GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

EMARLON I. BROWN,
DPA
DIRECTOR

February 11, 2026

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

RE: License #: AM590395969
Investigation #: 2026A1029014
Golden Life Assisted Living #2

Dear Ms. Dykstra:

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 licensee designee and a date.

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. 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,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM590395969
Investigation #:	2026A1029014
Complaint Receipt Date:	12/19/2025
Investigation Initiation Date:	12/19/2025
Report Due Date:	02/17/2026
Licensee Name:	Golden Life AFC, LLC
Licensee Address:	1230 S. Lafayette St, Greenville, MI 48838
Licensee Telephone #:	(616) 263-7726
Administrator:	Joanne Dykstra
Licensee Designee:	Joanne Dykstra
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:	07/22/2025
Expiration Date:	07/21/2027
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
The direct care staff members at Golden Life Assisted Living #2 do not administer medications to residents correctly. There were missed doses, unavailable medications, and inaccurate recordings on the electronic medication administration records (eMAR) during November – December 2025.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/19/2025	Special Investigation Intake 2026A1029014
12/19/2025	Special Investigation Initiated – Telephone call to Amanda Blasius
12/19/2025	APS Referral -New concerns sent from APS. Leslie Brugel and Carole Dreyer are also investigating medication concerns.
12/22/2025	Contact - Telephone call made to direct care staff members Hailey McIntosh and Margaret Boxx. Left message
12/23/2025	Contact - Telephone call made to ORR CeCe McIntyre, Leslie Brugel APS, left message
12/23/2025	Inspection Completed On-site - Trista Gorsuch, Resident A, Resident B, Resident C, and Resident D at Golden Life Assisted Living 2
01/07/2026	Contact - Telephone call received from Leslie Brugel APS
01/20/2026	Contact - Document Sent - Email to MCN nurse Alicia Faling
01/21/2026	Contact - Telephone call made to RN Alicia Faling
01/21/2026	Contact - Telephone call made to direct care staff member Brandon Boik, email to Bonnie Harris Optimal Care, phone call from Angela Loiselle, email from ORR Cece McIntyre, and telephone call to licensee designee Joanne Dykstra.
01/22/2026	Contact - Telephone call received from ORR Angela Loiselle
01/23/2026	Contact - Telephone call made to Optimal Care Dr. Sandra Wilfore

01/28/2026	Contact - Telephone call made to direct care staff members Lisa Alcalla and Casey Townsend, left message for both and Chloe Petersen, APS Carol Dreyer
01/29/2026	Contact - Telephone call received from direct care staff member Casey Townsend
02/05/2026	Contact – Telephone call to Optimal Care, Cassie Manning. Left message and sent email. Received email response from Cassie Manning.
02/06/2026	Exit conference with licensee designee Joanne Dykstra

ALLEGATION: The direct care staff members at Golden Life Assisted Living #2 do not administer medications to the residents correctly. There were missed doses, unavailable medications, and inaccurate recordings on the medication administration records (eMAR) during November – December 2025.

INVESTIGATION:

On 12/19/2025 an intake was received via an assigned Adult Protective Services (APS) complaint alleging that direct care staff members at Golden Life Assisted Living #2 do not administer medications to the residents correctly. The complaint stated there are missed doses, unavailable medications, and inaccurate recordings on the medication administration records during November–December 2025. The initial complaint listed the following alleged medication errors:

- Resident A had one medication that was not documented in November 2025 and then 19 medication administrations not documented as administered in December 2025.
- Resident B: There were 66 medication administrations that were not documented as administered over the month of November 2025 and 20 during the month of December 2025. In November 2025 Resident B's benztropine was documented as refused by resident, not in facility, have not come in yet, or ordered from pharmacy from November 8—25, 2025. Resident B's Hydralazine was also noted to not be in the medication cart from 11/14/2025-11/20/2025.
- Resident C had blood pressure medications that were not given despite her blood pressure being within the physician ordered parameters set in December 2025.
- Resident D's medication administration record (eMAR) included six administrations not documented as administered in November 2025 and three in December 2025. There was also documentation that Resident D had been given a flu shot three times in the month of November 2025 by AFC home staff.

Adult Protective Services (APS) specialist Carole Dreyer was assigned to investigate these concerns.

