GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 2, 2025

Jennifer Zandstra
Rehoboth AFC, Inc.
9505 Homerich Ave. SW
Byron Center, MI 49315

RE: License #: AM030365385
Investigation #: 2025A0579021
Rehoboth Oaks

Dear Jennifer Zandstra:

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,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W., Unit 13
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030365385
Investigation #:	2025A0579021
Complaint Receipt Date:	02/20/2025
Investigation Initiation Date:	02/20/2025
Report Due Date:	04/21/2025
Licensee Name:	Rehoboth AFC, Inc.
Licensee Address:	9505 Homerich Ave. SW Byron Center, MI 49315
Licensee Telephone #:	(616) 610-4097
Administrator:	Jennifer Zandstra
Licensee Designee:	Jennifer Zandstra
Name of Facility:	Rehoboth Oaks
Facility Address:	2990 138th Avenue Dorr, MI 49323
Facility Telephone #:	(616) 610-4097
Original Issuance Date:	04/16/2015
License Status:	REGULAR
Effective Date:	10/18/2023
Expiration Date:	10/17/2025
Capacity:	12
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's health care information records were not maintained in the home.	Yes
Resident A's records were not provided as requested after she moved from the home.	Yes
Medications are not properly disposed of.	Yes
Resident A's mail was thrown away.	Yes
Incident reports were not sent to Guardian A.	Yes
Resident A was discharged without notice.	No
Medications are kept unsecured in the garage.	No
Licensee Designee, Jennifer Zandstra, alters resident medications.	No
Residents do not receive adequate meals.	No
There is no menu posted in the home.	No

III. METHODOLOGY

02/20/2025	Special Investigation Intake 2025A0579021
02/20/2025	Special Investigation Initiated - Letter Complainant
02/25/2025	Contact- Telephone call made Guardian A
02/25/2025	Contact- Document received Guardian A
02/25/2025	Contact- Telephone call made Lucy Schuel, Former Direct Care Worker
02/25/2025	Contact- Face to Face Jennifer Zandstra, License Designee Anita Baker, Direct Care Worker Amelia Maldenado, Direct Care Worker
02/25/2025	Contact- Telephone call made Megan Aukerman, Licensing Consultant
02/26/2025	Contact- Document sent Jennifer Zandstra, Licensee Designee

02/27/2025	Contact- Document received Complainant
02/28/2025	Contact-Document received Phyllis Hepp, Social Worker
02/28/2025	Contact- Telephone call received Jennifer Zandstra, Licensee Designee
03/02/2025	Contact- Document received Jennifer Zandstra, Licensee Designee
03/03/2025	Contact- Document received Guardian A
03/05/2025	Contact- Document received Guardian A
03/06/2025	Contact- Document received Guardian A
03/10/2025	Contact- Document received Guardian A Jennifer Zandstra, Licensee Designee
03/11/2025	Contact- Document received Jennifer Zandstra, Licensee Designee
03/11/2025	Contact- Document received Guardian A
03/18/2025	Contact- Document sent Jennifer Zandstra, Licensee Designee
03/19/2025	Contact- Face to Face Amelia Maldenado, Direct Care Worker Jackie Melick, Direct Care Worker
03/21/2025	Contact- Document received Jennifer Zandstra, Licensee Designee
03/25/2025	Contact- Document received Guardian A
03/27/2025	Contact- Document sent Guardian A

03/28/2025	Contact- Document received Guardian A
03/28/2025	Contact- Document sent Jennifer Zandstra, Licensee Designee
03/31/2025	Exit Conference Jennifer Zandstra, Licensee Designee

ALLEGATION: Resident A's health care information records were not maintained in the home.

INVESTIGATION: On 2/20/25, I received this referral which alleged Guardian A requested Resident A's health care information records from licensee designee, Jennifer Zandstra on 11/27/24. Ms. Zandstra responded, "We don't keep the doc [sic] records because he keeps them all." Guardian A reportedly requested records numerous times, with the last time being 1/24/25, but has still has not received Resident A's health care information records.

On 2/20/25, I contacted the complainant confirming my receipt of the allegations. The complainant responded requesting I complete a telephone call with Guardian A for additional information.

On 2/25/25, I completed a telephone interview with Guardian A. She reported she has requested Resident A's health care information records multiple times beginning in November 2024. She stated Ms. Zandstra advised her Resident A's physician maintains the records so Ms. Zandstra does not have to.

