GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 30, 2025

Joanne Broidrick
Golden Life AFC, LLC
1230 S. Lafayette St
Greenville, MI 48838

RE: License #: AM590395969
Investigation #: 2025A0466021
Golden Life Assisted Living #2

Dear Ms. Broidrick:

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,

Julie Elkins

Julie Elkins, 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 #:	AM590395969
Investigation #:	2025A0466021
Complaint Receipt Date:	03/03/2025
Investigation Initiation Date:	03/04/2025
Report Due Date:	05/02/2025
Licensee Name:	Golden Life AFC, LLC
Licensee Address:	1230 S. Lafayette St Greenville, MI 48838
Licensee Telephone #:	(616) 263-7726
Administrator:	Joanne Broidrick
Licensee Designee:	Joanne Broidrick
Name of Facility:	Golden Life Assisted Living #2
Facility Address:	503 W. Montcalm Greenville, MI 48838
Facility Telephone #:	(616) 263-7726
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

II. ALLEGATION:

	Violation Established?
Resident A's needs are not met due to insufficient staffing.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/03/2025	Special Investigation Intake 2025A0466021.
03/03/2025	Contact - Document sent to Complainant.
03/04/2025	Special Investigation Initiated – Telephone call made Complainant interviewed.
03/13/2025	Inspection Completed on Site.
04/15/2025	Contact- Document sent to licensee designee Joanne Broidrick, requested documents that were not available at the time of the onsite investigation.
04/18/2025	Contact- Documents received from licensee designee Joanne Broidrick.
04/22/2025	Contact- Telephone call to DCW Brandon Boik interviewed.
04/29/2025	Contact- Telephone call to licensee designee Joanne Broidrick interview/exit conference.
04/29/2025	APS- referral not required no suspected abuse/neglect.
04/30/2025	Contact- Document sent to licensee designee Joanne Broidrick.
04/30/2025	Exit Conference with licensee designee Joanne Broidrick, message left.

ALLEGATION: Resident A's needs are not met due to insufficient staffing.

INVESTIGATION:
On 03/03/2025, Complainant reported Resident A has been in a state of rapid decline, medically and physically, over the past few months. Complainant reported Resident A falls frequently, averaging two times per 12-hour shift, requiring non-emergent emergency medical services (EMS) lift assistance to get him off the floor when only one direct care worker (DCW) is working third shift. Complainant reported Resident A falls in his room which is small with minimal open space due to his bed,

recliner, dresser, and other furniture being in the room. Complainant reported it is not safe for Resident A to remain in this facility as they do not have the proper equipment to care for him nor are there enough DCWs to safely provide for Resident A's personal care and mobility needs. Complainant reported Resident A is to the point where he cannot hold himself upright unsupported and is barely weight bearing. Complainant stated there are times there is only one DCW working (third shift) who is expected to care for Resident A and his extensive needs along with 11 other residents. Complainant reported that in early February 2025, Resident A fell headfirst in the wall which made a big hole in the drywall that the maintenance had to repair.

On 03/04/2025, Complainant reported Resident A was diagnosed with Parkinson's Disease in August 2024 which is when he started to use the walker for ambulation and then a wheelchair in January 2025. Complainant reported Resident A weighs about 250 pounds and if he falls on third shift when there is one DCW on duty, the DCW is supposed to call non-emergency dispatch for lift assistance. Complainant also reported that instead of staffing two DCWs on third shift, DCWs were told to call a direct care worker at home and wait for them to come to the facility to assist with lifting Resident A. Complainant reported calling non-emergent EMS at least three times for assistance with Resident A while working alone. Complainant reported that the proper tools are not available to assist Resident A with safe ambulation. Complainant reported Resident A should be assessed for a sit-to-stand and/or a Hoyer lift. Complainant reported Resident A's falls have not been addressed in his written *Assessment Plan for Adult foster Care (AFC) Residents*. Complainant reported Resident A had been using a walker for ambulation and that he is not using a wheelchair. Complainant reported that currently two residents use wheelchairs for ambulation, four residents use walkers to ambulate and six residents ambulate on their own. Complainant reported Resident B wanders and requires a DCW to monitor his "every move." Complainant reported that additional direct care workers were scheduled to work while Resident B was in the facility due to his wandering behavior. Complainant stated Resident B no longer resides at the facility so additional direct care worker staffing has decreased. Complainant reported additional direct care worker staffing has never been provided for Resident A despite the need for it.