Additional concerns were received from an assigned APS complaint alleging that Resident A is diagnosed with schizophrenia, anxiety, mild neurocognitive disorder, and hypertension and refused her inhaler and the provider was not notified. The complaint alleged that Resident A had subsequent emergency room visits for shortness of breath on 11/07/2025 and 11/27/2025. According to the complaint, there were some notes indicating the inhaler was not in the building and not located in the medication cart. The complaint also alleged that Resident A was supposed to be wearing oxygen and direct care staff members were supposed to make sure she wears it and provide education to her on her wearing it. APS Leslie Brugel was assigned to investigate these concerns.

On 12/23/2025 I completed an unannounced on-site investigation and met with direct care staff member, whose role is home manager, Trysta Gorsuch at Golden Life Assisted Living #2. Ms. Gorsuch stated there have been some resident medication errors because new direct care staff members did not document each medication administration correctly in the electronic medication administration record (eMAR). Ms. Gorsuch stated there is a drop down box and the new direct care staff selected the wrong entry. Ms. Gorsuch stated they also document medication administrations using a paper MAR when the system is down. Ms. Gorsuch stated ORR directed them to fill out a weekly *AFC Incident / Accident Report* for medications that were administered incorrectly which they have been doing. Ms. Gorsuch stated Resident A is supposed to wear her oxygen at all times which she does. Ms. Gorsuch stated she has no concerns the inhaler was not administered to Resident A correctly or that it was not available for her to use. Ms. Gorsuch stated she did not believe the flu shot was administered to Resident D three times because she wouldn't have had three flu shots and this would have been administered by a physician not any direct care staff.

Ms. Gorsuch stated medication administration training is completed by Montcalm Care Network (MCN) and all direct care staff members administering medications have been trained to do so. Ms. Gorsuch stated several medication errors were found during an MCN medication audit completed by RN Alicia Faling and they were working to address these concerns.

During the on-site investigation, I reviewed 10 *AFC Incident/Accident Reports* from the time period of 11/01/2025-12/14/2025 regarding various medications errors. Ms. Gorsuch stated all *AFC Incident/ Accident Reports* regarding medication errors were submitted to MCN. None of the *AFC Incident / Accident Reports* had any description of the medication error or indication why they were submitted.

I interviewed Resident A who stated direct care staff members administer all her medication and she has never heard about missing medications. Resident A stated she does not refuse her medications. Resident A stated she has not been to the hospital lately. I noticed there was an oxygen cannula next to her head and inquired about this. Resident A stated she is supposed to use her oxygen all the time and she was just getting ready to put it on. Resident A stated she has used oxygen for a couple years and has a nasal inhaler which she uses every morning when direct care staff members

bring it to her. Resident A stated direct care staff members remind her to wear her oxygen but she does not like to wear it or sleep with it on.

I interviewed Resident B who denied refusing her medications but stated there was a time when her medications were not in facility because of miscommunication with the pharmacy. Resident B could not recall when this occurred. Resident B stated there was a time when she missed her Gabapentin medication. Resident B stated she went almost a week without it but she does not recall when this occurred.

I interviewed Resident C who stated the direct care staff members do a “great job” administering her medications. Resident C was not aware of a time when she missed her medications. I interviewed Resident D who also stated she had no concerns regarding medication administration and has always had her necessary medications at the facility.

During the on-site investigation, I completed a medication audit for Resident A, Resident B, Resident C, and Resident D and all medication listed on the physicians order were available in the medication cart.

I was also able to review training certificates confirming direct care staff members Mr. Boik, Ms. Fiedler, Mr. Bradley, Ms. Boxx, Ms. Haack-Redner, Ms. Townsend, Ms. Peterson, Ms. Bird, Ms. Alcala, and Ms. Gorsuch had all completed Part I and Part II medication administration training.

I reviewed the November 2025 and December 2025 eMAR for Resident A, Resident B, Resident C, and Resident D which showed the following discrepancies:

Resident A had 20 blank date/time boxes on the eMAR which did not have direct care staff initials to indicate the medication was administered. These dates are listed below:

- 11/13/25- one medication not documented as administered with staff initials
- 12/04/2025 19 medications not documented as administered with staff initials. I received the following *AFC Incident / Accident Report* from ORR Ms. Loiselle since they were submitted to MCN: 12/04/2025 8 PM - "When I went to pass [Resident A’s] medications I noticed they were not in the cart. I then found out the doctor held all medications while they reviewed them to call in refills. Spoke with doctor, called house manager.” The *AFC Incident / Accident Report* was completed by Hailey McIntosh and there was documentation she contacted Dr. Wilfore.
    - I verified there was a provider order from Dr. Wilfore for Resident A to "Hold all medications for 12/4/2025 and 12/05/2025”, however the order was written after the medications were not administered.
    - I reviewed Progress Notes for Resident A which stated on 12/05/2025 written by Ms. McIntosh that Resident A took all medications per doctor orders, however the medications were held per Dr. Wilfore’s order. On the eMAR these entries are coded as

"No pass reason – out of building" which is inconsistent with the progress notes and the physician order.

