GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 26, 2025

Andrea Zylema
A.Zylema AFC LLC
1767 Deepwood Dr SW
Wyoming, MI 49519

RE: License #: AS410418441
Investigation #: 2025A0583030
Waterbury 3

Dear Mrs. Zylema:

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) 356-0183.

Sincerely,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410418441
Investigation #:	2025A0583030
Complaint Receipt Date:	03/18/2025
Investigation Initiation Date:	03/19/2025
Report Due Date:	04/17/2025
Licensee Name:	A.Zylema AFC LLC
Licensee Address:	1767 Deepwood Dr SW Wyoming, MI 49519
Licensee Telephone #:	(616) 634-6586
Administrator:	Andrea Zylema
Licensee Designee:	Andrea Zylema
Name of Facility:	Waterbury 3
Facility Address:	1666 Waterbury Kentwood, MI 49508
Facility Telephone #:	(616) 634-6586
Original Issuance Date:	07/09/2024
License Status:	REGULAR
Effective Date:	01/09/2025
Expiration Date:	01/08/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Licensee designee Andrea Zylema verbally mistreats residents.	Yes
Licensee designee Andrea Zylema placed a baby gate between the living area and the kitchen that restricts egress**.**	Yes
Additional Findings	Yes

III. METHODOLOGY

03/18/2025	Special Investigation Intake 2025A0583030
03/18/2025	Contact - Telephone call received Ashton Byrne, Recipient Rights
03/19/2025	Special Investigation Initiated - On Site Licensee Andrea Zylema, Resident A, Resident B, Resident C
03/21/2025	APS Referral
03/26/2025	Exit Conference Licensee Andrea Zylema

ALLEGATION: Licensee designee Andrea Zylema verbally mistreats residents.

INVESTIGATION: On 03/18/2025 I received a telephone call from Network 180 Recipient Rights staff Ashton Byrne. Ms. Byrne stated that she received a recipient rights complaint which alleged that licensee Andrea Zylema verbally mistreats residents.

On 03/18/2025 I received an email from Recipient Rights staff, Ashton Byrne. The email contained a recipient rights complaint form, dated 03/14/2025 that alleged the following: *'I have had several complaints from individuals, their families and friends regarding outbursts/screaming/tone from AFC homeowner/manager Andrea Zylema. A friend of this individual overheard this screaming as she was on the phone with the individual at the time and was alarmed by it. This individual is also a Christian and states that Andrea frequently takes the Lord's name in vain in front of her which is bothersome to her and unprofessional. A co-worker who also has an individual in the same home has said the same thing. My individual added that Andrea has also made comments to her such as "well Jesus sleeps" as if to mock her beliefs.'*

On 03/19/2025 I completed an onsite investigation at the facility and interviewed Resident A, Resident B, Resident C, and licensee designee Andrea Zylema. Recipient Rights staff Ashton Byrne was present during the interview.

Resident A stated that licensee designee Andrea Zylema verbally mistreats residents. Resident A stated that she is afraid that if she shares examples of Ms. Zylema' s verbal mistreatment, Ms. Zylema would become upset with Resident A. Resident A stated that Ms. Zylstra "mocks" her religion by taking "the lord's name in vain". Resident A stated that Ms. Zylema has said, "why in Jesus' name do you need to stay out so late, think of people other than yourself". Resident A explained that she often spends evenings at her church or with friends from church and Ms. Zylema gets upset that Resident A is not home before 10:00 PM. Resident A stated that Ms. Zylema has stated, "I don't trust Christians" which upsets Resident A because she identifies as a practicing Christian. Resident A stated that Ms. Zylema stated, "if you were my daughter, I would whoop you" after Resident A became argumentative. Resident A stated that Ms. Zylema has never called her "dumb" but has told Resident A, "that was a stupid thing to do". Resident A stated that she overheard Ms. Zylema tell other residents, "Don't be stupid". Resident A stated that after Ms. Zylema was notified of the complaint allegations, Ms. Zylema called Resident A via telephone and asked Resident A "who complained?" Resident A stated that Ms. Zylema was upset that a complaint had been filed and said, "my life and my job" cold be affected by the complaint and that this situation was "serious". Resident A stated that Ms. Zylema raised her voice during the telephone conversation and Resident A cried as a result.

Resident B stated that Ms. Zylema speaks to residents in a "stern voice". Resident B stated that she has observed residents become upset by Ms. Zylema's stern voice, but Resident B denied observing any resident cry due to their interaction with Ms. Zylema. Resident B stated that she has never observed Ms. Zylema call residents dumb or stupid.

