Resident A documented that Resident A's "health status and behaviors" confirmed sleep apnea as a medical diagnosis.

On 07/27/2026, I reviewed the *Medication Administrations* for Resident A. The *Medication Administrations* for Resident A documented that clotrimazole (Lotrimin) 1% cream PRN was prescribed by Dr. Elise Anderson on 07/20/2026. The *Medication Administrations* for Resident A documented that no administrations of Resident A's Lotrimin 1% cream occurred from 07/18/2026 until 07/20/2026.

On 07/27/2026, I reviewed the *Residential Nursing Assessment* for Resident A, dated 07/18/2026. The *Residential Nursing Assessment* for Resident A documented a review of symptoms for Resident A, which documented a rash on Resident A's left arm.

On 07/27/2026, I reviewed the *Centerpointe CRS Adult Psychiatric Admission Evaluation* for Resident A, dated 07/18/2026. The *Centerpointe CRS Adult Psychiatric Admission Evaluation* for Resident A documented that Resident A identified being recently diagnosed with obstructive sleep apnea and instructed to use a CPAP.

The *Centerpointe CRS Adult Psychiatric Admission Evaluation* for Resident A documented that prior to admission at this facility, Resident A was only prescribed two medications and neither of these was Lotrimin 1% cream.

On 07/27/2026, I reviewed the *Residential Nursing Assessment* for Resident A, dated 07/18/2026. The *Residential Nursing Assessment* for Resident A documented the current facility-administered medications prescribed by Dr. Anoop Takher however Lotrimin 1% cream was not included in this list.

The *Residential Nursing Assessment* for Resident A documented a review of symptoms for Resident A, which documented a rash on Resident A's left arm.

On 07/27/2026, I reviewed the *CRS Care Provider Progress Note Shift: 2nd* for Resident A, dated 07/19/2026 and completed by direct care staff Daquayvion Jones. The *CRS Care Provider Progress Note Shift: 2nd* for Resident A documented a time frame of 2300 to 0700. The *CRS Care Provider Progress Note Shift: 2nd* for Resident A did not document any observed or reported medical or behavioral concerns for Resident A during this time.

On 07/27/2026, I reviewed the *CRS Care Provider Progress Note Shift: 2nd* for Resident A, dated 07/19/2026 and completed by direct care staff Annie Norman. The *CRS Care Provider Progress Note Shift: 2nd* for Resident A documented a time frame of 1500 to 2300. The *CRS Care Provider Progress Note Shift: 2nd* for Resident A did not document any observed or reported medical or behavioral concerns for Resident A during this time. The *CRS Care Provider Progress Note Shift: 2nd* for Resident A documented that Resident A was provided with assistance in setting up an extension cord for this CPAP machine.

On 07/27/2026, I reviewed the *CRS Care Provider Progress Note Shift: 2nd* for Resident A, dated 07/20/2026 and completed by direct care staff Daquayvion Jones. The *CRS Care Provider Progress Note Shift: 2nd* for Resident A documented a time frame of 2300 to 0700. The *CRS Care Provider Progress Note Shift: 2nd* for Resident A did not document any observed or reported medical or behavioral concerns for Resident A during this time.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	During this investigation, which consisted of interviews with Resident A, direct care staff Jonny Gettle, direct care staff Amanda Oliver, direct care staff Hayden Edelberg, and direct care staff Samara Trout, as well as a review of pertinent documentation relevant to this investigation, there was no enough evidence that direct care staff did not provide Resident A with Lotrimin cream as requested. Upon admission to the facility there was no physician prescription for this medication. However, during this investigation it was determined that Resident A did not have a prescribed order describing the terms of use or directions for use (such as use outside of regular sleeping hours) for his CPAP machine that was made available to Resident A in this facility.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident A was denied personal clothing as this clothing was provided to another resident.

INVESTIGATION:

On 07/23/2026, Complainant provided an additional allegation that all Resident A's clothing, with the exception of what he was wearing, was given to another resident. Complainant reported that Resident A went two days without his clothing before discovering what had happened to his clothes.

