GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 1, 2026

Belinda Ide
Ide AFC Home, LLC
1188 S. Gunnell Road
Eaton Rapids, MI 48827

RE: License #: AM470417042
Investigation #: 2026A0466062
Ide Assisted Living

Dear Ms. Ide:

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) 335-5985.

Sincerely,



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 #:	AM470417042
Investigation #:	2026A0466062
Complaint Receipt Date:	09/08/2026
Investigation Initiation Date:	09/09/2026
Report Due Date:	11/07/2026
Licensee Name:	Ide AFC Home, LLC
Licensee Address:	1188 S. Gunnell Road Eaton Rapids, MI 48827
Licensee Telephone #:	(517) 897-1845
Administrator:	Belinda Ide
Licensee Designee:	Belinda Ide
Name of Facility:	Ide Assisted Living
Facility Address:	2111 N. Latson Rd Howell, MI 48855
Facility Telephone #:	(517) 897-1845
Original Issuance Date:	05/01/2024
License Status:	REGULAR
Effective Date:	11/01/2024
Expiration Date:	10/31/2026
Capacity:	12
Program Type:	MENTALLY ILL AGED

II. ALLEGATION:

	Violation Established?
Medication was not administered as prescribed to Resident A.	Yes
Additional Findings	Yes

**Please note other allegations were listed in the intake; however they were not AFC rule or statute related and were not investigated.*

III. METHODOLOGY

09/08/2026	Special Investigation Intake 2026A0466062.
09/08/2026	APS Referral denied for investigation.
09/09/2026	Special Investigation Initiated - On Site.
09/22/2026	Contact- telephone call made to Abigail Hospice, Beth Martin interviewed. Asked nurse Veronica to contact me if she had any concerns about the medication administration provided to Resident A.
09/29/2026	Contact- document sent to licensee designee Belinda Ide, documents never recevied.
10/01/2026	Exit Conference with licensee designee Belinda Ide.

ALLEGATION: Medication was not administered as prescribed to Resident A.

INVESTIGATION:
On September 8, 2026, Adult Protective Services (APS) Central Intake submitted a complaint from a third party to the Department of Licensing and Regulatory Affairs (LARA) regarding Resident A, age 71, who had a diagnosis of dementia and was residing at Ide Assisted Living Home. Complainant reported that Resident A had lived at the facility for the past four years. According to Complainant, Resident A was hospitalized approximately one month prior because she was not feeling well; the hospital reportedly did not identify any medical concerns, and she was returned to the facility.

Complainant reported that it was suspected physicians were over-medicating Resident A. Complainant stated that two weeks prior, Resident A had been feeling well and eating normally. Complainant further alleged that licensee designee Belinda Ide wanted to administer Dilaudid to Resident A because she was roaming around

the facility, unable to settle down, and was difficult to manage. Complainant reported that Resident A was given Dilaudid every three hours for three consecutive days. Complainant reported that two weeks later, Resident A was bedridden and placed on hospice services. Complainant stated that hospice nurse Veronica (no last name provided) informed Relative A1 that Resident A was being overmedicated. Complainant also reported that Resident A passed away on August 28, 2026, and that her death certificate listed colon cancer as the cause of death, despite Resident A never having been diagnosed with cancer.

On September 9, 2026, I conducted an unannounced onsite investigation. Direct care worker (DCW) Riley Warres was on shift and reported that she has only worked at the facility for two weeks. DCW Warres stated that she worked one day with Resident A; however, she did not administer any medications to Resident A nor was she aware of any medications that she was prescribed.

I interviewed DCW Patricia Mount, who reported that she began working at the facility at the end of July 2026. DCW Mount stated that she is not trained in medication administration and therefore does not pass medications, nor does she know what medications Resident A was prescribed. DCW Mount stated that Resident A was not sleeping and wandered throughout the house. She further reported that in the days before Resident A passed away, Resident A slept often.

While I was onsite, licensee designee Belinda Ide called. I informed her by phone that Resident A's *Medication Administration Records* (MARs) for May 2026, June 2026, July 2026, and August 2026 were not present in the resident record. I also advised her that the signature pages for Resident A's written *Assessment Plan for Adult Foster Care (AFC) Residents* and Resident A's *Resident Care Agreement* were missing from the record. Licensee designee Ide stated that she would have those documents emailed to me; however, I did not receive them by the time this report was completed.

At the time of the unannounced onsite investigation Resident A's medications were not at the facility as she had passed away on August 28, 2026 and her family members had already taken her belongings.

