GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 25, 2024

Jordan Shepler
Seasons Of Life AFC Home, LLC
2033 W Moorestown Rd
Lake City, MI 49651

RE: License #: AM570415918
Investigation #: 2024A0870018
Seasons of Life AFC

Dear Mr. Shepler:

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 #:	AM570415918
Investigation #:	2024A0870018
Complaint Receipt Date:	03/14/2024
Investigation Initiation Date:	03/14/2024
Report Due Date:	05/13/2024
Licensee Name:	Seasons Of Life AFC Home, LLC
Licensee Address:	2033 W Moorestown Rd Lake City, MI 49651
Licensee Telephone #:	(231) 920-1621
Administrator:	Jordan Shepler
Licensee Designee:	Jordan Shepler
Name of Facility:	Seasons of Life AFC
Facility Address:	2033 W. Moorestown Rd Lake City, MI 49651
Facility Telephone #:	(231) 229-4416
Original Issuance Date:	11/27/2023
License Status:	TEMPORARY
Effective Date:	11/27/2023
Expiration Date:	05/26/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A informed facility staff that she had injected herself with another resident's insulin and the staff did not call EMS. Resident A stated that she had to make to make the call to EMS.	No
Resident A was brought to the emergency room because she gained access to another resident's insulin and a needle in an unlocked medication cart in an attempt to kill herself.	Yes

III. METHODOLOGY

03/14/2024	Special Investigation Intake 2024A0870018
03/14/2024	APS Referral This referral came from the Michigan Department of Health and Human Services, Protective Services Central Intake unit.
03/14/2024	Special Investigation Initiated - Telephone Telephone interview with Lora Minidis, Munson Hospital, Traverse City.
03/18/2024	Inspection Completed On-site Interviews conducted with facility staff and residents.
03/18/2024	Contact - Telephone call made. Telephone interview with staff member Jamie Watt.
03/19/2024	Contact - Telephone call made. Telephone interview with home manager Amanda Hall.
03/19/2024	Contact - Telephone call made. Telephone interview with Lee Storch, Guardian for Resident A.
03/20/2024	Contact - Telephone call made. Telephone interview with Resident A.
03/20/2024	Contact - Telephone call made. Telephone interview with staff member April Cockeram.
03/21/2024	Contact – Telephone call made. Telephone interview with Licensee Designee Jordan Shepler.

03/21/2024	Inspection Completed-BCAL Sub. Non-Compliance
03/25/2024	Exit Conference Completed with Licensee Designee Jordan Shepler.

ALLEGATION: Resident A informed facility staff that she had injected herself with another resident's insulin and the staff did not call EMS. Resident A stated that she had to make the call to EMS.

INVESTIGATION: On March 14, 2023, I conducted a telephone interview with Lora Minidis of Munson Hospital, Traverse City. Ms. Minidis confirmed that Resident A was brought into the hospital emergency room on March 13, 2024, after being transferred from Munson Hospital Cadillac. She noted that Resident A remains a patient in the hospital ER awaiting further evaluation. She did not have information pertaining to who had initially called for EMS.

On March 18, 2024, I conducted an unannounced on-site special investigation at the Season of Life AFC home. I spoke with staff member Maleea Harris and informed her of the allegations. Ms. Harris stated she was aware that Resident A was taken by ambulance to the hospital and noted that she was not working that shift. She provided me with a copy of the *AFC Licensing Division – Incident/accident Report (BCAL-4607)*.

On March 18, 2024, I reviewed the *AFC Licensing Division – Incident/accident Report (BCAL-4607)* provided to me by Ms. Harris. This report notes that it was written by home manager Amanda Hall on March 14, 2024. It states that on March 13, 2024, Resident A "stated she had taken a bunch of insulin that wasn't prescribed to her and that she had gotten the needle earlier in the day." The report further states that, "staff called EMT's and contacted manager and owner. EMT's arrived, took vitals, and she was taken to the hospital. Guardian and case manager notified." The report identifies that staff members Jamie Watt and April Cockeram were "other persons involved/witnesses" and the incident occurred on March 13, 2024, at 6:30 p.m.

On March 18, 2024, I conduced telephone interview with staff member Jamie Watt. Ms. Watt stated she was working "last week", along with staff member April Cockeram. She stated Resident A approached her and informed that she had injected herself with insulin. Ms. Watt stated she asked Resident A how and where she injected herself, but Resident A did not respond to these questions. She stated she informed Ms. Cockeram, who called home manager Amanda Hall to inform her of this incident. Ms. Watt stated that Ms. Cockeram then called EMS who responded to the facility, evaluated Resident A, and transported her to the hospital.

On March 19, 2024, I conduced a telephone interview with home manger Amanda Hall. Ms. Hall stated she was informed of this incident from Resident A directly.

She did not know if this call, from Resident A, was before or after staff had called 911. Ms. Hall reiterated that, to her knowledge, it was facility staff who had called for EMS, not Resident A.

On March 20, 2024, I conducted a telephone interview with staff member April Cockeram. Ms. Cockeram stated she was working, along with Ms. Watt, when Resident A approached them and informed them that she had injected herself with insulin. Ms. Cockeram stated she called 911 immediately after Ms. Watt had informed Ms. Hall and Mr. Shepler of the incident.

