GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 2, 2021

Jennifer Spomer
3169 County Rd 451
ROGERS CITY, MI 49779

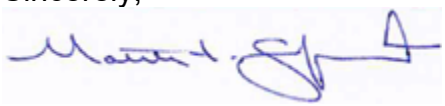
RE: License #: AS710386919
Investigation #: 2021A0360036
Jen's AFC

Dear Ms. Spomer:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 .

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS710386919
Investigation #:	2021A0360036
Complaint Receipt Date:	09/07/2021
Investigation Initiation Date:	09/07/2021
Report Due Date:	11/06/2021
Licensee Name:	Jennifer Spomer
Licensee Address:	3169 County Rd 451 ROGERS CITY, MI 49779
Licensee Telephone #:	(989) 734-0284
Administrator:	Jen Spomer
Licensee Designee:	N/A
Name of Facility:	Jen's AFC
Facility Address:	207 Larke Ave Rogers City, MI 49779
Facility Telephone #:	(989) 474-9028
Original Issuance Date:	05/31/2017
License Status:	REGULAR
Effective Date:	11/30/2019
Expiration Date:	11/29/2021
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was given the wrong medication and was hospitalized.	No

III. METHODOLOGY

09/07/2021	Special Investigation Intake 2021A0360036
09/07/2021	Special Investigation Initiated - On Site Resident A, DCS Samantha Holtz
09/07/2021	Contact - Telephone call received licensee Jen Spomer
11/2/2021	Exit Conference With licensee Jen Spomer

ALLEGATION: Resident A was given the wrong medication and was hospitalized.

INVESTIGATION: On 9/7/2021 I was assigned a complaint from the LARA online complaint system.

On 9/7/2021 I conducted an unannounced onsite inspection at the facility. Resident A stated he was hospitalized a couple of weeks ago on August 19, 2021. He stated he was having having suicidal thoughts and became light-headed and couldn't remember very much of what happened. He denied being given the wrong medication. He stated he may have said something about getting the wrong medication to the hospital staff but stated he didn't really remember. He stated he is not aware of any medication errors that occurred that led to his hospitalization. He stated it was because of his suicidal thoughts and passing out.

While at the facility on 9/7/2021 I interviewed the direct care staff Samantha Holtz. Ms. Holtz stated she was not aware of any medication errors that occurred. She provided the August 2021 medication administration record for Resident A. There were no medication errors listed and all medications were documented that they were administered as prescribed. Ms. Holtz also provided the incident report from 8/19/2021. It documented that Resident A had passed out and an ambulance was called, and he was hospitalized. There was no documentation of any medication errors.

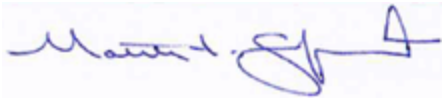
On 9/7/2021 I was contacted by the licensee Jen Spomer. Ms. Spomer stated she was not aware of any medication errors for Resident A. She stated he was hospitalized for mental health issues after having passed out and the ambulance getting called on 8/19/2021.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	The complaint alleged that Resident A was given the wrong medication and was hospitalized. Resident A was hospitalized on 8/19/2021 after passing out and having suicidal thoughts. He denied being administered the wrong medication but stated he may have told hospital staff that he received the wrong medication. Direct care staff Samantha Holtz provided Resident A's medication administration record which documented he received all medication as prescribed. The licensee Jen Spomer denied there was any medication errors for Resident A. There is not a preponderance of evidence that Resident A was hospitalized after receiving the wrong medication.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 11/2/2021 I conducted an exit conference with the licensee Jen Spomer. Ms. Spomer stated she concurred with the findings of the investigation.

IV. RECOMMENDATION

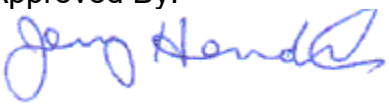
I recommend no change in the status of the license.



11/02/2021

Matthew Soderquist Date
Licensing Consultant

Approved By:



11/02/2021

Jerry Hendrick Date
Area Manager