GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 7, 2024

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

RE: License #: AM590395969
Investigation #: 2024A1029019
Golden Life AFC #2

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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM590395969
Investigation #:	2024A1029019
Complaint Receipt Date:	12/11/2023
Investigation Initiation Date:	12/13/2023
Report Due Date:	02/09/2024
Licensee Name:	Golden Life AFC, LLC
Licensee Address:	4386 14 Mile Rd, NE, Rockford, MI 49341
Licensee Telephone #:	(616) 307-7719
Administrator:	Mike Dykstra
Licensee Designee:	Mike Dykstra
Name of Facility:	Golden Life AFC #2
Facility Address:	503 W. Montcalm, Greenville, MI 48838
Facility Telephone #:	(616) 232-2584
Original Issuance Date:	01/22/2019
License Status:	REGULAR
Effective Date:	07/22/2023
Expiration Date:	07/21/2025
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

ALLEGATION(S)

	Violation Established?
Direct care staff member Laura Kelly appears to be under the influence during her shift at Golden Life AFC #2.	No
There are medication errors at Golden Life AFC #2. 1. On December 1, 2023, direct care staff member Caitlin Marvin administered Resident A's Klonopin 5 MG in the AM instead of the PM as prescribed. 2. On December 19, 2023, direct care staff member Stacy Veltkamp administered Resident A's Klonopin 5 MG in the AM instead of the PM as prescribed. 3. Direct care staff member Laura Kelly failed to administer Resident A's Biofreeze to Resident A.	Yes Yes No

II. METHODOLOGY

12/11/2023	Special Investigation Intake 2024A1029019
12/13/2023	Special Investigation Initiated – Letter ORR Cecelia McIntyre
12/13/2023	Contact - Telephone call made Cecelia McIntyre
12/18/2023	Contact - Document Sent to Cecelia McIntyre ORR
12/27/2023	Contact - Document Received - Additional concerns received regarding another medication error.
01/02/2024	Inspection Completed On-site Contact - Face to Face with direct care staff members Heather Gorsuch and Ms. Stacey Veltkamp at Golden Life AFC #2.
01/11/2024	APS Referral made to Centralized Intake
01/23/2024	Contact - Telephone call made to direct care staff member Caitlyn Marvin and Trysta Gorsuch
01/30/2024	Contact – Telephone call made to direct care staff member Laure Kelly (Left message), Stacy Veltkamp, ORR Milessa Leach, ORR Cecelia McIntyre (left message), Resident A, Resident B
01/31/2024	Contact – Telephone call from ORR Cecelia McIntyre
01/31/2024	Contact – Telephone call to licensee designee Mike Dykstra

01/31/2024	Exit conference with licensee designee Mike Dykstra

ALLEGATION: Direct care staff member Laura Kelly appears to be under the influence during her shift at Golden Life AFC #2.

INVESTIGATION:

On December 11, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system regarding alleging that direct care staff member Laura Kelly acts like she is under the influence of alcohol while she is providing care to residents.

On January 23, 2024, I interviewed direct care staff member Caitlyn Marvin. Ms. Marvin stated she works with Ms. Kelly a few times per week. Ms. Marvin stated she was unable to give any specific incidents of Ms. Kelly acting under the influence of substances while at work. Ms. Marvin stated she has never smelled alcohol or any other type of substance on Ms. Kelly while she is working with residents.

On January 23, 2024, I interviewed direct care staff member whose current role is Training and Development Manager for Golden Life, Trysta Gorsuch. Ms. T. Gorsuch stated she has never had any concerns that Ms. Kelly was under the influence of substances while she was working. Ms. T. Gorsuch stated she has never smelled any substances on her or had any concerns with her interactions with the residents and she did “very well with the residents.”

On January 30, 2024, I interviewed direct care staff member whose role is Stacy Veltkamp. Ms. Veltkamp stated she has never observed Ms. Kelly acting like she was intoxicated while working. Ms. Veltkamp stated she has never smelled any alcohol on her or saw her using substances while she was working.

