GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 2, 2025

Allison King
3935 E Long Lake Rd
Traverse City, MI 49685

RE: License #: AS280378535
Investigation #: 2025A0870021
King Adult Living Center

Dear Allison King;

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On May 28, 2025, you submitted a request to have the license closed effective June 30, 2025. I will consider your request to close the license as an acceptable written corrective action plan and will close your license to operate this Adult Foster Care home effective June 30, 2025.

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 #:	AS280378535
Investigation #:	2025A0870021
Complaint Receipt Date:	05/07/2025
Investigation Initiation Date:	05/07/2025
Report Due Date:	07/06/2025
Licensee Name:	Allison King
Licensee Address:	3935 E Long Lake Rd Traverse City, MI 49685
Licensee Telephone #:	(231) 929-1311
Name of Facility:	King Adult Living Center
Facility Address:	3935 E. Long Lake Road Traverse City, MI 49685
Facility Telephone #:	(231) 929-1311
Original Issuance Date:	06/14/2016
License Status:	REGULAR
Effective Date:	12/14/2024
Expiration Date:	12/13/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was burned while cooking and was not taken for medical care.	Yes

III. METHODOLOGY

05/07/2025	Special Investigation Intake 2025A0870021
05/07/2025	APS Referral Phone case discussion with Grand Traverse County MDHHS APS worker Kieran Goodman.
05/07/2025	Special Investigation Initiated - Telephone Email sent to Northern Lakes Community Mental Health Authority Caseworker Tamara Stanfield
05/08/2025	Inspection Completed On-site Interviews with Licensee Allison King, staff member Hazel Moore, Resident B and Resident C.
05/08/2025	Contact - Face to Face Interview with Resident A.
05/28/2025	Contact - Telephone call made Case discussion with APS worker Kieran Goodman.
05/28/2025	Exit Conference Completed with Licensee Allison King.
05/28/2025	Contact – Document Received Written request to have the license closed NLT June 30, 2025, received from Licensee Allison King.

ALLEGATION: Resident A was burned while cooking and was not taken for medical care.

INVESTIGATION: On May 7, 2025, I spoke by telephone with Michigan Department of Health and Human Services, Adult Protective Services (APS) worker Kieran Goodman. Mr. Goodman and I discussed the above allegation and coordinated a joint on-site investigation for the following day.

On May 7, 2025, I conducted an interview, via e-mail conversation, with Tamara Stanfeld, IDD case manager with Northern Lakes Community Mental Health Authority. Ms. Stanfeld stated she was informed during a meeting with Resident A's guardian that Resident A had spilled a cup of soup on herself which resulted in 2nd degree burns to her chest, stomach and groin. Ms. Stanfeld noted that the AFC staff did not take Resident A for medical care at the ER or an urgent care. She noted the burn occurred on May 3, 2025, and Resident A's guardian took her in for medical treatment on May 6, 2025. Ms. Stanfeld commented that the AFC staff did inform Resident A's guardian that she was burned, but did not tell her "how bad it was."

On May 8, 2025, I conducted an on-site special investigation at the King Adult Living Center AFC home. I was accompanied by MDHHS APS worker Kieran Goodman. We me with Licensee Allison King and informed her of the above stated allegation. She noted that the facility has four residents in care, which includes Resident A. Ms. King noted that she was not present at the facility at the time as she was away from May 1, 2025 to May 7, 2025, but was aware of the situation with Resident A via communication with the facility staff. Ms. King noted that staff member Hazel Moore was working the morning of May 3, 2025, when Resident A was burned. She noted that Ms. Moore had contacted another staff member, Janette Davis, concerning the issue and Ms. Davis suggested that Ms. Moore call Resident A's guardian, Dawn Hamilton. Ms. King stated that she sent Ms. Hamilton pictures of the burn shortly afterwards and Ms. Hamilton responded that "looks like a sunburn" and that "what you did was ok." Ms. King noted that "what they did" was clean the burn and apply Aquafina cream." Ms. King stated that Ms. Hamilton took Resident A to an appointment on May 5, 2025, and then took Resident A to urgent care on May 6, 2025, due to her concerns regarding Resident A's burn. When I asked Ms. King why facility staff did not take Resident A to seek medical treatment for the burn when blistering appeared, she stated "I thought that if the guardian said don't take her to the doctor, then you don't take her."

On May 8, 2025, I conducted an in-person interview with staff member Hazel Moore. Ms. Moore stated that she was working the morning of May 3, 2025, the day Resident A was burned, and was the only staff member on duty with four residents. She stated she saw Resident A using the kitchen microwave and "didn't think anything of it." Ms. Moore noted that she stepped outside to take out garbage and when she reentered the facility, she saw Resident A standing by her bedroom door "crying and screaming." She reportedly asked Resident A "what is wrong" and Resident A did not respond. Ms. Moore stated that "a couple minutes later she approached Resident A again and Resident A showed her stomach, chest and legs to her. Ms. Moore sated she saw "lots of red and some blistering on Resident A's stomach." She took pictures of Resident A's injuries and sent them to Licensee Allison King, who said she would send the pictures to Resident A's guardian. Ms. Moore stated she later spoke with coworker Janette Davis, who told her she had spoken with Resident A's guardian Dawn Hamilton, telling her she should come and check out Resident A's burn. Ms. Moore stated Ms. Davis told her that Ms. Hamilton said it looks like a sunburn and its ok. Ms. Moore noted she gave Resident A "a

couple Tylenol" and put Aquafina on the burn. Ms. Moore stated she worked the following day, May 4, 2025, and observed "blistering, real bad, worse than the day before." She stated she is unaware if anyone called Resident A's guardian, Dawn Hamilton, to inform her that the burn and blistering was worse. Ms. Moore noted that on May 5, 2025, Ms. Hamilton came to take Resident A to an appointment and then took Resident A to the doctor the next day for the burn.

