GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 26, 2025

Joanne Broidrick
Golden Life AFC, LLC
1230 S. Lafayette St
Greenville, MI 48838

RE: License #: AM590395969
Investigation #: 2025A1033037
Golden Life Assisted Living #2

Dear Ms. Broidrick:

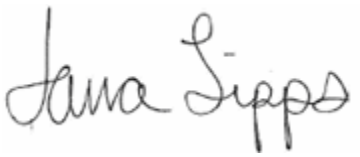
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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.

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 (517) 335-5985.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM590395969
Investigation #:	2025A1033037
Complaint Receipt Date:	05/21/2025
Investigation Initiation Date:	05/22/2025
Report Due Date:	07/20/2025
Licensee Name:	Golden Life AFC, LLC
Licensee Address:	1230 S. Lafayette St Greenville, MI 48838
Licensee Telephone #:	(616) 263-7726
Administrator:	Joanne Broidrick
Licensee Designee:	Joanne Broidrick
Name of Facility:	Golden Life Assisted Living #2
Facility Address:	503 W. Montcalm Greenville, MI 48838
Facility Telephone #:	(616) 263-7726
Original Issuance Date:	01/22/2019
License **Status:**	REGULAR
Effective Date:	07/22/2023
Expiration Date:	07/21/2025
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff did not administer Resident A's migraine medication as it was prescribed.	Yes

III. METHODOLOGY

05/21/2025	Special Investigation Intake 2025A1033037
05/21/2025	Contact - Document Sent- Email correspondence sent to complainant.
05/22/2025	Special Investigation Initiated – Letter- Email correspondence with Complainant.
05/28/2025	Inspection Completed On-site- Interviews conducted with direct care staff/home manager, Tysta Gorsuch, direct care staff, Haylie Gregory. Review of documentation initiated on-site.
05/28/2025	Contact - Document Received- Email correspondence received from direct care staff/home manager, Trysta Gorsuch.
06/18/2025	Contact – Telephone call made- Interview conducted with licensee designee, Joanne Broidrick, via telephone.
06/24/2025	Contact – Telephone call made Attempt to interview direct care staff/home manager, Trysta Gorsuch. Voicemail message left, awaiting response.
06/25/2025	Contact – Telephone call received Interview conducted with direct care staff/home manager, Trysta Gorsuch.
06/25/2025	Contact – Telephone call made Attempt to interview Montcalm Care Network, Cece McIntrye. Voicemail message left and email correspondence sent. Awaiting response.
06/26/2025	APS Referral No referral, as no current suspicion of abuse, neglect, or exploitation.

06/26/2025	Exit Conference Conducted via telephone with licensee designee, Joanne Broidrick.

ALLEGATION: Direct care staff did not administer Resident A's migraine medication as it was prescribed.

INVESTIGATION:

On 5/21/25 I received an online complaint regarding the Golden Life Assisted Living #2, adult foster care facility (the facility). The complaint alleged that Resident A has been ordered a medication for the control of her migraines and this medication is an injection that is to be administered monthly. The complaint further alleges that the direct care staff have not been administering this medication monthly as it has been ordered. The complaint also reported that the direct care staff have not been properly trained to administer the medication.

On 5/22/25 I had email correspondence with Complainant. Complainant reported that Resident A was prescribed this migraine medication by her neurologist for the prevention of migraine headaches. Complainant reported direct care staff are to administer this injection to Resident A on a monthly basis and direct care staff failed to administer the injection for an unspecified month, due to Resident A being on a leave of absence from the facility the date the medication was due. Complainant reported that Resident A did refuse her injection for the month of May 2025 and reported that she does not feel the medication is effective and the injection is painful.

On 5/28/25 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/home manager, Trysta Gorsuch. Ms. Gorsuch reported that Resident A was prescribed Aimovig 70mg, subcutaneous injection, to be administered once per month, on 11/20/24. Ms. Gorsuch reported that this medication is administered the same way that insulin would be administered, either by arm, thigh, or stomach. She reported that there are 8-10 direct care staff members who are all trained to administer medications. Ms. Gorsuch reported that Resident A has made statements to direct care staff that she does not like to have this medication administered as she does not feel any benefit from the medication and the injection is painful. Ms. Gorsuch reported that there was a concern brought forth by Montcalm Care Network (MCN) staff that the direct care staff need training in administering the Aimovig medication and a nurse from MCN is scheduled to provide training to the direct care staff on 5/30/25. Ms. Gorsuch was able to present the Medication Administration Records (MARs) for Resident A for November 2024 through May 2025. I observed that Resident A received her Aimovig medication in November, refused the injection in December, there was no documentation of administration in January, the medication was administered in March, Resident A was out of the facility when the administration was due in April and did not receive

