GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 12, 2026

Sarah Barnes
Lake Life AFC
6844 W Redman Dr
Lake City, MI 49651

RE: License #: AS570419455
Investigation #: 2026A0870032
Lake Life AFC

Dear Sarah Barnes:

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 #:	AS570419455
Investigation #:	2026A0870032
Complaint Receipt Date:	08/03/2026
Investigation Initiation Date:	08/03/2026
Report Due Date:	09/02/2026
Licensee Name:	Lake Life AFC
Licensee Address:	6844 W Redman Dr Lake City, MI 49651
Licensee Telephone #:	(231) 667-7601
Administrator:	Sarah Barnes
Licensee Designee:	Sarah Barnes
Name of Facility:	Lake Life AFC
Facility Address:	6844 W Redman Dr Lake City, MI 49651
Facility Telephone #:	(231) 295-1063
Original Issuance Date:	12/23/2025
License Status:	REGULAR
Effective Date:	06/23/2026
Expiration Date:	06/22/2028
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, AGED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was left unsupervised in a wheelchair in the roadway for approximately 25 minutes, placing him at risk from passing traffic.	Yes

III. METHODOLOGY

08/03/2026	Special Investigation Intake 2026A0870032
08/03/2026	Special Investigation Initiated - Telephone Review of photos emailed by Complainant -1.
08/04/2026	Inspection Completed On-site Interview with staff member Tiffany Holmes and Resident A.
08/04/2026	Contact - Telephone call made Text exchange with Licensee Designee Sarah Barnes.
08/06/2026	Contact - Telephone call made Telephone interview with staff member Brenda Knight
08/06/2026	APS Referral Referral made to the Michigan Department of Health and Human Services, Protective Services Centralized Intake unit.
08/06/2026	Contact - Telephone call made Telephone interview with staff member Irma Muntz.
08/07/2026	Contact - Telephone call made Email exchange with Complainant -1.
08/10/2026	Inspection Completed-BCAL Sub. Compliance
08/12/2026	Exit Conference Completed with Licensee Designee Sarah Barnes.

ALLEGATION: Resident A was left unsupervised in a wheelchair in the roadway for approximately 25 minutes, placing him at risk from passing traffic.

INVESTIGATION: On August 3, 2026, I reviewed five photographs emailed to me by Complainant -1. I observed in these photographs an individual, later identified as

Resident A, who appears to be sleeping. Resident A is seated in a power scooter/wheelchair and is located within the roadway. Two of the photographs show a vehicle passing Resident A. The roadway does not have “shoulders” and Resident A is clearly situated within the roadway/line of traffic. The photographs also show that Resident A is approximately 10 to 15 yards from the AFC driveway entrance. The posted speed limit for this roadway is 25 miles per hour.

On August 4, 2026, I conducted an on-site special investigation at the Lake Life AFC home. I met with staff member Tiffany Holmes. Ms. Holmes stated she was aware of Resident A “being asleep in the road.” She noted that she was called by staff member Brenda Knight, who told her she found Resident A asleep in his chair in the roadway when she arrived for her shift at 9:00 a.m. on July 31, 2026. Ms. Holmes stated staff member Irma Muntz was working at the time and she was the only staff member on duty with six residents. Ms. Holmes noted that “this was the first time (Resident A) had fallen asleep in the road.” She further noted that Resident A does like to go outside and will “doze off” in his chair at times. Ms. Holmes stated that none of the residents have enhanced supervision requirements.

Ms. Holmes provided me with Resident A’s *Assessment Plan for AFC Residents (BCHS-3265).* I noted that Resident A’s assessment states he is able to move independently within the community. I did not note any indicators within this assessment that Resident A requires enhanced supervision.

Ms. Holmes provided me with the staff shift log. I observed an entry into this log, made by staff member Irma Muntz on July 31, 2026, which states that Resident A went “outside waiting for ride 8:15 a.m.” I further observed an entry made by staff member Brenda Knight on July 31, 2026, which states, “when staff arrived (Resident A) was in his electric wheelchair. sitting in the sun he said, but he was in the road!”