On 07/23/2026, I interviewed Resident A regarding the allegations. Resident A reported that when he was admitted to this facility, he was informed of a preventative heat treatment for pests which required the facility to accept all his clothing with the exception of the clothing he was wearing for ten hours. Resident A reported the following day that he had asked for his clothing that had received preventative heat treatment to be returned and none of the direct care staff could locate his clothing. Resident A reported that direct care staff Annie Norman even attempted to locate his clothing by sending a group text to other direct care staff at this facility. Resident A reported that Annie Norman was able to determine that his clothing was given to another resident. Resident A reported eventually receiving his clothing back but

reported that he was admitted on 07/18/2026 and his clothing was not returned to him until 07/20/2026. Resident A acknowledged that he was provided with spare clothing that was available at this facility, but Resident A clarified that he did not use clothing that did not belong to him to mitigate any health risk. Resident A acknowledged that his clothing being given to another resident was accidental and that none of his clothing was still missing, damaged, or not returned.

On 07/27/2026, Integrated Services of Kalamazoo recipient right officer Kate Koyak and I interviewed direct care staff Jonny Gettle regarding the allegations. Jonny Gettle acknowledged that all Resident A's clothing would have been put in a "hotbox" for preventative pest control, and that Resident A's clothing was given to another resident by accident. Jonny Gettle reported Resident A's clothing was put outside the wrong room but was corrected the next day. Jonny Gettle reported that prior to locating Resident A's clothing, Resident A was provided access to a bin of spare clothing kept at this facility in the event someone is admitted to this facility without an adequate amount of clothing.

APPLICABLE RULE	
R 400.637	Handling of resident funds and valuables.
	(2) Resident funds or valuables that have been accepted for safekeeping must be treated as a trust obligation.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Resident A and direct care staff Jonny Gettle, there was not enough evidence that Resident A's valuables to include clothing were not fully returned to Resident A with no indication of damage or missing clothing.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A was forced to leave this facility without appropriate discharge planning.

INVESTIGATION:

On 07/22/2026, Complainant alleged that Resident A was forced to leave this facility without appropriate discharge planning.

On 07/23/2026, I interviewed Resident A regarding the allegations. Resident A acknowledged the allegations as reported and stated that after expressing his dissatisfaction with services provided at this facility, Resident A requested to be discharged from this facility on 07/20/2026. Resident A reported making this request around 1PM and was informed by direct care staff Hayden Edelberg and direct care

staff Amanda Oliver that a discharge was being “worked on.” Resident A reported waiting until 5PM, when he had asked Hayden Edelberg on the status of his discharge from this facility and requested a note for Resident A’s employer. Resident A reported Hayden Edelberg informed Resident A that he was sorry, but Resident A’s discharge would not be occurring on 07/20/2026. Resident A reported he was informed by Hayden Edelberg that direct care staff at this facility wanted to be sure that Resident A had time to “cool off” and let Resident A decide if his request for discharge was what Resident A intended.

Resident A reported later finding out that no one from this facility had contacted his Integrated Services of Kalamazoo case manager on 07/20/2026. Resident A reported that had direct care staff at this facility done so, his case manager reported that Resident A’s discharge would have occurred the same day. Resident A expressed that since he was a voluntary admission to this facility, his voluntary discharge should have required direct care staff to follow the department rules related to an emergency discharge.

Resident A reported that instead of providing a written notice of discharge in writing, a petition for treatment was drafted by direct care staff at this facility and Kalamazoo Township Police were requested to transport Resident A to a local hospital. Resident A reported the petition drafted at this facility was not certified by any medical or psychiatric professional. Resident A reported that he appreciated the law enforcement officer who responded to the facility, as this Kalamazoo Township Police officer spent time listening to Resident A’s concerns and tried to provide Resident A with assistance. Resident A reported law enforcement was led to believe by direct care staff that law enforcement was “under order” to transport Resident A to the local hospital. Resident A reported that had he been forcibly transported to the hospital by law enforcement, this could have potentially escalated the situation and resulted in harm to himself or others. Resident A reported feeling this attempt at “getting rid of” him with a petition involving law enforcement was an attempt by direct care staff at this facility to retaliate against him for his expressed concerns.

