GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 27, 2022

Michael Clark
Northern Springs Management Co.
6361 Myers Rd. NE
Kalkaska, MI 49646

RE: License #: AL400294299
Investigation #: 2022A0870028
Meadow View AFC

Dear Mr. Clark:

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 #:	AL400294299
Investigation #:	2022A0870028
Complaint Receipt Date:	05/20/2022
Investigation Initiation Date:	05/20/2022
Report Due Date:	07/19/2022
Licensee Name:	Northern Springs Management Co.
Licensee Address:	6361 Myers Rd. NE Kalkaska, MI 49646
Licensee Telephone #:	(231) 632-7565
Administrator:	Michael Clark
Licensee Designee:	Michael Clark
Name of Facility:	Meadow View AFC
Facility Address:	5536 Gonyer Road Fife Lake, MI 49633
Facility Telephone #:	(231) 879-4023
Original Issuance Date:	08/01/2008
License Status:	REGULAR
Effective Date:	02/01/2021
Expiration Date:	01/31/2023
Capacity:	15
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
On April 15, 2022, AFC staff did not check on Resident A for an extended amount of time, which led to medical complications following a heart attack.	No
AFC staff did not provide Resident A with his medications as ordered.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/20/2022	Special Investigation Intake 2022A0870028
05/20/2022	APS Referral This referral came from the Michigan Department of Health and Human Services, Centralized Intake unit, who declined to investigate.
05/20/2022	Special Investigation Initiated - Telephone Telephone discussion with Kalkaska County Adult Services worker Kelly Schwab.
05/23/2022	Inspection Completed On-site Interviews conducted with staff and facility residents.
06/24/2022	Contact - Telephone call made Telephone interview with Monica Crain.
06/24/2022	Exit Conference Completed with Licensee Designee Mike Clark.
06/24/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On April 15, 2022, AFC staff did not check on Resident A for an extended amount of time, which lead to medical complications following a heart attack.

INVESTIGATION: On May 20, 2022, I spoke with Kalkaska County Department of Health and Human Services (DHHS), Adult Services worker Kelly Schwab. Ms. Schwab stated she does not currently have an active DHHS adult services case with

Resident A and could not provide any information to this consultant regarding these allegations.

On May 23, 2022, I conducted an unannounced on-site special investigation at the Meadow View AFC home. I spoke with home manager Lynette Thompson and informed her of the above allegations. Ms. Thompson noted that the incident with Resident A occurred five weeks prior to this day and exact details of events may be difficult to remember. She noted that she worked the morning of April 15, 2022, arriving at approximately 6:30 a.m. Ms. Thompson recalled seeing Resident A upon her arrival, as he was in the bathroom, and observed him walk back to his bedroom. She noted she was surprised to see Resident A as he had left the day prior to spend the night, (April 14, 2022) with a friend in Traverse City, and she did not anticipate that he would be home that morning. Ms. Thompson stated that she did not see or speak with Resident A the rest of that morning. She stated that she left the home at 11:00 a.m. and was relieved by staff member Val Silvercrow, who worked from 11:00 a.m. to 9:00 p.m. She further noted that it is not unusual for Resident A to sleep through breakfast. Ms. Thompson stated she did not dispense any medications to Resident A that morning as Ms. Silvercrow had provided Resident A with his April 15th morning medications the afternoon of the day prior, April 14th, when he left the home for what he stated would be an overnight away from the facility. She stated she does not know if Resident A took his medications the morning of April 15, 2022. Ms. Thompson stated she was informed that Ms. Silvercrow went to check on Resident A shortly after 11:00 a.m. to ask him if he wanted lunch, found him on the floor and called 911 immediately thereafter.

On May 23, 2022, I conducted an in-person interview with staff member Val Silvercrow. Ms. Silvercrow stated she worked on April 14, 2022, the day Resident A left to spend the night away from the facility. She noted that Resident A left the facility “around 1:00 p.m.” stating that he was walking to Kalkaska to a friends’ home, and then they would be going to Traverse City, where he had an appointment with an oral surgeon later that afternoon. Ms. Silvercrow stated Resident A informed her that he would be spending the night in Traverse City and would return the next day, April 15th. She stated that she provided Resident A with his medications for the evening of April 14, and the morning of April 15, 2022, “the time he said he would be gone” from the facility. Ms. Silvercrow stated that Resident A unexpectedly returned to the facility “around 8:00 p.m.” on April 14th and that he informed her that he had already taken his evening medications. She stated she did not ask Resident A about the medications she provided to him for April 15th, nor request that he return them to her. Ms. Silvercrow stated Resident A had a snack and “seemed a bit strange” but he “did not smell drunk.” She noted he informed her that “he was alright.” Ms. Silvercrow stated that she went downstairs to her apartment noting Resident A and “a couple other residents” were still up watching TV. Ms. Silvercrow stated she began her next shift at 11:00 a.m. on April 15, 2022, and went to check on Resident A around 11:30 a.m. She stated she found Resident A on the floor of his bedroom leaning against a nightstand with what looked like vomit on the floor, she shook him, and when he did not respond she called 911.

