GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 18, 2024

Connie Clauson
Suthern Adult Care, LLC
613 Progress St
West Branch, MI 48661

RE: License #: AL650308159
Investigation #: 2025A1038006
The Horizon Senior Living III

Dear Ms. Clauson:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (616) 356-0100.

Sincerely,

Johnnie Daniels, Licensing Consultant

Bureau of Community and Health Systems
350 Ottawa Ave NW
Grand Rapids MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL650308159
Investigation #:	2025A1038006
Complaint Receipt Date:	10/28/2024
Investigation Initiation Date:	10/28/2024
Report Due Date:	12/27/2024
Licensee Name:	Suthern Adult Care, LLC
Licensee Address:	617 Riverview Ct. Gladwin, MI 48624
Licensee Telephone #:	(989) 343-9404
Licensee Designee:	Connie Clauson
Name of Facility:	The Horizon Senior Living III
Facility Address:	613 Progress St. West Branch, MI 48661
Facility Telephone #:	(989) 343-9404
Original Issuance Date:	02/11/2011
License Status:	REGULAR
Effective Date:	09/16/2023
Expiration Date:	09/15/2025
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility was not handling resident's medications properly.	Yes

III. METHODOLOGY

10/28/2024	Special Investigation Intake 2025A1038006
10/28/2024	Special Investigation Initiated - Telephone call made to Complainant
11/12/2024	Inspection Completed On-site
11/12/2024	Contact - Face to Face interviews were conducted with Resident A and Resident B.
11/12/2024	Contact - Face to Face interviews were conducted with DCS Terri Furgerson, DCS Madison Delmotte and home manager Kristaphor Ostrander.
11/13/2024	Inspection Completed-BCAL Sub. Compliance
11/13/2024	Contact - Telephone call made to DCS Autumn Bratcher
11/18/2024	Exit Conference with LD Connie Clauson.
11/18/2024	APS Referral Not required as there is no suspected abuse or neglect.

ALLEGATION:

The facility was not handling resident's medications properly.

INVESTIGATION:

On 10/28/24, I received a complaint from the bureau of community and health systems on-line complaint system regarding the facility. The complaint alleged the facility was not handling residents medications properly.

On 10/28/24, I interviewed the Complainant via telephone. The Complainant verified the information.

On 11/12/24, I conducted an unannounced investigation at the facility. I interviewed direct care staff (DCS) Terri Furgerson who verified there was medication missing for Resident A and Resident B. Ms. Furgerson verified the West Branch Police Department was at the facility conducting an investigation regarding the missing narcotics. Ms. Furgerson stated there has been policy changes put into place by home manager Kristaphor Ostrander for proper documenting of medication when it is received. Ms. Furgerson stated the residents were still able to get their medication as the facility ordered more medications through Advanced pharmacy RX and Walmart pharmacy with the residents insurance.

On 11/12/24, I interviewed home manager Kristaphor Ostrander whose statement was consistent with those made by Ms. Furgerson. Mr. Ostrander added there was close to 120 narcotics missing for Resident A and Resident C. Resident D's Gabapentin was also missing. Mr. Ostrander stated all staff have been trained in medication administration. Mr. Ostrander stated the facility investigated and was unable to determine the whereabouts of the missing medication.

On 11/12/24, I interviewed DCS Madison Delmotte who provided a statement that was consistent with those made by Ms. Furgerson and Mr. Ostrander.

On 11/12/24, I was unable to interview Resident A as she was unable to hear the questions I was asking.

On 11/12/24, I attempted to interview Resident B who was only able to respond with yes or no answers. Resident B answered yes to liking it at the facility and yes to her getting her medication.

On 11/12/24, I verified the medication training of staff at the facility. All staff were properly trained on medication administration. I viewed the medication administration records which showed residents were still given their proper medication.

On 11/13/24, I interviewed DCS Autumn Bratcher via telephone. Ms. Bratcher's statement was consistent with those made by Ms. Furgerson, Mr. Ostrander and Ms. Delmotte.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	While it is unknown for certain how the medications went missing, an active police investigation is ongoing. Based on my interview with staff and the review of documents, the staff was not handling nor monitoring the medication properly.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan. I recommend the status of the license to remain unchanged.

11/18/24

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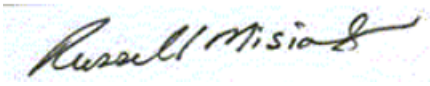
Johnnie Daniels Date
Licensing Consultant

Approved By:



11/25/24

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Russell B. Misiak Date
Area Manager