According to the allegations, Resident A's Hydralazine was not in the medication cart from 11/14/2025-11/20/2025. The eMAR had the following codes listed for the Hydralazine:

- 11/14/2025 was blank with no staff initials documenting the medication as administered
- 11/15/2025 was coded as "other"
- 11/16/2025 at 7:16 PM was coded as refused by resident but earlier in the day at 2:49 PM it was coded as "not in med cart"
- 11/17/2025 – "not in med cart"
- 11/18/2025 –" Other –not in facility"
- 11/19/2025 – No pass reason – out of building.

Resident B had 97 blank date/time boxes on the eMAR which did not have direct care staff initials to indicate the medication was administered.

- 11/05/2025- two medications not documented as administered with staff initials
- 11/08/2025- two medications not documented as administered with staff initials
- 11/12/2025- 17 medications not documented as administered with staff initials
- 11/15/2025- one medication not documented as administered with staff initials
- 11/17/2025- one medication not documented as administered with staff initials
- 11/18/2025- two medications not documented as administered with staff initials
- 11/19/2025 17 medications not documented as administered with staff initials
- 11/22/2025- one medication not documented as administered with staff initials
- 11/30/2025- 25 medications not documented as administered with staff initials
- 12/03/2025- one medication not documented as administered with staff initials
- 12/07/2025- one medication not documented as administered with staff initials
- 12/09/2025-18 medications not documented as administered with staff initials
- 12/11/2025- one medication not documented as administered with staff initials
- 12/14/2025- one medication not documented as administered with staff initials

- 12/20/2025- seven medications not documented as administered with staff initials.

Resident C had three blank date/time boxes on the eMAR which did not have direct care staff initials to indicate the medication was administered.

- 11/13/2025- one medication not documented as administered with staff initials
- 12/09/2025- one medication not documented as administered with staff initials
- 12/20/2025- one medication not documented as administered with staff initials.

There was also an allegation that Resident C's blood pressure medication was not administered despite Resident C's blood pressure readings falling within physician designated parameters to administer medication. According to the December 2025 physician instructions for Midodrine 10 mg tablet, Resident C should take 1 tablet by mouth twice daily but hold the medication if Resident C's systolic blood pressure (SBP) reads above 140. After reviewing the eMAR I found the following errors:

- 11/25/2025 PM Resident C's blood pressure reading was 151/81 so the medication should have been held, however it was administered to her by direct care staff member Mr. Bradley.
- 12/17/2025 AM Resident C's blood pressure reading was 106/78 and Ms. Bird documented the medication as "No pass per vitals" and it should have been administered since her blood pressure was not over 140.

Resident D had 21 blank date/time boxes on the eMAR which did not have direct care staff initials to indicate the medication was administered. The dates are listed as follows:

- 11/03/2025- one medication not documented as administered with staff initials.
- 11/04/2025- one medication not documented as administered with staff initials.
- 11/08/2025- three medications not documented as administered with staff initials.
- 11/11/2025- one medication not documented as administered with staff initials.
- 11/12/2025- two medications not documented as administered with staff initials.
- 11/13/2025- four medications not documented as administered with staff initials.
- 11/26/2025- one medication not documented as administered with staff initials.
- 12/03/2025- five medications not documented as administered with staff initials.
- 12/08/2025- two medications not documented as administered with staff initials.
- 12/12/2025- one medication not documented as administered with staff initials.

The allegations included concerns Resident D was given a flu shot three times in November 2025 by direct care staff members. According to November 2025 eMAR Resident A received the flu shot on 11/9/2025, 11/10/2025, and 11/12/2025 and this was administered by Mr. Bradley. Fluad Trivalent 2025-2026 Syringe included an order to administer contents of syringe intramuscularly X1 dose. The eMAR did not include a notation of why this was given three times.

