



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 14, 2025

Jill Smude
Hidden Creek AFC, Inc.
2848 Hartland Road
Hartland, MI 48353

RE: License #: AM470295474
Investigation #: 2026A0577002
Hidden Creek AFC

Dear Ms. Smude:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 11/10/2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

Bridget Vermeesch

Bridget Vermeesch, 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 #:	AM470295474
Investigation #:	2026A0577002
Complaint Receipt Date:	10/16/2025
Investigation Initiation Date:	10/20/2025
Report Due Date:	12/15/2025
Licensee Name:	Hidden Creek AFC, Inc.
LicenseeAddress:	2848 Hartland Road Hartland, MI 48353
Licensee Telephone #:	(810) 632-7670
Licensee Designee:	Jill Smude
Administrator:	Jill Smude
Name of Facility:	Hidden Creek AFC
Facility Address:	2848 Hartland Rd. Hartland, MI 48353
Facility Telephone #:	(810) 632-7670
Original Issuance Date:	02/16/2012
License Status:	REGULAR
Effective Date:	08/07/2024
Expiration Date:	08/06/2026
Capacity:	12
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided enhanced supervision, leading to falls.	No
Resident A fell twice, and medical attention was not sought.	No
Resident A was not administered medication as prescribed.	Yes

III. METHODOLOGY

10/16/2025	Special Investigation Intake 2026A0577002
10/17/2025	Contact - Telephone call made- Complainant- left message and sent email.
10/20/2025	Special Investigation Initiated – Telephone call made to Julie Elkins, AFC Licensing Consultant.
10/21/2025	Contact - Telephone call received, Message from Complainant.
10/22/2025	Contact - Document Sent Via Email to Complainant, requested documentation.
10/22/2025	Contact - Telephone call received, Interview with Complainant.
10/31/2025	APS Referral
10/31/2025	Contact - Telephone call made, Alex Duncan, RN with Open Arms Hospice.
11/04/2025	Contact - Telephone call made, Tracy Carr, DON-Open Arms
11/04/2025	Exit Conference, Jill Smude, LD.
11/04/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

- Resident A was not provided enhanced supervision, leading to falls.
- Resident A fell twice, and medical attention was not sought.
- Resident A was not administered medication as prescribed.

INVESTIGATION:

On October 16, 2025, the following complaint was received alleging that on August 8, 2024, Resident A, experienced two falls during the night. Documentation surrounding these incidents contains conflicting information regarding both the cause and the resulting injuries. The complaint reported that several entries referenced a missed medication dose as the contributing factor to the fall, though it is not clear which medication was missed. Two separate medications, Tramadol and Trazodone, were both listed as the medication that was omitted. The complaint reported one nursing summary, completed by RN Alex Duncan indicated that Trazodone had been missing from the Medication Administration Record (MAR), leading to restlessness and the falls when Resident A attempted to climb out of bed. The complaint reported another entry described the falls as occurring while Resident A tried to use the bathroom, resulting in a right forearm skin tear. Elsewhere, the same event was documented as causing a back injury. The complaint documented, "it remains unclear whether both injuries occurred or whether the documentation is inconsistent. This incident is particularly concerning given [Resident A's] history of falls, which previously resulted in a right wrist fracture and a possible pelvic fracture, rendering [Resident A] chair and bed bound." The complaint reported records indicated Resident A required total assistance for ambulation and was unable to sit upright without support, reflecting a high level of physical dependency. Despite this, there is no clear explanation for the missed medication dose, no evidence of enhanced supervision following the incident, and no detailed follow-up regarding the injuries sustained. The complaint reported, "vague language such as two more falls in 1 night because Trazodone was not administered, further limits the ability to assess the facility's response." The complaint reported that the discrepancies in both the medications involved, and the nature of the injuries complicated the evaluation of care and raise concerns about documentation accuracy, medication management, and injury follow-up. The complaint alleged that the lack of clear, consistent, and comprehensive records impedes a thorough assessment of the facility's practices and reinforces concerns about oversight by both Hidden Creek AFC and the hospice provider. The complaint alleged that without additional documentation, the incident raises serious questions about the facility's medication administration protocols, fall prevention strategies, and overall quality of care.

On October 17, 2025, I left a message and emailed Complainant. On October 22, 2025, I interviewed Complainant who reported an audit on Open Arms Hospice was completed and during the audit the discrepancies mentioned in the complaint were observed. Complainant verified the incidents occurred in August of 2024. Complainant reported not having any of the documents or records reviewed or referenced in their complaint. Complainant reported they do not have any contact information pertaining Alex Duncan, Registered Nurse (RN).

