GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 17, 2026

Jonathan Book
AH Jenison Subtenant LLC
Ste 1600
1 Towne Sq
Southfield, MI 48076

RE: License #: AL700397747
Investigation #: 2026A0467013
AHSL Jenison Cottonwood

Dear Mr. Book:

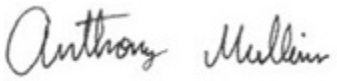
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

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

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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

Sincerely,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700397747
Investigation #:	2026A0467013
Complaint Receipt Date:	02/05/2026
Investigation Initiation Date:	02/05/2026
Report Due Date:	04/06/2026
Licensee Name:	AH Jenison Subtenant LLC
Licensee Address:	Ste 1600 1 Towne Sq Southfield, MI 48076
Licensee Telephone #:	(616) 432-2112
Administrator:	Jonathan Book
Licensee Designee:	Jonathan Book
Name of Facility:	AHSL Jenison Cottonwood
Facility Address:	834 Oak Crest Lane Jenison, MI 49428
Facility Telephone #:	(616) 457-3576
Original Issuance Date:	03/11/2019
License Status:	REGULAR
Effective Date:	09/11/2025
Expiration Date:	09/10/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Staff member Ruth Flokstra had an inappropriate relationship with Resident A.	Yes

III. METHODOLOGY

02/05/2026	Special Investigation Intake 2026A0467013
02/05/2026	APS Referral Ottawa County APS worker Emily Fewless has been notified of the allegations by licensee designee, Jonathan Book
02/05/2026	Special Investigation Initiated - Telephone Licensee designee informed me of the allegations via phone
02/10/2026	Inspection Completed On-site
02/10/2026	Exit conference completed Onsite with licensee designee, Jonathan Book.

ALLEGATION: Staff member Ruth Flokstra had an inappropriate relationship with Resident A.

INVESTIGATION: On 2/5/26, I received a call from licensee designee Jonathan Book reporting that staff member Ruth Flokstra was alleged to have an inappropriate relationship with Resident A. Mr. Book stated that Mrs. Flokstra had been communicating with Resident A via text messages and Facebook. When Resident A did not respond to her messages, Mrs. Flokstra contracted staff member Jennifer Johnson and asked her to check on Resident A.

Ms. Johnson reported that Resident A allowed her to check his phone to determine why he was not receiving messages. While reviewing the phone, Ms. Johnson observed a photo of Mrs. Flokstra and Resident A kissing. She immediately returned the phone to Resident A and reported the incident to her supervisor.

Mr. Book confirmed that Resident A is not in the memory care unit but he has been deemed incapacitated, and his son is his power of attorney. According to Mr. Book, Resident A's son indicated that his father previously sent him a message that appeared to be intended for Mrs. Flokstra. Mr. Book was informed that a formal investigation would be conducted to address these concerns.

On 02/10/2026, I conducted an announced onsite investigation at the facility. Upon arrival, I spoke to licensee designee Jonathan Book regarding the allegations. Mr. Book reported that an internal investigation had been completed and confirmed that Mrs. Flokstra engaged in an inappropriate relationship with Resident A. As part of the internal investigation, all involved staff members provided written statements for review.

According to the written statements, staff member Jennifer Johnson reported that on 2/2/26, at approximately 6:38pm, she received a message from staff member Ruth Flokstra stating that she had been attempting to contact Resident A via Facebook messenger and text message without success. Mrs. Flokstra indicated that she wanted to purchase sweatpants for Resident A and wanted to confirm that Resident A was okay with her ordering them through Amazon.

Concerned that Resident A's phone might not be working properly, Mrs. Flokstra asked Ms. Johnson to check on him. Ms. Johnson stated that when she spoke with Resident A, he handed her his phone and consented to her reviewing his Facebook messages to determine why he was not receiving messages from Mrs. Flokstra. While doing so, Ms. Johnson observed A picture sent by Mrs. Flokstra showing her and Resident A kissing. Ms. Johnson immediately returned the phone to Resident A and reported the incident to her supervisor.

According to the written statements, staff member Ruth Flokstra reported that she developed a close relationship with Resident A while providing care in the home. Mrs. Flokstra admitted to engaging in an inappropriate relationship with Resident A, which included texting, phone conversations, and connecting on Facebook. She stated that a discussion between them about "iconic kisses" led to a consensual kiss, which she took a picture of and sent to Resident A.

Mrs. Flokstra acknowledged that her actions demonstrated "extremely poor judgement" and were not appropriate. Mrs. Flokstra made it known that the interaction with Resident A was consensual and that she did not force Resident A to do anything he didn't want to do. She also shared that she did not receive any financial compensation for purchasing items for him. Mrs. Flokstra resigned from her position, stating that this was the most appropriate course of action. Licensee Designee Jonathan Book confirmed that Mrs. Flokstra would have been terminated had she not resigned prior to the conclusion of the investigation.

In addition to the written statements by the two involved staff members, Mr. Book provided a written statement signed by Resident A and his power of attorney (adult son). In the statement, Resident A reported that he did not recall any pictures on his phone involving himself and Mrs. Flokstra. Resident A described his relationship with Mrs. Flokstra as a close friendship as opposed to a romantic relationship and indicated that he had not experienced any harm as a result of their interactions.

According to the written statements, the assistant wellness director Kim Steigenga

administered an elder abuse questionnaire to Resident A as part of the internal investigation on 02/05/2026. Resident A reported feeling safe within the facility and denied experiencing any threats, non-consensual contact, or restrictions on daily activities.

Prior to concluding the onsite investigation, I conducted an exit conference with licensee designee Jonathan Book. He was informed of the investigative findings and agreed to complete a corrective action plan within 15 days of receipt of this report. Mr. Book provided copies of in-service training records for AHSL Jenison Cottonwood and the three additional facilities on-site (Beechwood, Maplewood, & Sandalwood). These records confirm that all staff were reeducated on abuse prevention policies, facility procedures, and recognizing and reporting abuse.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(3) A licensee shall ensure that interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.
ANALYSIS:	Staff member Mrs. Flokstra admitted to engaging in an inappropriate relationship with Resident A. This included purchasing clothing, exchanging text messages, phone conversations, and physical contact. Mrs. Flokstra resigned from her position and no longer has access to Resident A. Mr. Book confirmed that termination would have occurred had she not resigned. Based on these findings, there is sufficient evidence to conclude a violation of this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no changes to the current license status.

Anthony Mullins 02/17/2026

Anthony Mullins Date
Licensing Consultant

Approved By:

02/17/2026

Jerry Hendrick Date
Area Manager