On 01/07/2026 I interviewed APS Ms. Brugel who stated her APS case originated from an allegation that Resident A was not wearing her oxygen cannula as required. Ms. Brugel stated when she completed her unannounced on-site investigation Resident A was wearing her oxygen cannula as required. Ms. Brugel stated Ms. Gorsuch informed her that all direct care staff members working in the facility were relatively new with most having started in March 2025. Ms. Brugel stated Ms. Gorsuch informed her the medications are in the home and are being administered but not properly charted. Ms. Brugel stated that Ms. Gorsuch also explained to her that direct care staff members were not consistent with how they were marking the eMAR because direct care staff were picking the wrong response from the drop down box. Ms. Brugel stated she visited Golden Life Assisted Living #2 at 7:30 AM on 12/15/2025 when Ms. Alcala was administering medications. Ms. Alcala informed her that direct care staff members were selecting the wrong response from the drop down box when administering medications. Ms. Brugel stated the allegations in the APS complaint were all regarding Resident A. Ms. Brugel stated Resident A also informed her she was not refusing her inhaler. Ms. Brugel stated Resident B and Resident D also have open APS cases and these are assigned to APS worker Carole Dreyer. Ms. Brugel stated Resident C does not have an open APS case at this time.

On 01/21/2026 I interviewed Montcalm Care Network RN Alicia Faling who stated she found several concerns after completing a medication audit regarding medications. RN Faling stated direct care staff members were documenting the eMAR incorrectly when medications were given to the residents. RN Faling stated she was able to review the eMARs for November and December 2025. Ms. Faling stated there was some documentation that would say a resident was out of the building but when the internal charting showed the resident was in the building. RN Faling stated there were also medications that she suspected they did not have in the building. RN Faling stated now that MCN has access to the electronic eMAR, the entries have been more consistent now that she can review it on their end. RN Faling stated she found an entry that Resident D received a flu shot three times which would have been given by the direct care staff members however, the direct care staff members should not be administering a flu shot nor should she have it three times.

RN Faling stated she provides medication training to direct care staff members so they should all know what to input into eMAR since this is part of the training. RN Faling states she discusses in the training that you cannot put “Out of building” on a medication if someone refuses and the importance of using the right responses on the eMAR.

On 01/21/2026 I interviewed direct care staff member Brandon Boik. Mr. Boik stated he has no concerns regarding medication errors. Mr. Boik stated there are times the medications aren't available because Ms. Gorsuch does not order the medications timely from the pharmacy. Mr. Boik stated he was not aware of any medications for Resident A that weren't administered in December 2025 and had no information why some of the entries on the eMAR would be left blank with no staff initials verifying administration. Mr. Boik stated he has no concerns that medications were not in the cart

for any of the residents when he works. Mr. Boik stated he was not aware of Resident D getting a flu shot three times in November 2025.

On 01/21/2026 I interviewed licensee designee Joanne Dykstra. Ms. Dykstra stated there were blank date/time boxes on the eMAR because there are times when they use a paper chart and some of those have an *AFC Incident / Accident Report* completed for the error. Ms. Dykstra stated she recently retrained all direct care staff members about how to document the eMAR and told them not to check "other" so there is a clear description about what happened with that specific medication administration. Ms. Dykstra stated sometimes residents are out of the building for appointments like when Resident B goes to dialysis every other day. Ms. Dykstra stated if direct care staff send the medications with her, they put LOA on the eMAR for that medication administration. Ms. Dykstra stated she believes it's more of an issue of incorrect documentation than medications not being administered. Ms. Dykstra stated she spoke with Ms. Gorsuch who told her she was not reviewing eMARs daily but would start doing so. I informed Ms. Dykstra there was a medication investigation in July 2025 and part of the corrective action plan was to review the eMAR weekly but she stated this was only for Resident C's eMAR and not all residents. Ms. Dykstra stated direct care staff members remind Resident A to put the oxygen cannula on and sometimes they will find her with the mask upside down which is corrected. Ms. Dykstra did not have information why Resident D would have received the flu shot three times in November 2025.

On 01/22/2026 I received a call from ORR Ms. Loiselle who stated she received a corrective action plan from Golden Life administration on 01/22/2026 but did not approve it because there was not enough information. Ms. Loiselle stated as a result of her investigation, she found a preponderance of evidence to substantiate a violation of Neglect Class III by Ms. Gorsuch.