On September 23, 2026, I interviewed Beth Martin with Abigail Hospice. Ms. Martin reported that Resident A had been prescribed Dilaudid, also known as hydromorphone HCl, beginning when Resident A was admitted to hospice on July 16, 2026, and continuing until Resident A passed away on August 28, 2026. Ms. Martin stated that Resident A was initially prescribed 0.5 mg pro re nata (PRN) every 3 hours for pain management. Ms. Martin further reported that on August 26, 2026, Resident A's medication regimen was changed to Dilaudid 0.5 mg every 6 hours as

a scheduled medication, while the 0.5 mg PRN dosage every 3 hours remained available for breakthrough pain.

On September 29, 2026, I emailed licensee designee Ide to again request the documents that were missing from Resident A's record at the time of the unannounced onsite investigation. I asked that the documents be submitted to me for review. On September 30, 2026, licensee designee Ide responded to the email however the requested documents were not provided.

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. **(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:** **(b) Complete an individual medication log that contains all of the following:/sc** **(i) Medication name.** **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) Initials of the individual who administered the medication at the time given.** **(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.** **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.**
ANALYSIS:	Although hospice verified that Dilaudid was prescribed for Resident A and that she had both a standing/scheduled order and an additional order for the same medication for breakthrough pain, licensee designee Ide had no documentation of medication administration onsite as required nor did she provide this after multiple requests. Due to the lack of available records, the absence of MARs/the removal of medications, a violation has been established as there is no documentation to support that medication was administered as prescribed. Additionally, there is no documentation to support that a medication log was completed as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On September 9, 2026, I conducted an unannounced investigation. At the time of my arrival, DCW Warres was on shift alone as DCW Mount had taken a resident into the community. DCW Warres reported that she has worked at the facility for the last two weeks as a DCW.

On September 29, 2026, I conducted an audit of the Michigan Workforce Background Check system (WBC) and there was no documentation that DCW Warres has been fingerprinted and is eligible to work in an AFC as required.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under

	subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	On September 9, 2026, DCW Warnes was working in the facility by herself even though she has not been fingerprinted though the Michigan Workforce Background Check system prior to taking on AFC duties, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
During the unannounced onsite investigation on September 9, 2026, Resident A's resident record contained a *Health Care Appraisal* dated May 22, 2025. There was no updated *Health Care Appraisal* in the record for 2026 as required. A missing or outdated health care appraisal prevents verification of a resident's current medical status, needs, and physician-recommended care.

While onsite, I informed licensee designee Ide that an updated *Health Care Appraisal* was required for Resident A. She acknowledged the concern and reported she would look into the matter and send an updated document if one existed. However, no updated *Health Care Appraisal* was ever received, and no further information was provided to demonstrate that an annual appraisal had been completed.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(10) A resident or resident's designated representative shall provide a written health care appraisal or a medical discharge summary by an appropriate health care professional that is completed within the 90-day period before admission. A written health care appraisal must be completed at least annually thereafter. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be completed no later than 30 days after admission.

ANALYSIS:	Resident A's *Health Care Appraisal* had not been updated annually as the *Health Care Appraisal* in Resident A's record was dated May 22, 2025. Licensee designee Ide did not provide an updated completed annual *Health Care Appraisal* for Resident A as required. The failure to produce an updated appraisal upon request further demonstrates noncompliance with the record-keeping requirements.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On September 9, 2026, I conducted an unannounced investigation. Resident A's record did not contain the signature pages for Resident A's written *Assessment Plan for Adult Foster Care (AFC) Residents* and Resident A's *Resident Care Agreement*. Licensee designee Ide was notified of these missing records while I was onsite. She stated that she would email the documents because the direct care workers on duty were unable to retrieve them electronically. However, despite this assurance, the documents were never received**.**

On September 29, 2026, I emailed licensee designee Ide to again request the documents that were missing from Resident A's record at the time of the unannounced onsite investigation. I asked that the documents be submitted to me for review. On September 30, 2026, licensee designee Ide responded to the email, however the requested documents were not provided.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge. **(8) A resident care agreement must be signed by all applicable parties. A copy of the signed resident care agreement along with copies of the policies listed in subrule (6) of this rule must be provided to the resident or the resident's designated representative and maintained in the resident's record.**

ANALYSIS:	During the unannounced investigation on September 9, 2026, Resident A's resident record did not contain required documentation, including, the signature page for Resident A's written *Assessment Plan for Adult Foster Care (AFC) Residents* and Resident A's *Resident Care Agreement* were missing from the record. These documents are required components of the resident record and must be maintained onsite and available for review at all times. Licensee designee Ide was notified of these missing records while I was onsite. She stated that she would email the documents because the direct care workers on duty were unable to retrieve them electronically. However, despite this assurance, the documents were never received therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



10/01/2026

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Julie Elkins — Date
Licensing Consultant

Approved By:



10/01/2026

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Dawn N. Timm — Date
Area Manager