Resident A reported that once the Kalamazoo Township Police officer deescalated the situation, an unknown direct care staff tore up the petition in front of Resident A. Resident A reported leaving the facility ACA or against clinical advice and added the facility “basically kicked me” out and staff at this facility did not follow the department rules related to an emergency discharge. Resident A reported that all he wanted was a coordinated discharge and direct care staff at this facility made no attempt to do so.

On 07/27/2026, Integrated Services of Kalamazoo recipient right officer Kate Koyak and I interviewed direct care staff Jonny Gettle regarding the allegations. Jonny Gettle acknowledged that Resident A had requested to be discharged from this facility around 1PM on 07/20/2026. Jonny Gettle reported that the decision for discharge from this facility would be made by a psychiatrist. Jonny Gettle reported Resident A was not approved for a discharge by the facility psychiatrist and denied

this process was influenced by business hours. Jonny Gettle reported beginning the protocol for Resident A to be discharged against clinical advice and began returning Resident A's items to Resident A when Resident A decided he wasn't going to leave. Jonny Gettle reported later that day that Resident A was throwing food and threatened to smear feces on walls and made comments to direct care staff that he would "make life hell" for them before entering the conference room during an all-staff meeting. Jonny Gettle reported Resident A entered this conference room and was swearing and making rude gestures to a teleconference camera before ripping papers off the wall and making threats of termination against direct care staff. Jonny Gettle reported turning off the camera for this teleconference meeting while Resident A continued swearing and making threats of using an online ordering platform to have alcohol delivered to this facility to allow residents to have a party. Jonny Gettle reported leaving the conference room and entering a staff office to discuss with other administrative staff if a petition for Resident A should be used due to Resident A requiring a higher level of care. Jonny Gettle reported Resident A entered this staff office. Jonny Gettle reported that due to Resident A's escalating behavior, law enforcement was notified. Jonny Gettle denied that law enforcement was notified to transport Resident A to the hospital to enact the petition, and clarified the petition was not sent to court or signed. Jonny Gettle reported direct care staff "Sophie" had notified law enforcement.

Jonny Gettle reported once law enforcement arrived, an officer spoke with him, and the other officer spoke with Resident A. Jonny Gettle reported being informed by the law enforcement officer that Resident A wanted a letter for his employer and he would leave this facility. Jonny Gettle reported that he informed Resident A that he could provide a note covering his absence. Jonny Gettle reported that Resident A informed him this note would not work and Resident A called the human resources department for his employer. Jonny Gettle reported the human resources department for Resident A's employer informed them a letter would be needed from a medical doctor and nothing that Jonny Gettle could write would be sufficient. Jonny Gettle reported that he informed Resident A that he could provide Resident A with a blank letterhead so that Resident A could follow up with his own physician or Integrated Services of Kalamazoo. Jonny Gettle reported that law enforcement encouraged Resident A to leave this facility and Resident A did so around 9:30PM. Jonny Gettle reported no discharge planning took place as Resident A left this facility against clinical advice. Jonny Gettle reported notifying Integrated Services of Kalamazoo by telephone and informing the crisis worker that Resident A had left this facility against clinical advice. Jonny Gettle reported a discharge summary was completed for Resident A a discharge summary is completed when a resident leaves this facility under any circumstances.

Jonny Gettle denied that Resident A was forced or discharged from this facility and clarified that Resident A left this facility against clinical advice. Jonny Gettle denied the petition for treatment was an attempt at retaliating against Resident A for expressing his concerns for safety or care at this facility and clarified that Resident

A's demonstrated behavior prompted the involvement of law enforcement around the same time a petition was being discussed.