the dosage, and Resident A refused administration in May 2025. Ms. Gorsuch reported that she is uncertain why Resident A did not receive her dosage in January 2025 and viewed the direct care staff schedule and noted that direct care staff, Haylie Gregory, had been working on this date and had initialed for the administration of Resident A's other morning medications and had left this medication administration for the Aimovig blank. Ms. Gorsuch also reported that the April 2025 dosage was not administered as Resident A had been on a leave of absence from the facility at the time the injection was due to be administered and the ECP MAR Program that the direct care staff use to document medication administration does not have an option to re-prompt the direct care staff later in the day to offer to administer the medication at another time. She reported that the ECP MAR Program does have a re-prompt feature available of a resident refuses their scheduled medication, but it does not have a re-prompt feature for it a resident is marked as being on a leave of absence.

During the on-site investigation on 5/28/25 I interviewed Ms. Gregory, regarding the allegation. Ms. Gregory reported that she has worked at the facility for about one year. She reported that she does administer medications and has administered Resident A's Aimovig medication before. She reported that the box the injection comes in has very easy to follow instructions for administration. She reported that the dose she administered was in the Fall of 2024. She reported that she is certain she has not administered the Aimovig at all during this calendar year. She did not know why the medication was not administered during the month of January 2025.

During the on-site investigation on 5/28/25 I attempted to interview Resident A regarding the allegations. Resident A declined to be interviewed on this date.

During the on-site investigation on 5/28/25, I reviewed the following documents:

- *Active Medications for [Resident A], Standard Order*. This document lists medications that have been ordered for Resident A and identifies that the Aimovig medication was ordered for administration at the facility on 11/20/24.
- *Medication Administration Records (MARs)* for Resident A for the months, November 2024 through May 2025. These documents identified that Resident A refused doses in December 2024 & May 2025 and was not administered the medication in January 2025 & April 2025. The January MAR did not document why the medication was not administered during this month. The April MAR did identify that Resident A was "Out of Building" at the time of administration.

On 5/28/25 I received email correspondence from Ms. Gorsuch, providing copies of the MARs reviewed and Resident A's *Assessment Plan for AFC Residents* document.

On 6/18/25 I interviewed licensee designee, Joanna Broidrick, via telephone. She reported that she is uncertain why the MAR for January 2025 does not identify any reasoning why Resident A was not administered the Aimovig medication. She

reported she would like to speak with the pharmacy to see if there is further reasoning.

On 6/25/25 I interviewed Ms. Gorsuch regarding the missed medication administration in January 2025 for Resident A's Aimovig medication. Ms. Gorsuch reported that she was not employed by the facility in January of 2025, but did speak with several direct care staff members who were employed and the consensus was that the staff from Montcalm Care Network (MCN) had advised direct care staff not to administer the medication in the month of January 2025 due to medication changes. Ms. Gorsuch could not identify who the staff member with MCN was that gave this directive, but she reported that she recently spoke with MCN staff, Cece McIntyre, who confirmed they were not concerned about the January 2025 administration of the Aimovig medication.

On 6/26/25 I interviewed Ms. Broidrick via telephone and conducted the exit conference. Ms. Broidrick reported that she did not have documentation from a physician or a pharmacist regarding Resident A's Aimovig medication administration for the month of January 2025. She reported that it is believed that the MCN nurse visited Resident A in January and administered the medication during his visit to the facility, but there is no current documentation to support this statement. Ms. Broidrick reported that she is understanding of the violation cited on this report as there was not adequate documentation to demonstrate that Resident A was offered or received her medication in January 2025.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based upon interviews conducted with the Complainant, Ms. Gorsuch, Ms. Gregory, & Ms. Broidrick as well as review of the MARs for Resident A for the months November 2024 through May 2025, it can be determined that on 1/20/25 Resident A was scheduled to receive the Aimovig injection and there is no available documentation identifying that she received, refused, or in any way was offered this medication. Ms. Gregory was administering medications on this date, according to Ms. Gorsuch and the initials on the MAR and Ms. Gregory stated that she has not administered this medication to Resident A within the current calendar year and has no information as to why Resident A did not receive this medication on 1/20/25. Furthermore, Resident A was scheduled to receive the medication on 4/20/25 and was on a leave of absence during the scheduled administration time. Ms. Gorsuch reported that the medication administration system currently in use does not allow for a "re-prompt" when a resident is on a leave of absence, and therefore the Aimovig medication was also not administered during the month of April 2025. Based upon this information it can be determined that Resident A has not been administered/offered administration of her Aimovig medication as prescribed and a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

06/26/25

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Jana Lipps Date
Licensing Consultant

Approved By:

06/26/2025

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Dawn N. Timm Date
Area Manager