



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 9, 2026

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

RE: License #: AM590395969
Investigation #: 2026A0622027
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

A handwritten signature in cursive script, appearing to read "Amanda Blasius".

Amanda Blasius, 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 #:	2026A0622027
Complaint Receipt Date:	03/03/2026
Investigation Initiation Date:	03/03/2026
Report Due Date:	05/02/2026
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:	07/22/2025
Expiration Date:	07/21/2027
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Hospital discharge medication orders were not followed.	Yes

III. METHODOLOGY

03/03/2026	Special Investigation Intake- 2026A0622027
03/03/2026	Special Investigation Initiated – Letter. Documentation received from Alicia Failing, nurse from Montcalm Care Network.
03/19/2026	Inspection Completed On-site
04/06/2026	Inspection Completed-BCAL Sub. Compliance
04/08/2026	Exit conference with licensee designee, Joanne Broidrick

ALLEGATION: Hospital discharge medication orders were not followed.

INVESTIGATION:

On 03/03/2026, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, Resident A was discharged from the hospital on 2/26/26 and the transfer of care document was provided to the home manager, direct care worker Trysta Gorsuch. On 02/27/2026, nurse Alicia Failing visited the home and was provided a copy of the transfer of care document for Resident A. The complaint stated upon review of document it is noted that gabapentin was stopped and duloxetine (Cymbalta) dose was decreased from 60mg to 30mg by the hospitalist for somnolence. According to the complaint, nurse Alicia Failing reviewed the homes electronic medication administration system and on 02/27/2026 at 2pm the medication did not reflect discharge orders obtained the day prior.

On 03/03/2026, I received documentation from nurse, Alicia Failing.

On 03/03/2026, I reviewed the transfer of care document for Resident A. The form was dated 2/26/26 at 5:17pm.

On page 10 of the document, it stated discharge instructions in bold letters:

- “Changes have been made to your medication as described above; please take as prescribed. Especially important changes in:
 1. Please TAKE a dose of Tamiflu tomorrow after dialysis, this medication treats your influenza, you only need one more dose tomorrow to complete the full course.

2. Please STOP taking your gabapentin and reduce our Cymbalta to 30 mg daily due to your renal dysfunction. Follow up with your primary care physician to discuss restarting your gabapentin.”

The discharge order was electronically signed by Dr. Luke E Schanz, DO on 02/26/2026.

On 03/03/2026, I viewed Resident A's electronic medication administration record from 2/23/26-03/04/26. Resident A returned home from the hospital on 02/26/26. According to Resident A's electronic medication administration record, she was administered gabapentin, 300mg on 2/28/26 and 3/1/26 at 5pm. Resident A was away from the home on 2/27/26 and 3/2/26 and did not receive gabapentin. According to Resident A's electronic medication administration record, her gabapentin 300mg was stopped on 3/3/26. A dose of Tamiflu was provided to Resident A but was not documented on Resident A's medication administration record.

According to Resident A's electronic medication administration record, Resident A received Duloxetine 60mg(Cymbalta) on 02/27/26, 02/28/26 and 03/01/26 at 8am. Resident A did not receive Duloxetine of any dose on 03/2/26 and then received Duloxetine 30mg on 03/03/26 at 8am.

On 03/03/2026, I reviewed Resident A's health care appraisal. Resident A's health care appraisal was completed on 02/27/26, by nurse Alicia Failing. On the health care appraisal, it stated the following under current medications and instructions: “administer medication as hospital discharge instructions provided from 2/26/26.” According to nurse Alicia Failing, she sent the health care appraisal on 02/27/26 at 2pm via email.

