GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 11, 2024

Lindsay Nedow
8155 Blackman Rd.
Kingsley, MI 49649

RE: License #: AF280409799
Investigation #: 2024A0870038
Lindsay's Countryside Senior AFC

Dear Lindsay Nedow:

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 (231) 922-5309.

Sincerely,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF280409799
Investigation #:	2024A0870038
Complaint Receipt Date:	09/23/2024
Investigation Initiation Date:	09/23/2024
Report Due Date:	11/22/2024
Licensee Name:	Lindsay Nedow
Licensee Address:	8155 Blackman Rd. Kingsley, MI 49649
Licensee Telephone #:	(231) 835-0250
Name of Facility:	Lindsay's Countryside Senior AFC
Facility Address:	8155 Blackman Rd. Kingsley, MI 49649
Facility Telephone #:	(231) 649-0678
Original Issuance Date:	11/10/2021
License Status:	REGULAR
Effective Date:	05/10/2024
Expiration Date:	05/09/2026
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On July 31, 2024, Resident A was found to have maggots in a wound on his leg.	Yes
Facility residents go without medication because the Licensee does not pick-up the medication from the pharmacy.	No
Licensee Lindsay Nedow has been spending the residents' money on a new motorcycle for herself.	No
The home serves "outdated" food.	No
An electrical circuit breaker in a resident bedroom randomly flips off.	Yes

III. METHODOLOGY

09/23/2024	Special Investigation Intake 2024A0870038
09/23/2024	APS Referral This referral was made by APS.
09/23/2024	Special Investigation Initiated - Telephone Email case discussion with APS worker Kieran Goodman.
09/23/2024	Inspection Completed On-site Interviews with Licensee Designee Lindsay Nedow and facility residents.
09/25/2024	Contact - Telephone call made Case discussion with APS worker Kieran Goodman.
09/25/2024	Contact - Telephone call made Telephone interview with staff member Lynn Rogers.
09/27/2024	Contact - Telephone call made Telephone interview with staff member Corrine VanLoon.
09/30/2024	Contact - Telephone call received Email discussion with APS worker Kieran Goodman.
10/01/2024	Contact - Telephone call made

	Telephone interview with Amanda Gaylord.
10/02/2024	Contact - Telephone call made Email discussion with APS Kieran Goodman.
10/08/2024	Inspection Completed-BCAL Sub. Compliance
10/08/2024	Exit Conference Completed with Licensee Lindsay Nedow.

ALLEGATION: On July 31, 2024, Resident A was found to have maggots in a wound on his leg.

INVESTIGATION: On September 23, 2024, I spoke with Michigan Department of Health and Human Services, Grand Traverse County, Adult Protective Services (APS) worker Kieran Goodman. Mr. Goodman stated he had received an APS referral with the above stated allegations. We coordinated a joint on-site investigation later this same day.

On September 23, 2024, I conducted an on-site special investigation at the Lindsay's Countryside Senior AFC home. I met with Licensee Lindsay Nedow and informed her of the above stated allegations. Ms. Nedow acknowledged that Resident A was found with maggots in a wound on his leg by facility staff on July 31, 2024. She stated that she took Resident A to the hospital emergency department that same day for treatment. Ms. Nedow stated she believes that this issue developed due to staff member Charity Darling not doing the dressing changes to Resident A's leg wound as instructed. She noted that Ms. Darling ended her employment at the facility shortly afterwards. Ms. Nedow noted that Resident A has a visiting nurse who oversees the care of Resident A's leg wounds, both before, and now after, the maggots were discovered.

On September 23, 2024, I conducted an interview with Resident A at the facility. Resident A stated that he feels that the facility staff members do a "good job" in caring for his leg and foot. He further noted that a visiting nurse comes twice weekly to provide care for him at the home. Resident A noted that he did have maggots in his leg wound, but his doctor told him that this was "probably a good thing." He further stated that he feels that the AFC staff "take good care of me."

On September 25, 2024, I conducted a telephone interview with staff member Lynn Rogers. Ms. Rogers stated that she is aware of the maggots found on Resident A's leg wound but has no direct knowledge of the situation, as she was not working in the facility at the time. Ms. Rogers stated that Resident A does have a visiting nurse come to the home twice weekly to treat his leg wounds. She noted that she had heard that when the maggots were found on Resident A, Ms. Nedow took him to the hospital "right away."

