GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 1, 2025

Roger Covill
North-Oakland Residential Services Inc
P. O. Box 216
Oxford, MI 48371

RE: License #: AS630012424
Davison Lake House
881 W. Davison Lake Rd.
Oxford Township, MI 48371

Dear Roger Covill:

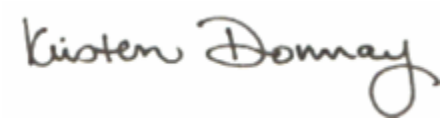
Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific dates 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 licensee designee and a date.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan within 15 days.

Please contact me with any questions. In the event that I am not available and you need to speak to someone immediately, you may contact the local office at (248) 972-9136.

Sincerely,



Kristen Donnay, Licensing Consultant
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Cadillac Place
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Detroit, MI 48202
(248) 296-2783

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AS630012424
Licensee Name:	North-Oakland Residential Services Inc
Licensee Address:	106 S. Washington Oxford, MI 48371
Licensee Telephone #:	(248) 969-2392
Licensee Designee:	Roger Covill
Administrator:	Roger Covill
Name of Facility:	Davison Lake House
Facility Address:	881 W. Davison Lake Rd. Oxford Township, MI 48371
Facility Telephone #:	(248) 628-4570
Original Issuance Date:	12/02/1985
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 09/30/2025

Date of Bureau of Fire Services Inspection if applicable: N/A

Date of Environmental/Health Inspection if applicable: 06/18/2025

No. of staff interviewed and/or observed 2
No. of residents interviewed and/or observed 6
No. of others interviewed 2 Role: Lic. desig./area mgr.

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.
- Medication(s) and medication record(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☒ No ☐ If no, explain.
- Meal preparation / service observed? Yes ☐ No ☒ If no, explain. Inspection did not occur during meal time
- Fire drills reviewed? Yes ☒ No ☐ If no, explain.
- Fire safety equipment and practices observed? Yes ☒ No ☐ If no, explain.
- E-scores reviewed? (Special Certification Only) Yes ☒ No ☐ N/A ☐ If no, explain.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.
- Incident report follow-up? Yes ☒ No ☐ If no, explain.
- Corrective action plan compliance verified? Yes ☒ CAP date/s and rule/s: 10/04/23: 310(3), 312(4)(b), 410(1), 403(1) N/A ☐
- Number of excluded employees followed-up? N/A ☒
- Variances? Yes ☐ (please explain) No ☐ N/A ☒

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:

R 330.1803	**Facility environment; fire safety.**
	(3) A facility that has a capacity of 4 or more clients shall conduct and document fire drills at least once during daytime, evening, and sleeping hours during every 3- month period.

During the period under review, a fire drill was not conducted during sleeping hours for the three-month period of July-September 2024.

R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

Based on a review of Resident L and Resident M's medication administration records (MARs), medications, and prescriptions on file, it was determined that medications were not being given pursuant to label instructions. The following medication discrepancies were noted:

- Resident L's Amlodipine 10mg Tab (take 1 tablet by mouth daily) was discontinued on 04/29/25. Staff initialed the April 2025 MAR indicating that the medication was passed on 04/30/25 after it was discontinued.
- Resident L's appointment information record from 04/29/25 signed by the nephrologist states, "Stop Amlodipine. Start Lasix 40mg t po daily for about 2 weeks then take as needed for lower extremity edema." Resident L's May 2025 MAR does not show that this medication was administered during the month of May, so it could not be determined if it was administered as prescribed. The medication Furosemide 40mg tab (generic for Lasix) is listed on the June MAR with instructions to take one tablet my mouth daily. It was never changed to a PRN medication per the written instructions from the doctor.
- The label instructions for Resident M's Ketoconazole 2% Shampoo state to shampoo with a small amount 3 times a week. From February 2025-August 2025, staff initialed Resident M's MARs indicating that the shampoo was used every day. It could not be determined if the prescription shampoo was being used as prescribed.
- The label instructions for Resident M's Scopolamine 1mg patch state to apply 1 patch to the skin every 72 hours. From May 2025-August 2025, staff initialed Resident M's MARs indicating that the patch was applied every day.

