



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 17, 2025

Peggy Root
411 Silver Street
Reading, MI 49274

RE: License #: AM300008365
Investigation #: 2026A1032005
Heritage House AFC

Dear Peggy Root:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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,

A handwritten signature in black ink, appearing to read "Dwight Forde".

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
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 #:	AM300008365
Investigation #:	2026A1032005
Complaint Receipt Date:	10/31/2025
Investigation Initiation Date:	11/05/2025
Report Due Date:	12/30/2025
Licensee Name:	Peggy Root
Licensee Address:	411 Silver Street, Reading, MI 49274
Licensee Telephone #:	(517) 283-1478
Administrator:	Peggy Root
Name of Facility:	Heritage House AFC
Facility Address:	121 West State Street, Reading, MI 49274
Facility Telephone #:	(517) 283-3152
Original Issuance Date:	08/02/1993
License Status:	REGULAR
Effective Date:	04/23/2024
Expiration Date:	04/22/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had sepsis due to improper care.	No
Additional Findings	No

III. METHODOLOGY

10/31/2025	Special Investigation Intake 2026A1032005
11/05/2025	Special Investigation Initiated - On Site
11/21/2025	Contact - Telephone call made Interview with Guardian A1
12/02/2025	Contact - Document Received Hospital Discharge, Resident Care Agreement and Health Care Appraisal.
12/17/2025	Exit Conference

ALLEGATION:

Resident A had sepsis due to improper care.

INVESTIGATION:

On 11/5/25, I interviewed licensee Peg Root in the facility. Ms. Root stated that Resident A had apparently pulled her catheter out, and in an attempt to keep it stable, employee Alyson Baker taped the catheter tube to Resident A's leg. I asked Ms. Root if she was aware of any specific practices or procedures associated with care for the catheter and she reported that there were none in place from Resident A's doctor. She advised that Resident A has a very high pain tolerance as a means

of explaining how she was able to pull the catheter out and why the area got infected.

I attempted to interview Resident A but I was unable to do so due to a mental condition. Resident A appeared happy and was going to eat lunch during the onsite inspection.

On 11/21/25, I interviewed Guardian A1 by telephone. Guardian A1 advised that Resident A has lived at the facility for several years. She confirmed that Resident A was provided in home nursing services as a result of the hospital trip. She reported that she had accompanied employee Alyson Baker to the original appointment where the catheter was inserted, and acknowledged that there were no solid instructions provided for catheter care.

On 12/2/25, I reviewed Resident A's hospital discharge papers, which stated that Resident A did not have sepsis, and that a referral was made for home health services.

APPLICABLE RULE	
R 400.689	Resident health care.
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	There were no clear instructions provided to the facility for catheter care. This became clear from interviews with Ms. Root and Guardian A1. Resident A appears to have interfered with the catheter but now receives in home health services. As a result, there is insufficient evidence to establish a violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 12/17/25, I conducted an exit conference with licensee Peggy Root. I shared my findings, and Ms. Root agreed with the conclusions reached. She added that Guardian A1 had been approached about sending Resident A to the hospital but offered resistance, due to the potentially high medical bill.

IV. RECOMMENDATION

I recommend no change to the status of this license.

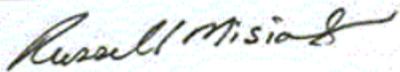


12/17/25

Dwight Forde
Licensing Consultant

Date

Approved By:



2/5/26

Russell B. Misiak
Area Manager

Date