On September 27, 2024, I conducted a telephone interview with staff member Corrine VanLoon. Ms. VanLoon stated that she is the staff member who discovered the maggots on Resident A's leg wound. She stated she called Ms. Nedow and informed her of the situation. Ms. VanLoon stated that Ms. Nedow took Resident A to the hospital emergency department shortly afterwards. Ms. VanLoon noted that Resident A did have a visiting nurse coming to the facility twice weekly with the facility staff doing the wound care on the other days of the week, changing his dressings every other day. She stated that staff member Charity was "supposed to do the dressing changes but Resident A told her that Charity didn't want to do it (change the dressings)." Ms. VanLoon noted that staff member Charity Darling "quit about a month ago."

On October 1, 2024, I conducted a telephone interview with Amanda Gaylord, RN. Ms. Gaylord noted she is a visiting nurse employed by Great Lakes Home Care and has been providing in-home nursing care to Resident A at the home. She stated that she initially was working with Resident A, providing care to his catheter. Ms. Gaylord stated that Resident A was treated by his physician for a skin pressure wound on July 10, 2024, and received an order to have his dressing changed every other day. She noted that on July 11, 2024, she provided an in-service training to facility staff members on wound care and dressing changes for Resident A. Ms. Gaylord stated that on August 7, 2024, she began in-home nursing care for his pressure wounds, now on his heal and calf, after he returned from the hospital. Ms. Gaylord stated she is unsure why maggots developed in his wound but noted that "in her professional opinion the cause was a combination of staff members not changing his dressings as ordered and (Resident A) refusing to allow staff to change the dressing."

APPLICABLE RULE	
R 400.1416	**Resident healthcare.**
	(1) A licensee, in conjunction with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician regarding medications, special diets, and other resident healthcare needs that can be provided in the home.
ANALYSIS:	Resident A and the facility staff received an order, on July 10, 2024, from Resident A's physician, to change the dressings on his pressure wound every other day. Amanda Gaylord, RN, visiting nurse, provided facility staff with an in-service training on wound care and dressing changes on July 11, 2024.

	Resident A was found with maggots in his skin wound, requiring medical treatment and hospitalization. Amanda Gaylord, RN, stated that in her professional opinion the cause of Resident A developing maggots in his skin wound was a combination of staff members not changing his dressings as ordered and Resident A refusing to allow staff to change the dressing. The Licensee failed to follow Resident A's physicians' instructions regarding wound dressing changes.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Facility residents go without medication because the Licensee does not pick-up the medication from the pharmacy.

INVESTIGATION: Ms. Nedow denied residents are going without their prescription medications. She noted that most of the resident prescription medications are delivered to the home by a local pharmacy. Ms. Nedow acknowledged that one medication, Gabapentin, for Resident C, was delayed by one single dose, as he is a veteran and receives his medication from the VA through mail delivery. She noted that she had reordered this medication "many" days in advance, but for an unknown reason, the refill did not arrive until the day he ran out. Ms. Nedow stated she informed Resident C's provider, and he was given this medication the next scheduled time.

On September 23, 2024, I reviewed the medication administration records for all six of the facility residents for the months of September and August 2024. The medication records show that all residents received their prescription medications as prescribed. The medication record did note the one missed dose of Gabapentin for Resident C.

On September 23, 2024, I conducted separate, private interviews, at the facility, with Resident A, B and C. Each stated they believe they are receiving all their prescription medications as ordered.

On September 30, 2024, I spoke with APS worker Kieran Goodman. Mr. Goodman stated he had conducted a telephone interview on this day with the daughter of Resident D. He noted that Resident D's daughter stated she does not know of anytime when the facility ran out of medications for her mother or anytime that her mother has missed any doses of her medications.

Ms. Rogers stated that the facility has the resident medications home delivered from a local pharmacy. She noted that she did not know of a time when the facility ran

out of medications.

Ms. Van Loon stated that the only occurrence of a resident missing a dosage of medication was earlier this month, September 2024, when Resident C missed one morning dose of Gabapentin, because his mail order from the VA was delayed. She noted that Resident C's medications are ordered a minimum of 10 days ahead of time, but "for some reason this one was delayed with delivery." Ms. Van Loon stated the other residents have their prescription medications delivered by a local pharmacy right to the AFC home.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(2) Medication shall be given pursuant to label instructions.
ANALYSIS:	Facility residents are being provided with their medications pursuant to the label instructions.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Licensee Lindsay Nedow has been spending the residents' money on a new motorcycle for herself.