On 03/13/2025 I conducted an unannounced investigation and I interviewed DCW Alex Gorney who reported that he began working at the facility in November 2024 and he works both daytime and overnight shifts. DCW Gorney reported that two DCWs work from 7am-7pm and one DCW works from 7pm to 7am. DCW Gorney reported Resident A is currently at a rehibition center after being hospitalized. DCW Gorney reported he is unaware why Resident A was hospitalized. DCW Gorney reported Resident A does fall a lot and uses a walker and a wheelchair for ambulation. DCW Gorney reported Resident A requires assistance with transferring but he does not always use the call button for assistance. DCW Gorney reported he has worked third shift by himself and has had to call non-emergency EMS dispatch for lift assistance twice when Resident A fell and he could not get Resident A up on

his own. DCW Gorney reported that Resident A cannot help at all with getting up from a fall and that is why one direct care worker cannot assist him off the ground when he falls. DCW Gorney reported that Resident A would benefit from using a Hoyer lift. DCW Gorney reported that no other residents require the assistance of two direct care workers.

I interviewed DCW Casey Townsen who reported that she has worked for the facility for about two months. She reported she had been working when Resident A had fallen and she had to engage the assistance of another DCW to help him get up. DCW Townsen reported Resident A cannot help getting up and that his body just shakes. DCW Townsen reported she has not had to call for lift assistance as she has not worked alone or on the overnight shift which has one caregiver. DCW Townsen reported Resident A cannot help with transfers either. DCW Townsen reported that Resident A would benefit from using a Hoyer lift. DCW Townsen reported that there are no other residents in the facility that require two DCWs to assist with personal care, transferring or mobility assistance.

On 04/11/2025, I interviewed Stacy Vahlkamp whose role was DCW/house manager until March 17, 2025. DCW Vahlkamp reported Resident A required assistance with all his activities of daily living (ADL). DCW Vahlkamp stated Resident A experienced shakiness in his extremities causing liquid spills, including his spilling his urinal, and falls. DCW Vahlkamp reported Resident A refused to use his call light for assistance with transfers leading to falls. DCW Vahlkamp reported that two DCWs were scheduled for 7am-7pm and one DCW for the 7pm-7am shift. DCW Vahlkamp reported that if the DCW on duty required assistance with Resident A, that initially non-emergency dispatch was called for lift assistance. However, DCW Vahlkamp reported that after the emergency medical services got upset with the frequency and number of calls for providing lift assistance for Resident A, licensee designee Joanne Broidrick instructed direct care workers to contact a direct care worker, who was not working at the time and lived close to the facility, for assistance with lifting Resident A from the floor. DCW Vahlkamp reported that Resident A weighs about 245 pounds and was approximately six feet tall. DCW Vahlkamp reported Resident A was typically up all night which increased his fall risk. DCW Vahlkamp reported she requested a second person to be added to the second shift and the request was denied by licensee designee Broidrick.

On 04/18/2025, licensee designee Broidrick reported that the facility has two or three direct care workers on duty during daytime hours 8a-8p and then after evening medications are administered and residents are in bed, there is only one direct care worker on duty. Licensee designee Broidrick reported direct care worker staffing numbers would be increased, if residents' care needs changed or if residents could not be evacuated timely.

