GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 4, 2025

Bonnie Kilchermann
P.O Box 108
Edmore, MI 48829

AM590009155
RE: License #: 2025A0622047
Investigation #: Kilchermann

Dear Mrs. Kilchermann:

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.

A six-month provisional license is recommended**. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled.** Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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) 335-5985.

Sincerely,

Amanda Blasius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

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

I. IDENTIFYING INFORMATION

License #:	AM590009155
Investigation #:	2025A0622047
Complaint Receipt Date:	06/24/2025
Investigation Initiation Date:	06/24/2025
Report Due Date:	08/23/2025
Licensee Name:	Bonnie Kilchermann
Licensee Address:	8280 N Neff Road Edmore, MI 48829
Licensee Telephone #:	(989) 427-5245
Administrator:	Bonnie Kilchermann
Licensee:	Bonnie Kilchermann
Name of Facility:	Kilchermann
Facility Address:	8280 N. Neff Road Edmore, MI 48829
Facility Telephone #:	(989) 427-5245
Original Issuance Date:	10/20/1989
License Status:	REGULAR
Effective Date:	04/18/2024
Expiration Date:	04/17/2026
Capacity:	9
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The AFC home is being treated for bed bugs. During the heat treatment, residents spent two days, 10 hours each day, on 6/23 and 6/24 in a barn that was not air conditioned.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/24/2025	Special Investigation Intake 2025A0622047
06/24/2025	Special Investigation Initiated - On Site
06/25/2025	Contact - Telephone call made to Residents B, C and D. Interviews with direct care workers, Cindy Ordiway and Olivia Beebe.
06/30/2025	Contact - Telephone call made to direct care worker, Erica Webber
07/01/2025	Inspection Completed On-site
07/10/2025	Contact - Telephone call made to Guardian A1
07/14/2025	Contact - Telephone call made to PACE nurse, Krista Bly.
07/21/2025	Contact - Telephone call made and document received from PACE nurse, Krista Bly.
07/21/2025	Inspection Completed-BCAL Sub. Compliance
8/04/2025	Exit conference with licensee designee Bonnie Kilchermann

ALLEGATION: The AFC home is being treated for bed bugs. During the heat treatment, residents spent two days, 10 hours each day, on 6/23 and 6/24 in a barn that was not air conditioned.

INVESTIGATION:
On 06/24/2025, this allegation was assigned to me through a phone call adult foster care licensing consultant, Jennifer Browning received. According to the allegations, the Kilchermann adult foster care home was getting a heat treatment for bed bugs on 06/23/25 and 06/24/2025. According to the complaint, licensee Bonnie

Kilchermann was taking the nine residents to a barn with no air conditioning for ten hours each day because residents were required to be out of the foster home while it was treated for bed bugs.

On 06/24/2025, I received a phone call from Angie Loiselle, Recipient Rights Officer. Ms. Loiselle reported she was informed that Kilchermann adult foster home had all the residents in a barn at another location on 6/23/25 and one of the residents ended up in the hospital. Ms. Loiselle stated that the residents were at the barn again on 06/24/2025 and she went over to the location. Ms. Loiselle explained that she found the residents and two caregivers in an old barn, with missing walls, fans and a port-a-john for a bathroom. Ms. Loiselle stated that when she arrived, she found licensee Bonnie Kilchermann in a house on the property with air conditioning, not in the barn with the residents. Ms. Loiselle reported that there was another home with an attached garage on the property also. Ms. Loiselle stated that she informed licensee Bonnie Kilchermann that she needed to move the residents to another location that offered cooler temperatures, and she assisted Ms. Kilchermann with locating cooling centers for the residents. Ms. Loiselle reported that they were going to move the residents after lunch. Ms. Loiselle provided me with pictures from her visit on 06/24/25.

