GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 6, 2025

Shequita Brown
1961 Reynolds
Muskegon, MI 49440

RE: License #:	AF610417971
Investigation #:	2025A0356018
	Organic Care

Dear Ms. Brown:

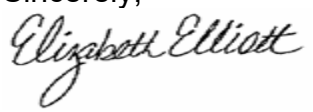
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF610417971
Investigation #:	2025A0356018
Complaint Receipt Date:	01/06/2025
Investigation Initiation Date:	01/06/2025
Report Due Date:	03/07/2025
Licensee Name:	Shequita Brown
Licensee Address:	1961 Reynolds Muskegon, MI 49440
Licensee Telephone #:	(870) 635-3599
Name of Facility:	Organic Care
Facility Address:	1961 Reynolds St. Muskegon, MI 49442
Facility Telephone #:	(870) 635-3599
Original Issuance Date:	11/21/2023
License Status:	REGULAR
Effective Date:	05/21/2024
Expiration Date:	05/20/2026
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's medications are not administered or documented as administered.	Yes
Resident A was not offered alternative food options.	No

III. METHODOLOGY

01/06/2025	Special Investigation Intake 2025A0356018
01/06/2025	Special Investigation Initiated - Face to Face Shequita Brown, review of medications.
01/06/2025	Inspection Completed On-site
01/07/2025	Contact - Telephone call made Meagan Frost, DCW.
01/10/2025	Contact - Telephone call received Shequita Brown, Licensee.
01/10/2025	Contact - Telephone call received Briana Fowler, ORR.
01/13/2025	Contact – Telephone call received Contact-Document received Brianna Fowler, ORR
02/04/2025	Contact - Document Received Brianna Fowler, ORR, Ottawa County. Shequita Brown, Licensee.
02/06/2025	Contact - Document Sent Briana Fowler, ORR. Deandra Robinson, DCW.
03/05/2025	Contact - Telephone call received Phone interview with Resident A.
03/06/2025	Exit Conference-Shequita Brown, Licensee.

ALLEGATION: Resident A's medications are not administered or documented as administered.

INVESTIGATION: On 01/06/2025, I received an Ottawa County Office of Recipient Rights complaint. The complainant reported that on 10/25/2024, Resident A did not get her medication, Acetaminophen at 6:00a.m. because staff refused to administer it. The complainant reported that Dr. Andrew Schulte prescribed the medication to be administered three times daily as a PRN and that staff refused to administer it. The complainant reported that Resident A also did not get the medication Carvedilol on 10/24/2024.

On 01/06/2025, I reviewed a letter written by Resident A that documented the following information, *'this morning* (10/25/2024) *Deandra* (Robinson) *refused to give me my acetaminophen at 6:00a.m. ordered by Doctor Andrew Schulte at my last visit with him, he said I could take my acetaminophen at 6:00a.m. and at 2:00p.m. and at 8:00p.m. It is a PRN and I asked for it but she refused giving it to me today, October 25, 2024, she was in the med cabinet when I asked so it was not something she was unable to do.*' Resident A also documented the following in the letter, *'I called the police and called different places to report abuse because Meagan* (Frost) *told staff Marty not to give me my Carvedilol at 8:00p.m. when I was getting my 8:00p.m. medications. Marty (*staff*) asked me then if I had gotten my Carvedilol at 5:00p.m. because I am scheduled to have it at that time. She couldn't find anything to record it at that time, so she asked me if I had gotten it and I said no, that I believed I did not receive it at 5:00p.m. I wanted to take it then* (Carvedilol) *with food because I was saying prayers when they asked me if I was going to eat squash and rice soup. I told them I was fasting at that time so then they put it down that I refused to eat and because I refused to eat, the staff Meagan recorded that I refused my medication because I was refusing to eat with it at 6:00p.m. on October 24, 2024. I explained that at 8:00p.m. or sooner they could have given me my medication with crackers or some other food other than squash rice soup.'*

On 01/06/2025, I conducted an inspection at the facility and interviewed Shequita Brown, Licensee. Ms. Brown stated Resident A's medications are administered as prescribed including Acetaminophen and Carvedilol. Ms. Brown stated Resident A is her own guardian. She visits and calls her doctor on her own and she requests and gets changes in prescriptions and medications without staff knowing and staff must be alert of regular changes to Resident A's medications. Ms. Brown stated she contacted Tina Johnston, Resident A's Health West case manager and was informed that Resident A can talk to her doctor about her medications, but Ms. Brown stated she and staff are not able to. Ms. Brown stated Resident A is prescribed Acetaminophen as a scheduled medication and as a PRN (as needed). There are two different prescriptions both being written on the same date, 10/18/2024. The scheduled medication is prescribed to be administered at 8:00a.m., 2:00p.m. and 8:00p.m. and there needs to be 6 hours in between administration time so staff must make sure they do not give a PRN of Acetaminophen prior to the 6 hours as ordered by Resident A's doctor.

On 01/06/2025, I did not conduct a face-to-face interview with Resident A because she is not at the home and is out at day a program.