On 2/25/25, I received screenshots of text messages from Guardian A which she reported were between her and Ms. Zandstra. She requested and/or discussed needing Resident A's health care information records on 11/11/24. Ms. Zandstra agreed to provide the documentation Guardian A requested, noting it may take time to get the documents from the physician. Guardian A requested the records again on 11/27/24 and Ms. Zandstra responded she can provide a medication list, but Resident A's physician would have the additional information needed. Guardian A requested the records again on 12/2/24 and Ms. Zandstra apologized for not being able to assist with the records. Guardian A requested the records again on 1/18/25 and Ms. Zandstra responded that Resident A's Health Care Appraisal (HCA) was expired as of the end of December 2024 and Guardian A was given a new form to update with Resident A's physician which was not received. Guardian A requested records again on 1/24/25.

On 2/25/25, I completed an unannounced on-site investigation at the home. Interviews were completed with Ms. Zandstra and direct care workers (DCWs) Amelia Maldenado and Anita Baker.

Ms. Maldenado and Ms. Baker reported they complete medication logs and health care information records are maintained in resident files. They reported Ms. Zandstra would have better knowledge of Resident A's health care information records since Resident A moved from the home in January 2025.

Ms. Zandstra stated she told Guardian A that Resident A's physician would have copies of Resident A's health care information records. She stated the physician comes to the home and maintains the records. She stated she believes the physician just needed proof of Guardian A's guardianship and Guardian A could have obtained the records from him. I inquired if Ms. Zandstra maintained a log of physician contacts and physician's orders. She reported she does not, as that is maintained by the physician. She stated she does have a HCA form for Resident A from 2023 which needed updating with the assistance of Guardian A but was not received prior to Resident A moving from the home. She stated she was working with the home's assigned consultant, Megan Aukerman, on other matters when Ms. Aukerman inquired about Resident A's records, so she took the records to her office in another building to scan and send to licensing which is why Resident A's records are not available in the home today. I requested the records be sent to me.

On 2/25/25, I completed a telephone call with Ms. Aukerman. She confirmed she was working with Ms. Zandstra on other matters and inquired about Resident A's paperwork. She stated she requested Ms. Zandstra send copies of the documents to licensing on 2/24/25.

On 2/26/25, I sent an email to Ms. Zandstra clarifying the documents I need including Resident A's HCA, medication logs from November 2024 to when Resident A discharged, and a record of Resident A's physician contacts.

On 2/28/25, I received an email from Phyllis Hepp, Social Worker from Wings of Hope Hospice. She reported Resident A was set to begin palliative care services on 12/3/24. She stated Wings of Hope administrative staff requested the health care information records from Resident A's physician on 11/19/24 and from Ms. Zandstra on 11/20/24. She reported documentation from 11/26/24 noted no records had been received despite multiple requests. On 12/10/24, Ms. Hepp became involved, and Guardian A requested assistance with obtaining Resident A's health care information records. Ms. Hepp emailed Ms. Zandstra requesting the records and did not receive a response. On 1/2/25, she spoke with Ms. Zandstra who reported she does not have access to Resident A's health care information records, and she was aware Guardian A had requested the records, but contact would need to be made with Resident A's physician. She called the physician's office but was unable to make contact and did not receive the records.

On 2/28/25, I completed a telephone interview with Ms. Zandstra. She stated she is certain she had Resident A's HCA from 2023 but could not locate it. She stated she attempted to obtain a copy from the physician who completed it, but his office was unable to assist her as the physician is now deceased.

On 3/2/25, I received records from Ms. Zandstra. I received the medication logs I requested. I did not receive any additional health care information records for Resident A.

On 3/10/25, Ms. Zandstra reported she had sent copies of all the records she has for Resident A.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(d) Health care information, including all the following:** **(i) Health care appraisals.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.**
ANALYSIS:	Ms. Zandstra reported she relies on the resident's physician for maintaining health care information records including physician contacts and instructions and acknowledged she does not maintain them in the home. She reported she could not locate Resident A's Health Care Appraisal from 2023 and a new one was due at the end of December 2024 but not received. Guardian A and Ms. Hepp reported they requested Resident A's health care information records on multiple occasions and did not receive them. Based on the interviews completed and documentation reviewed, there is sufficient evidence Resident A's health care information including health care appraisals, instructions for prescribed medications, and record of physician contacts were not maintained in the home as required by the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's records were not provided as requested after she moved from the home.

