GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 3, 2024

Dennis Beemer
AFC Homes Corp
PO Box 417
406 W 5th
Evart, MI 49631

RE: License #: AM670009368
Investigation #: 2025A0009004
Beemer Evart Townhouse

Dear Mr. Beemer:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame 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 (616) 356-0100.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM670009368
Investigation #:	2025A0009004
Complaint Receipt Date:	11/14/2024
Investigation Initiation Date:	11/15/2024
Report Due Date:	12/14/2024
Licensee Name:	AFC Homes Corp
Licensee Address:	PO Box 417 406 W 5th Evart, MI 49631
Licensee Telephone #:	(616) 446-5647
Administrator:	Dennis Beemer
Licensee Designee:	Dennis Beemer
Name of Facility:	Beemer Evart Townhouse
Facility Address:	406 W. Fifth Street Evart, MI 49631
Facility Telephone #:	(231) 734-3810
Original Issuance Date:	11/23/1983
License Status:	REGULAR
Effective Date:	05/03/2023
Expiration Date:	05/02/2025
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL & AGED

II. ALLEGATION(S)

	Violation Established?
Resident A took another resident's medication.	Yes

III. METHODOLOGY

11/14/2024	Special Investigation Intake 2025A0009004
11/15/2024	Special Investigation Initiated - On Site Interview with direct care worker Deanne Beach and Face to face contact with Resident A
12/02/2024	APS Referral
12/03/2024	Exit conference with licensee designee Dennis Beemer

ALLEGATION: Resident A took another resident's medication.

INVESTIGATION: I conducted a site visit at the Beemer Evart Townhouse adult foster care facility on November 15, 2024. I spoke with direct care worker Deanne Beach at that time. She said that she had worked at the home for about a year or so. Ms. Beach said that she had worked in other facilities where medication is administered and has experience administering medication. Ms. Beach stated that she had been educated in the proper administration of medication when she was first employed at the Beemer Evart Townhouse as well. I asked her about the medication administration error that had been recently reported to me. She replied that it had happened two days before, on November 13, 2024. Ms. Beech stated that the residents were sitting around the tables in the dining room. She was administering medication to them. As she was carrying a cup of medication to a resident, she heard a scream from another room. She hurriedly set the cup of medication down on a table so that she could respond to the scream. Ms. Beach said that she determined that the resident who had screamed was in the bathroom. The resident had yelled because she had seen a bug in the bathroom. Once Ms. Beach determined that it was not actually an emergency she returned immediately to the dining room. The noted that the medication cup that she had been carrying was empty. The empty cup was sitting in front of Resident A. He said that he thought they had been his and he took them. She called her supervisor immediately following him taking the wrong pills and was told to call the licensee designee, Dennis Beemer. Mr. Beemer told her that she is supposed to always stand right there and watch each resident take their medication. She told him that she knew that but had been distracted by the other resident screaming. Ms. Beach said that

she told him that another direct care worker was already on their way to the home to take Resident A to the hospital. Ms. Beach said that she continued to observe Resident A for any adverse reaction during that time but he seemed fine. The other staff person arrived and took Resident A to the hospital shortly following the accidental ingestion. Resident A told her that he was feeling tired but otherwise okay. Resident A was checked out at the hospital, was found to be doing fine and discharged shortly after. Ms. Beach denied that she had ever been involved in a medication administration error at the facility before. She denied that she was aware of any other staff at the facility not administering medication properly before. I told Ms. Beach that she did make a mistake regarding the medication administration but that she did the right thing by reporting it immediately so that it could be determined that Resident A was okay.

I spoke with direct care worker Heather Beach while she took me to meet Resident A. She said that she was not sure that it had been an accident that Resident A had taken the other resident's medication. He has substance abuse issues and has been known to seek out illicit drugs or medication that is not prescribed to him.

I asked for the discharge papers from Resident A's hospital visit while on-site. Ms. Beach provided me with the After Visit Summary from the Reed City Hospital dated November 13, 2024. The report indicated that the reason for his visit was "accidental drug ingestion". He was given an x-ray, blood test and his vitals were taken. He was found to be stable at that time and discharged. Ms. Beach stated that the staff at the facility continued to observe Resident A for the rest of that day and he had seemed fine.

APPLICABLE RULE	
R 400.14312	**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:	On November 13, 2024, medication from another resident was left within reach of Resident A for a short time while staff left the room. Resident A took the medication either accidentally or purposely at that time. It was confirmed through this investigation that the licensee did not take reasonable precautions to ensure that prescription medication was not used by a person other than the resident for whom the medication was prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with licensee designee Dennis Beemer by telephone on December 3, 2024. He was told of the findings of the investigation and given the opportunity to ask questions.

IV. RECOMMENDATION

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

12/03/2024

Adam Robarge Date
Licensing Consultant

Approved By:

12/03/2024

Jerry Hendrick Date
Area Manager