On 06/24/2025, I completed an unannounced onsite investigation to the secondary location in Vestaburg. Upon arrival, I found licensee Bonnie Kilchermann in a house on the property with air conditioning, along with her adult son who is an employee of the facility. Licensee Bonnie Kilchermann showed me where the residents have been staying over the last two days while the AFC home was heat treated. The barn observed had two and half sides with steel sides, a cement floor, folding camp chairs set up, two large fans, outdoor games and a small table. Upon my arrival around 2pm, the residents were no longer at the barn and had been taken to the library. Using my thermometer, usually used to test the water temperature in homes, the outdoor temperature was 90.3 degrees without fans on. I also viewed the port-a-john that was brought onto the property for the residents to use. Licensee Bonnie Kilchermann confirmed that Resident A needed to have the ambulance called on the evening of 06/23/2025 and was being treated for double pneumonia. Licensee Bonnie Kilchermann reported that she did not think that it was too hot outside for the residents to be in the barn and stated that the residents “enjoy spending time outside anyway.” Licensee Kilchermann reported that she could not have all nine residents in her home with air conditioning, as they would not all fit. Ms. Kilchermann reported that nine residents were in the barn on 6/23/25 for ten hours and seven residents were in the barn on 6/24/25 for five hours before being asked to find a cooler option by Angie Loiselle, Recipient Rights Officer. Based on my observations of the barn, camping chairs and two older chairs were the only options available for resting or napping besides laying down on the cement ground or out in the hot sun on the grass. One small table was available for eating, which was not large enough for all nine residents. During my investigation of the barn, I did not observe any of the residents’ personal belongings.

On 06/24/2025, I interviewed Guardian A1 who confirmed that Resident A was transferred to a Saginaw County hospital because he was placed on a ventilator after being taken to the hospital in the evening of 06/23/2025. Guardian A1 reported that all she was aware of is that Resident A was diagnosed with double pneumonia at the hospital. Guardian A1 was unaware that Resident A spent the entire day outside in a barn before needing an ambulance on the evening of 6/23/25.

On 06/23/2025, the outdoor temperature was a high of 93 degrees and Montcalm County was under a heat advisory until 6/23/25 at 8pm, according to the National Weather Service, as heat indexes could reach a high of 101 degrees. On 06/24/2025, the outdoor temperature was a high of 93 degrees according to the National Weather Service.

On 06/25/2025, I interviewed Resident B via phone. Resident B confirmed that he spent the day at a barn on 6/23/25 and 6/24/25. Resident B reported that he was at the barn all day on 6/23/25 and on 6/24/25, he and other residents and direct care staff left halfway through the day and went to Edmore Park to have pizza and then to the library. Resident A stated that he had McDonalds for lunch on 6/23/25 and there was water, coke and diet Pepsi available for drinks. Resident B described playing games at the barn, using the port-a-john and still getting his medications dispended. Resident B stated that he was “sweating some” but there were coolers with drinks available.

On 06/25/2025 and 07/31/2025, I interviewed direct care worker(DCW), Cindy Ordiway via phone. She reported that she worked on 06/23/2025 and 06/24/2025 from 7am-5:30pm. DCW Ordiway explained that residents were provided breakfast at the home and then lunch was provided at the barn. DCW Ordiway stated that residents played games throughout the day. DCW Ordiway explained that resident medications were brought to the barn but kept them locked in licensee Bonnie Kilchermann’s house on the property. She stated that five residents receive noon medications. DCW Ordiway explained that the port-a-john was brought in for the residents to use and only one resident went into Ms. Kilchermann’s home to use the bathroom. DCW Ordiway stated that “it was pretty cool if you stay in the barn.” She explained that one resident regularly does not take his hoodie off and one resident who won’t wear shorts. DCW Ordiway explained that it was hot coming out of the port-a-john, and she tried to keep them as cool as she could. DCW Ordiway stated that she tried to use wash cloths to keep residents cool. DCW Ordiway reported that it was hot, and Resident A’s face was a little red, but none of the residents were acting sick, including Resident A. DCW Ordiway reported that she did not hear Resident A make any statements about not feeling well, nor did she observe any behaviors that caused concern regarding Resident A being sick. She explained that she needed to assist Resident A with walking to the bathroom with his walker as he was unstable and would not be able to make it to Bonnie Kilchermann’s home, nor would he be able to climb the stairs leading into the house. DCW Ordiway stated that Resident A has been dependent on a walker and it was not due to the heat or him not feeling well. DCW Ordiway explained that Resident A’s briefs were changed