INVESTIGATION: On 2/20/25, I reviewed the referral which alleged Resident A had moved from the home and her records had not been received as requested after she left the home.

On 2/25/25, Guardian A confirmed Resident A no longer resides at the home. She moved out in January 2025, and no records have been received regarding Resident A although they were requested multiple times, including on 1/24/25.

On 2/25/25, Guardian A provided multiple screenshots of her requests for Resident A's records from Ms. Zandstra, with the last being on 1/24/25 after Resident A moved from the home. Ms. Zandstra responded at that time that she was out of town and would provide the records when she returned.

On 2/25/25, Ms. Zandstra acknowledged that Guardian A did request Resident A's records after Resident A moved from the home. She stated she was out of town and agreed to provide them when she returned. She confirmed she has still not provided the records to Guardian A.

On 2/28/25, Ms. Hepp confirmed Resident A left the home on 1/6/25 and records were not provided by Ms. Zandstra when Guardian A requested them after Resident A left the home.

On 3/3/25, Guardian A reported she has still not received records from Ms. Zandstra.

On 3/5/25, Guardian A reported she received some of the records from Ms. Zandstra but expressed concern that all the information she requested was not received. I advised she may include me in an email to Ms. Zandstra requesting the documentation she has not received as I had been unable to review all the documents at that time.

On 3/10/25, Guardian A contacted Ms. Zandstra discussing the paperwork she received and requesting additional documents. I was included in the email. Ms. Zandstra responded that she had provided all the documents she had available at that time.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(8) At the time of discharge, a licensee shall provide copies of resident records to the resident and his or her designated representative when requested, and as

	determined appropriate, by the resident or his or her designated representative. A fee that is charged for copies of resident records shall not be more than the cost to the licensee of making the copies available.
ANALYSIS:	Ms. Zandstra acknowledged Guardian A requested Resident A's records after Resident A moved from the home in January 2025. She agreed to provide the records but had not done so by the time the investigation began nearly a month later. Guardian A and Ms. Hepp confirmed Guardian A requested documentation after Resident A moved from the home and the documentation was not received. There is sufficient evidence resident records were not provided as requested by Guardian A at the time of Resident A's discharge from the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Medications are not properly disposed of.

INVESTIGATION: On 2/25/25, Guardian A reported she has learned from former direct care workers that Ms. Zandstra keeps discontinued medications in the medication cart and in a shed on the property and does not dispose of them properly.

On 2/25/25, I was contacted by and placed a return phone call to Lucy Schuel. She reported she is a former direct care worker. She stated she has witnessed that Ms. Zandstra does not destroy discontinued medications appropriately and stated they are kept in the medication cart or in the shed. She clarified the shed is the garage near the parking lot of the home.

On 2/25/25, Ms. Maldenado and Ms. Baker denied that medications are not disposed of properly. They reported the proper procedure of putting medications into coffee grounds or kitty litter to destroy them is utilized when medications are discontinued. They stated Ms. Zandstra or the home manager does this. They stated medications are not kept in the garage or any outbuilding on this property. They stated medications are only kept in the locked medication cart.

Ms. Zandstra stated the home manager typically is responsible for appropriately destroying discontinued medications in kitty litter or coffee grounds. She stated she believes the home manager recently destroyed discontinued medications and she does not believe there are any in the home. She denied that medications are ever

kept in the garage of the home. She stated all medications are kept in the medication cart until they are discontinued and destroyed.

I observed the locked medication cart. When opening the bottom drawer, Ms. Zandstra acknowledged there were several discontinued medications that she thought were destroyed that were in the cabinet. She stated she understands these should have been destroyed and she thought they had been but apparently there had been a miscommunication with the home manager. Ms. Zandstra immediately began removing the medications and reported she would properly destroy them after I leave the home. She removed them from the home while I was present. I observed approximately 20 monthly medication packs that Ms. Zandra confirmed were discontinued medications that had not been destroyed.

I observed the garage of the home and found it to be exceptionally organized. I was able to clearly observe two rows of shelving units and did not see any medications in the garage.