Resident C stated that she was concerned that Ms. Zylema would become upset with Resident C for disclosing verbal mistreatment of facility residents by Ms. Zylema. Resident C stated that Ms. Zylema's stern communication towards residents has caused Resident C to "want to cry". Resident C stated that during one conversation, Ms. Zylema told Resident C to "shut up" when discussing Resident C's Christian beliefs.

Licensee designee Andrea Zylema denied that she verbally mistreats residents of the facility. Ms. Zylema stated that she was informed by Recipient Rights staff Ashton Byrne that complaint allegations were filed and would be investigated. Ms. Zylema admitted to calling Resident A via telephone after learning of the complaint allegations. Ms. Zylema stated that during the phone conversation she did not verbally threaten or accuse Resident A of disclosing verbal mistreatment but acknowledged that Resident A was upset during the phone conversation. Ms. Zylema stated that she has never mocked any residents' religious beliefs but acknowledged that she "might have taken the lord's name in vain". Ms. Zylema stated that she has never told any resident that they were dumb or stupid but stated that she may have said "that was a stupid thing" a resident did. Ms. Zylema denied telling any residents that she would physically spank them if they were her children.

On 03/24/2025 I received intake 204777 from Marquest McLemore of Adult Protective Services via email which indicated that Adult Protective Services was investigating the complaint allegations.

On 03/26/2025 I completed an exit conference via telephone with licensee Andrea Zylema. Ms. Zylema stated that she does not verbally mistreat facility residents, but she acknowledged she has raised her voice level when addressing residents' with hearing issues. Ms. Zylema stated that she will submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Resident A stated that licensee designee Andrea Zylema verbally mistreats residents, and she is afraid that if she shares examples of Ms. Zylema' s verbal mistreatment, Ms. Zylema will become upset with Resident A. Resident A stated that Ms. Zylstra "mocks" her religion by taking "the lord's name in vain". Resident A stated that Ms. Zylema has stated, "I don't trust Christians" which upsets Resident A because she identifies as a practicing Christian. Resident A stated that Ms. Zylema stated, "if you were my daughter, I would whoop you" after Resident A became argumentative. Resident A stated that Ms. Zylema has never called her "dumb" but has told Resident A, "that was a stupid thing to do". Resident A stated that she overheard Ms. Zylema tell other residents, "Don't be stupid". Resident A stated that after Ms. Zylema was notified of the complaint allegations Ms. Zylema called Resident A via telephone and asked Resident A "who complained?" Resident A stated that Ms. Zylema was upset that a complaint had been filed and said, "my life and my job" cold be affected by the complaint and that this situation was "serious". Resident A stated that Ms. Zylema raised her voice during the telephone conversation and Resident A cried as a result. Resident B stated that Ms. Zylema speaks to residents in a "stern voice". Resident B stated that she has observed

	residents become upset by Ms. Zylema's stern voice. Resident C stated that she was concerned that Ms. Zylema would become upset with Resident C for disclosing verbal mistreatment of facility residents by Ms. Zylema. Resident C stated that Ms. Zylema' s stern communication towards residents. Resident C stated that during one conversation, Ms. Zylema told Resident C to "shut up" when discussing Resident C's Christian beliefs. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Licensee designee Andrea Zylema verbally mistreats residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Licensee designee Andrea Zylema placed a baby gate between the living area and the kitchen that restricts egress.

INVESTIGATION: On 03/18/2025 I received a telephone call from Network 180 Recipient Rights staff Ashton Byrne. Ms. Byrne stated that she received a recipient rights complaint which alleged that licensee Andrea Zylema placed a gate between the kitchen/dining room area and the communal living room to restrict residents' access to the kitchen for food.

On 03/19/2025 I completed an onsite investigation at the facility and interviewed licensee designee Andrea Zylema, Resident A, Resident B, and Resident C. Recipient Rights staff Ashton Byrne was present during the interview.

Licensee designee Andrea Zylema acknowledged that she has placed a baby gate to separate the shared kitchen/dining room area from the communal living area. Ms. Zylema stated that she placed the gate to contain a puppy and restrict the food access of Resident C. Ms. Zylema stated that Resident C is a "food seeker". Ms. Zylema stated that Resident C does not have a behavioral plan in place to restrict Resident C's access to food.