in the porta-a-john to provide privacy. DCW Ordiway stated that Resident A showed no signs of sickness on 06/23/25 such as coughing but was acting more confused such as going into the bathroom and sitting on the toilet with his pants up and banging on the walls. She stated that prior to 06/23/25 Resident A was also waking up in the middle of the night and doing this same behavior too. DCW Ordiway stated that Resident A would not go to the bathroom but sit in the dark without the lights on. DCW Ordiway reported that a few days prior to 6/23/25, Resident A was having more toileting accidents, so she sent extra clothes and briefs with Resident A on the PACE bus the week prior. DCW Ordiway explained that when they left the barn on 6/23/25, staff and residents sat outside under the tree for about 30 minutes before entering the AFC as it was too hot. DCW Ordiway stated that she and the other staff member, Olivia Beebe went inside and put fans on and turned the air conditioner on. She explained that the bed bug company had opened the windows already. DCW Ordiway reported that Bonnie Kilchermann arrived at the AFC about 20 minutes after the residents arrived. DCW Ordiway reported that on 6/24/25, she and the residents left the barn and went to the park to have pizza and then stayed at the library until 5pm. She stated that she was not working when Resident A fell at the home and needed assistance from emergency services. DCW Ordiway explained that the only other option that was discussed besides taking the residents to the barn, was a hotel, but Ms. Kilchermann was worried about taking the bed bugs to the hotel.

On 06/25/2025 and 07/31/2025 I interviewed direct care worker Olivia Beebe via phone. She reported that she worked on 6/23/25 from 7am-1pm and then came back from 4pm-8pm. DCW Beebe stated that it was not too hot in the barn with shade and fans, but out in the sun it was very hot. DCW Beebe explained that the residents had McDonalds for lunch and had dinner at the barn. She stated that they had extra clothes, briefs and wipes for residents who needed assistance with being changed. DCW Beebe explained that she tried to keep the residents hydrated and used rags on Resident A's head and ice in his shirt to keep him cool. She stated that Resident A had on a gray tee shirt and shorts on. Beebe stated that she helped load Resident A in her car and drove him to the adult foster home. She explained that Resident A held a conversation with her on the way home. She stated that he appeared more confused the few days prior than during the ride back to the facility on 06/23/2025. DCW Beebe reported that when they arrived back at the foster home, she helped open all the windows, turn fans on and the air as it was very hot in the home still. It was reported that Resident A and the other residents sat in the shade for about 15-30 minutes, but Resident A had to use the bathroom and came into the house within 15 minutes and then went back outside. DCW Beebe explained that she was informed by another resident that Resident A fell on the porch and he also had an accident at the same time, so she assisted him with getting to the toilet. She explained that Resident A did not look well, as he was very pale, eyes were white and his cheeks were starting to sink in. DCW Beebe reported that they had been at the foster home for about 15-20 minutes before Resident A fell. She explained that they took his blood pressure, which was very high with a reading of 207/95 and a pulse of 115. DCW Beebe stated that DCW Ordiway and DCW Webber then called 911. DCW Beebe reported that Ms. Kilchermann arrived at the

AFC about the same time as the residents. DCW Beebe was unaware if any other options were explored instead of using the barn on 6/23 and 6/24. She stated that it can be normal for Resident A to have accidents, and he can clean himself up most of the time and staff assist as needed.

On 06/25/2025, I interviewed Resident C via phone. Resident C stated that he was required to spend the two days at the barn due to the home undergoing a heat treatment for bed bugs. Resident C stated that at the barn he was provided with water, food and a port-a-john for using the bathroom. Resident C explained that there were fans in the barn, and it was not too bad. Resident C explained that when they returned to the home, it was very hot and he stated it was “350 degrees in the home.”

