GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 20, 2026

Lisa Springett
30744 White Oak Dr
Bangor, MI 49013

RE: License #: AS800386223
Investigation #: 2026A0790020
Eiraina Adult Foster Care

Dear Lisa Springett:

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 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 (616) 356-0100.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
gillr@michigan.gov
(517) 980-1433

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS800386223
Investigation #:	2026A0790020
Complaint Receipt Date:	02/25/2026
Investigation Initiation Date:	02/26/2026
Report Due Date:	04/26/2026
Licensee Name:	Lisa Springett
Licensee Address:	30744 White Oak Dr Bangor, MI 49013
Administrator:	Lisa Springett
Licensee Telephone #:	(269) 217-9359
Name of Facility:	Eiraina Adult Foster Care
Facility Address:	30744 White Oak Drive Bangor, MI 49013
Facility Telephone #:	(269) 217-9359
Original Issuance Date:	06/21/2017
License Status:	REGULAR
Effective Date:	06/11/2024
Expiration Date:	06/10/2026
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member did not ensure Resident A was safely buckled in the van before accelerating.	Yes

III. METHODOLOGY

02/25/2026	Special Investigation Intake 2026A0790020
02/26/2026	Special Investigation Initiated – Telephone call made. I interviewed the Complainant.
02/26/2026	Contact - Telephone call made. I interviewed recipient rights director Candice Kinzler.
02/26/2026	Inspection Completed On-site- I interviewed direct care staff member (DCSM) Glenbee Geary. Resident A was on vacation and would not be returning for more than a week.
03/17/2026	Contact - Face to Face- I interviewed Resident A, DCSM Diana Kindig who functions as the medical manager for the facility, and licensee Lisa Springett.
03/17/2026	Exit Conference with licensee Lisa Springett.
03/18/2026	APS Referral was entered on the Michigan Online Reporting System (MORS) portal.
03/18/2026	Inspection Completed-BCAL Sub. Compliance
03/18/2026	Corrective Action Plan Requested and Due on 04/01/2026

ALLEGATION: Direct care staff member did not ensure Resident A was safely buckled in the van before accelerating.

INVESTIGATION:

On 2/25/26, I reviewed a Michigan Department of Licensing and Regulatory Affairs – Bureau of Community and Health Systems Online Complaint Form dated 2/25/26. The complaint indicated that on an unknown date, a direct care staff member (DCSM) Name Unknown reported that she asked if all the residents were in the van.

The DCSM stated she thought she heard everyone say yes. The DCSM heard a noise and Resident A fall down outside the van. The complaint indicated that Resident A disclosed she was not all the way in the van before the DCSM accelerated to leave causing Resident A to fall. The DCSM checked Resident A for injury. Resident A received abrasions to her chin, hands, and knees. The complaint indicated that Resident A refused medical treatment immediately after the incident occurred. The complaint indicated that Resident A went to the emergency room (ER) days after the incident took place and was diagnosed with a fractured little (pinky) finger.

On 2/26/26, I interviewed Complainant via phone. Complainant confirmed that the allegations were accurate and comprehensive.

On 2/26/26, I interviewed recipient rights director Candice Kinzler via phone, and she indicated she is currently investigating the same allegation. Ms. Kinzler said she interviewed Resident A at the facility and Resident A indicated that the allegations are true. Ms. Kinzler indicated that she has yet to interview the DCSM involved in the incident. Ms. Kinzler said she has obtained several supporting documents and will email them to me.

On 2/26/26, I conducted an unannounced onsite investigation. I interviewed DCSM Glenbee Geary. Ms. Geary stated that she has worked at the Adult Foster Care (AFC) facility for approximately twelve years. Ms. Geary informed me that Resident A is currently on vacation with her family in Florida and will be gone until next week.

Ms. Geary said she is sometimes responsible for transporting the residents. She said DCSM Julie Zecklin is primarily responsible for transporting the residents and normally does so. Ms. Geary stated that Ms. Zecklin is responsible for transporting the residents on outings and to and from scheduled appointments. She said occasionally Ms. Zecklin is not available to transport the residents and she or another DCSM will fill in. Ms. Geary said when she transports residents she makes sure all the residents are in the van with their seatbelts buckled up before she places the van in drive and drives away.