Resident A, Resident B and Resident C each stated that staff place the baby gate to restrict residents' access to the kitchen because residents are not allowed to access the kitchen outside of scheduled meals and snacks times.

While onsite I observed a baby gate that separates the communal living room area from the kitchen. I observed that the baby gate restricts access to two means of egress including the garage door egress and the dining room slider door egress.

On 03/26/2025 I completed an exit conference via telephone with licensee Andrea

Zylema. Ms. Zylema stated that the baby gate will be removed, and she will submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(1) A means of egress shall be considered the entire way and method of passage to free and safe ground outside a small group home.
ANALYSIS:	Resident A, Resident B, and Resident C each stated that staff place the baby gate to restrict residents' access to the kitchen because residents are not allowed to access the kitchen outside of scheduled meals and snacks times. While onsite I observed a baby gate that separates the communal living room area from the kitchen. I observed that the baby gate restricts access to two means of egress including the garage door egress and the dining room slider door egress. Licensee designee Andrea Zylema acknowledged that she has placed a baby gate to separate the shared kitchen/dining room area from the communal living area. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. A baby gate installed by staff restricts residents' access to egress.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Staff failed to document Resident D's monthly weight.

INVESTIGATION: On 03/21/2025 I emailed licensee designee Andrea Zylema and requested copies of residents' weight records.

On 03/21/2025 I received and reviewed an email from licensee designee Andrea Zylema. I observed that the facility failed to record Resident D's weight for the month of December 2024.

On 03/24/2025 I received an email from licensee designee Andrea Zylema which stated the following: *'December is really no excuse but that it didn't happen. I will note that to all staff and remind myself. That can not be missed.'*

On 03/26/2025 I completed an exit conference via telephone with licensee Andrea Zylema. Ms. Zylema did not dispute that a rule violation had occurred and stated

that she would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	Facility weight records indicated that the facility staff failed to record Resident D's weight for the month of December 2024. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. Resident D was not weighed monthly.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Resident A did not receive breakfast on 03/08/2025.

INVESTIGATION: While onsite, on 03/19/2025 I interviewed licensee designee Andrea Zylema and Resident A.

Licensee designee Andrea Zylema stated that on the morning of 03/08/2025 staff Stephanie Brown "did not show up" for her assigned shift at 7:00 AM. Ms. Zylema stated that staff Sarah Vanliere worked at the facility the previous shift from 11:00 PM 03/07/2025 until 7:00 AM 03/08/2025. Ms. Zylema stated that Ms. Vanliere never left the facility but instead continued working at the facility until Ms. Zylema arrived at approximately 7:20 AM. Ms. Zylema stated that Resident A did not get breakfast that morning because Resident A was not aware that Ms. Vanliere was still at the facility before Resident A left for her scheduled outing.

Resident A stated that on the morning of 03/08/2025, she awoke and found no staff working at the facility. Resident A stated that she was scheduled to leave the facility for an outing that morning and did so without being provided breakfast. Resident A stated that staff at a local convenience store provided her breakfast because she informed them that she had not be provided breakfast by facility staff.

On 03/26/2025 I completed an exit conference via telephone with licensee Andrea Zylema. Ms. Zylema did not dispute that Resident A did not receive breakfast on 03/08/2025. Ms. Zylema stated that she would submit and acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**

	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Licensee designee Andrea Zylema stated that on the morning of 03/08/2025 staff Stephanie Brown "did not show up" for her assigned shift at 7:00 AM. Ms. Zylema stated that staff Sarah Vanliere worked at the facility the previous shift and continued working until Ms. Zylema arrived at approximately 7:20 AM. Ms. Zylema stated that Resident A did not get breakfast that morning because she was not aware that Ms. Vanliere was still at the facility before Resident A left for her scheduled outing. Resident A stated that on the morning of 03/08/2025, she awoke and found no staff working at the facility. Resident A stated that she was scheduled to leave for an outing that morning and did so without being provided breakfast. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule. On 03/08/2025, facility staff did not provide Resident A breakfast.
CONCLUSION:	**VIOLATION ESTABLISHED**

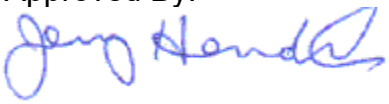
IV. RECOMMENDATION

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

03/26/2025

Toya Zylstra Date
Licensing Consultant

Approved By:



03/26/2025

Jerry Hendrick Date
Area Manager