On August 4, 2026, I conducted an in-person interview at the facility with Resident A. Resident A stated he was waiting for his bus ride and since it was a “chilly” morning, he moved in his power wheelchair to a sunny spot “just up the road.” Resident A stated he “was resting” and “never fell asleep.” Resident A expressed that he is his “own man” and doesn’t have a guardian. He noted that one of the facility staff came out and talked to him about being in the road but he “just wanted to be in the sun.”

On August 6, 2026, I spoke with Licensee Designee Sarah Barnes. We discussed the allegation. She noted that Resident A does not have a guardian and his assessment notes he is able to go into the community without supervision.

On August 6, 2026, I conducted a telephone interview with staff member Brenda Knight. Ms. Knight stated she arrived for work at the Lake Life AFC at approximately 8:45 a.m. on July 31, 2026. She stated that as she approached the facility, she observed Resident A in the road and “he appeared to be asleep.” Ms. Knight described Resident A as having “his head down, chin on his chest and his eyes closed.” Ms. Knight stated she parked her car in the facility driveway and went to

Resident A telling him that he “can’t sit in the road, its not safe, and he must wait in the driveway.” She stated she does not know how long Resident A was in the road.

On August 6, 2026, I conducted a telephone interview with staff member Irma Muntz. Ms. Muntz stated that she observed Resident A go outside to wait for his bus ride at approximately 8:15 a.m. She noted that the bus typically arrives between 9:00 a.m. and 10:00 a.m. Ms. Muntz noted that she was unaware that Resident A had gone onto the road until Ms. Knight arrived at work at approximately 8:45 a.m. and informed her that Resident A was in the road. Ms. Muntz commented that Resident A “nods off all the time” but is not “sleeping sleeping.”

On August 7, 2026, I contacted Complainant -1 via email enquiring as to the timing of his observations of Resident A “sleeping” in the road. Complainant -1 stated that his wife observed Resident A in the road at 8:20, “not moving” and when he arrived home at 8:40 a.m. he observed Resident A was “definitely sleeping from 8:40 a.m. to 8:52 a.m. when a staff member arrived and retrieved him (Resident A).”

FOR REFERANCE: PA 218 of the Public Acts of 1979, as amended

400.707 (7) “Supervision” means guidance of a resident in the activities of daily living, including all of the following:

(d) Being aware of a resident’s general whereabouts even though the resident may travel independently about the community.

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:	Staff member Brenda Knight stated that she observed Resident A in the roadway with “his head down, chin on his chest and his eyes closed” as she arrived for her work shift at approximately 8:45 a.m. on July 31, 2026. Staff member Irma Muntz stated that she observed Resident A go outside to wait for his bus ride at approximately 8:15 a.m. Complainant -1 states that his wife observed Resident A in the road at 8:20 a.m., “not moving” and he observed Resident A was “definitely sleeping from 8:40 a.m. to 8:52 a.m. when a staff member arrived and retrieved him (Resident A).”

	Photographs provided by Complainant -1 show Resident A, sitting in his wheelchair, appearing to be sleeping, while in the road with a car passing him. Resident A's *Assessment Plan for AFC Residents (BCHS-3265).* states that he is able to move independently within the community. There are no indicators within this assessment that Resident A requires enhanced supervision. Although Resident A's assessment states he can move independently within the community, he was observed to be "sleeping" in the road with traffic passing him. Facility staff member Irma Muntz was unaware that Resident A was in the road. The Licensee did not appropriately provide Resident A with "Supervision" as Ms. Muntz was unaware of Resident A's general whereabouts as required by PA 218 of 1979 as amended, 400.707(7)(d).
CONCLUSION:	**VIOLATION ESTABLISHED**

On August 12, 2026, I provided Licensee Designee Sarah Barnes with an exit conference and informed her of my finding. Ms. Barnes stated she understood the finding, had no additional information to provide, nor questions to ask concerning this special investigation. She stated she would submit a corrective action plan to address the cited rule violations within the established 15-day timeframe.

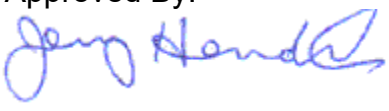
IV. RECOMMENDATION

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

August 12, 2026

Bruce A. Messer Date
Licensing Consultant

Approved By:



August 12, 2026

Jerry Hendrick Date
Area Manager