Licensee designee Broidrick reported that Resident A’s admission to the facility was in 2015. Licensee designee Broidrick reported that “during this time his health has been all over the board mostly due to his poor personal choices.” Licensee

designee Broidrick reported facility administration has asked Resident A's physician to petition the court in hopes of getting him a state appointed guardian to help with Resident A's decision making, especially regarding his health care decisions. Licensee designee Broidrick reported that when it comes to Resident A's falls, some (not all) are behavior related. Licensee designee Broidrick stated Resident A likes to often fall to get female staff to help him up as he seeks their attention. Licensee designee Broidrick reported that Resident A takes the public transit into the community to Walmart where he likes the female employees working at the self-checkout station, so he falls and needs assistance to get up. Licensee designee Broidrick reported that Resident A is diabetic and utilizes his own funds to purchase drink and food items that greatly elevate his blood sugar. Licensee designee Broidrick reported Resident A's "poor choices" alone will make him unsteady and likely to fall. Licensee designee Broidrick reported the facility does have a Hoyer lift but there currently is no physician's order to use this with Resident A.

I reviewed a document dated 02/17/2025 which was labeled as "hospital follow up, Medicare annual visit" completed by Community Life Medical and signed by Dr. Shelia Gendich. This form documented that Resident A is 5 foot 10 inches and 240 pounds. This form documented that Resident A is diagnosed with "chronic tremor and muscle weakness" along with many other chronic diagnoses dating back to 2012.

I reviewed Resident A's *Health Care Appraisal* that was dated 3/25/2024 and signed by Dr. Shelia Gendich which documented "non intentional tremor, left fourth toe amputation and ulcer right great toe." In the mobility/ambulatory status it stated, "uses walker."

On 04/15/2025, I requested Resident A's written *Assessment Plan for AFC Residents* from licensee designee Broidrick and I reviewed it on 04/24/2025. The document provided did not have a title but had Resident A's name, birthday and page 1 are listed on the page. It documented that Resident A requires one person assistance with bathing, grooming, dressing, personal hygiene, mobility and stair climbing. It documented that Resident A uses a hospital bed, booties for wound on feet, walker, cane and lift chair for assistive devices. It documented that Resident A is on a no salt, low sugar diet. Resident A's written *Assessment Plan for Adult Foster Care (AFC) Residents* was dated 3/22/2025 and signed by Resident A. It documented that Resident A does access the community independently, he is alert to surroundings, communicates needs, follows instructions, controls sexual behavior and gets along with others. Resident A's written *Assessment Plan for (AFC) Residents* documented that Resident A can be aggressive. Neither of the assessment plans that were reviewed documented Resident A's history of falls.

On 04/22/2025, I interviewed DCW Brandon Boik who has worked at the facility for five years. DCW Boik reported that he works third shift alone. DCW Boik reported that he has called non-emergency dispatch for lift assistance for Resident A multiple times due to Resident A falling and he was unable to get him up by himself. DCW Boik reported Resident A is 5'8 and 240 pounds and he cannot get Resident A off

the floor by himself as Resident A cannot assist in this effort. DCW Boik reported Resident A is sometimes weak and his legs do not seem to work. DCW Boik reported that they do not use a Hoyer with Resident A nor do they use a sit and stand. DCW Boik thought that maybe physical therapy would help Resident A with his strength.

On 04/29/2025, I interviewed licensee designee Broidrick by phone and she reported that Resident A falls two to three times per week and his falls can be unpredictable as he is less steady after he eats sugar and he does not wait for DCWs to assist him with transferring. Licensee designee Broidrick stated Resident A is inpatient and does not use his call button to ask for DCW assistance. Licensee designee Broidrick reported that she believes some of Resident A's falls are behavioral with a motive to have a female staff assist him. Licensee designee Broidrick reported Resident A is up and down thought out the night. Licensee designee Broidrick reported that most of the other residents are independent. Licensee designee Broidrick reported midnight direct care workers have contacted non-emergent emergency medical services for lift assistance when working alone to lift Resident A after a fall. Licensee designee Broidrick reported having staff on "stand by" which she described as utilizing DCWs who are employed at another licensed AFC or DCWs that live in close proximity that are called to come to the facility to assist. Licensee designee Broidrick stated this also included contacting the maintenance manager to assist with Resident A if needed