On January 30, 2024, I interviewed Resident A and Resident B. Both residents stated they had no concerns about any of the direct care staff members being under the influence while working. Both Resident A and Resident B denied they smelled alcohol or any other substance on Ms. Kelly when she was working or have witnessed any suspicious behaviors to make them think she was under the influence.

On January 31, 2024, I interviewed licensee designee Mike Dykstra who denied having any knowledge of Ms. Kelly coming to work under the influence of alcohol.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications:

	(b) Be capable of appropriately handling emergency situations.
ANALYSIS:	Based on interviews with Ms. Marvin, Ms. T. Gorsuch, and Ms. H. Gorsuch, there is no indication Ms. Kelly has been under the influence of substances while she was working at Golden Life AFC #2. Resident A and Resident B both stated they had no concerns because they have never smelled alcohol on Ms. Kelly or witnessed any suspicious behavior that would lead them to believe she was under the influence.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There are medication errors at Golden Life AFC #2.

- **On December 1, 2023, direct care staff member Caitlin Marvin administered Resident A's Klonopin 5 MG in the AM instead of the PM as prescribed.**
- **On December 19, 2023, direct care staff member Stacy Veltkamp administered Resident A's Klonopin 5 MG in the AM instead of the PM as prescribed.**
- **Direct care staff member Laura Kelly failed to administer Resident A's Biofreeze to Resident A.**

INVESTIGATION:

<u>December 1, 2023 Klonopin error</u>

On December 11, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns there was suspicion that direct care staff member Laura Kelly signed direct care staff member Caitlin Marvin's name on a narcotic count for December 1, 2023 which showed Resident A was administered her Klonopin in the AM instead of the PM as prescribed.

On December 13, 2023, I interviewed Community Mental Health Office of Recipient Rights (ORR) advisor, Cecelia McIntyre. Ms. McIntyre stated she completed an on-site investigation and although there were concerns regarding medication administration, Ms. McIntyre stated she confirmed Ms. Marvin signed narcotic count sheets as scheduled.

On December 18, 2023, I received an email from ORR Ms. McIntyre who stated she interviewed Resident A at Golden Life AFC #2 who reported she always received her medications as prescribed. Ms. McIntyre stated she also interviewed Ms. Kelly who denied signing any other direct care staff members name on the medication administration records or narcotic count sheets.

On January 2, 2024, I completed an unannounced on-site investigation at Golden Life #2 and met with direct care staff member Heather Gorsuch. Ms. Gorsuch stated Ms. Marvin was logged in as the direct care staff member to administer medications for the full day on November 30, 2023 and administered the 7 AM medications because Laura Kelly was late for work on the morning of December 1, 2023. During this timeframe, Ms. Marvin administered Resident A's Klonopin in the AM instead of at night on December 1, 2023. According to the medication count sheet, on November 30, 2023 Resident A's Klonopin was never documented on the narcotics count sheet showing she received the medications. I also reviewed Resident A's December 2023 MAR which indicated direct care staff member Brandon Boik also administered Resident A's medication the evening of December 1, 2023 which caused Resident A to have two doses of the medication instead of one as prescribed.

I also reviewed the narcotic count sheet for this time period and confirmed Ms. Marvin's initials were documented for December 1 at 7 AM. I also observed a note that the Klonopin medication is off by 1 showing she was given an extra dose of Klonopin during this timeframe on the morning of December 1, 2023.
The following narcotic counts were listed for Resident A's Klonopin:
November 29 7 PM – 19 – Initialed by CM
November 30 There was no count or initials for this day.
December 1 - 7 AM 18 Initialed CM
December 1 - 7 PM – 16 - Initialed by Brandon Boik

I reviewed the prescription order for Resident A and confirmed Resident A is supposed to receive Klonopin .5 MG tab one tablet by mouth at bedtime.