INVESTIGATION: Ms. Nedow denied that she spends any of the residents personal spending money on herself, for any item. She stated that she does not handle any resident funds, personal spending money, and she has not done so since April 2024. Ms. Nedow stated she did purchase a motorcycle, but used her own personal money, which she earns through her AFC business.

Residents A and B both stated they "handle their own money" and that Ms. Nedow does not have access to their personal funds. Resident C stated his niece handles his finances.

On September 30, 2024, I spoke with APS worker Kieran Goodman. Mr. Goodman stated he had conducted a telephone interview on this day with the daughter of Resident D and the daughter of Resident E. Mr. Goodman stated they both informed him that they manage their respective mothers' finances and Ms. Nedow does not have access to that money.

Ms. Rogers stated that she does not know of Ms. Nedow managing any of the current residents' finances nor has she heard from any of the facility residents that Ms. Nedow is taking their money.

Ms. Van Loon stated she "doesn't know anything about Ms. Nedow taking the residents' money." She stated the residents' family members usually bring them

"stuff" and she had never heard from any of the residents, or their families, that Ms. Nedow is taking any of their money, other than what they owe her for the cost of care at the AFC home.

APPLICABLE RULE	
R 400.1421	**Handling of resident funds and valuables.**
	(2) All resident funds and valuables which have been accepted by a licensee for safekeeping shall be treated by the licensee as a trust obligation.
ANALYSIS:	Ms. Nedow does not accept resident funds for safekeeping.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The home serves "outdated" food.

INVESTIGATION: Ms. Nedow denied that she serves "outdated" food items and noted that she serves the residents wholesome, healthy and nutritious meals. She noted she has never had a resident complain about the food served at this facility.

Residents A, B, and C all stated they feel the meals served at this facility are "very good." All three expressed their opinion that the meals are healthy and nutritious. None expressed anything but full satisfaction with what they are fed.

Resident D and E's daughters both expressed satisfaction with the meals served to their mothers at the facility. Neither had any concerns.

Ms. Rogers and Ms. Van Loon both stated the facility serves healthy and nutritious meals to the residents. Both denied that "outdated" food is served.

During my on-site investigation, I observed fresh fruits and vegetables in the facility kitchen. Ms. Nedow noted that these are items that will be served to the residents this day or in the coming days. I observed that refrigerated items all appeared to be appropriate for resident meals. I observed canned food items in the facility pantry. I did not note any items past their expiration dates. I did not observe any food items in the facility which were spoiled or appeared to be unsafe for human consumption.

APPLICABLE RULE	
R 400.1425	**Food service.**
	(1) All food shall be from sources approved or considered satisfactory by the department and shall be clean; wholesome; free from spoilage, adulteration, and misbranding; and safe for human consumption.

ANALYSIS:	The food provided to the facility residents are satisfactory, free from spoilage, adulteration, or misbranding; and are safe for human consumption.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: An electrical circuit breaker in a resident bedroom randomly flips off.

INVESTIGATION: Ms. Nedow stated that this past winter an electrical plug in a resident bedroom began to periodically stop working. She noted she called an electrician who informed her that the breaker "faults." Ms. Nedow stated that "it still trips occasionally, about once a month or so." She stated she will have another electrician come out and "get it fixed."

APPLICABLE RULE	
R 400.1441	**Electrical service.**
	(2) Where conditions indicate a need for inspection, the electrical service shall be inspected by a qualified electrical inspection service. If there are violations, a copy of the inspection report shall be submitted to the department, together with a corrective action plan. A copy of the certificate of approval from the qualified electrical inspection service shall be maintained in the home and available for department review.
ANALYSIS:	An electrical issue exists in one resident bedroom circuit. The facility electrical system needs an inspection by a qualified electrical service and any noted problems need to be resolved.
CONCLUSION:	**VIOLATION ESTABLISHED**

On October 8, 2024, I provided Licensee Lindsay Nedow with an exit conference. I explained my findings as noted above. Ms. Nedow stated she understood the findings, had no further information to provide, or questions to ask, concerning this special investigation. She stated she would complete and submit a corrective action plan which addresses the cited rule violations.

IV. RECOMMENDATION

I recommend, contingent upon the submission of an acceptable corrective action plan, that the status of the license remain unchanged.

October 11, 2024

Bruce A. Messer Date
Licensing Consultant

Approved By:

October 11, 2024

Jerry Hendrick Date
Area Manager