On 01/06/2025, Ms. Brown and I conducted a review of the ECP e-MAR (electronic medication administration record) system and reviewed Resident A's Acetaminophen medication for the month of October 2024. On 10/25/2024, the MAR is documented by staff initials (Deandra Robinson and Armani McBride) showing Acetaminophen was administered as prescribed, 500mg, 8:00a.m., 2:00p.m. and 8:00p.m. The MAR documented Acetaminophen Tab, 500mg, PRN, as needed was not administered on 10/25/2024. Ms. Brown stated staff was concerned about giving Resident A's PRN Acetaminophen at 6:00a.m. when it was due as a scheduled medication to be administered at 8:00a.m. Ms. Brown stated if staff administer a PRN dose of Acetaminophen prior to the 8:00a.m. dose, staff will document on the e-MAR as PRN and then mark the scheduled medication on the e-MAR as "other" with staff initials only administering the medication at 6 hour intervals as prescribed. I observed 5 times on the e-MAR, on 10/22/24 at 8:00a.m., 10/23/2024 at 2:00p.m., 10/24/2024 at 8:00a.m., 10/26/2024 at 8:00a.m. and 10/27/2024 at 8:00a.m. marked as "other" and PRN Acetaminophen was administered and documented under the PRN medication area on the MAR. I compared the scheduled medication on the MAR to the PRN medication on the MAR and the administration of the PRN Acetaminophen corresponds with the same dates marked as "other" on the e-MAR for the regularly scheduled Acetaminophen administration. Upon further review of the e-MAR, on 10/20/2024, 8:00p.m., Acetaminophen Tab 500mg is not documented as administered. There are no staff initials indicating the medication was administered and no staff notes explaining the reason for the missed dose or any indication it was passed as a PRN. Ms. Brown confirmed the Acetaminophen was administered however, it was a new employee, and she failed to follow protocol and document the passed medication on the e-MAR system. Ms. Brown stated this staff is no longer working at the home.

On 01/06/2025, Ms. Brown and I reviewed the orders on the e-MAR for PRN medications. The e-MAR documented, *'Acetaminophen Tab 500mg, take 2 tablets (1,000mg) by mouth three times daily as needed (no more than 3 times daily) **max of 4 gms Apap/24hr from all sources**'* and '*Acetaminophen Tab 500mg, take 1 tablet by mouth every 6 hours as needed for mild pain (take three times daily at 6am, 2pm, 8pm) max 4.'* Written by Dr. Andrew Schulte, start date 10/16/2024.

On 01/06/2025, Ms. Brown and I reviewed the orders on the e-MAR for scheduled medications. The e-MAR documented, *'Acetaminophen Tab 500mg, take 2 tablets(1000mg) by mouth three times daily **max of 3gms Apap/24 hr from all sources**'* Written by Dr. Andrew Schulte, start date 10/18/2024.

On 01/06/2025, Ms. Brown and I reviewed the e-MAR, and it documented Resident A was prescribed Carvedilol Tab 6.25mg, take 1 tablet by mouth twice daily, at 8:00a.m. and 5:00p.m. with meals. The October 2024 e-MAR documented the administration of Carvedilol each day, each time except for 10/24/2024 at 5:00p.m.

The e-MAR for that date had a triangle with an explanation mark in the middle of the triangle. Ms. Brown stated there is an explanation for that date in the notes section of the e-MAR. Ms. Brown stated upon review of the e-MAR, she surmises that staff did not complete the process of marking the e-MAR as refused so the symbol of the triangle with an explanation mark in the middle is marked in the box. Ms. Brown stated staff noted Resident A's refusal of the medication and explained the refusal. I reviewed the staff notes with the initials MF (Meagan frost) on the e-MAR, at 4:40p.m., the reason documented as *'refused by resident,'* and noted '*resident refused and said she was fasting and didn't want the pill.'*

On 01/07/2025, I interviewed Meagan Frost, direct care worker via telephone. Ms. Frost stated staff administered Resident A's medications as prescribed including the Acetaminophen and Carvedilol. Ms. Frost stated Resident A had a scheduled prescription for Acetaminophen, scheduled for 8:00a.m., 2:00p.m. and 8: 00p.m, and a PRN that allowed for 3 doses. Ms. Frost stated Resident A wanted to take them prior to every 6 hours as prescribed so they were concerned about doing that and had to make sure they were following those directives. Ms. Frost confirmed that Resident A refuses medications and those refusals are documented on the e-MAR system. Ms. Frost stated she has never denied Resident A medications and must follow the prescribed medication instructions.

On 02/06/2025, I interviewed Deandra Robinson, direct care worker, via telephone. Ms. Robinson stated staff were administering Resident A's medications as prescribed including the Acetaminophen and Carvedilol and documenting each medication pass on the e-MAR system and did not refuse to give Resident A her prescribed medications including Acetaminophen. Ms. Robinson also stated she has never denied Resident A medications and must follow the prescribed medication instructions.

