GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 14, 2024

Angela Tuck
Tucks Health Services LLC
7236 Pawnee Trail
Rogers City, MI 49779

RE: License #: AL710406406
Investigation #: 2024A0360008
Golden Beach Manor

Dear Angela. Tuck:

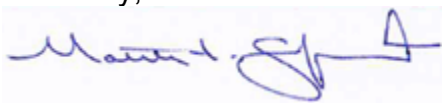
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (866) 865-0006.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
931 S Otsego Ave Ste 3
Gaylord, MI 49735
(989) 370-8320
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL710406406
Investigation #:	2024A0360008
Complaint Receipt Date:	12/26/2023
Investigation Initiation Date:	12/26/2023
Report Due Date:	02/24/2024
Licensee Name:	Tucks Health Services LLC
Licensee Address:	18955 Us 23 N Millersburg, MI 49759
Licensee Telephone #:	(989) 351-8091
Administrator/Licensee Designee:	Angela Tuck
Name of Facility:	Golden Beach Manor
Facility Address:	18955 Us 23 N Millersburg, MI 49759
Facility Telephone #:	(989) 351-8091
Original Issuance Date:	03/01/2022
License Status:	REGULAR
Effective Date:	09/01/2022
Expiration Date:	08/31/2024
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
A firearm discharged in the kitchen of the facility and made a hole in the floor.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/26/2023	Special Investigation Intake 2024A0360008
12/26/2023	Special Investigation Initiated - Telephone Licensee Angie Tuck
12/28/2023	Inspection Completed On-site DCS Jami Splan, DCS Laura Patterson, Resident A, Resident B
12/28/2023	Contact - Telephone call made Licensee designee Angie Tuck
12/28/2023	Contact - Face to Face Chris Flewelling Presque Isle County Sheriff's Department
01/08/2024	Contact - Telephone call received Deputy Luke Ryan PICSD
01/10/2024	APS Referral
01/11/2024	Inspection Completed On-site APS Jeanetta Dawson, DCS Cheyenne Gardner
01/25/2024	Contact - Telephone call made Licensee designee Angie Tuck
01/26/2024	Inspection Completed On-site DCS Carrie Sherman
02/12/2024	Contact - Telephone call made DCS Tammy Trojanowski

02/12/2024	Contact - Telephone call made Former DCS Casey Wolgast
02/12/2024	Contact - Telephone call made Licensee Angie Tuck
02/13/2024	Contact - Telephone call made Former DCS Casey Wolgast
02/15/2024	Exit Conference With licensee designee Angela Tuck

ALLEGATION:

A firearm discharged in the kitchen of the facility and made a hole in the floor.

INVESTIGATION:

On 12/26/23, I received a call from the licensee designee Angela Tuck. Ms. Tuck stated that several of her staff have been talking about a gun going off in the home kitchen and there being a hole in the floor. She stated she called Staff 1, and he admitted that he accidentally discharged a gun in the kitchen of the home. She stated he is no longer working at the home. Ms. Tuck stated that she has reported the incident to the Presque Isle County Sheriff's Department. She stated Staff 1 lived in a separate apartment connected to the home and had been talking about getting a handgun. She stated she told him under no circumstances was a gun allowed in the home.

On 12/28/23, I conducted an unannounced onsite inspection at the home. I observed an approximately 2-inch hole in the kitchen of the floor that had been filled with some sort of putty.

I then interviewed direct care staff (DCS) Jami Splan. Ms. Splan stated she did not know anything about a gunshot in the kitchen. Ms. Splan stated she asked her coworkers about the hole in the kitchen floor, but no one knew what had happened.

I then interviewed DCS Laura Patterson. Ms. Patterson stated she noticed the hole in the kitchen floor about a week ago and assumed it had happened from moving some furniture or bedding through the kitchen.

I then interviewed Resident A. Resident A stated about two weeks ago Staff 1 accidentally shot a hole in the floor with a gun. She stated her and her roommate, Resident B, were in the living room at the time. She stated she heard a bang and

then saw Staff 1 with a gun in the kitchen. She stated he kept apologizing that the gun went off.

I then interviewed Resident B. Resident B stated she was in the living room a couple of weeks ago and heard a loud bang. She stated she then saw Staff 1 in the kitchen with a gun and that's all she was going to say.

On 12/28/23, I went to the Presque Isle County Sheriff's Office and confirmed with Undersheriff Chris Flewelling that the discharge of the firearm had been reported. He stated it was assigned to Deputy Luke Ryan.

