GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 3, 2022

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

RE: License #: AM400282377
Investigation #: 2022A0870037
Walnut Street 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 #:	AM400282377
Investigation #:	2022A0870037
Complaint Receipt Date:	09/08/2022
Investigation Initiation Date:	09/08/2022
Report Due Date:	11/07/2022
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:	Walnut Street AFC
Facility Address:	417 Walnut St. Kalkaska, MI 49646
Facility Telephone #:	(231) 258-9478
Original Issuance Date:	08/25/2006
License Status:	REGULAR
Effective Date:	03/27/2021
Expiration Date:	03/26/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's discontinued medications were not properly disposed of.	Yes
Resident A's medications were not dispensed as ordered, as the licensee has an excessive amount of several different prescription medications on hand in the facility or did not have medications that were prescribed.	Yes

III. METHODOLOGY

09/08/2022	Special Investigation Intake 2022A0870037
09/08/2022	Special Investigation Initiated - Telephone Email sent to NCCMH Caseworker Kim Liverance.
09/13/2022	Inspection Completed On-site Interview with Licensee Designee Mike Clark and staff members Cody Gehl-Thompson and Sara Ryan.
09/13/2022	Exit Conference Completed with LD Mike Clark.
09/13/2022	Inspection Completed-BCAL Sub. Compliance
09/16/2022	APS Referral APS referral made by NCCMH was confirmed by this Consultant.
09/16/2022	Contact – Telephone call made Case discussion with Kalkaska PD officer Ghayge Toomey.

ALLEGATION:

- **Resident A's discontinued medications were not properly disposed of.**
- **Resident A's medications were not dispensed as ordered, as the licensee has an excessive amount of several different prescription medications on hand in the facility or did not have medications that were prescribed.**

INVESTIGATION: On September 8, 2022, I conducted an interview with North Country Community Mental Health Authority caseworker Kim Liverance. Ms. Liverance stated she had recently relocated Resident A from the Walnut AFC home, and when doing so, noted that facility staff member Sara Ryan had given her a bag of Resident A's medications containing several different medications which had been discontinued. She also noted that she was provided with many medications for which the facility had an excessive amount on hand. Ms. Liverance further stated she was not provided with two medications that were prescribed and should have been provided to Resident A. Ms. Liverance stated this led her to believe that perhaps the facility was not properly dispensing medications to Resident A.

Late this same day Ms. Liverance provided me with a list of Resident A's medications that she had received from the facility, the amounts received and a notation as to whether they had been discontinued. Notable entries on this list include:

Lorazepam 1 mg – PRN 1 daily – prescription missing and last filled on August 22, 2022.

Senna Tabs 8.6 mg – PRN 2-3 daily – Missing for current month, last filled April 21, 2022.

Clonidine .2 mg – 1 pill twice daily – filled on December 20, 2021, with 21 pills remaining, January 27, 2022, with 44 pills remaining, February 24, 2022, with 16 pills remaining, March 24, 2022, with 48 pills remaining, June 16, 2022, with 28 pills remaining, July 14, 2022, with 54 pills remaining, August 12, 2022, with 43 pills remaining.

Simvastatin 40 mg – 1 pill daily – filled on July 11, 2022, with 2 pills remaining and August 12, 2022, with 30 pills remaining. This medication had been discontinued/

Omeprazole 40 mg – 1 pill daily – filled on July 14, 2022, with 10 pills remaining and August 12, 2022, with 27 pills remaining.

Movantik 25 mg – 1 pill daily – filled on July 14, 2022, with 9 pills remaining and August 12, 2022, with 27 pills remaining.

Loratadine 10 mg – 1 pill daily, filled on August 12, 2022 ,with 18 pills remaining. This medication had been discontinued.

Oxybutin 10 mg – 1 pill daily, filled on December 2021, January, February, March, June and August 2022. This medication had been discontinued.

On September 13, 2022, I conducted a special investigation at the Walnut AFC home. I met with Licensee Designee Mike Clark, staff member Kody Gehl-Thompson and later with staff member Sara Ryan, who was at another facility during that interview. Ms. Ryan stated that when Resident A's caseworker arrived to pick her up on September 1, 2022, she gave the caseworker, Ms. Liverance, all of Resident A's medications and that Mr. Gehl-Thompson gave her Resident A's medication log. Ms. Ryan noted that Ms. Liverance did not request to "go through" or audit, the medications prior to leaving. Mr. Clark, Mr. Ryan and Mr. Gehl-Thompson had no explanation for the large number of excess medications, as noted above, and stated that they "did not notice" the discontinued medications were being kept in the facility. Mr. Gehl-Thompson stated that he began his employment at this facility on August 1, 2022 and had been concentrating on cleaning up the house and had not noticed the excessive medications being stored in the facility. Mr. Clark noted that he recently terminated the employment of all of the facility staff just prior to Mr. Gehl-Thompson being hired, and thus there are no present employees who might explain the discrepancies in Resident A's medications.

Mr. Clark provided me copies of Resident A's medication administration logs for June, July and August 2022. The medication logs indicate all medications listed as being administered, except those listed as discontinued.

Resident A has been relocated out of the area and was thus unavailable to be interviewed.

On September 16, 2022, I confirmed with Michigan Department of Health and Human Services Adult Protective Services (APS) staff that a referral to APS, regarding these allegations, had been made.

On September 16, 2022, I spoke with officer Ghayge Toomey of the Kalkaska Police Department. He stated he is conducting an investigation into the alleged missing medications as one of the medications, Ativan, is a "controlled substance" and is noted as being missing and unaccounted for.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions. **(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.**

ANALYSIS:	The licensee had a large number of discontinued prescription medications at the facility which were prescribed for Resident A. The Licensee had several months' worth of multiple prescription medications at the facility for Resident A. Licensee Designee Mike Clark had no explanation as to why he had these excessive amounts of medications Resident A's medications were not being given pursuant to label instructions. The facility failed to properly dispose of Resident A's medications after those medications were discontinued.
CONCLUSION:	**VIOLATION ESTABLISHED**

On September 13, 2022, I conducted an exit conference with Licensee Designee Mike Clark. I explained my findings as noted above. Mr. Clark stated he understood. I provided Mr. Clark with technical assistance and consultation regarding rules related to resident medication administration, storage and disposal. Mr. Clark stated he would develop a corrective action plan based on our discussions and submit that plan within 15 days of this report.

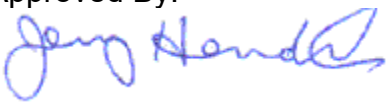
IV. RECOMMENDATION

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

October 3, 2022

Bruce A. Messer — Date
Licensing Consultant

Approved By:



October 3, 2022

Jerry Hendrick — Date
Area Manager