Ms. Geary said she does not have any firsthand knowledge regarding the incident. She stated she was at the facility with the remaining residents when the incident took place. Ms. Geary said the incident happened approximately two weeks ago. She stated that Ms. Zecklin had taken three residents on an outing. Ms. Geary said after the outing Ms. Zecklin got back into the van and then the three residents allegedly did the same. Ms. Geary said Ms. Zecklin asked if the residents were all in the van and thought she heard someone say “yes”, so Ms. Zecklin put the van in drive and began to drive away. She heard Resident A yell “stop” and the resident that was in the passenger seat shouted, “[Resident A] is not all the way in the van.” Ms. Geary stated that Ms. Zecklin stopped, put the van in park, and got out to check on Resident A. Ms. Zecklin helped Resident A to her feet and into the van and called DCSM Diana Kindig who functions as the medical manager. Ms. Kindig arrived at

the scene of the incident and examined Resident A for injuries. Ms. Geary said Resident A was brought back to the facility and indicated she did not need medical attention. Ms. Geary indicated that Resident A is her own person and competent to make all of her own decisions.

On 3/17/26, I conducted an onsite investigation at the facility and interviewed Resident A who stated that she has lived at the facility for over a year and likes living there. She stated that an incident like the one that recently happened to her has never happened before at least since she has lived there. Resident A stated that the incident happened last month (February 2026) and the allegations are accurate. She said she was at the library in Bangor with DCSM Julie Zecklin and two other residents. Resident A said when they were leaving the library, Ms. Zecklin got into the van and asked if everyone else was in. She said Ms. Zecklin thought she heard someone say “yes” so she put the van in drive and began to drive away. Resident A said she was not quite in the van yet and kind of fell out onto the ground. She stated that her chin, knuckles, and both knees were scraped up after the incident.

Resident A stated that DCSM Diana Kindig asked if she wanted to seek medical attention after the incident and she told Ms. Kindig “no” that she did not require any medical attention. Resident A said she did not realize her pinky finger on her righthand was fractured at the time. She stated that later it bruised, swelled up, and began hurting. Resident A stated that Ms. Kindig transported her to the emergency room because her pinky finger was bruised, swollen, and hurting. Resident A showed me her pinky finger, and it no longer appeared bruised or swollen. Resident A stated that her finger is healing and no longer hurts. Resident A said there has been no subsequent incidents that have occurred.

I interviewed DCSM Diana Kindig. Ms. Kindig stated that she functions as medical management for the facility and ensures all the residents medical needs are provided. Ms. Kindig provided me with supporting documentation and admitted that the allegations that I am looking into are accurate and comprehensive. She did not add any additional information.

I interviewed licensee Lisa Springett. Ms. Springett said that she and DCSMs involved have been honest and forthcoming from the very beginning regarding the incident that took place on 2/9/26. She admitted that the allegations are accurate and comprehensive. Ms. Springett had no information to add as she and the DCSMs involved have shared all that occurred before, at the time of, and since the incident in its entirety.

On 3/18/26, I reviewed Resident A’s *Resident Records.* I specifically reviewed Resident A’s Individual Information Sheet and found that Resident A is her own guardian and does not require a designated representative, guardian, or payee.

I reviewed an *AFC Licensing Division – Incident / Accident Report* dated 2/9/26 and written by DCSM Julie Zecklin. The report indicated that Ms. Zecklin and the

residents got in the van. Ms. Zecklin asked, “Is everyone in?” Ms. Zecklin thought she heard someone say “yes”. The report indicated that Ms. Zecklin started to pull off and heard a noise. Ms. Zecklin realized that Resident A was not all the way in van and had fallen to the ground. The report indicated that Ms. Zecklin called DCSM Diana Kindig who functions as the medical manager. Ms. Kindig arrived on scene and instructed Ms. Zecklin to take Resident A back to the facility. Ms. Kindig examined Resident A at the facility. The report indicated that Ms. Kindig found that Resident A had scrapes on her chin, knuckles, and right knee. Resident A also had small bruises on both knees. Resident A told Ms. Kindig that she was fine and did not require medical attention.