On 06/25/2025, I interviewed Resident D via phone. Resident D stated that he was at the barn on 06/23/2025 and he spent most of the day in his jeep. Resident D reported that he parked his jeep in the shade. Resident D stated that “I’m from Arizonia and it’s not hot yet.” Resident D explained that he was provided with food, water and used the port-a-john. Resident D stated that he didn’t see any residents go into Ms. Kilchermann’s home. Resident D reported that he made the choice to not go to the barn on Tuesday, 6/24/2025 and he went out into the community by himself.

On 06/30/2025 and 07/31/2025, I interviewed direct care worker, Erica Webber via phone. DCW Webber stated that she worked on 6/23/25 from 3pm-11pm. DCW Webber stated that all the residents were having fun, playing games, having snacks and napping while in the barn. DCW Webber stated that there was a breeze coming through and they also had fans. She also explained that the residents had a port-a-john to use for the bathroom. DCW Webber reported that when they returned to the AFC home, she and the other staff members went inside to turn on the air and get fans going. DCW Webber reported that Ms. Kilchermann arrived at the AFC around the same time as the residents and she was helping her son and dog into the home. The residents stayed under a tree in the shade, but soon after arriving at the home, Resident A had to use the bathroom. Resident A was walking down the porch, after using the bathroom and another resident came in and told her Resident A fell outside. DCW Webber explained that she went outside and helped get Resident A on his walker and to the bathroom, as he had an accident when he fell. DCW Webber reported that it looked like Resident A had a heat stroke and they put a cool washcloth and fan on him. DCW Webber explained that they took his blood pressure which was high. DCW Webber reported that when Resident A was on the toilet, he was shaking and staring off. DCW Webber reported that “the inside of the house was so hot, it might have made his sickness pop out.” DCW Webber stated that Resident A did not seem overheated at the barn, nor did she observe him to be sick the days prior to the heat treatment in the barn. DCW Webber explained that she did not observe Resident A to be confused prior to 6/23/2025. DCW Webber stated that besides going to a park, she was unaware of any other plans for the residents to go anywhere else besides the barn on 06/23 and 6/24.

On 07/01/2025, I completed an unannounced onsite investigation to Kilchermann adult foster home. During the unannounced onsite investigation, I reviewed residents' documents and interviewed licensee Bonnie Kilchermann. Ms. Kilchermann reported that Resident A was diagnosed with double pneumonia at the hospital. Licensee Kilchermann stated that Resident A had a heart attack last year and has been more confused recently, but she stated he also has dementia, and she did not address his confusion at that time. Ms. Kilchermann stated that she received a phone call from the hospital stating he can't walk and needs to work on his ADL's with physical therapy. Ms. Kilchermann continued to not understand why the residents could not be in the barn with a heat index of 101 and stated they enjoy being outside. She reported that since Resident A is a registered sex offender, he could not have gone to the library or park. I asked Ms. Kilchermann if she called guardians or family members to find options for them to stay during the heat treatment and she stated that the residents don't have any family members and most have public guardians who don't visit often. Ms. Kilchermann did not attempt to find cooling centers. Ms. Kilchermann reported that the porta-a-john was brought in for the residents to use the bathroom for these two days and wipes and briefs were available as needed.

After reviewing the residents' files in the home, it was found that the following residents have medical needs based on their *medical statement* and *Assessment Plan for AFC Residents.*

Resident A: briefs, walker/cane
Resident C: Right partial hemiparesis but ambulatory.
Resident : Limited decision and mobility
Resident E: Inhaler, heart smart diet, COPD, GERD, cognitive limitations.
Resident F: Cognitive disorder, blind, poor balance

On 07/10/2025, I interviewed Guardian A1 via phone. Guardian A1 reported that Resident A was being transferred to a rehabilitation facility soon in Clare County. Guardian A1 stated that Resident A needs to work on his mobility for about four weeks and then will return to the AFC. Guardian A1 also confirmed that Resident A is a registered sex offender and can't visit public places such as libraries.

On 07/14/2025, I spoke with Resident A's PACE nurse, Krista Bly via phone. She reported that she would gather discharge paperwork from Resident A's hospital stay. She stated that Resident A is currently at the rehabilitation facility and is doing well.

