GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 10, 2026

Julie King
7212 S. Michigan Ave
Rothbury, MI 49452

RE: License #: AS640418664
Investigation #: 2026A0870021
Sunny Knoll South

Dear Julie King:

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 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,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS640418664
Investigation #:	2026A0870021
Complaint Receipt Date:	04/29/2026
Investigation Initiation Date:	04/30/2026
Report Due Date:	06/28/2026
Licensee Name:	Julie King
Licensee Address:	7212 S. Michigan Ave Rothbury, MI 49452
Licensee Telephone #:	(231) 894-0049
Name of Facility:	Sunny Knoll South
Facility Address:	6699 B North Oceana Dr Hart, MI 49420
Facility Telephone #:	(231) 301-8020
Original Issuance Date:	08/14/2024
License Status:	REGULAR
Effective Date:	02/14/2025
Expiration Date:	02/13/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided with her prescription medication Clonazepam because facility staff failed to obtain a new order for the medication refill.	Yes

III. METHODOLOGY

04/29/2026	Special Investigation Intake 2026A0870021
04/29/2026	APS Referral This referral came from the Michigan Department of Health and Human Services, Protective Services Centralized Intake unit.
04/30/2026	Special Investigation Initiated - Telephone Telephone call with West Michigan Community Mental Health Authority, Supports Coordinator Jennifer Pochyla.
05/04/2026	Inspection Completed On-site Interviews with facility staff and Resident A.
05/05/2026	Contact - Telephone call made Telephone interview with Licensee Julie King.
05/19/2026	Contact - Telephone call made Telephone interview with Licensee Julie King.
05/28/2026	Contact - Telephone call received Email with Licensee Julie King along with documents from pharmacy.
06/09/2026	Contact - Telephone call made Interview with Amy Crossett, medical team with WMCMH.
06/09/2026	Exit Conference Completed with Licensee Julie King.

ALLEGATION: Resident A was not provided with her prescription medication Clonazepam because facility staff failed to obtain a new order for the medication refill.

INVESTIGATION: On April 30, 3026, I conducted telephone interview with Jennifer

Pochyla, Case Manager with West Michigan Community Mental Health Authority. Ms. Pochyla stated she recently conducted a case management visit to the Sunny Knoll AFC to meet with Resident A. She stated Resident A informed her that she had not been feeling well recently. Ms. Pochyla, while reviewing Resident A's medications, noted that the facility had not given Resident A any of her "as needed" Clonazepam medications for an extended period of time, from late January 2026 until mid-March 2026. Ms. Pochyla noted that although this medication is prescribed to be administered "as needed", Resident A had been recieving this medication at least twice per day, every day. She further stated that when she asked facility staff why they had not provided Resident A with any Clonazepam during this time period, the staff stated, "We thought it was discontinued." Ms. Pochyla confirmed that this medication, Clonazepam, had not been discontinued.

On May 4, 2026, I conducted an unannounced on-site special investigation at the Sunny Knoll South AFC home. I met separately with staff members Monica Gagnon and Holly Revilla. Ms. Revilla stated that Resident A "ran out" of her prescribed medication Clonazepam "a couple of times" in February (2026) through early March (2026). Ms. Revilla stated she had informed Ms. Gagnon that "we need to order more" of the Clonazepam for Resident A. Ms. Revilla stated that Ms. Gagnon is the staff "in charge of resident medications."

Ms. Gagnon stated that "there was a time when the Clonazepam was discontinued" but was later reinstated at the insistence of Resident A's guardian. I asked Ms. Gagnon for the documentation of the medication being discontinued. Ms. Gagnon could not find an order from Resident A's physician discontinuing the Clonazepam.

Ms. Gagnon provided me with Resident A's Medication Administration Records. I reviewed these records for the months of November 2025 to present. I observed that the facility had administered the prescription medication Clonazepam on a near daily basis, at least one dose per day, during this time frame with the exception of January 31, 2026, through March 11, 2026, where there is no record of this medication being administered to Resident A.

On May 4, 2026, I conducted an in-person interview with Resident A. Resident A stated that she "ran out" of her prescribed medication Clonazepam. She noted that it made her "feel sick" but she is "getting it now."

On May 5, 2026, I conducted a telephone interview Licensee Julie King. I informed her of the above stated allegation. Ms. King explained that there was a period of time, this past late winter, when Resident A's doctor did not send in a new prescription to the pharmacy. She further explained that due to the nature of this medication, a new order/prescription must be sent monthly from the prescribing CMH doctor to the pharmacy. Ms. King, when asked if the medication was ever "discontinued" noted that she was not aware of it being discontinued, just that the order is done monthly and each month the prescribing doctor must reauthorize and prescribe the medication and this order is sent to the pharmacy.

On June 9, 2026, I conducted a telephone interview with Amy Crossett. Ms. Crossett is the medical coordinator for West Michigan CMH Authority. She stated that Resident A was originally prescribed Clonazepam, as needed (PRN), maximum twice daily, on March 9, 2023. Ms. Crossett noted that this was increased to three times maximum daily PRN on March 22, 2026. Ms. Crossett explained that this medication can only be filled one month at a time and needs to be reauthorized and prescribed, each month by Resident A's physician. She further explained that the process is, and always has been, that the AFC home contacts the pharmacy "for a refill", then the pharmacy contacts the prescribing physician for the reauthorization. Ms. Crossett stated that upon reviewing Resident A's medical notes/records, it documents that the most recent reauthorizations in 2026 for Clonazepam were on January 8, 2026, April 22, 2026, and June 3, 2026. Ms. Crossett confirmed that each order is for a one-month period. She further noted that Resident A's Clonazepam was not "discontinued", just that the prescribing physician was not contacted to reauthorize the medication "refill" in February and March.

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.
ANALYSIS:	Resident A was not provided with her prescribed medication Clonazepam from January 31, 2026, through March 11, 2026. WMCMH Case Manger Jennifer Pochyla and Medical Coordinator Amy Crossett both stated that Resident A's Clonazepam medication was not discontinued during this timeframe. Resident A's Medication Administration Record, maintained by the facility, shows that Resident A was not provided with her prescribed medication Clonazepam from January 31, 2026, through March 11, 2026. The Licensee failed to give Resident A her prescribed medication Clonazepam as ordered by her licensed health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.689	**Resident health care.**

	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	The Licensee failed to follow the instructions of Resident A's physician when they did not provide her with the prescribed medication Clonazepam.
CONCLUSION:	**VIOLATION ESTABLISHED**

On June 9, 2026, I provided Licensee Julie King with an exit conference. I explained my findings as noted above. Ms. King stated she understands the findings, that she had no additional information to provide, nor any additional questions to ask, concerning this investigation. Ms. King stated she will submit a corrective action plan addressing the above cited rule violations within 15 days of receipt of this report.

IV. RECOMMENDATION

I recommend, contingent upon the submission of an acceptable corrective action plan, that the status of the license remain unchanged.

June 10, 2026

Bruce A. Messer — Date
Licensing Consultant

Approved By:

June 10, 2026

Jerry Hendrick — Date
Area Manager