On 03/19/2026, I completed an unannounced onsite investigation to Golden Life Assisted Living #2. During the unannounced onsite investigation, I interviewed direct care worker, Trysta Gorsuch, who identified as the home manager. She reported that she received a phone call from a nurse named Allison (no last name known) at the hospital on 02/26/2026 before Resident A was discharged. DCW Gorsuch reported that she asked nurse Allison if there were any medication changes for Resident A and nurse Allison reported no, besides hydralazine which is now scheduled instead of a PRN. DCW Gorsuch reported that nurse Alicia Failing came to the home on 2/27/26 to visit Resident A. DCW Gorsuch provided nurse Failing with the discharge summary from the hospital for Resident A. DCW Gorsuch stated that when nurse Failing left the home, she did not report any changes and stated she would email her the health care appraisal. DCW Gorsuch reported that on 03/2/26, she received a phone call from DCW Alicia Failing to complete an incident report for a medication error for Resident A, due to not administering medication according to the hospital discharge order. DCW Gorsuch stated that she had called Hometown Pharmacy on 03/02/2026 and they did not receive any orders from the hospital. She stated that she discovered that Resident A's new medications were sent to Pioneer of Sparta Pharmacy, therefore all medications needed to be sent to the correct pharmacy.

On 03/19/2026, I reviewed the transfer of care summary for Resident A, it stated on page 14 that Resident A's medications were sent to Pioneer of Sparta Pharmacy. The document provided an address and phone number for the pharmacy.

On 03/19/2026, I viewed an incident report for Montcalm Care Network regarding the medication errors. Information provided was consistent with the information provided in the other documents and interviews completed.

Special Investigation Report #2025A1033037 cited for the equivalent rule of 400.14312 on 06/26/2025. The investigation determined direct care staff members did not administer Resident C's migraine medication as prescribed. A corrective action plan was submitted on 07/01/2025 and approved with the following plan: "Staff will be trained to print eMAR and have Montcalm Care Network nurses document medications that are given by their staff. Staff will also document in eMAR that medication was administered by a health care professional. Medications will only be held or discontinued following formal orders from medical professionals. Trysta Gorsuch home manager will monitor and audit eMAR weekly to ensure medications are being properly charted."

Special investigation Report # 2026A1029014 from 2/11/2026 cited Rule 400.675 (1)(4)(b)(v). "Based on the interviews with RN Faling, Ms. Gorsuch, Ms. Loiselle, and Dr. Wilfore, and my review of multiple residents' eMARs, resident medications were not given as prescribed as there was no verification via staff members' initials on the eMAR that the medication was administered. Further there was documentation on eMARs of medications not being refilled or available to administer. Also, there were over 100 date/time boxes on multiple residents' eMARs with no direct care staff initials indicating who administered the medication and at what time as required." A corrective action plan was submitted on 12/23/25 and approved with the following plan: "All MARS will be audited and scanned for errors each day by the home manager for each resident residing in the home moving forward. The executive director will review MARS weekly and again at the end of the month before filing in residents charts. If there is a ECP error it will be documented on paper and kept in the residents file and/or a incident report will be completed as necessary."

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	Based upon interviews completed and documentation reviewed it was determined that Golden Life Assisted Living #2 did not follow Resident A's discharge orders from her transfer of care document that was provided to home manager, Trysta Gorsuch upon Resident A's arrival back at the home on 02/26/26. According to the discharge orders signed electronically by Dr. Luke E Schanaz on 02/26/26, Resident A should have been provided one dose of Tamiflu, stopped taking her gabapentin and reduced her dose of Duloxetine 60mg(Cymbalta) to 30mg. The medication administration record for Resident A confirmed that Resident A received her gabapentin 300mg on 2/28/26 and 3/1/26 at 5pm. The medication administration record for Resident A also confirmed that Resident A received her Duloxetine 60mg(Cymbalta) dose on 02/27/26, 02/28/26 and 03/01/26 at 8am. Resident A never received her final dose of Tamiflu. A violation was established as direct care workers did not review Resident A's transfer of care summary, nor follow the new established discharge orders from Dr. Luke E Schanaz that went into effect on 02/26/2026.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



04/09/2026

Amanda Blasius
Licensing Consultant

Date

Approved By:



04/09/2026

Dawn N. Timm
Area Manager

Date