- Resident M's medication basket had a pack of Scopolamine patches that were filled by the pharmacy on 05/08/25. There were still 10 patches remaining in the pack, indicating that the patch was not administered as prescribed.
- The instructions for Resident M's Benecalorie liquid state to drink 1 can by mouth daily. From February 2025-August 2025, Resident M's MARs were initialed twice a day, indicating that he received Benecalorie at 6:00am and 5:00pm instead of once daily as prescribed.
- An "E-Script New Prescription Request" dated 08/04/25, shows that Resident M was prescribed Abilify 5mg tablet- take one tablet by mouth daily. The E-script indicates, "This Rx is a change. Please discontinue previous Abilify 15mg tablet from 05/20/25." Resident M's August 2025 MAR shows that Aripirazole 15mg Tab (generic for Abilify) was not discontinued until 08/26/25. The 15mg dose was initialed indicating that it was administered from 08/01/25-08/25/25. Aripirazole 5mg (take 1 tablet by mouth daily) was also added to the August MAR on 08/01/25. The 5mg dose was initialed indicating that it was also administered from 08/01/25-08/26/25. According to the August MAR, Resident A received 20mg in total of Aripirazole (Abilify) from 08/01/25-08/26/25 when he should have been receiving 5mg beginning on 08/04/25.
- An "E-Script New Prescription Request" dated 08/04/25, shows that Resident M was prescribed Prozac 10mg tablet- take one capsule by mouth once daily. The E-script indicates, "This Rx is a change. Please discontinue previous Prozac 20mg capsule from 05/20/25." Resident M's August 2025 MAR shows that Fluoxetine (generic for Prozac) 20mg cap- take 2 capsules (40mg) by mouth daily was not discontinued until 08/26/25. The 40mg dose was initialed indicating that it was administered from 08/01/25-08/25/25. Fluoxetine 10mg (take one capsule by mouth daily) was also added to the August MAR on 08/01/25. The 10mg dose was initialed indicating that it was also administered from 08/01/25-08/26/25. According to the August MAR, Resident A received 50mg in total of Fluoxetine (Prozac) from 08/01/25-08/25/25 when he should have been receiving 10mg beginning 08/04/25.
- Resident M is prescribed Gentamicin 0.1% ointment- apply a small amount topically daily to right arm. It could not be determined if this medication was being administered as prescribed, as Resident M had three tubes of ointment in his medication basket, which were dispensed by the pharmacy on the following dates: 01/06/25 with a use by date of 07/05/25; 02/03/25 with a use by date of 08/02/25; and 03/31/25 with a use by date of 09/27/25. Only one of the tubes had been opened, and it was nearly full. There was no start date to indicate when the tube was first opened or put into use.

- Resident M is prescribed Ketoconazole 2% cream- apply as directed topically twice a day. It could not be determined if this medication was being administered as prescribed, as there were two tubes of cream in Resident A's medication basket, which were dispensed on 03/31/25 and 08/14/25. Both tubes of cream were unopened and had not been used.
- An "E-Script New Prescription Request" dated 08/14/25 shows that Resident M was prescribed Hydrocortisone 2.5% topical cream- apply as needed for flares only. There is a handwritten note on the E-script dated 08/18/25 which states that per doctor frequency is BID (twice daily). Resident M's September 2025 MAR indicates that this medication was discontinued. There was no documentation on file showing when it was discontinued. The cream was still in Resident M's medication basket at the time of the onsite inspection and had a label that stated "Apply topically twice a day as needed for flares only."

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: (b) Complete an individual medication log that contains all of the following information: (i) The medication. (ii) The dosage. (iii) Label instructions for use. (iv) Time to be administered. (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.

Based on a review of Resident L and Resident M's medication administration records (MARs), it was determined that staff were not properly transcribing medication instructions or the times medications are to be administered. Staff were not following proper medication passing protocols by completing their required checks, and they were initialing the MARs on a daily basis for medications that were to be administered every three days. Staff were not consistently or accurately discontinuing medications according to the physician instructions, and they did not contact the pharmacy to remove medications that continued to be listed on the MAR for several months after they were discontinued. The following medication documentation errors were noted:

- Resident L's Amlodipine 10mg Tab (take 1 tablet by mouth daily) was discontinued on 04/29/25. The April 2025 MAR did not indicate that the medication was discontinued and staff initialed the MAR on 04/30/25.
- Resident L's Amlodipine 10mg Tab (take 1 tablet by mouth daily) was discontinued on 04/29/25. Staff did not follow up with the pharmacy to remove the medication from the MAR, so it continues to be listed as a prescribed medication. On the July 2025 MAR, staff did not note that the medication was discontinued. They initialed the MAR showing that the medication was passed every day for the month of July when the medication was likely not in the home, indicating that they were not following proper medication passing procedures or completing their checks.
- Resident M's bubble pack for Levothyroxine 50mcg tablet (take 1 tablet by mouth daily) indicates that the medication is administered at 8:00pm; however, the MARs indicate that the medications is administered at 6:00am.
- The label instructions for Resident M's Ketoconazole 2% Shampoo state to shampoo with a small amount 3 times a week. From February 2025-August 2025, staff initialed Resident M's MARs indicating that the shampoo was used every day.
- The label instructions for Resident M's Scopolamine 1mg patch state to apply 1 patch to the skin every 72 hours. From May 2025-August 2025, staff initialed Resident M's MARs indicating that the patch was applied every day.
- Resident M's Aripirazole 15mg Tab (generic for Abilify) was discontinued on 08/04/25, but the August 2025 MAR shows that it was not discontinued until 08/26/25.
- Resident M's Fluoxetine (generic for Prozac) 20mg cap- take 2 capsules (40mg) by mouth daily was discontinued on 08/04/25, but the August 2025 MAR shows that it was not discontinued until 08/26/25.
- Resident M was prescribed Abilify (Aripirzole) 5mg tablet and Prozac (Fluoxetine) 10mg tablet on 08/04/25, but the medications were listed and initialed on the August 2025 MAR beginning 08/01/25.

REPEAT VIOLATION ESTABLISHED
Reference Renewal Licensing Study Reports Dated: 10/05/2021 & 10/04/2023; CAPs Dated: 10/05/21 & 10/04/23

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: (e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.

Based on a review of Resident L and Resident M's medication administration records (MARs), medications, physician notes, appointment record forms, and health care chronological forms it was determined that the instructions regarding residents' prescription medications are not being recorded in writing on a consistent basis. The following medication issues were noted:

- Resident L's appointment information record from 04/29/25 signed by her nephrologist states, "Stop Amlodipine. Start Lasix 40mg t po daily for about 2 weeks then take as needed for lower extremity edema." Resident L's May 2025 MAR does not show that this medication was administered during the month of May. The medication Furosemide 40mg tab (generic for Lasix) is listed on the June MAR with instructions to take one tablet my mouth daily. It was never changed to a PRN after two weeks. There was no prescription on file or additional instructions recorded in writing to show that this medication is to be given daily.
- Resident M's file did not have any written instructions indicating that his Abilify (Aripirzole) 5mg tablet and Prozac (Fluoxetine) 10mg tablet were discontinued on 08/27/25.
- Resident M's file did not have any written instructions indicating that the Hydrocortisone 2.5% topical cream was discontinued on 09/01/25.

R 400.14316	Resident records.
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: (d) Health care information, including all of the following: (iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures. (iv) A record of physician contacts.

Based on a review of Resident L and Resident M's medication administration records (MARs), medications, physician notes, appointment record forms, and health care chronological forms, it was determined that the files did not include all physician contacts. There were appointment records missing from the files, including e-visits completed with the psychiatrist. The health care chronological forms did not include all appointments or contacts and did not contain detailed information. Resident M's health care chronological notes on 08/07/25, "Follow up discussed med change," but it did not include information regarding what medication changes were made or who ordered the changes. It also notes on 09/05/25, "Follow up med," but does not include any additional information.

Resident M's weight record form notes that the dietician is to be notified if his weight falls below 117 pounds or if he loses or gains 5 pounds. Resident A went from 123 pounds on 04/20/25 to 109.5 pounds on 04/27/25 and from 118 pounds on 06/29/25 to 110 pounds on 07/05/25. There was no documentation on file to show that the dietician or physician was contacted regarding his weight loss.

R 400.14318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.

During the period under review, a fire drill was not conducted during sleeping hours for the three-month period of July-September 2024.

R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

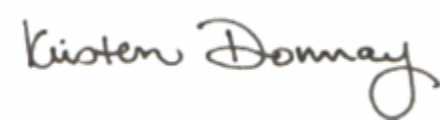
During the onsite inspection, the following maintenance issues were observed:

- The wooden doors, doorframes, and molding were damaged and splintering throughout the home.
- The siding on the exterior of the home was missing, damaged, and loose.
- The wood finishing on the kitchen cabinets and the back side of the kitchen counter was worn and damaged.
- The front door was dented and showing signs of excessive wear and tear.

REPEAT VIOLATION ESTABLISHED
Reference Renewal Licensing Study Reports Dated: 10/05/2021 & 10/04/2023;
CAPs Dated: 10/05/21 & 10/04/23

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, issuance of a provisional license is recommended.



10/01/2025

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Kristen Donnay Date
Licensing Consultant