On 07/21/2025, I spoke with PACE nurse, Krista Bly Via phone. She reported that she is concerned about the decision, licensee Bonnie Kilchermann made regarding taking the residents to the barn on 6/23/25 and 6/24/25 for extended hours while it was dangerously hot outdoors. She sent discharge paperwork from the hospital for Resident A. The discharge paperwork stated the following:

Discharge diagnosis

- *Acute hypoxic respiratory failure requiring intubation-extubated on 06/24*

- *Acute sepsis present on admission*
- *Nosocomial pneumonia*
- *Acute metabolic encephalopathy due to sepsis and pneumonia*
- *History of hypertension with Hypotension on admission secondary to hypovolemia due to dehydration and sepsis.*

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 06/23/2025, licensee Bonnie Kilchermann had nine residents in an outdoor barn for ten hours when a heat advisory warning was given and the heat index was 101 degrees while the AFC home was heat treated for bed bugs. On 06/24/2025, the residents were in an outdoor barn for five hours, until being told by Recipient Rights to take them to a cooling center. Resident C reported that he was required to go to the barn due to the heat treatment for bed bugs. Requiring nine residents to sit in an outdoor barn while their county was under a heat advisory put all the resident's safety at risk. The residents were continuously exposed to additional heat by returning to a home that had not been cooled. Licensee designee, Bonnie Kilchermann reported that she did not attempt to reach out to cooling centers, guardians/family members of the residents or additional options, including rescheduling the heat treatment, to provide the residents relief from the extreme heat. Due to Ms. Kilchermann not rescheduling the bed bug heat treatment for days when the heat index was lower or providing additional options for the residents to obtain relief from the heat besides sitting in a barn for 10 hours, a violation was established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 07/01/2025, I completed an unannounced onsite investigation to Kilchermann AFC. During the onsite, I viewed *Assessment Plans for AFC Residents* for all nine residents. Eight residents had *Assessment Plans for AFC Residents* that have not been updated annually.

- Resident A had an *Assessment Plans for AFC Residents* dated 2/22/24 and was not signed by his guardian.
- Resident B had an *Assessment Plans for AFC Residents* dated 3/10/24.
- Resident C had an *Assessment Plans for AFC Residents* dated 2/22/24 and was not signed by his guardian.
- Resident D had an Assessment *Plans for AFC Residents* dated 9/26/23.
- Resident E had an *Assessment Plans for AFC Residents* dated 1/24/24 and was not signed by his guardian.
- Resident F had an *Assessment Plans for AFC Residents* dated 1/22/24 and was not signed by his guardian.
- Resident G had an *Assessment Plans for AFC Residents* dated 4/02/24 and was not signed by his guardian.
- Resident H had an *Assessment Plans for AFC Residents* dated 01/27/2024 and Resident H is his own guardian.

On 03/26/2024, *Licensing Study Renewal Report* from 2024*,* cited a rule violation of R 400.14301 (4). The analysis section of the report stated that there was no verification, such as the resident's designated representative's signature, to confirm the assessment plan had been completed with their participation. The correction action plan (CAP) dated 4/8/24 and signed by Bonnie Kilchermann stated that the "assessment plan has been signed by the guardian and returned."

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

ANALYSIS:	Based on review of all nine resident files, eight resident files had outdated *Assessment Plans for AFC Residents,* which had not been updated in the required annual year. Five of the resident files were also missing signatures from their designated representative or responsible agency to confirm their participation in completing the assessment. After review of the 2024, renewal report and correction action plan dated 4/8/24, it was found to be a repeat violation of assessment plans not having verification, such as the resident's designated representative's signature, to confirm the assessment plan had been completed with their participation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE 2024 LSR and CAP DATED 4/08/24].**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan and due to the quality of care violations, I recommend modification of the license to provisional status due to the resident safety violations.

07/24/2025

_____

Amanda Blasius Date
Licensing Consultant

Approved By:

08/04/2025

_____

Dawn N. Timm Date
Area Manager