On October 20, 2025, I spoke with Julie Elkins, Adult Foster Care Licensing Consultant with Licensing and Regulatory Affairs (LARA) and the Bureau of Community Health Services (BCHS), who reported the facility has not had any Special Investigations regarding quality of care of residents since 2022.

On October 28, 2025, I completed an unannounced onsite investigation and interviewed Sarah Gruno, Home Manager (HM), who reported she was not working on August 08, 2024, and cannot provide specific information. Ms. Gruno reported the facility does not have any *AFC Licensing Division-Incident/Accident Report (IR)* for Resident A on August 08, 2024. Ms. Gruno reported there is a completed IR from August 06, 2024, involving Resident A falling. I reviewed and received a copy of the IR completed on August 06, 2024, documenting an incident that occurred at 10:00pm, when direct care staff (DCS) Pattie Beaune and Anna Preetz went into Resident A's bedroom and found Resident A on the floor with a skin tear to right elbow, due to Resident A climbing over her bedrail. The IR documented range of motion and an examination was completed on Resident A with no injuries found other than the skin tear, which was cleaned and bandaged. IR reported Resident A was assisted off of the floor and put back into bed. IR documented, "repeated incident at 12:00am." IR documented corrective measures taken included ordering a bed alarm. Ms. Gruno reported Resident A is prescribed Trazadone and has been for a long time, but Resident A is not prescribed Tramadol. Ms. Gruno provided me with a copy of Resident A's *Medication Administration Record* from August 2024 which documented in handwriting and not typed by the pharmacy, Trazadone, 50mg, 1 table at bedtime. The MAR has an arrow through August 01 through August 06, 2024, with the first initials of direct care staff administering Trazadone for the first time in the month of August, on August 07, 2024. The MAR also documents Trazadone not administered on August 18, 19, 23, 25, 26, and 30 2024 with no documentation of why it was not administered. Ms. Gruno reported in August 2024 that Resident A required assistance with mobility from a wheelchair, required assistance from direct care staff with activities of daily living such as bathing, toileting, dressing, and grooming, but Resident A did not require any additional supervision. Ms. Gruno provided me with a copy of Resident A's *Assessment Plan for AFC Residents* which was completed on May 19, 2024, documenting support of what Ms. Gruno reported pertaining to mobility and required assistance from direct care staff. Per Resident A's *Assessment Plan for AFC Residents* and physician order, Resident A was prescribed a hospital bed with bed rail to assist Resident A with falls from bed and transferring out of bed.

On October 31, 2025, I interviewed Alex Duncan, Registered Nurse with Open Arms Hospice, who reported he is currently in the field and does not have access to his progress notes at this time but can provide as much information as possible. RN Duncan advised upon completion of our interview I call the main office for additional information. RN Duncan reported Resident A was moved to the facility due to having frequent falls at home causing multiple injuries. RN Duncan reported back in August 2024, stating, "I believe on August 08, 2024, I completed a visit at the facility and was notified by a direct care staff, name unknown, of [Resident A] having two falls in the night." RN Duncan reported he is not sure of the specific date of the falls. RN Duncan reported he was not notified by direct care staff at the times of the falls, but Resident A did not sustain any injuries significant enough for hospice on-call to be notified at the time of the fall. RN Duncan reported Resident A had a skin tear on her right elbow that was treated by direct care staff, but no other injuries were found or reported. RN

Duncan reported Resident A was prescribed Trazadone to be administered at bedtime to assist with Resident A's restlessness but Trazadone was not on the MAR at the time of his visit and had not been administered the night of the two falls. RN Duncan reported Resident A is not prescribed Tramadol and this should not be administered at any point. RN Duncan reported Resident A did not require any enhanced supervision at the time of the falls, used a wheelchair for mobility and required hands on assistance from direct care staff when bathing, toileting, and getting dressed.

On November 04, 2025, I contacted Open Arms Hospice and spoke with Tracy Carr, Director of Nursing (DON), who reported per RN Duncan's progress notes, RN Duncan was notified of Resident A falling on August 08, 2024, during a nurses visit on August 14, 2024. Ms. Carr reported per RN Duncan's progress note that the only injury observed by RN Duncan and reported by direct care staff was a skin tear that has been treated with Vaseline gauze. Ms. Carr reported there is no mention in RN Duncan's progress notes from August 14, 2024, of Resident A not being administered Trazadone. nor on call being notified of the fall. Ms. Carr reported on August 20, 2024, RN Duncan completed a nurse's call and the progress note documented, "trazadone is not back on the administration record which had dropped off, likely causing [Resident A] to be restless, climbing out of her bedroom and falling twice on August 08, 2024. Staff stated sleeping habits have been stable since trazadone has been reinstated and administered." Ms. Carr reported she found an incident report completed by RN Duncan dated August 08, 2025, documenting Resident A having two falls from climbing out of bed on August 08, 2024.