On 3/2/25, Ms. Zandstra reported she spoke to DCW Patty Paul to clarify what occurred with the discontinued medications. She stated Ms. Paul reported she intended to destroy the medications on 2/22/25 but had to leave the home that day and then forgot to follow-up on destroying the medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	Guardian A and Ms. Schuel reported medications are not properly disposed of after they are discontinued. They are kept in the medication cart and garage of the home. I observed approximately 20 medication packs in the bottom drawer of the medication cart that Ms. Zandstra confirmed were discontinued medications. She reported she thought the home manager had destroyed the medications but there was a misunderstanding. She immediately removed the medications from the home and agreed she would destroy them after I left the home. Based on the observation made and interviews completed, there is sufficient evidence that medication no longer required by residents was not properly disposed of.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's mail was thrown away.

INVESTIGATION: On 2/25/25, Guardian A reported Ms. Zandstra told her that she throws Resident A's mail away.

On 2/25/25, Guardian A provided screenshots of text messages with Ms. Zandstra from 12/4/24. She inquired what happens to Resident A's mail when it comes to the home. Ms. Zandstra responded if a resident receives mail, it goes in Ms. Zandstra's mailbox, and Ms. Zandstra provides it to the guardian. Ms. Zandstra reported Resident A did not have mail before Ms. Zandstra left the state, but Ms. Zandstra would check the mailbox. Guardian A inquired about medical bills that were addressed to the home. Ms. Zandstra reported she was told by the physician's office assistant years ago to disregard those statements and throw them away, so she has been doing that.

On 3/18/25, Ms. Zandstra reported she explained to Guardian A multiple times that the physician had an arrangement with a lab for testing and reported the lab does not charge for testing. She stated she was told the bill would be sent one time and it could be disposed of due to not needing to be paid. She explained she is not certain if she ever received a bill for lab testing for Resident A. She stated if it was sent, she is not certain it was addressed to Resident A or Ms. Zandstra. She stated she does not recall throwing this statement away for Resident A. She stated the physician would be able to answer this but unfortunately, he is now deceased, and his office is unable to assist. She denied throwing any other resident mail away.

On 3/28/25, I received a copy of a video Guardian A had taken of her speaking with Ms. Zandstra. Ms. Zandstra was not on camera but was recognized by her voice. Ms. Zandstra repeated to Guardian A what she had told me. She stated she did not throw all Resident A's mail away; but she threw the mail from the lab away as advised by the physician. Guardian A reported she needed the statement because Resident A had an outstanding balance. Ms. Zandstra stated Guardian A did not need to pay the balance as advised by the physician. Ms. Zandstra stated she is not certain she ever received or threw away a lab statement for Resident A.

On 3/28/25, Guardian A reported Resident A did not receive any mail in the 13 months she lived at the home. She stated she changed Resident A's mailing address from the home around December 2024 and has received billing statements on 12/4/24, 12/24/24, 1/17/25 and 2/19/25. She stated she was told by the lab that all previous billing statements went to the home. She stated she received a bill from a separate lab dated 11/7/24 which was not given to her until she requested it from Ms. Zandstra on 12/4/24. She stated Priority Health also shows a balance, and she confirmed with them previous statements were sent to the home. She provided the billing statements dated above.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**

	(1) Upon a resident's admission to the home, a licensee shall inform a Resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all the following resident rights: **(d) The right to write, send, and receive uncensured and unopened mail at his or her own expense.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Guardian A reported Resident A did not receive mail while living in the home. Guardian A reported and provided statements confirming that once Resident A's mailing address was changed, Guardian A was sent regular billing statements from multiple labs. Ms. Zandstra denied withholding all Resident A's mail. She reported she was advised to throw away lab billing statements from the physician's office, so she did that. She denied knowing if a statement was received in Resident A's name or in her name. Based on the interviews completed and documentation reviewed, there is sufficient evidence Resident A and Guardian A did not receive uncensured and unopened mail sent to the home due to billing statements not being given to Guardian A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Incident reports were not sent to Guardian A.

INVESTIGATION: On 3/11/25, Guardian A reported she just received Incident/Accident Report forms from Ms. Zandstra that were never sent to her while Resident A lived in the home.

On 3/11/25, I reviewed the Incident/Accident Report forms Ms. Zandstra had sent to Guardian A and myself. The "Persons Notified" section of the form was blank. It was noted on 5/17/24, Resident A attempted to punch DCWs leading to two purple swollen bumps on her hands. On 8/31/24, Resident A slapped and "clawed" a DCW's arms while Resident A was being toileted. On 9/20/24, Resident A punched another resident in the face and attempted to hit him with a chair. On 1/2/25, Resident A was hitting residents and DCWs.

