



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 25, 2024

Paul Wyman
Retirement Living Management of Ionia, L.L.C.
1845 Birmingham SE
Lowell, MI 49331

RE: License #: AL340390582
Investigation #: 2024A0622036
Green Acres of Ionia

Dear Mr. Wyman:

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) 284-9727.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Amanda Blasius', written in a cursive style.

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 #:	AL340390582
Investigation #:	2024A0622036
Complaint Receipt Date:	06/12/2024
Investigation Initiation Date:	06/12/2024
Report Due Date:	07/12/2024
Licensee Name:	Retirement Living Management Of Ionia, L.L.C.
Licensee Address:	1845 Birmingham SE Lowell, MI 49331
Licensee Telephone #:	(616) 897-8000
Administrator:	Caitlin Campbell
Licensee Designee:	Paul Wyman
Name of Facility:	Green Acres of Ionia
Facility Address:	2550 Commerce Lane Ionia, MI 48846
Facility Telephone #:	(616) 527-3300
Original Issuance Date:	01/11/2018
License Status:	REGULAR
Effective Date:	07/11/2022
Expiration Date:	07/10/2024
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A given wrong medication on March 27 th , 2024.	Yes

III. METHODOLOGY

06/12/2024	Special Investigation Intake 2024A0622036
06/12/2024	Special Investigation Initiated - Administrator called and reported concerns. Also sent an incident report.
06/20/2024	Contact - Phone call to complainant.
06/20/2024	Inspection Completed-BCAL Sub. Compliance
06/26/2024	Exit Conference with Caitlin Campbell

ALLEGATION: Resident A given wrong medication on March 27th.

INVESTIGATION:

On 06/12/2024, I received this complaint through the Bureau of Community and Health Systems online complaint system. According to the complaint, Resident A was given the wrong medication on 03/27/24. Complainant stated that staff called to inform her of the mistake. Complainant stated that she called the administrator, Caitlin Campbell and was informed that direct care worker, Makayla Schafer, would be suspended from passing medications and would undergo additional training. Complainant stated that she visited Resident A a few days later and observed direct care worker (DCW) Makayla Schafer passing medication. Complainant also stated that DCW Makayla Schafer has had three previous medication errors, one with Resident A and the two other times, were with another resident. Complainant explained that the other resident informed Makayla Schafer that she had the wrong medication. The complainant stated that she had discussed her concerns with three different managers and felt they were not taking her concerns seriously by only suspending DCW Schafer for three days from passing medication.

On 06/12/2024, I received a phone call from administrator, Caitlin Campbell who explained that there has been a medication error and Relative A1 brought up concerns about DCW Schafer continuing to pass medications. Administrator sent an incident report that was completed due to the medication error.

On 06/20/24, I spoke with Complainant via phone. She reported that she talked with the director of Green Acres, and she understands that errors occur, but her concern is that DCW Schafer has made several medication errors and no action is being taken. Complainant stated she was told DCW Schafer would be suspended from passing medication and that did not occur. Complainant stated that when she was visiting the facility she found a medication pill on the floor and was not sure how long it had been there. She explained that DCW Schafer has made three medication errors, and she was told that she would receive a disciplinary action. Complainant stated that she had talked with three managers and felt that her concerns were not being taken into consideration, therefore she called the owner, Paul Wyman. Mr. Wyman told Complainant that he would investigate, and the outcome was that DCW Schafer would be taken off from passing medication permanently.

On 06/20/2024, I completed an unannounced onsite investigation to Green Acres of Ionia. I interviewed administrator, Caitlin Campbell in person. She reported that a medication error did occur in March 2024 and DCW Schafer was suspended from medication for three days. Administrator, Caitlin Campbell stated that DCW Schafer has made three medication errors in 2023. She explained that around June 10th, 2024, DCW Schafer has been taken off from passing medication. She stated that there is not a plan to allow her to pass medication in the future.

Documentation was reviewed regarding DCW Schafer's disciplinary actions and the medication errors. Based on the documentation reviewed, DCW Schafer had a medication error on 09/28/2023. According to documentation reviewed, DCW Schafer did not pass a residents scheduled stool softener for two days resulting in the resident becoming constipated. On 09/29/2023, DCW Schafer did not pass a scheduled antibiotic before the resident's dental appointment. On 11/5/2023, DCW Schafer gave a resident a scheduled medication at the wrong time. On 3/11/2024, DCW Schafer gave Resident A Pregabalin 50mg that was not ordered for her. Documentation from DCW Schafer's disciplinary records state that for medication errors that occurred on 09/28/2023, 09/29/2023 and 11/5/2023 a discussion occurred regarding checking for notes and completing the 6 medication rights. On 3/11/2024, DCW Schafer was suspended from passing medication from 3/12/24-3/14/24.

APPLICABLE RULE	
R 400.15312	Resident medications.
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

ANALYSIS:	Based on the documentation reviewed DCW Makayla Schafer had four medication errors within 6 months. DCW Schafer was not required to re-complete medication administration training and was suspended from medication passing for three days after her fourth medication error. DCW Schafer was taken off from medication passing permanently by licensee designee Paul Wyman.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.



06/28/2024

Amanda Blasius
Licensing Consultant

Date

Approved By:



06/28/2024

Dawn N. Timm
Area Manager

Date