I reviewed a second *AFC Licensing Division – Incident / Accident Report* dated 2/11/26. The report indicated that because of the accident on 2/9/26 where Resident A fell, Resident A’s pinky finger began swelling up on 2/10/26. Resident A was still able to bend and move the finger so DCSMs applied an ice pack to get the swelling to go down. The report indicated that on the morning of 2/11/26 Resident A’s finger was still swollen so Ms. Kindig transported Resident A to the doctor and found out that Resident A’s finger was fractured. The report indicated that DCSMs would monitor Resident A for health and safety.

I reviewed an *After Visit Summary* (summary) for Resident A dated 2/11/26. The summary indicated that Resident A was found to have a closed nondisplaced fracture of the middle phalanx of right little finger, initial encounter. Resident A had her finger x-rayed (right minimum two views). Resident A’s follow-up instructions include a preventative visit with Doctor Jenna Ruple, MD at Bronson Lakeview Family Care – Paw Paw on 12/2/26 at 12:45 p.m.

I reviewed a statement written by DCSM Julie Zecklin on 2/23/26. The statement indicated that on 2/9/26 at 11:30 a.m., Ms. Zecklin and three residents were leaving the library in Bangor, MI. The three residents got into the van to leave the library. Ms. Zecklin was in the drivers seat and asked if everyone was in the van. Ms. Zecklin heard someone say “yes” and proceeded to put the van in drive mode. Upon doing so, Ms. Zecklin heard Resident A holler “stop.” Ms. Zecklin immediately put the van in park and looked in the back seat. Ms. Zecklin saw that Resident A had fallen on the ground and scraped her chin and knuckles.

The statement indicated that Ms. Zecklin got out of the van and helped Resident A get into the back seat to check for injuries. Ms. Zecklin called EHI medical manager Diana Kindig who came to the library as she was in town when she received the call.

The statement indicated that Ms. Zecklin was instructed to take Resident A back to the facility where she was cleaned up. Ms. Kindig cleaned the scrape on Resident A’s chin and put antibiotic ointment on it. Ms. Kindig asked Resident A if she wanted to go to the doctor’s office. Resident A responded “no” and said she was fine. Ms. Kindig checked Resident A for additional injuries and found a few scrapes across

her knuckles and her knees. The statement indicated that both of Resident A's parents were notified of the incident.

The statement indicated that two days later on 2/11/26 DCSMs noticed that Resident A's pinky finger was bruised and swollen. Ms. Kindig transported Resident A to the Emergency Room at Bronson South Haven and found that Resident A had fractured her pinky finger on her right hand. A splint was placed on the finger. At a follow up appointment, the doctor said Resident A's finger was healing nicely. I reviewed two sets of x-rays of Resident A's finger. The first set of x-rays dated 2/11/26 showed that the finger was fractured. The second set of x-rays dated 2/20/26 showed that the fractured finger was in the process of healing.

I reviewed the policies and procedures for Eiraina Adult Foster Care. I specifically reviewed the facility driving policy. The policy indicated that all drivers of facility vehicles must be between the ages of 25 – 75 years old. They must have a valid driver's license and up to date vehicle insurance. The policy indicated that all passengers should wear seat belts. The policy stated the driver should be the last to enter the vehicle after ensuring all passengers are in the vehicle and buckled up. The policy stated that driving records will be obtained by the home provider.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with the Complainant, Ms. Kinzler, Ms. Geary, Resident A, Ms. Kindig, and Ms. Springett there was sufficient evidence found indicating that on 2/9/26, DCSM Julie Zecklin did not ensure Resident A was safely buckled in the van before accelerating. Resident A sustained injuries because of this incident including scrapes on her chin, knuckle, both knees, and a fractured right little (pinky) finger. Facility policy requires that the driver makes sure all residents are in the vehicle and buckled up before entering the vehicle themselves.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/17/26, I conducted a face-to-face exit conference with licensee Lisa Springett at her facility. Ms. Springett was informed of the outcome of this special investigation and did not dispute the findings. Ms. Springett stated she would provide an acceptable Corrective Action Plan (CAP) within the required timeframe.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

3/19/26

Rodney Gill — Date
Licensing Consultant

Approved By:

for 03/20/2026

Russell B. Misiak — Date
Area Manager