On 3/28/25, I emailed Ms. Zandstra, due to her reporting she is out of the state and not available by telephone. I inquired if Incident/Reports were sent to Guardian A noting the form had not been completed regarding who was notified.

On 3/31/244, Ms. Zandstra responded she does not send Incident/Accident Report forms to guardians, she reports the incident via telephone. She stated she believed this was allowed.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(iii) Attempts at self-inflicted harm or harm to others.**
ANALYSIS:	Guardian A reported she did not receive Incident/Accident Report forms that were completed regarding Resident A displaying serious hostility and attempts at harm to others. I reviewed four Incident/Accident Reports that noted Resident A was engaging in serious hostility and harm to others. The “Persons Notified” section was blank and did not document Guardian A being notified. Ms. Zandstra reported she does not send Incident/Accident Report forms to guardians, she notifies them via telephone. Based on the interviews completed and documentation reviewed, there is sufficient evidence Guardian A did not receive Incident/Accident Report forms within 48 hours of incidents where Resident A exhibited serious hostility and attempts of harm to others.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was discharged without notice.

INVESTIGATION: On 2/20/25, I reviewed the referral which alleged Resident A was discharged from the home. Resident A was taken to the hospital and Ms. Zandstra reported Resident A could not return to the home. No notice was given.

On 2/25/25, Guardian A reported Ms. Zandstra requested Resident A be taken to the hospital so she could be admitted to Pine Rest for mental health treatment. She stated Pine Rest would not accept Resident A because Ms. Zandstra was initially stating Resident A could not return to the home. She stated Ms. Zandstra had to agree that Resident A could return to the home in order for Resident A to be admitted to Pine Rest. She stated Resident A was admitted to Pine Rest and she then went and retrieved Resident A's belongings from the home. She stated she was not given a notice for Resident A to discharge from the home. She stated staff from Pine Rest reported to appropriate agencies that Resident A was inappropriately discharged from the home at the time it occurred.

On 2/25/25, Ms. Maldenado stated she was present when Guardian A came to remove Resident A's belongings from the home. She stated it was unexpected. She stated her understanding was that Resident A was temporarily receiving mental health treatment and would be returning to the home when her behaviors were regulated. She stated Resident A was discharged from the home voluntarily by Guardian A and not at the request of Ms. Zandstra.

Ms. Zandstra denied discharging Resident A from the home which was why a discharge notice was not given. She stated Resident A was having escalating behaviors of aggression and she requested Resident A receive mental health treatment. She stated Guardian A agreed for Resident A to go to the emergency department so she could be evaluated and sent to Pine Rest for mental health treatment. She stated Pine Rest would not agree to accept Resident A unless Resident A could discharge back to this home. She stated she expressed that due to Resident A's behaviors, it was unsafe for Resident A and others for Resident A to be in this home without mental health treatment and/or medication adjustment. She stated she agreed once Resident A's behaviors were stabilized Resident A could return to the home. She stated after Resident A was admitted to Pine Rest, Guardian A removed Resident A's belongings, without being asked to.

On 2/25/25, Ms. Aukerman stated she did not receive allegations that Resident A was inappropriately discharged from the home. She stated she received a dismissed Adult Protect Services referral regarding allegations not relating to licensing rules which were therefore dismissed. She stated an inappropriate discharge was not discussed as a part of that referral. She stated she inquired about Resident A's discharge from the home when she spoke to Ms. Zandstra and Ms. Zandstra told her she did not issue a discharge notice because it was agreed Resident A would be returning to the home after mental health treatment but then Guardian A removed Resident A's belongings from the home.

On 3/2/25, I received an email from Ms. Zandstra that was forwarded communication between her and Pine Rest staff on 1/7/25. It stated, “We are willing to take (Resident A) back once she is no longer hitting especially during activities of daily living.”

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.**
ANALYSIS:	Ms. Zandstra reported she did not issue a discharge notice for Resident A because Resident A was set to return to the home after receiving mental health treatment. Ms. Zandstra and Guardian A reported Pine Rest would not accept Resident A for mental health treatment without Ms. Zandstra agreeing Resident A could return to the home. Resident A was accepted to Pine Rest. Ms. Zandstra forwarded communication with Pine Rest where she agreed Resident A could return to the home after mental health treatment. Ms. Zandstra, Ms. Maldenado, and Guardian A reported once Resident A was placed at Pine Rest, Guardian A removed Resident A’s belongings from the home. Ms. Zandstra denied requesting Resident A’s belongings be removed from the home.

