GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 4, 2021

Mike Dykstra
Golden Life AFC, LLC
4386 14 Mile Rd, NE
Rockford, MI 49341

RE: License #: AL590398548
Investigation #: 2021A0584026
Golden Life AFC #3

Dear Mr. 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.
- 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.

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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) 284-9727.

Sincerely,

Candace L. Pilarski

Candace Pilarski, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 243-7590

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL590398548
Investigation #:	2021A0584026
Complaint Receipt Date:	08/05/2021
Investigation Initiation Date:	08/05/2021
Report Due Date:	10/04/2021
Licensee Name:	Golden Life AFC, LLC
Licensee Address:	4386 14 Mile Rd, NE Rockford, MI 49341
Licensee Telephone #:	(616) 307-7719
Administrator:	Megan Lilly
Licensee Designee:	Mike Dykstra, Designee
Name of Facility:	Golden Life AFC #3
Facility Address:	8675 S. Grow Road Greenville, MI 48838
Facility Telephone #:	(616) 225-2649
Original Issuance Date:	07/22/2019
License Status:	REGULAR
Effective Date:	01/22/2020
Expiration Date:	01/21/2022
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had multiple trips to the ER in the month of July 2021 and Resident B was in the hospital July 23, 2021. Concerns multiple resident's incident reports are not being reported.	Yes

III. METHODOLOGY

08/05/2021	Special Investigation Intake 2021A0584026
08/05/2021	Special Investigation Initiated - Letter email to Jennifer Browning, License Consultant
08/13/2021	Contact - Telephone call received From Angela Loiselle, Montcalm CMH Recipient Rights
09/01/2021	Contact - Face to Face With Resident A
09/01/2021	Contact - Face to Face With Guardian A-1
09/01/2021	Contact - Face to Face With Megan Lilly, Administrator
09/02/2021	Contact - Telephone call received From Guardian A-1
09/22/2021	Exit Conference Via phone, left message to Mike Dykstra, licensee designee

ALLEGATION:

Resident A had multiple trips to the ER in the month of July 2021 and Resident B was in the hospital July 23, 2021. Concerns multiple resident incident reports are not being reported.

INVESTIGATION:

On September 1, 2021, I conducted an unannounced inspection at Golden Life #3 located at 8675 S. Grow Road Greenville, MI 48838. I met with Megan Lilly, administrator of the home. Ms. Lilly provided me with Resident A's and Resident B's resident files. I reviewed Resident A's *AFC Incident/Accident Report- BCAL-4607* forms that were in the file. Resident A's file had two incident reports for the month of July 2021 where he went to the hospital emergency room. The two incident reports had written documentation they were faxed to BCHS in Mt. Pleasant. Ms. Lilly stated there was a couple of other times that Resident A did go to the ER and that Guardian A-1 took him. Ms. Lilly admitted she did not do any incident reports when the guardian took him in. Ms. Lilly was provided technical assistance regarding the requirements for incident reporting and she stated she has not been on top of getting those out. Ms. Lilly was given consultation regarding filing incident reports and she copied the rule out of my rule book to review. Ms. Lilly stated that she has missed three incident reports in July 2021. Ms. Lilly stated she knows there are two for Resident A she has not filed and one for Resident B she did not file. Ms. Lilly was informed that there may be different rules regarding incident reporting for any responsible agencies that are involved with residents in the home. Ms. Lilly understood the rule she was provided by me pertains to reports that our department requires to receive.

I reviewed Resident B's *AFC Incident/Accident Report- BCAL-4607* forms section in his file. One incident report was found that listed he went the emergency room in early July 2021. Ms. Lilly stated that Resident B was in the hospital and she completed an incident report on his last stay which was July 29. Ms. Lilly found Resident B's incident report near the fax and she realized she sent it. Ms. Lilly stated that Resident B was in the hospital a second time later in the month and then released back to the home. Ms. Lilly stated Resident B was at the home only a few minutes before he went out the door. Ms. Lilly stated she informed the police Resident B left and they told her they had picked him up. Ms. Lilly stated that Resident B is incarcerated as of this date and will not be returning back to the home.

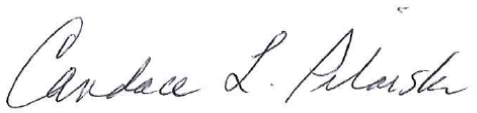
On September 1, 2021, I saw Resident A face-to-face, but did not interview him. Resident A was in the home's office having a virtual doctor's visit. Guardian A1 was with him. Ms. Lilly stated she will have Guardian A1 call me on a different day since I told Ms. Lilly I did not wish to disturb them during their appointment.

On September 2, 2021, I conducted a phone interview with Guardian A1. Guardian A1 stated that Resident A went to the ER four times in July 2021 that she can recall. She did not have the exact dates. Guardian A1 stated she took Resident A in twice. Guardian A1 stated she is very happy with the care the home provides Resident A and has no complaints.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	Ms. Megan Lilly, administrator, and I reviewed the resident files of Resident A and Resident B to locate *AFC Incident/Accident Report- BCAL-4607* forms. After reviewing the files and talking with Guardian A1, it was discovered that two incident reporting forms were not completed or sent to the department. Ms. Lilly found that one report regarding Resident B going to the hospital was not sent in as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

After receiving an acceptable corrective action plan, I recommend no change in the status of this license.



9/23/2021

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Candace Pilarski Date
Licensing Consultant

Approved By:

10/04/2021

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Dawn N. Timm Date
Area Manager