GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 5, 2024

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

RE: License #: AL590398548
Investigation #: 2024A0622005
Golden Life AFC #3

Dear Mr. Dykstra:

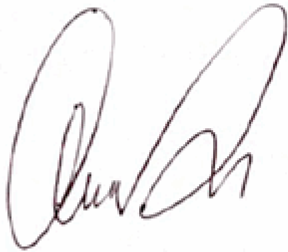
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- 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 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.

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,



Amanda Blasius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL590398548
Investigation #:	2024A0622005
Complaint Receipt Date:	12/26/2023
Investigation Initiation Date:	12/27/2023
Report Due Date:	02/24/2024
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
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:	01/22/2022
Expiration Date:	01/21/2024
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
DCW Ugeania Powers admitted to giving the wrong medication to a resident.	Yes

III. METHODOLOGY

12/26/2023	Special Investigation Intake 2024A0622005
12/27/2023	Special Investigation Initiated - Telephone Telephone call with Recipient Rights officer Milessa Leach.
01/02/2024	Contact-Telephone call made to Relative A1
01/03/2024	Contact-Telephone call with DCW Ugeania Powers.
01/03/2024	Inspection completed onsite. Interviewed administrator Megan Lilly and Resident A.
01/04/2024	APS Referral Sent.
02/05/2024	Exit conference with administrator, Joanne Broidrick

ALLEGATION: Direct Care Worker (DCW), Ugeania Powers admitted to giving the wrong medication to a resident.

INVESTIGATION:
On 12/27/2023, I interviewed recipient rights officer, Milessa Leach via phone. Ms. Leach reported that DCW Powers admitted to giving the wrong medications to Resident A. She ended up giving Resident A, eight medications that belonged to Resident B. Ms. Leach reported that she reviewed the medication check out process for Golden Life #3 and learned a check out process is not in place currently. Ms. Leach stated that she is requesting that a medication check out and check in process be implemented. Ms. Leach also stated that she will be conducting additional training for direct care staff members at the facility due to the medication error.

On 12/27/2023, I reviewed medication administration records (MARS) documentation for Resident A, which confirmed Resident A takes Zenpep Cap 3000 with each meal three times a day. DCW Powers, Ms. Lilly, Relative A1 and Resident

A all confirmed that Resident A missed his 12pm dose of Zenpep Cap 3000 on 12/16/2023 because the medication was not available to him while he was with his family.

On 12/27/2023, I also reviewed training documentation for DCW Powers which verified DCW Powers completed basic health and medication training on 11/18/2019 and part 1 of medication administration classroom training on 12/15/2023. I also observed five medication administration employee observation checklists dated between 2019-2023. DCW Powers completed a medication classroom training on 12/15/2023, which was the day before the medication error occurred on 12/16/2023.

On 01/02/2024, I interviewed Relative A1 via phone. Relative A1 reported that she takes Resident A home each Saturday at 10am. On 12/16/2023, she picked up Resident A from Golden Life #3 around 10am. At 2pm, on 12/16/23, Relative A1 went to give Resident A his medications and Resident A stated that it was not his medication. Relative A1 reported she reviewed the medications and determined the medications belonged to another resident within the AFC Golden Life #3. Relative A1 reported that she had eight prescribed medications for Resident B. Relative A1 called the facility to inform them of the medication error. She stated that she spoke with Ms. Lilly who offered to meet her half way to correct the medication error. Relative A1 reported that she declined the offer, as she lives two hours from Golden Life #3. Relative A1 stated that she returned Resident A to the facility by 5pm, so Resident B would not miss his 5pm medication. Relative A1 stated due to the medication error, Resident B’s confidentiality was breached.

On 01/03/2024, I interviewed DCW Ugeania Powers via phone. She reported that Resident A was leaving for the day to visit family and he needed to have his medications checked out for the day. DCW Powers reported that she was “busy preparing lunch and helping other residents at the same time.” DCW Powers stated she grabbed the mediations and gave them to Resident A. DCW Powers explained that Ms. Lilly received a call around 2pm from Relative A1 reporting she was not given Resident A’s medications rather she was given Resident B’s medications. DCW Powers reported that Ms. Lilly offered to bring the correct medication to Resident A. DCW Powers stated, "I’m taking full responsibility. Should have slowed down and check the meds. It is my fault.”

On 01/03/2024, I interviewed Resident A in person. Resident A reported that on 12/16/2023, he was given Resident B’s medications when he was leaving to visit family for the day. Resident A explained that he was not aware of the error until he was given his medication at 2pm at his family home. Resident A stated that he noticed it was not the same color pill that he was used to taking and he informed Relative A1. Resident A stated Relative A1 then reviewed all the medications and it was confirmed that they all belonged to Resident B. Resident A stated that Relative A1 called the facility and talked with staff member B.

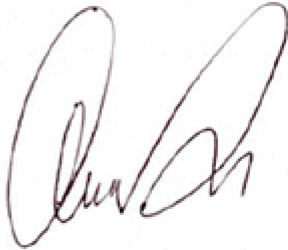
APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to the label instructions. **(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.**
ANALYSIS:	Due to the medication error on 12/16/2024, Resident A missed his noon medication administration as his family was given the wrong medications to administer. DCW Ugeania Powers admitted to giving the wrong medications to Resident A which caused resident A to miss a dose of his Zenpep. DCW Powers was not following the six rights of medication administration when preparing Resident A’s medication. DCW Powers did not confirm that Resident A had the appropriate medication before providing him his medication for the day.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(q) The right to confidentiality of records as stated in section 12(3) of the act.**

	(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.
ANALYSIS:	Based on interviews with staff, Ms. Leach, Relative A1 and Resident A it was confirmed that Resident A was given Resident B’s medications. Due to the medication error, Resident B’s right to confidentiality was breached as Relative A1 was inadvertently given access to Resident B’s private medical information.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

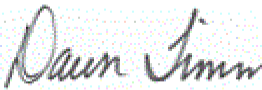
Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.



02/05/2024

Amanda Blasius Date
Licensing Consultant

Approved By:



02/05/2024

Dawn N. Timm Date
Area Manager