On March 20, 2024, I conducted a telephone interview with Resident A, who had returned to the facility the day prior. Resident A stated that "April (Cockeram) called the ambulance, not me."

On March 21, 2024, I spoke with Licensee Designee Jordan Shepler. I informed him of the above stated allegations. Mr. Shepler stated that facility staff called him to inform him of the situation with Resident A and they immediately called 911 thereafter.

APPLICABLE RULE	
R 400.14310	**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:	The *AFC Licensing Division – Incident/accident Report (BCAL-4607)* notes that "staff called EMT's." Staff members Jamie Watt and April Cockeram both stated it was Ms. Cockeram who called 911. Resident A states that Ms. Cockeram called for an ambulance. The group home staff did obtain needed care immediately after being informed by Resident A that she had injected herself with insulin that was not prescribed for her.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A was brought to the emergency room because she gained access to another resident's insulin and a needle in an unlocked medication cart in an attempt to kill herself.

INVESTIGATION: Ms. Minidis stated that emergency room record states that Resident A had informed medical staff that she had injected herself with insulin twice. The record states that Resident A said she injected 24 units in one leg and 30 units in the other leg. Ms. Minidis also stated the emergency room records do confirm that insulin was taken by Resident A, and this had caused her to have an adverse reaction which required medical treatment. Ms. Minidis stated the diagnosis is listed as Hypoglycemia.

Ms. Harris noted that the facility medication cart, along with a mini refrigerator for insulin, are now located in an upstairs staff office, which has a locked door. She stated that prior to this incident, insulin was stored in the kitchen refrigerator.

The *AFC Licensing Division – Incident/accident Report (BCAL-4607)* provided to me by Ms. Harris states that on March 13, 2024, Resident A "stated she had taken a bunch of insulin that wasn't prescribed to her and that she had gotten the needle earlier in the day." The report identifies that staff members Jamie Watt and April Cockeram were "other persons involved/witnesses" and the incident occurred on March 13, 2024, at 6:30 p.m.

On March 18, 2024, I conduced a private interview, at the facility, with Resident B. Resident B stated that Resident A "got the insulin out of the refrigerator." I asked Resident B which refrigerator she was referring to and she stated, "the refrigerator in the kitchen."

Ms. Watt stated she "has no idea how Resident A got ahold of the insulin." She stated the insulin, at the time of this incident, was stored in the kitchen refrigerator and the needles used to inject the insulin are stored in the medication cart, locked upstairs. Ms. Watt further explained that "she thinks" the vials of insulin are kept upstairs in the refrigerator and the insulin pens are downstairs in the kitchen refrigerator. She stated she was unsure of which type of insulin Resident A injected herself with.

Ms. Hall stated that, prior to this incident, insulin was stored in the kitchen refrigerator, downstairs, and was not in any type of locked box. She further explained that the insulin needs to have a needle screwed onto the pen to be injected. Ms. Hall stated needles "should have been locked in the medication cart, which was located in the kitchen."

Ms. Hall, who serves as the "home manger" stated that Resident A did not suffer any adverse effects from the insulin and was admitted to Traverse City Hospital for a psychiatric evaluation.

Ms. Cockeram stated that insulin was stored in the kitchen refrigerator and was not in a locked box or container, "just a bag." She further noted that the needles, used to inject insulin, were stored in the medication cabinet, locked in the kitchen. Ms.

Cockeram stated that Resident A had commented to her that she had “snuck the needles earlier in the day from the medication cart.

Resident A stated, “the insulin was in the refrigerator, in the kitchen, and was not locked up.” She further stated, “the needles were in the med cart, not locked, which was located in the kitchen.”

Mr. Shepler stated the needles used with the insulin pens are locked in the facility medication cabinet. He stated he does not know why, or how, Resident A obtained the needle she used to inject herself with insulin. Mr. Shepler stated the insulin “should have been in a lock box in the refrigerator.” He noted he “has no good explanation as to why it was not.”

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 S333.1101 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:	Resident A stated the insulin she obtained to inject herself was in the kitchen refrigerator and was not locked. She noted the needle she used to inject herself with insulin was taken from an unlocked medication cart located in the kitchen. Ms. Hall and Ms. Cockeram both acknowledged insulin was stored in the kitchen refrigerator and was not kept in a locked container. Insulin, prescribed for other facility resident was obtained and used by Resident A. The insulin was kept in the facility kitchen and not locked in a drawer or cabinet. The equipment (needles) used to administer the insulin, although kept in the facility medication cabinet, was not kept locked.

CONCLUSION:	VIOLATION ESTABLISHED

On March 25, 2024, I provided Licensee Designee Jordan Shepler with an exit conference. I informed Mr. Shepler of my findings as noted above. Mr. Shepler stated he understands and that he had no further information to provide, or questions to ask, concerning this special investigation. He noted he would submit a corrective action plan to address the cited area of noncompliance.

IV. RECOMMENDATION

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

March 25, 2024

Bruce A. Messer — Date
Licensing Consultant

Approved By:

March 25, 2024

Jerry Hendrick — Date
Area Manager