



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 14, 2025

Dennis Strode
Strudwick & Strode AFC Inc
3726 Delta River Dr.
Lansing, MI 48906

RE: License #: AS230244372
Strudwick AFC Inc #2
1425 Elmwood
Lansing, MI 48917

Dear Mr. Strode:

This letter is a follow-up to the Department's findings regarding the interim inspection conducted at your facility on 10/13/2025. The purpose of this inspection was to determine compliance with applicable licensing statutes and administrative rules for an Adult Foster Care small group home.

*This report is an interim inspection related to special investigation report (SIR) #2025A1033036. For consistency the report will use the same code sheet as SIR #2025A1033036. Due to this, the coded individuals in this report may not appear in sequential order.

The violations that were found are:

R 400.14208

Direct care staff and employee records.

(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information:

- (a) Names of all staff on duty and those volunteers who are under the direction of the licensee.
- (b) Job titles.
- (c) Hours or shifts worked.
- (d) Date of schedule.
- (e) Any scheduling changes.

I conducted an unannounced, interim inspection on 10/13/25. I interviewed direct care staff, Montoya Boyd, and requested to review the current direct care staff schedule. Ms. Boyd reported that there was not an available direct care staff schedule at the facility on this date.

R 400.14312 Resident medications.

(2) Medication shall be given, taken, or applied pursuant to label instructions.

During the on-site inspection on 10/13/25, I reviewed all resident medications. I observed that Resident E was prescribed, Probiotic Formula CAP to be take one time per day, Vitamin C 500 MG to be taken one time per day, and Lidoderm 5% Patch to be changed every twelve hours. These three medications were not available at the facility for direct care staff to administer, yet the Medication Administration Record (MAR) for Resident E indicated that the direct care staff have been administering these medications. Ms. Boyd was not able to locate any of these medications in the medication cabinet at the time of the on-site inspection. Ms. Boyd reported that she is not aware of Resident E being prescribed a patch that must be administered every twelve hours, however her initials appear on Resident E's MAR as having administered these patches.

R 400.14312 Resident medications.

(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

(b) Complete an individual medication log that contains all of the following information:

(i) The medication.

(ii) The dosage.

(iii) Label instructions for use.

(iv) Time to be administered.

(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.

(vi) A resident's refusal to accept prescribed medication or procedures.

During the on-site inspection on 10/13/25, I observed two medications prescribed for Resident D, in the medication cabinet. These medications were, Metformin 500MG to be administered by mouth once daily, and Bactrim to be administered two times daily. There was not a completed MAR for Resident D for direct care staff to document the administration of these two medications. The Metformin was filled on 9/12/25 and 10/11/25, and the Bactrim was filled by the pharmacy on 9/18/25. The Bactrim was a full bottle. Ms. Boyd reported that she did not have a MAR available to document the administration of these medications.

R 400.14312 Resident medications.

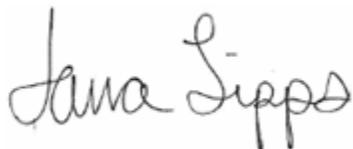
(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.

During the on-site investigation I found Atorvastatin 10MG medication for Citizen 2 in the medication cabinet. During SIR #2025A1033036 investigation it was documented that Citizen 2's medications remained on-site after he was discharged from the facility. During this interim inspection this medication remained in the medication cabinet for Citizen 2. Ms. Boyd reported that the other medications for Citizen 2 had been destroyed and disposed of, and this one must have been overlooked. This medication will need to be destroyed and disposed of properly.

A final renewal inspection will be conducted to determine compliance with adult foster care licensing rules. If you have questions about how to obtain compliance, please let me know. The Department provides technical assistance to meet the licensing requirements and consultation to improve services.

Please 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
Enclosures