On May 23, 2022, I conducted an in-person interview with Resident B. Resident B stated he shares a bedroom with Resident A. He noted that he woke up on April 15, 2022, around 8:00 a.m. and observed that Resident A was laying on the floor. Resident B stated he heard Resident A snoring and believed that he was sleeping, noting "I didn't think anything of it" as Resident A sleeps "on the floor that way all the time." Resident B stated it is not unusual for Resident A to sleep late into the day, through breakfast as Resident A is "up all night and sleeps all day."

On May 23, 2022, I conducted a telephone interview with Licensee Designee Michael Clark. I informed Mr. Clark of the above allegations. Mr. Clark noted that Resident A is a "parolee" and is allowed to be away from the facility overnight. He provided contact information for Resident A's parole agent.

On June 24, 2022, I conducted a telephone interview with Monica Crain. Ms. Crain stated she is Resident A's Reentry Program caseworker. She confirmed that Resident A is allowed to go unsupervised into the community, including overnights. Ms. Crain informed me that Resident A had cannabis and benzodiazepine in his system when he was hospitalized on April 15, 2022. She stated she has been to the Meadowview AFC home on multiple occasions and has "no issues with the care the facility provided to (Resident A)." Ms. Crain stated she feels that they do a "really goo job" with the parolees she has placed in the facility over the years and has "never had a concern with Meadowview AFC." She further stated that "what happened to (Resident A)", which led to his hospitalization on April 15, 2022, "was not the AFC's fault, it was (Resident A's)."

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Staff member Val Silvercrow, upon discovery of Resident A needing medical attention, called 911, seeking emergency medical care for Resident A. The Licensee did treat Resident A with dignity, providing protection and safety to him when he was discovered to require emergency medical care.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Staff member Val Silvercrow, upon discovery of Resident A needing medical attention, called 911, seeking emergency medical care for Resident A. The Licensee did seek and obtain needed care immediately upon discovering that Resident A was in need to emergency medical care.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: AFC staff did not provide Resident A with his medications as ordered.

INVESTIGATION: Ms. Silvercrow stated she provided Resident A with his medications for the morning of April 15, 2022, on the afternoon of April 14, 2022, as he stated he would be gone from the facility overnight. She noted that he unexpectedly returned at approximately 8:00 p.m. on April 14, 2022. Ms. Silvercrow stated she did not ask Resident A about the medications she provided to him for April 15th, nor request that he return them to her.

Ms. Thompson stated she did not dispense any medications to Resident A the morning of April 15, 2022, as Ms. Silvercrow had provided Resident A with his April 15th morning medications the afternoon of the day prior, April 14, 2022.

Ms. Thompson provided me with Resident A's April 2022, medication records. I noted that this record states Resident A has nine prescription medications that are to be dispensed at 8:00 a.m. She noted that his medication containers are no longer at the facility as he was hospitalized a month ago and is not expected to return.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	According to Resident A's medication record, he is to be provided with nine prescription medications at 8:00 a.m. Ms. Thomson, who worked from approximately 6:30 a.m. until 11:00 a.m. on April 15, 2022, states she did not dispense any medications to Resident A the morning of April 15, 2022. The facility staff did not give Resident A his medications pursuant to label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

Ms. Silvercrow stated she did not ask Resident A about the medications she provided to him for April 15th, nor request that he return them to her when he returned to the home the evening of April 14, 2022.

APPLICABLE RULE	
R 400.15312	**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:	Ms. Silvercrow did not request or obtain Resident A's prescription medications so she could lock them in the facility medication cabinet.
CONCLUSION:	**VIOLATION ESTABLISHED**

On June 24, 2022, I conducted an exit conference with Licensee Designee Michael Clark. I explained my findings as noted above. Mr. Clark stated he understood and that he would submit a corrective action plan to address the noted established rule violations. He had no further questions concerning this special investigation.

IV. RECOMMENDATION

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

June 27, 2022

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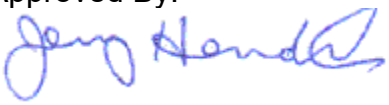
Bruce A. Messer Date
Licensing Consultant

Approved By:



June 27, 2022

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Jerry Hendrick Date
Area Manager