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Complainant, DCW Gorney, DCW Townsen, DCW Vahlkamp, DCW Boik and licensee designee Broidrick all reported that two direct care workers are on shift from 7 am-7pm and one direct care worker working from 7pm-7am. Complainant, DCW Gorney, DCW Townsen, DCW Vahlkamp and DCW Boik all reported that Resident A cannot help DCWs at all with getting up from a fall due to weakness and DCWs were instructed to contact non-emergent EMS dispatch for lift assistance when working independently. Complainant, DCW Gorney, DCW Boik and licensee designee Broidrick all reported that midnight direct care workers have contacted emergency medical services for lift assistance when working alone after a fall occurred with Resident A. Non-emergent emergency medical services is not intended to be regularly used to assist with resident transfer needs. Licensee designee Broidrick also reported using direct care workers she described as “stand by” who were either working in another licensed facility or were off duty and called to come to the facility to assist with lifting Resident A. This second direct care worker would not be onsite at the time of Resident A’s falls leaving Resident A to wait unnecessarily for assistance to arrive. Based on all the above interviews and review of pertinent documentation, Resident A requires two direct care workers to lift him from the floor after a fall and this need is not immediately available during third shift as only one direct care worker is scheduled during that time frame. Consequently, having only one direct care worker scheduled is not sufficient to meet Resident A’s personal care needs, especially after a fall.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 03/13/2025, I conducted an unannounced investigation and I interviewed DCW Gorney and DCW Townsen who both reported that they did not have access to the resident records. DCW Gorney and Townsen both reported that house manager Stacy Vahlkamp, who was off until 03/17/2025, could access the records but otherwise they did not have access to resident records.

On 04/18/2025, Licensee designee Broidrick stated she was sorry direct care workers did not know how to access resident records electronically from the computer located with the medication cart.

APPLICABLE RULE	
R 400.14316	**Resident Records**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.** **(b) Date of admission.** **(c) Date of discharge and the place to which the resident was discharged.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Weight record.** **(h) Incident reports and accident records.** **(i) Resident funds and valuables record and resident refund agreement.** **(j) Resident grievances and complaints**.

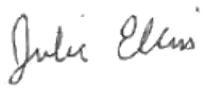
ANALYSIS:	Resident A's resident record was not available for review at the time of the unannounced investigation on 03/13/2025 as DCW Gorney and Townsen both reported that they did not have access to the resident records when house manager Stacy Vahlkamp was not at the facility. DCWs did not have knowledge to access electronic resident records.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 04/29/2025, I interviewed licensee designee Broidrick by phone and she reported having "stand by" DCWs which she described as utilizing DCWs who are employed at another licensed AFC or DCWs that live in close proximity that are called to come to the facility to assist. Licensee designee Broidrick stated this also included contacting the maintenance manager if needed. Licensee designee Broidrick reported that she documented this on her evacuation scores for her special certification license to include the standby assistance described above.

APPLICABLE RULE	
R 330.1803	**Facility environment; fire safety**
	(5) The capability of the clients to evacuate a facility in the event of a fire shall be assessed using methods described in appendix f of the 1985 life safety code of the national fire protection association. Appendix f of the 1985 life fire protection association is adopted by reference as part of these rules. A copy of the adopted appendix f is available from the Department of Mental Health, Lewis Cass Building, Lansing, MI 48913, at cost. A copy of appendix f may also be obtained from the National Fire Protection Association Library, Battermarch Park, P.O. Box 9101, Quincy, Massachusetts 02269-9101, 1-800-344-3555. A prepaid fee may be required by the national fire protection association for a copy of appendix f. A price quote for copying of these pages may be obtained from the national fire protection association.
ANALYSIS:	Licensee designee Broidrick includes "stand by" direct care workers in her special certification evacuation score which is not accurate as only direct care workers available at the time of the fire drill are to be included in the "shift" score." Therefore the evacuation scores are not accurate because the evacuation score is not based on DCWs in the building and immediately available to assist with evacuation of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in license status.



04/30/2025

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Julie Elkins Date
Licensing Consultant

Approved By:

04/30/2025

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Dawn N. Timm Date
Area Manager