I received a copy of the Golden Life *AFC Complaint / Concern Form* dated December 5, 2023 and written by Stacy Veltkamp with the following complaint:

> *"Ms. Marvin thinks Ms. Kelly forged her initials on December 1, 2023.*
>
> *What was done to solve the concern:*
>
> *I [Ms. Veltkamp] looked into the concern and found that Ms. Marvin had worked on December 1, 2023 the time of the said forgery and indeed had passed the medication and initiated the narc book. Ms. Kelly was late that morning and that was why Ms. Marvin passed the medication."*

On January 23, 2024, I interviewed direct care staff member whose current role is Training and Development Manager for Golden Life. Trysta Gorsuch. Ms. T. Gorsuch stated she does not have concerns that Ms. Marvin's initials were forged because she was the one administering medications at that time. Ms. T. Gorsuch stated Ms. Marvin refused to attend medication administration training after this incident and she did not show for her next two scheduled shifts.

On January 23, 2024, I interviewed former direct care staff member Ms. Marvin. Ms. Marvin stated she did not have the Klonopin to administer on November 30, 2023

because no one ordered it and it did not come on time. Ms. Marvin stated it came later that night around 12:30 AM to the facility but since it was too late to give it to her, she did not administer the medication. Ms. Marvin stated Ms. Kelly was late to work so she was going to administer medications for her but Ms. Kelly arrived at around 7:30 AM and administered the medications. Ms. Marvin stated she did not recall any incident when Resident A received her Klonopin in the AM instead of in the PM as prescribed. Ms. Marvin denied making an error and administering the medication at the wrong time.

On January 30, 2024, I interviewed direct care staff member whose current role is home manager, Ms. Veltkamp. Ms. Veltkamp stated there was an incident when Resident A received her Klonopin medication on December 1, 2023 during the AM instead of PM when Ms. Marvin was administering her medications. Ms. Veltkamp stated Ms. Marvin did not want to be blamed for the medication error and told everyone Ms. Kelly forged her name so she would not get in trouble. Ms. Veltkamp was able to confirm Ms. Marvin administered all Resident A's medications on December 1, 2023 at 7 AM. Ms. Veltkamp also confirmed direct care staff member Mr. Boik also administered the Klonopin medication as prescribed at 7 PM on December 1, 2023 as the MAR shows causing Resident A to have two doses instead of one.

On January 30, 2024, I interviewed Resident A. Resident A stated she does not remember a time where her medications were given at the wrong time.

On January 31, 2024, I interviewed licensee designee Mike Dykstra who was aware of the medication error on December 1, 2023 from Ms. Marvin. Mr. Dykstra stated he was aware Ms. Marvin stated another direct care staff member was forging her name so she would not be held accountable. Mr. Dykstra stated Ms. Marvin has been terminated as an employee at Golden Life AFC #2.

December 19, 2023 Klonopin error

On December 27, 2023 additional concerns were received alleging direct care staff member Stacey Veltkamp signed the controlled drug receipt record/disposition form that she administered Resident A's Klonopin 0.5 mg tablet in the morning on December 19, 2023 instead of at bedtime per the label instructions. Direct care staff member Heather Gorsuch noticed that the tablet had already been passed when she was getting evening medications ready to administer and she completed an *AFC Incident / Accident Report.* ORR advisor Milessa Leach stated she will be investigating these concerns. As a result of this error, Ms. Veltkamp instructed Ms. Gorsuch to not administer Resident A's Klonopin at bedtime on December 19, 2023 as the documentation shows she already had it in the morning.

On January 2, 2024, I completed an unannounced on-site investigation at Golden Life #2 and interviewed direct care staff member Heather Gorsuch who stated this incident was similar to the incident on December 1, 2023, error.

I reviewed Resident A's November and December 2023 MAR which included documentation that on December 19, 2023 Resident A did not receive her 8 PM dosage of Klonopin which is documented by "0-Not administered, see notes" and documentation was completed by Ms. H. Gorsuch that "Medication on hold."