	Guardian A reported an inappropriate discharge was reported by Pine Rest when Resident A was placed there. No referrals were received regarding Resident A's discharge until this referral. Based on the interviews completed and documentation reviewed, there is insufficient evidence Resident A was discharged from the home without proper notice.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Medications are kept unsecured in the garage.

INVESTIGATION: On 2/25/25, Guardian A reported she has learned from former direct care workers that Ms. Zandstra keeps discontinued medications in a shed on the property and does not dispose of them properly.

On 2/25/25, Ms. Schuel reported discontinued medications are kept in the locked medication cart and in the garage of the home.

On 2/25/25, Ms. Maldenado and Ms. Baker stated medications are not kept in the garage or any outbuilding on this property. They stated medications are only kept in the locked medication cart.

Ms. Zandstra denied that medications are left in the garage of the home. She stated medications are kept in the locked medication cart.

I observed the garage of the home and found it be exceptionally organized. I clearly observed the rows of shelving and did not see any medications in the garage.

On 3/18/25, Ms. Melick denied that resident medications are kept in the garage of the home. She reported all resident medications are kept in the locked medication cart.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as

	amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Guardian A and Ms. Schuel reported medications are kept unsecured in the garage of the home. Ms. Zandstra, Ms. Baker, Ms. Melick, and Ms. Maldenado denied that medications are kept unsecured in the garage of the home and reported they are kept in the locked medication cabinet. I observed the garage and did not discover any medications. Based on the observations made and interviews completed, resident medications are not kept in a locked cabinet or drawer.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Licensee Designee, Jennifer Zandstra, alters resident medications.

INVESTIGATION: On 2/25/25, Guardian A reported she has learned from former direct care workers that Ms. Zandstra keeps discontinued medications and tells DCWs they may use the medications for residents they are not prescribed for.

On 2/25/25, Ms. Schuel reported Ms. Zandstra directs DCWs to give discontinued medications to residents they are not prescribed for at her discretion. She stated one time she was advised by Ms. Zandstra to use the Tramadol of a resident who had passed away for another resident. She denied knowing exactly when this occurred.

On 2/25/25, Ms. Maldenado and Ms. Baker stated DCWs only give medications as they are prescribed by a physician. They stated Ms. Zandstra does not alter resident medications or advise DCWs to use discontinued medications for residents they are not prescribed for and works with the physician to adjust medications if needed.

Ms. Zandstra denied advising DCWs to alter medications or to administer discontinued medications to residents they are not prescribed to. She stated medications are regularly disposed of and she works with physicians to get physician approval before passing any medications.

On 3/19/25, Ms. Melick reported resident medications are given to residents as prescribed by a physician and not altered by Ms. Zandstra and discontinued medications are not given to residents they are not prescribed to.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	Guardian A and Ms. Schuel reported Ms. Zandstra advises DCWs to alter resident medications and administer discontinued medications to residents they are not prescribed to. Ms. Zandstra, Ms. Baker, Ms. Maldenado, and Ms. Melick denied that Ms. Zandstra alters resident medications or advises DCWs to give discontinued medications to residents they are not prescribed to. Based on the interviews completed, there is insufficient evidence Ms. Zandstra adjusts or modifies resident medications without instruction from a physician or pharmacist who has knowledge of the needs of the resident.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents do not receive adequate meals.

INVESTIGATION: On 2/27/25, Guardian A reported she regularly observed residents given ramen noodles and cheeseballs to eat, and it was rare she saw fruits or vegetables in the home.

On 3/19/25, I arrived at the home unannounced, in the middle of lunch meal service. I observed residents were eating a beef patty with a bun, side salad, fruit, and cookies.

I observed the kitchen of the home and found adequate food consistent with a balanced diet including protein, dairy, grains, vegetables and fruits.

Ms. Maldenado reported what residents were served today is consistent with what they typically eat. She stated meals are balanced and include protein, dairy, grains, vegetables, and fruits. She stated residents are not served ramen and cheeseballs

as a main meal. She stated the home does “teatime” and they will have snacks and may choose to have ramen or cheeseballs since that is an additional meal outside of their three balanced meals. She stated if a resident were to request ramen or cheeseballs as a meal, they would be offered a sandwich and fruit to go along with those items. She stated she has never witnessed a resident have only ramen and cheeseballs as a meal. She stated Ms. Zandstra does the grocery shopping and ensures nutritionally balanced foods are available in the home. She stated she also updates the grocery list if something is needed to ensure Ms. Zandstra can maintain nutritionally balanced food in the home.