On 01/23/2026 I interviewed Optimal Care Dr. Sandra Wilfore. Dr. Wilfore stated she believes Ms. Gorsuch is trying to rectify the situation with medications because she has recently asked for orders for all medications. Dr. Wilfore stated Resident B has many hospitalizations so she is thinking direct care staff do not document that correctly on the eMAR. Dr. Wilfore stated she also provides care to Resident A, which started on 12/10/2025. Dr. Wilfore stated there was some confusion if Resident A needed oxygen at all times so she asked for medical records from previous providers. Dr. Wilfore stated she hasn't received any notices that Resident A has refused her Trelegy Ellipta inhaler or the Albuterol inhaler which is a PRN. Dr. Wilfore stated there was some miscommunication regarding the flu shot because when she saw Resident D in early November 2025, she informed Ms. Gorsuch all residents could have a flu shot. Dr. Wilfore stated she has no information about how or why she would have been given three flu shots.

On 01/28/2026 I interviewed direct care staff member Chloe Petersen and on 01/29/2026 I interviewed direct care staff member Casey Townsend. Neither of the direct care staff members were aware of medication concerns. Both of them stated they have been trained to document medication administration in the eMARs. Ms. Petersen

stated she wasn't sure why there would be blanks on Resident B's medications but sometimes she would want to sleep and not want to take her medications so direct care staff members may have forgotten to go back and give it to her or mark it in the eMAR as a refusal. Ms. Peterson and Ms. Townsend both stated Resident A regularly wears her oxygen but they do need to remind her to keep it on because she takes it off to go outside and smoke cigarettes. Neither Ms. Townsend nor Ms. Petersen had any information about why there would be documentation that Resident D had three flu shots in November.

Special Investigation Report #2025A1033037 cited for the equivalent rule of 400.14312 on 06/26/2025. The investigation determined direct care staff members did not administer Resident C's migraine medication as prescribed. A corrective action plan was submitted on 07/01/2025 and approved with the following plan:
"Staff will be trained to print eMAR and have Montcalm Care Network nurses document medications that are given by their staff. Staff will also document in eMAR that medication was administered by a health care professional. Medications will only be held or discontinued following formal orders from medical professionals. Trysta Gorsuch home manager will monitor and audit eMAR weekly to ensure medications are being properly charted."

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. **(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:** **(b) Complete an individual medication log that contains all of the following:** **(v) Initials of the individual who administered the medication at the time given.**

ANALYSIS:	Based on the interviews with RN Faling, Ms. Gorsuch, Ms. Loiselle, and Dr. Wilfore, and my review of multiple residents' eMARs, resident medications were not given as prescribed as there was no verification via staff members' initials on the eMAR that the medication was administered. Further there was documentation on eMARs of medications not being refilled or available to administer. Also, there were over 100 date/time boxes on multiple residents' eMARs with no direct care staff initials indicating who administered the medication and at what time as required.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR # 2025A1033037 DATED 06/26/2025. CAP DATED 07/01/2025.]**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 12/23/2025 I completed an unannounced on-site investigation and met with direct care staff member whose role is home manager Ms. Gorsuch at Golden Life Assisted Living #2. Ms. Gorsuch stated when there is a medication error the physician is contacted so they are aware of it and to provide instruction. Ms. Gorsuch stated direct care staff do not document on the eMAR that the physician was notified of the error because there is not room on the eMAR document. Ms. Gorsuch stated sometimes direct care staff members will put notes in to say who they contacted. Ms. Gorsuch stated a meeting was held with Montcalm Care Network and now there is a plan to document these calls so it's more consistent.

On 01/07/2026 I interviewed APS Ms. Brugel who stated she was informed by Ms. Gorsuch if a resident refuses medication, direct care staff are supposed to contact her immediately. Ms. Brugel stated she did not know if Ms. Gorsuch contacted the health care professional at the time of the medication error or what follow up is done.

On 01/21/2026 I interviewed Montcalm Care Network RN Faling. RN Faling stated Resident B was refusing psychiatric medications for weeks and the provider was never notified. RN Faling stated Resident A and Resident B both had multiple hospital visits during that timeframe but it's hard to tell if medication refusals and/or errors contributed to those hospital visits. RN Faling stated direct care staff supposed to send *AFC Incident / Accident Reports* to them when there was a medication refusal or error but this was not done consistently. RN Faling stated she does not know if Ms. Gorsuch was contacting the resident's primary physician for any of the errors.

