GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Karen LaFave
Adult Learning Systems - UP, Inc
Suite-4
228 West Washington
Marquette, MI 49855

January 22, 2025

RE: License #: AS520302805
Investigation #: 2025A0873007
Woodridge

Dear Ms. LaFave:

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 (616) 356-0100.

Sincerely,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N. W.
Grand Rapids, MI 49503
(906) 250-9318
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS520302805
Investigation #:	2025A0873007
Complaint Receipt Date:	12/03/2024
Investigation Initiation Date:	12/03/2024
Report Due Date:	02/01/2025
Licensee Name:	Adult Learning Systems - UP, Inc
Licensee Address:	Suite-4 228 West Washington Marquette, MI 49855
Licensee Telephone #:	(906) 228-7370
Administrator:	Karen LaFave
Licensee Designee:	Karen LaFave
Name of Facility:	Woodridge
Facility Address:	169 Fairbank Street Marquette, MI 49855
Facility Telephone #:	(906) 273-1100
Original Issuance Date:	10/01/2009
License Status:	REGULAR
Effective Date:	03/21/2024
Expiration Date:	03/20/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION

	Violation Established?
Untrained staff passed medication to Resident A	Yes
Additional Findings	Yes

III. METHODOLOGY

12/03/2024	Special Investigation Intake 2025A0873007
12/03/2024	Special Investigation Initiated - Telephone Interview with ORR
12/11/2024	Inspection Completed On-site
12/11/2024	Contact - Face to Face Interviews with Staff
01/22/2025	Contact - Telephone call made Interview with Guardian B
01/22/2025	Contact - Telephone call received Interview with Staff
01/22/2025	Exit Conference With Karen LaFave

ALLEGATION:

Untrained staff passed medication to Resident A.

INVESTIGATION:

On 12/3/24, I interviewed Pathways community mental health officer of recipient rights Casey Olson. Woodridge staff Gabriella Bell passed medication to Resident A even though she was not trained to do so.

On 12/11/24, I interviewed manager Cherry Mashue at the facility. On 11/30/24 the facility's washing machine flooded parts of the facility. This resulted in water flooding

Resident B's bedroom floor. Resident B's guardian arrived at the facility during this time and expressed concern to the staff at what was happening. Staff Gabriella Bell had been witness to administering medications in the past and took the medication to Resident A in her bedroom. Staff Wanda Wallenslager signed off on the medication pass in the QuickMAR system and staff Icesis Williams signed off on the controlled medication count.

On 12/11/24, I interviewed Ms. Williams at the facility. Ms. Williams was to be passing medications that day but with the recent bedroom flood and the guardian at the facility ,she was only able to sign off on the medication count. Ms. Bell ended up passing the medication.

On 1/22/25, I interviewed Ms. Bell over the telephone. The day she passed the medication the washing machine had flooded and a guardian had arrived at the home. Ms. Bell signed into the QuickMAR system to prepare to pass Resident A's medication. She popped three doses out of the medication packet and Ms. Wallenslager signed off on QuickMAR and then left the medication room. No one directly told Ms. Bell to pass the medication but she was left alone in the unlocked medication room with the pills and took it upon herself to take the medication to Resident A in her bedroom.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Staff Gabriella Bell was not properly trained in the administration of medication but passed medications to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

On 12/11/24, I interviewed manager Cherry Mashue at the facility. Staff Gabriella Bell administered three doses of medication to Resident A rather than the required single dose.

On 12/11/24, I interviewed Ms. Wallenslager at the facility. Staff Bell signed into the QuickMAR system in preparation to pass Resident A's medication. After Resident A

swallowed the medication, she informed Ms. Bell the dosage was not correct. Ms. Bell brought this to the attention of Ms. Williams who informed her that Resident A was supposed to have received one dose of medication instead of the three that Ms. Bell incorrectly gave to her. Staff called the home manager and the on-call doctor to inform them of what had happened. The doctor requested staff observe Resident A and call back during her evening dose with an update.

On 12/11/24, I interviewed Ms. Williams at the facility. Ms. Bell passed three doses to Resident A instead of the required single dose. Staff called the manager and the on-call doctor and were told to observe Resident A and update as needed.

On 12/11/24, I reviewed an incident report dated 11/30/24, which stated that Resident A received her evening dose of medication three pills, rather than her usual afternoon dose, one pill.

On 1/22/25, I interviewed Ms. Bell over the telephone. She admits to administering three does of medication to Resident A instead of a single dose. Ms. Bell informed staff who called the facility manager and the on-call doctor.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist.
ANALYSIS:	During the course of the investigation I discovered Ms. Bell had incorrectly passed the wrong dosage of medication to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/22/25, I explained the findings of this report to licensee designee Karen LaFave. She thanked me.

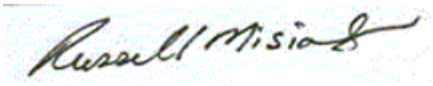
IV. RECOMMENDATION

Contingent upon approval of an appropriate corrective action plan, I recommend no changes to the status of this license.

1/22/25

Garrett Peters Date
Licensing Consultant

Approved By:



1/23/25

Russell B. Misiak Date
Area Manager