STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

September 3, 2024

Connie Clauson
Suthern Adult Care, LLC
617 Riverview Ct.
Gladwin, MI 48624

RE: License #: AL650308159
Investigation #: 2024A1038048
The Horizon Senior Living III

Dear Ms. Clauson:
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

Johnnie Daniels, Licensing Consultant
Bureau of Community and Health Systems
1999 Walden Dr.
Gaylord, MI 49735

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL650308159
Investigation #:	2024A1038048
Complaint Receipt Date:	08/12/2024
Investigation Initiation Date:	08/14/2024
Report Due Date:	09/11/2024
Licensee Name:	Suthern Adult Care, LLC
Licensee Address:	617 Riverview Ct. Gladwin, MI 48624
Licensee Telephone #:	(989) 343-9404
Licensee Designee:	Connie Clauson
Name of Facility:	The Horizon Senior Living III
Facility Address:	613 Progress St. West Branch, MI 48661
Facility Telephone #:	(989) 343-9404
Original Issuance Date:	02/11/2011
License Status:	REGULAR
Effective Date:	09/16/2023
Expiration Date:	09/15/2025
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident was given the wrong medication	Yes

III. METHODOLOGY

08/12/2024	Special Investigation Intake 2024A1038048
08/14/2024	Special Investigation Initiated - Telephone call with Complainant.
08/14/2024	APS Referral was not needed as there is no suspected abuse or neglect.
08/14/2024	Contact – Telephone Call made to Guardian A1.
08/23/2024	Contact - Face to Face interviews were conducted with manager Kristaphor Ostrander.
08/23/2024	Contact - Face to Face interview was conducted with Resident A.
08/30/2024	Inspection Completed-BCAL Sub. Compliance
09/04/2024	Exit Conference With LD Connie Clauson.

ALLEGATION:

Resident was given the wrong medication.

INVESTIGATION:

On 8/12/24, I received a complaint from the Bureau of Community and Health Systems On-line complaint forms regarding the facility. The complaint alleged a resident was given the wrong medicine.

On 8/14/24, I interviewed the Complainant via telephone who verified the information.

On 8/14/24, I interviewed Guardian A1 who verified the information. Guardian A1 stated she was contacted regarding the incident with Resident A getting the wrong medication.

On 8/23/24, I conducted an unannounced investigation at the facility and interviewed manager Kristaphor Ostrander. Mr. Ostrander verified the allegation to be true. Mr. Ostrander stated direct care staff (DCS) Michelle Klepenger gave Resident A the wrong medication on 8/2/24. Mr. Ostrander stated Ms. Klepenger no longer works at the facility. Mr. Ostrander stated the facility followed their protocol of contacting Resident A's doctor and 911. Mr. Ostrander stated Resident A's doctor advised them to withhold his medication. Mr. Ostrander stated EMS was at the facility and stated Resident A does not need to go to the emergency room. Mr. Ostrander stated the facility contacted Resident A's guardian and advised her of the incident.

On 8/23/24, I interviewed Resident A who stated he does not remember getting the wrong medication. Resident A was unable to recall any situation of EMS showing up at the facility to speak with him. Resident A stated he had no concerns with the facility. Resident A stated his guardian would answer question regarding the facility.

On 8/23/24, I reviewed the written warning disciplinary record for DCS Michelle Klepinger, I reviewed the Incident Report written by Ms. Klepinger and Resident A's Medical Administrator Record, which verify the wrong medication was given to Resident A.

On 9/4/24, I shared the findings of this report with licensee designee Connie Clauson.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on my interview with staff, Guardian A1 and the review of documents, there was enough corroborating evidence of Resident A getting the wrong medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

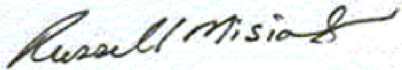
IV. RECOMMENDATION

Contingent upon receival of a corrective action plan. I recommend the status of the license to remain unchanged.

9/3/24

Johnnie Daniels Date
Licensing Consultant

Approved By:



9/6/24

Russell B. Misiak Date
Area Manager