On November 04, 2025, via email from Tracy Carr, DON with Open Arms Hospice, I received copies of current physician order, nursing progress notes, and incident report (IR). The current physician order documented on June 05, 2024, Resident A was prescribed Trazadone, 50mg, take one tablet by mouth at bedtime, order status is still current. An IR was completed on August 08, 2024, by RN Duncan documenting on August 08, 2024, at 2:00am, [Resident A] fell out of bed, causing a skin tear to right arm, first aid administered, physician, family, and licensee were notified. The completed progress notes from RN Duncan dated August 14, 2024, documented RN Duncan was notified by direct care staff of Resident A having a fall and only injury found was a skin tear on Resident A's right arm elbows, the skin tear was approximated and covered with a Vaseline gauze and mepilex. The progress notes of August 14, 2024, also documented on August 08, 2024, a fall X2, no injuries observed. The progress notes from RN Duncan dated August 20, 2024, documented "[Resident A's] sleeping habits are good now that Trazadone is on the MAR after it has dropped off causing Resident A to fall X2 one night due to being wrestles" The progress notes from RN Duncan dated August 28, 2024, "staff reported [Resident A's] sleeping habits have returned back to normal after the Trazadone was re-established and put back on the MAR after falling off, all medications have been updated." The progress notes documented Resident A is prescribed a 4-wheel walker and wheelchair to assist with mobility, Resident A requires hands on assistance from direct care staff with toileting, bathing, dressing, and grooming.

On November 05, 2025, I interviewed Anna Preetz, direct care staff (DCS) who reported she was working third shift on August 06, 2024, when Resident A climbed over her bedrail and fell out of bed on two separate occasions during DCS Preetz's shift. DCS Preetz reported Resident A was examined, range of motion completed, and a skin tear found on Resident A's right elbow. DCS Preetz reported no other injuries were found and no additional medical attention was needed at the time of the falls. DCS Preetz reported she is not aware of Resident A falling out of bed on any other day. DCS Preetz reported she knows Resident A is prescribed Trazadone to be administered nightly but cannot speak to if Resident A was administered Trazadone on the night of August 06, 2024, due to medications being administered at 8:00pm by second shift. DCS Preetz reported Resident A used a walker for mobility at the time of the incident and has since declined and is now in a wheelchair. DCS Preetz reported Resident A did not require any enhanced supervision such as 1:1 or line of sight by direct care staff at any time.

On November 04, 2025, an exit conference was completed with Licensee Designee, Jill Smude, who reported the first week of August 2024 is when Ms. Smude purchased the facility and looking back over the records, Resident A's Trazadone was being filled by Pioneer Pharmacy and not Pharma Script, which was the pharmacy used to fill resident prescriptions, so Trazadone was not put on Resident A's August 2024 MAR or administered until a medication cart audit was completed. Ms. Smude reported upon completion of the medication cart audit, Trazadone was found in the medication cart to be administered. Ms. Smude stated the confusion occurred since the Trazadone was filled by a different pharmacy and not added to the MAR with the rest of Resident A's medications.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	Based on the information gathered during the investigation, per Resident A's <i>Assessment Plan for AFC Residents</i> completed on May 19, 2024, Resident A requires a walker and wheelchair for mobility, and hands on assistance from direct care staff with toileting, bathing, dressing, and grooms. Resident A is also prescribed a hospital bed with bedrails to assist with falls while in bed and when transferring from the bed. There was no evidence found that Resident A required any enhanced supervision, like 1:1 supervision, and that not receiving such supervision led to Resident A falling in August 2024. Resident A was provided with supervision, protection, and personal care as specified in Resident A's assessment plan and prescribed by Open Arms of Hospice.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.689	Resident health care.
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Based on an IR completed on August 06, 2024, by DCS Anna Preetz, Resident A climbed out of bed on two separate occasions that night, with the only injury documented Resident A having a skin tear on her right elbow. RN Duncan documented in progress notes from his nurses visit on August 14, 2024, that the only observed injury was a skin tear on Resident A's right elbow due to two falls. No other injuries were observed. Direct care staff treated Resident A's skin tear without needing to contact hospice services.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