On 07/27/2026, Integrated Services of Kalamazoo recipient right officer Kate Koyak and I interviewed administrator Candy McKenney regarding the allegations. Candy McKenney denied the petition was an attempt to avoid the discharge process or retaliate against Resident A. Candy McKenney reported that based on Resident A's demonstrated behavior, it was determined that Resident A needed a higher level of care and this was why a petition was considered. Candy McKenney reported Resident A's demonstrated behavior was not consistent with the behavior of a resident they would discharge to the community. Candy McKenney reported that Resident A would not be discharged without being examined by the psychiatrist. Candy McKenney reported that the psychiatrist would have been notified to appropriately discharge Resident A, but none of the staff at this facility felt that Resident A was "stable".

On 08/30/2026, I requested police records and documentation from the Township of Kalamazoo Police Department involving Resident A and occurring at this facility between 07/18/2026 and 07/20/2026. Township of Kalamazoo Police Department administrative assistant Lisa Jensen reported that only one incident/call for service occurred on 07/20/2026 and was not assigned a case number but identified *Incident Number 2026-00011784*.

On 09/09/2026, I reviewed *Incident Number 2026-00011784* and the associated dispatch MP4 recording, provided by the Kalamazoo County Consolidated Dispatch Authority. The MP4 recording associated with *Incident Number 2026-00011784* documented a telephone call made by direct care staff Sophie Wagnon on 07/20/2026, who identifies herself to Kalamazoo County Consolidated Dispatch Authority as a case manager at this facility. The MP4 recording associated with *Incident Number 2026-00011784* documented that Sophie Wagnon informed Kalamazoo County Consolidated Dispatch Authority that Resident A was increasingly aggressive towards staff, destroying property, and being verbally aggressive. The MP4 recording associated with *Incident Number 2026-00011784* documented direct care staff at this facility wanted Resident A taken to the hospital to be seen for a "higher level of care". The MP4 recording associated with *Incident Number 2026-00011784* documented that Sophie Wagnon informed Kalamazoo County Consolidated Dispatch Authority that direct care staff would not be sent with Resident A and this facility would be "discharging him (Resident A) into the other hospital's care."

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to:

	(o) Request and receive assistance from the responsible agency in relocating to another living situation.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Resident A, direct care staff Jonny Gettle, and administrator Candy McKenney, as well as a review of pertinent documentation relevant to this investigation, Resident A's request to receive assistance from his responsible agency in relocating to another living situation was not respected and safeguarded by the licensee. No telephone call was made to Resident A's responsible agency at the time he stated his desire to leave the facility which impeded discharge planning.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: (g) Voice grievances and present recommendations pertaining to the policies, services, and facility rules without fear of retaliation.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Resident A, direct care staff Jonny Gettle, and administrator Candy McKenney, as well as a review of pertinent documentation relevant to this investigation, there was not enough evidence to substantiate the allegation that after Resident A voiced his grievances with the conditions and services at this facility, that Resident A was retaliated against by the licensee or any direct care staff when they discussed providing a petition for treatment for Resident A, or requested the assistance of law enforcement on 07/20/2026 in response to Resident A's demonstrated behavior.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A was provided with access to resident protected health information.

INVESTIGATION:

On 07/22/2026, Complainant alleged that Resident A was provided with access to another resident's confidential and sensitive information, such as a treatment plan, medications, clinical goals and personal history.

On 07/23/2026, I interviewed Resident A regarding the allegations. Resident A reported that on 07/20/2026, he had entered a conference room where all direct care staff were present, including Jonny Gettle. Resident A reported that Candy McKenney was present by teleconference. Resident A reported that Candy McKenney told direct care staff to leave the room while she asked Resident A why he was upset. Resident A reported that he informed Candy McKenney that none of the direct care staff were coordinating his discharge and explained having to resort to using an extension cord for the use of his CPAP machine. Resident A reported having access to another resident's treatment plan when he was in this conference room alone. Resident A reported no longer recalling the resident's name but added that he also had access to a list of the residents' medications as well as the residents' personal history.