On 12/28/23, I contacted Angela Tuck by telephone. Ms. Tuck stated she saw the hole in the kitchen floor about two weeks ago. She stated she asked several staff about it, and no one knew how it happened. She stated she contacted Staff 1 on 12/23/23 and he stated he did bring a handgun into the kitchen of the home, and it went off. She stated he did not say what day this happened. She stated Staff 1 told her it was an accident and didn't mean for it to go off.

On 1/8/24, I received a telephone call from Deputy Luke Ryan from the Presque Isle County Sheriff's Office. Deputy Ryan stated he has not interviewed Staff 1, however they will be referring the case to the prosecutor for criminal charges related to the discharge of a firearm in the home.

On 1/11/24, I conducted an unannounced onsite inspection with adult protective services worker Jeanetta Dawson. We interviewed DCS Cheyenne Gardner. Ms. Gardner stated she found out about one week ago that the hole in the kitchen floor was caused by a gunshot but was not working when it occurred.

On 1/25/24, I contacted Ms. Tuck by telephone. Ms. Tuck stated that she has issued all the residents a 30-day notice as of 1/10/24. She stated she plans on closing her license.

On 1/26/24, I conducted another unannounced onsite inspection at the home. DCS Carrie Sherman stated she did not witness and does not know anything about the gunshot in the kitchen. She stated DCS Tammy Trajanowski was working when it happened.

On 2/12/24, I contacted DCS Tammy Trajanowski by telephone. Ms. Trajanowski stated she did not remember the exact date but around a week or two before Christmas she was working in the kitchen around midnight when Staff 1 came into the home and showed her his handgun. She stated all the sudden the gun went off and caused a hole in the floor. She stated he was very embarrassed and apologized to her. She stated he tried to fill the hole in with putty. She stated she was off work for about a week after the incident and did not report it to Ms. Tuck or anyone else.

On 2/13/24, I contacted Staff 1 by telephone. Staff 1 stated he relocated out of state. Staff 1 stated on 12/11/23 or 12/12/23 he left his apartment to take a walk and was open carrying his handgun. He stated he noticed his coworker Ms. Trajanowski in the kitchen of the home and went in to talk with her. He stated he was showing her his gun and it accidentally discharged into the floor of the kitchen. He stated that was the first time he had ever brought a gun into the home. He stated he does not remember Ms. Tuck telling him that guns were not allowed in the home. He stated he is sorry that the incident happened. He stated Resident A and Resident B were in the living room of the home and heard it happen and witnessed him with the gun.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	The complaint alleges a firearm discharged in the kitchen of the home damaging the floor. Interviews with Ms. Tuck, Ms. Trajanowski, Staff 1, Resident A and Resident B revealed that a firearm was discharged in the kitchen of the home and that the resident's safety was placed at risk While this appears to be an isolated incident, Ms. Trajanowski had a duty to escort Staff 1 out of the home immediately when he came into the kitchen with a gun and should have immediately reported it to the authorities and her supervisor.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 1/11/24, I conducted an unannounced onsite inspection at the home. I observed the medication room and cabinet both unlocked. Ms. Patterson stated she had been passing medications earlier and must have forgotten to lock the medication room door. She stated the medication cabinet lock was broken.

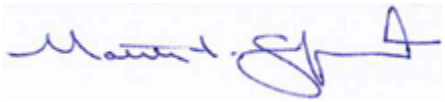
On 1/26/24, I conducted an unannounced onsite inspection at the facility. I again observed the medication room and cabinet both unlocked. Ms. Sherman stated the medication cabinet lock has not been repaired and she forgot to lock and close the medication room door after passing medications.

APPLICABLE RULE	
R 400.15312	**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:	During two unannounced onsite inspections at the facility on 1/11/24 and 1/26/24 I observed the medications to be unlocked.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/15/24 I conducted an exit conference with Ms. Tuck. Ms. Tuck concurred with the findings of the investigation. She stated she is still planning to close the facility once residents are relocated. She stated she will submit a corrective action plan for approval.

IV. RECOMMENDATION

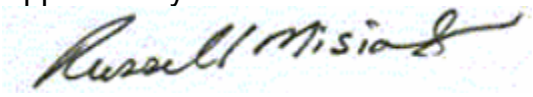
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



2/14/24

Matthew Soderquist Date
Licensing Consultant

Approved By:



2/15/24

Russell B. Misiak Date
Area Manager