I reviewed another AFC Incident / Accident Report which included the following information:

> *"While passing [Resident A's medications, her Klonopin shows on the narc page and the medication pack that Stacy Veltkamp had passed medication at 8:01 on December 19, 2023. The medication states to take one tablet at bedtime.*
>
> *Action taken by staff / treatment given:*
>
> *The medication has been held and not administered for tonight due to not wanting [Resident A] to get a double dose of medication. Called and notified the house manager."*

On January 30, 2024, I interviewed direct care staff member whose role is Ms. Veltkamp. Ms. Veltkamp stated if medication is administered, the MAR will be initialed by the direct care staff member who administered it, and if it is not administered it will have an "X." Ms. Veltkamp stated Resident A's Klonopin is only prescribed in the PM and on December 19, 2023 she administered Resident A's medication at the wrong time administering it to her in the morning instead. Ms. Veltkamp stated she does not know how this happened because she was being extra careful and she had just completed another Medication Administration training at Montcalm Care Network on December 15, 2023. Ms. Veltkamp stated on December 19, 2023 on the MAR it just shows "0-Not administered, see notes" because of the medication count, they did not give it so she did not receive it twice per day.

On January 30, 2024, I interviewed Resident A and Resident B. Resident A stated she does not remember a time where her medications were given at the wrong time. Resident B stated he has had no concerns regarding his medications and they are always given to him by the direct care staff members. Resident B stated there has never been a time where he needed a medication and he did not receive it.

Biofreeze Gel

On December 11, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns Ms. Kelly did not administer Resident A's Biofreeze on an unknown date.

On December 18, 2023, I received an email from ORR Ms. McIntyre. Ms. McIntyre stated she interviewed Resident A at Golden Life AFC #2 and she reported she has always received her Biofreeze as prescribed.

On January 2, 2024, I completed an unannounced on-site investigation at Golden Life #2 and met with direct care staff member Ms. H. Gorsuch. Ms. H. Gorsuch stated she was not aware of any concerns regarding Resident A not receiving her Biofreeze as prescribed. According to the prescription order from Daniel Brennan dated July 13. 2023 Biofreeze 5% Topical Gel is prescribed as a PRN for her right shoulder up to 4 times daily if needed. I was able to confirm by reviewing Resident A's MAR that she received Biofreeze as needed.

On January 23, 2024, I interviewed direct care staff member whose current role is Training and Development Manager for Golden Life, Trysta Gorsuch. Ms. T. Gorsuch stated she does medication cart audits were done in December and January to make sure all medications are present in the cart. Ms. T. Gorsuch stated she does not have any concerns Resident A was not getting her Biofreeze gel as needed.

On January 30, 2024, I interviewed direct care staff member whose role is Stacy Veltkamp. Ms. Veltkamp stated there were no concerns Resident A did not receive her Biofreeze Gel as prescribed since it is a PRN medication and it has always been in stock.

On January 30, 2024, I interviewed Resident A. Resident A stated she has always received her Biofreeze when she needed it. Resident A stated she only takes this Biofreeze when she needs it for pain in her shoulder.

On January 31, 2024, I interviewed licensee designee Mike Dykstra who was not aware of any instances of Resident A missing her Biofreeze gel as prescribed.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Resident A's Klonopin was not administered pursuant to label instructions on December 1, 2023 and December 19, 2023. During both errors, Resident A received her dosage in the AM instead of PM. Resident A's Klonopin medication was held during the evening of December 19, 2023 because Ms. H. Gorsuch caught the error when she was preparing evening medications, however, on December 1, 2023 Resident A received the Klonopin both at 7 AM and 7 PM instead of just one dose at 7 PM as required. There were no concerns Resident A did not receive her Biofreeze gel as needed. The Biofreeze gel is a PRN medication and the MAR documents she has received it periodically throughout the month and Resident A stated she receives it as needed.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning _____01/31/2024_____

Jennifer Browning
Licensing Consultant
Date

Approved By:

Dawn Timm 02/07/2024

_____

Dawn N. Timm
Area Manager
Date