On May 8, 2025, I conducted an in-person interview with Resident B. Resident B stated she did not see Resident A's injuries but noted that the facility residents can help with cooking and are allowed to make their own breakfast and lunches.

On May 8, 2025, I conducted an in-person interview with Resident C. Resident C stated she saw the burn to Resident A about 15 minutes after it occurred. She stated she observed that "the skin was torn and blistered."

On May 8, 2025, I conducted an interview with Terri Cieslik. Ms. Cieslik noted she is a staff member at the NLCMH work program which Resident A is a participant. She stated that that she observed, on May 6, 2025, that Resident A had "a very bad burn with torn and blistered skin." Ms. Cieslik stated the injuries were located on Resident A's groin and belly areas.

On May 8, 2025, I conducted an in-person interview Resident A at her NLCMH work program. I was accompanied by Mr. Goodman and Ms. Cieslik. Resident A stated that she "burned herself last Saturday", May 3, 2025. She described that she was cooking ramen noodles for lunch in the microwave, when she went to remove the cup from the microwave, she spilled it on herself. Resident A noted that "Hazel (Moore) was working, and she yelled for Hazel right away and showed her the burn. Resident A noted that her guardian Dawn (Hamilton) took her to the doctor for the burn. Resident A also commented that staff member Janette (Davis) told her on Monday, (May 5, 2025), before she left for her NLCMH work program, "not to tell anyone." I asked Resident A why Ms. Davis would instruct her not to tell anyone about the burn and she responded, "because she didn't want anyone to find out."

On May 28, 2025, I spoke with Mr. Goodman to discuss our concurrent investigations. Mr. Goodman noted he was concluding his investigation with a substantiated finding of neglect. He also stated that he had spoken with Resident A's guardian, Dawn Hamilton, who told him that the pictures she was sent "looked like a sunburn" but when she saw the burn "firsthand" she determined that Resident A needed to see a doctor for the burns.

On May 28, 2025, I spoke with Licensee Allison King by telephone. Ms. King stated that she will be closing the AFC home no later than June 30, 2025, and has sent discharged notices to the four residents' guardians and caseworkers. She stated she no longer wishes to have an AFC license or operate an AFC home. I asked her to email me a letter requesting that her AFC license be closed on June 30, 2025, and I will close the license on that date.

On May 28, 2025, I received a written request from Ms. King to have her AFC license closed on June 30, 2025.

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:	Resident A suffered burns to her body after spilling hot soup/noodles on herself on May 3, 2025. Facility staff member Hazel Moore stated she worked the following day, May 4, 2025, and observed “blistering, real bad, worse than the day before.” Resident C stated she saw the burn to Resident A about 15 minutes after it occurred. She stated she observed that “the skin was torn and blistered.” NLCMH work program staff member Terri Cieslik stated that that she observed, on May 6, 2025, that Resident A had “a very bad burn with torn and blistered skin.” Ms. Cieslik stated the injuries were located on Resident A’s groin and belly areas. Resident A’s guardian, Dawn Hamilton, took Resident A to “urgent care” on May 6, 2025, to seek medical care for Resident A’s burns. The License failed to obtain needed medical care immediately for Resident A’s burns.
CONCLUSION:	**VIOLATION ESTABLISHED**

On May 28, 2025, I conducted an exit conference with Licensee Allison King. I informed Ms. King of my finding as noted above. She stated she understood the finding, had no questions and no additional information to provide concerning the investigation. I further informed Ms. King that I would be recommending that the AFC license be modified to Provisional License status because of the finding and a corrective action plan would be required which addresses the cited rule noncompliance. Ms. King informed me that she wishes to close her license no later than June 30, 2025, and that she has already sent out discharge notices to all the residents, their guardians and their respective responsible agencies. I informed her that I will require a written request to have the license closed and will consider that

request in lieu of a corrective action plan, to conclude this investigation. She provided the written request to close the AFC license effective June 30, 2025, this same day.

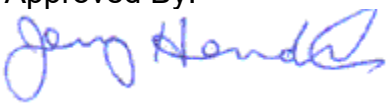
IV. RECOMMENDATION

In lieu of a recommendation to modify the license to Provisional status, I recommend that the Licensee be allowed to close her license, at her request, on or before June 30, 2025.

May 29, 2025

Bruce A. Messer Date
Licensing Consultant

Approved By:



June 2, 2025

Jerry Hendrick Date
Area Manager