On 07/27/2026, Integrated Services of Kalamazoo recipient rights director Lisa Smith and Integrated Services of Kalamazoo recipient right officer Kate Koyak and I interviewed direct care staff Jonny Gettle regarding the allegations. Jonny Gettle confirmed the allegations and clarified that on 07/20/2026, Resident A had access to another resident's treatment plan after Resident A forced his way into a private staff meeting where resident treatment plans were being reviewed. Jonny Gettle reported that Resident A entered this conference room and was swearing and making rude gestures to a teleconference camera before ripping papers off the wall and making threats of termination against direct care staff. Jonny Gettle reported that Resident A was unresponsive to verbal attempts at redirection and all staff eventually left the conference room, which allowed Resident A access to resident treatment plans that were laying unsecured on the conference room table.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to:
	(r) Have confidentiality of records.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Resident A and direct care staff Jonny Gettle, Resident A

	forcibly obtained access to a confidential area where a staff meeting relating to resident care was occurring. During interviews, it was determined that while in this confidential area, Resident A had demonstrated threatening and increasing physically aggressive behavior towards direct care staff, which resulted in direct care staff attempting to verbally redirect Resident A, which was unsuccessful. As a result, direct care staff were forced to leave the immediate area where they were safeguarding confidential resident records to deescalate the situation occurring with Resident A and avoid any risk to the personal safety of direct care staff.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Part of Resident A's record was destroyed instead of being appropriately retained.

INVESTIGATION:

On 07/22/2026, Complainant alleged that part of Resident A's resident records was destroyed without being appropriately retained.

On 07/23/2026, I interviewed Resident A regarding the allegations. Resident A confirmed the allegations as reported. Resident A reported that on 07/20/2026, staff at this facility had attempted to kick him out of this facility under threat of involuntary petition and threatening Resident A with the involvement of law enforcement. Resident A reported staff at this facility led law enforcement into thinking they were obligated to transport Resident A to the emergency room. Resident A reported that due to past trauma and medical reasons, he was not willing to go to an emergency room. Resident A reported that instead of forcing Resident A to be transported to an emergency room, law enforcement attempted to assist Resident A. Resident A reported that sometime after law enforcement had de-escalated the situation, an unidentified direct care staff member tore up this petition in front of him. Resident A reported not knowing what had prompted the petition to be torn up but clarified this action did not reflect department requirements for retaining resident records. Resident A reported not knowing who had drafted this petition or what the petition said regarding why Resident A needed to be petitioned. Resident A clarified this petition was never signed by any certifying authority.

On 07/27/2026, Integrated Services of Kalamazoo recipient right officer Kate Koyak and I interviewed administrator Candy McKenney regarding the allegations. Candy McKenney acknowledged that a petition was drafted relating to Resident A on

07/20/2026 and clarified that anyone can draft a petition for someone else to be evaluated at a local hospital. Candy McKenney reported that staff at this facility were not familiar with Resident A and did not know his baseline of behavior. Candy McKenney reported that due to escalating behaviors, it was decided to have Resident A evaluated for a higher level of care. Candy McKenney clarified that since Resident A had left the facility against clinical advice, the petition was not used or signed by any certifying authority. Candy McKenney acknowledged the petition referenced by Resident A was not retained as a part of Resident A's records.

APPLICABLE RULE	
R 400.691	Resident records.
	(1) A licensee shall complete and maintain a separate record for each resident that includes all of the following: (d) Health care information including all of the following: (i) Health care appraisals. (ii) Medication administration record. (iii) Name, address, and contact information of the preferred health care professional and hospital. (iv) Medical insurance. (v) Statements and instructions for supervising prescribed medication including dietary supplements and medical procedures. (vi) Instructions for emergency care and advanced medical directives. (3) Resident records must be kept on file in the facility for 2 years after the date of resident discharge unless a shorter retention is specified elsewhere in these rules.
ANALYSIS:	During interviews in this investigation, Resident A and administrator Candy McKenney acknowledged the petition for mental health evaluation that was drafted on 07/20/2026 in reference to Resident A was not signed by any certifying authority and was not used to obtain an evaluation for Resident A. There is no evidence that resident records identified by this department were not appropriately retained by the licensee.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.



09/09/2026

Eli DeLeon
Licensing Consultant

Date

Approved By:



09/11/2026

Dawn N. Timm
Area Manager

Date