Ms. Melick stated the meal that was served today is typically what is served in the home every day and meals are balanced. She stated residents are not given ramen and cheeseballs as a meal. She stated if ramen was to be served, it would be served with a sandwich, applesauce, and likely some type of vegetable as well. She stated residents may request ramen for a snack outside of their balanced meals.

On 3/19/25, I asked Ms. Zandstra about grocery shopping and meals in the home. She replied breakfast is around 8:00 a.m., the largest meal for residents is lunch which is served at 12:00 p.m., 3:00 p.m. is teatime snack, and 5:00 p.m. is dinner. She stated meals are nutritionally balanced and include protein, fruit, vegetables, and grains. She stated dinner usually includes soup, half a sandwich, and fruit. She stated ramen soup has never been served as a meal as that would not be sufficient for residents and they would be upset. She stated Ms. Melick told her on one occasion Guardian A was present for dinner when ramen soup, grilled cheese, and apple slices were served and Guardian A asked, “Is that all they are getting.” She stated Ms. Melick reported she told Guardian A residents receive their largest meal at lunchtime. She stated she previously had two DCWs who preferred to make ramen as part of the meal rotation, but they no longer work at the home, so she prefers not to purchase it anymore.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(2) Meals shall meet the nutritional allowances recommended pursuant to the provisions of "Appendix I: Recommended Dietary Allowances, Revised 1980" contained in the publication entitled "Basic Nutrition Facts: A Nutrition Reference," Michigan Department of Public Health publication no. H-808, 1/89. This publication may be obtained at cost from The Division of Research and Development, Michigan Department of Public Health, P.O. Box 30195, Lansing, Michigan 48909.
ANALYSIS:	Guardian A reported regularly observing residents eat meals that were not nutritionally balanced.

	Ms. Zandstra, Ms. Maldenado, and Ms. Melick denied the allegation and reported residents are given nutritionally balanced meals. I conducted an unannounced inspection and observed a lunch meal service and found residents were eating a balanced meal. I observed sufficient food, consistent with a balanced diet available in the home. Based on the interviews completed and observations made, there is insufficient evidence meals do not meet the nutritional allowances established by the rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: There is no menu posted in the home.

INVESTIGATION: On 2/27/25, Guardian A reported she never observed a menu in the home and does not believe a menu is posted.

On 3/19/25, I observed plastic sleeves with seasonal menus posted on the refrigerator of the home.

I observed that residents had access to and regularly entered the kitchen while I was present.

Ms. Maldenado stated the home uses a rotating menu that is kept where it was observed today, on the refrigerator of the home. She confirmed residents can and do regularly access the kitchen where the menu is posted.

Ms. Melick confirmed the rotating menu is kept on the refrigerator of the home.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	Guardian A reported she did not observe a menu posted in the home. I observed a series of rotating menus posted on the refrigerator in the home.

	I observed residents accessing the kitchen where the menus are posted. Ms. Maldenado and Ms. Melick reported menus are kept on the refrigerator of the home. Based on the interviews completed and observations made, there is insufficient evidence to support the allegation that menus are not prepared and posted at least a week in advance.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 3/31/25, I completed an exit conference via email with Ms. Zandstra. The findings and rules were discussed, and consultation was provided. Ms. Zandstra responded on 4/2/25 that she agreed to the findings regarding health care information, providing records at discharge, and distributing resident mail. She stated she does not agree with the findings regarding incident reports, noting she always calls the necessary parties and provides reports only if they request. Consultation was provided regarding the rule requirement of sending a written report within 48 hours and how this benefits residents, guardians, and Ms. Zandstra. She stated she does not agree with the medication disposal violation due to there being no timeframe specified in the rule and her feeling destroying medications once a month is sufficient. Consultation was provided regarding the rule, best practice, and how timely disposal would prevent allegations that medications were being held on to for misuse.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

Cassandra Duursma 04/02/2025

Cassandra Duursma Date
Licensing Consultant

Approved By:

04/02/2025

Jerry Hendrick Date
Area Manager