On 01/21/2026 I interviewed direct care staff member Mr. Boik. Mr. Boik stated he knows when there are multiple errors Ms. Gorsuch will send the direct care staff member back responsible through medication training again, however he was never

trained to contact the health care professional if an error was made. Mr. Boik stated he was not sure if Ms. Gorsuch calls the pharmacy for medication errors or refusals.

On 01/21/2026 I interviewed licensee designee Ms. Dykstra. Ms. Dykstra stated direct care called the MCN hotline to report a medication refusal for Resident B but were recently informed not to use the hotline for medication errors and refusals because she has a psychiatric doctor. Ms. Dykstra stated they are now completing a medication IR each week that explains the errors. Ms. Dykstra stated she has received "mixed messages" from MCN about who to contact for medication errors but stated she informed Ms. Gorsuch licensing rules come first so the residents' provider needs to be contacted.

On 01/23/2026 I interviewed Optimal Care Dr. Wilfore. Dr. Wilfore stated she believes Ms. Gorsuch is trying hard and has recently asked for physician orders for all medications. Dr. Wilfore stated she recently reviewed Resident B's medications because Resident B is not compliant with medications and has experienced renal failure, diabetes. Dr. Wilfore stated when she refuses her medications direct care staff report the refusal to her office. Dr. Wilfore stated she received one call in December 2025 and two in January 2026 for medication refusals. Dr. Wilfore stated she received notice that the Hydralazine was not in the medication cart from 11/14/2025-11/20/2025 however, these medications were sent to the pharmacy on 11/7/2025 so should have been available to Resident B. Dr. Wilfore stated she did not receive any notifications of Resident A refusing medication and stated she received on call that Resident D refused her Metformin on 1/14/2026.

On 01/28/2026 I interviewed direct care staff member Chloe Petersen and on 01/29/2026 I interviewed direct care staff member Casey Townsend. Both of the direct care staff members were aware the physician should be contacted when a medication error or refusal occurs. Ms. Petersen stated when there was a medication error or a refusal, they called a couple times but typically wrote an *AFC Incident / Accident Report* to give to Ms. Gorsuch to follow up with the physician. Ms. Townsend stated if a resident refuses their medications she puts it in the eMAR as a refusal, fills out the medication IR documenting the refusal or error and then at the end of the week fax to MCN. Ms. Townsend stated when this occurs she does not contact the physician or pharmacy to inform them because she brings this to Ms. Gorsuch's attention.

On 02/05/2026 I emailed Optimal Care, Cassie Manning to see if she has been receiving notifications of missed medications. Ms. Manning wrote back with the following information regarding contacts from Ms. Gorsuch and direct care staff members at Golden Life Assisted Living 2: "*Reviewing [Resident B]'s chart, we received phone calls to report high blood sugars, but "I do not have any reports of missed medications, I have checked through my emails as well and do not see anything. During this time, I was off on maternity leave, so the office was covering for me. I spoke with staff here and they have not received any communication either."*

The email included documentation of a phone call on 12/09/2025 requesting an order for Resident A to hold medications for 12/4/2025-12/05/2025 because they were not delivered yet. Ms. Gorsuch asked for an order for that time period and stated she has medication passes that she needs to answer for medications that were not administered during that time period.

On 02/06/2026 I received a phone call from Cassie Manning. Ms. Manning stated she did not realize there were times when they didn't have medications at Golden Life Assisted Living #2 since they use Hometown Pharmacy and they could "stat order" medications and they would be delivered to the facility within three hours.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(f) Contact the resident's licensed health care professional or the appropriately licensed health care professional who prescribed the medication when a medication error occurs.**
ANALYSIS:	Ms. Gorsuch was unable to verify if the health care professionals had been contacted after a medication administration error. According to Resident A and Resident B's primary providers, Dr. Wilfore and Ms. Manning are not receiving notifications of medication errors.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(g) Contact the appropriately licensed health care professional when a resident refuses a prescribed medication or procedure. A licensee, administrator, or staff shall document and follow the instructions given by the licensed health professional. Documented instructions may include procedures to follow when a resident refuses medication or procedures in the future.**

ANALYSIS:	Ms. Gorsuch was unable to verify if the health care professionals have been contacted when there is a medication refusal. According to Resident A and Resident B's primary provider, Dr. Wilfore and Ms. Manning are not receiving notifications of medication refusals.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning _____02/06/2026_____

Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 02/11/2026

_____

Dawn N. Timm Date
Area Manager