On 03/05/2025, I conducted a telephone interview with Resident A. Resident A stated she is her own guardian and Ms. Frost and Ms. Robinson do not listen to her, and they do not tell her about her medications especially about her new medications. Resident A stated she is getting her Acetaminophen and Carvedilol as prescribed.

On 03/06/2025, I conducted an exit conference with Licensee Shequita Brown via telephone. Ms. Brown stated staff training on the administration and documentation of resident medications is ongoing. Ms. Brown stated she will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	Resident medications. **(1) Prescription medication, including tranquilizers, sedatives, dietary supplements, or individual special medical procedures, shall be given or applied only as**

	prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy container which shall be labeled for the specific resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws.
ANALYSIS:	Based on investigative findings, Resident A's medication Acetaminophen was administered as prescribed on 10/25/2024 and Resident A's Carvedilol was administered as prescribed on 10/24/2024 at 8:00a.m. and documented as refused for the 5:00p.m. pass. A violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: **(a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.**
ANALYSIS:	Resident A's medication Acetaminophen Tab 500mg, 8:00p.m. is not documented as administered on 10/20/24. There are no staff initials indicating the medication was administered and no notes explaining the reason for the missed dose or any indication it was passed as a PRN. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was not offered alternative meal options.

INVESTIGATION: On 01/06/2025, I received an Ottawa County Office of Recipient Rights complaint, the complainant reported Resident A was fasting and she was not offered an alternative to squash and rice soup on 10/24/2024.

On 01/06/2025, I reviewed a letter written by Resident A that documented the following information, *'I had asked if there was any other food to eat and was told no, just squash rice soup.'*

On 01/06/2025, I conducted an inspection at the facility and interviewed Shequita Brown, Licensee. Ms. Brown stated there is plenty of other food in the house and if Resident A wanted an alternative meal, she could have something other than what is made. Ms. Brown stated they have frozen meals, and sandwiches that are readily available for residents who do not choose to have the prepared meals. Ms. Brown stated Resident A frequently tells staff she does not want their prepared meals and there is no telling what meal she will refuse because she refuses anything especially if it doesn't have ketchup on it.

On 01/06/2025, I conducted an inspection of the food available in the house. I saw several frozen senior meals in the freezer and a variety of foods such as sandwich meats, bread, vegetables, fruit, meat for dinner such as chicken, yogurt milk, cereal, oatmeal and snack foods.

On 01/06/2025, I did not conduct a face-to-face interview with Resident A because she is not at the home and is out at a day program.

On 01/07/2025, I interviewed Meagan Frost, direct care worker. Ms. Frost stated staff always feed Resident A and offer alternatives to her. Ms. Frost stated Resident A will make her own sandwiches if she does not want to eat what is being served. Ms. Frost stated residents have cereal and/or oatmeal for breakfast and on the weekends, they are served hot breakfasts such as waffles, pancakes and cinnamon rolls. Ms. Frost stated staff sit with the residents and they make the menu up with them, so the residents have input as to what they want to eat. I reviewed a binder with menus hand written showing meals such as hot or cold cereal with yogurt or fruit, pancakes, eggs, sausage, muffins for breakfast, lunch is usually documented as leftovers, prepared meals or packed lunch (as residents attend day programming) and dinner consists of, corned beef hash breakfast skillet, minestrone soup, salad, no bake cookies, pizza, shepherd's pie, taco's, cucumber and tomato salad and shrimp corn chowder.

On 01/13/2025, I reviewed Ottawa County Office of Recipient Rights investigative report dated 01/02/2025, written by Briana Fowler, Director of Recipient Rights. Ms. Fowler documented that Ms. Frost reported the following information, *'(Resident A) refused to eat squash rice soup because she wanted sugar added to the entire pot of soup. I refused to do that. This was an expensive organic squash soup. I found a recipe to make it better, with rice. The home does not have sugar available to add anyway.* (Resident A) *was told she could add her own sugar to her bowl if she wanted it.'* Ms. Frost also reported to Ms. Fowler, *'(Resident A) will not allow staff to make her breakfast. She does not want to eat when meals are served. (Resident A) is always welcome to make a sandwich if she does not like what is on the menu.'*

On 03/05/2025, I conducted a telephone interview with Resident A. Resident A stated the meals at the home are “better.” But she did not want squash and rice soup and acknowledged there is other food available in the house. Resident A stated she does not have any complaints about the food at the home at this time.

On 03/06/2025, I conducted an exit conference with Licensee, Shequita Brown via telephone. Ms. Brown stated alternatives to regularly scheduled meals are always offered and, in the future, the alternatives will be documented. Ms. Brown stated she agrees with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.1419	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular nutritious meals daily. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on investigative findings, the home has a variety of food, and menus showing a variety of meals prepared for the residents. Staff report residents are given other options if they do not want to eat the meal prepared and Resident A acknowledged there is other food available in the facility. A violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

03/06/2025

Elizabeth Elliott, Licensing Consultant Date

Approved By:

03/06/2025

Jerry Hendrick, Area Manager Date