GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 26, 2025

Teresa Murray
Murrays Country View
6201 HWY M-35
Gladstone, MI 49837

RE: License #: AH210396377
Investigation #: 2026A1028001
Murrays Country View

Dear Teresa Murray:

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

Sincerely,

Julie Viviano

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH210396377
Investigation #:	2026A1028001
Complaint Receipt Date:	10/07/2025
Investigation Initiation Date:	10/08/2025
Report Due Date:	12/06/2025
Licensee Name:	Murray's Country View, LLC
LicenseeAddress:	3670 Blacksmith 20.5 Ln Gladstone, MI 49837
Licensee Telephone #:	(906) 399-7581
Administrator:	Lindsey McDonough
Authorized Representative:	Teresa Murray
Name of Facility:	Murrays Country View
Facility Address:	6201 HWY M-35 Gladstone, MI 49837
Facility Telephone #:	(906) 428-1334
Original Issuance Date:	12/12/2018
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	25
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was not administered medication in accordance with physician orders resulting in a hospitalization.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/07/2025	Special Investigation Intake 2026A1028001
10/08/2025	Special Investigation Initiated - Letter
10/08/2025	APS Referral APS made referral to HFA.
10/09/2025	Contact - Telephone call made Interviewed Employee 1 via the telephone.
10/09/2025	Contact - Telephone call made Interviewed Employee 2 via the telephone.
10/09/2025	Contact - Document Sent Sent the facility administrator an email requesting documentation.
10/09/2025	Contact – Document Received Received return email from the facility administrator stating requested documentation would be sent by 10/14/2025.
10/20/2025	Contact – Document Sent Sent the facility administrator a second email to follow up on my documentation request because no documentation had been sent yet.
10/20/2025	Contact – Document Received Received the requested documentation from the facility administrator.
10/27/2025	Contact – Document Sent Sent the facility administrator requesting any additional documentation pertaining to the blank entries on the medication administration record.

10/302025	Contact – Document Received Received the requested information via from the facility administrator.

This special investigation 2025A1028020 will only address potential violations of Homes for the Aged (HFA) rules and regulations.

ALLEGATION:

Resident A was not administered medication in accordance with physician orders resulting in a hospitalization.

INVESTIGATION:

On 10/7/2025, the Bureau received the allegations through the online complaint system.

On 10/8/2025, Adult Protective Services (APS) made the referral to Homes for the Aged (HFA).

On 10/9/2025, I interviewed Employee 1 via telephone who reported Resident A was recently sent to the hospital due to not feeling well from missed medication. Employee 1 reported Resident A's Lithium had run out and that the facility sent several messages to the physician to get the medication refilled.

On 10/9/2025, I interviewed Employee 2 via telephone who confirmed that Resident A was taken to the hospital and will not be returning to the facility. Employee 2 reported that Resident A ran out of the medication Lithium and that the physician was contacted on 9/12/2025 due to there being no more refills. Employee 2 reported Resident A's authorized representative ended up bringing in a 2-week supply of the medication but is unsure of the date because [they] do not have access to the documentation to confirm the date at the time of the telephone interview. Employee 2 reported the medication issue, the physician communication, and the 2-week supply was documented in the record and that [they] will have the facility administrator retrieve the documentation upon [their] return to the facility. Employee 2 confirmed no other staff at the facility had access to the documentation because it was placed in a locked cabinet after Resident A was sent to the hospital and it was known that Resident A would not be returning to the facility.

On 10/9/2025, I emailed the facility administrator to request documentation pertaining to this special investigation.

On 10/10/2025, the facility administrator returned my email and reported [they] would forward the requested documentation to me on 10/14/2025 when they return to the facility.

On 10/20/2025, after sending a follow-up email to the facility administrator, I received the requested documentation via email.

On 10/27/2025, I reviewed the requested documentation which revealed the following:

- Resident A's authorized representative signed the service plan on 3/21/2025.
- Resident A required assistance with most care.
- The facility managed Resident A's medication administration.
- On 9/9/2025, 9/14/2025, and 9/15/2025 the medication administration record (MAR) is blank for the following:
    - 8pm administration of *2.5 tablets of 10mg of Lamotrigine.*
    - 8pm administration of *10mg of Olapine.*
    - 8pm administration of *1 pill of 300mg of Lithium Carbonate*.
    - 8pm administration of *2 tablets of .05mg of Lorazepam.*
- On 9/22/2025, the MAR is blank for the following:
    - 8pm administration of *2 tablets of .05mg of Lorazepam.*
- There is no reason given in the documentation as to why the MAR is blank.
- On 9/11/2025, it was documented on the 3pm to 7am shift that Resident A was out of the 300mg of Lithium Carbonate.
- On 9/12/2025, it was documented on the 7am to 5pm shift that a fax was sent to the physician that Resident A has no refills of the 300mg of Lithium Carbonate.
- On 9/12/2025, it was documented that Resident A initially refused to take [their] morning medications but finally took the medications at 10:15 am.
- On 9/21/2025, it was documented that Resident A's authorized representative is bringing a 2-week supply of the 300mg of Lithium Carbonate to the facility.
- On 9/21/2025 at 4:00pm, Resident A was sent to the hospital for not feeling well due to missing the 300mg of Lithium Carbonate for several days and for making statements about *"death and being dead by morning."*
- On 9/21/2025, it was documented in the record that Resident A was out of 300mg of Lithium Carbonate on 9/11/2025 with the facility requesting the physician order for refills the morning of 9/12/2025. The facility left a message for the pharmacy on 9/15/2025 at 4:30pm to inquire where the medication was. There is no further communication documented in the record about the medication after 9/15/2025.

On 10/27/2025, I sent the facility administrator a follow up email inquiring if there was other documentation pertaining to the blank entries in the MAR.

On 10/30/2025, I received an email from the facility administrator which *read "the blank spots are when [Resident A] refused the medication."* When reviewing the record, no corresponding information or documentation could be found in the record

to support that Resident A refused medication on 9/9/2025, 9/14/2025, and 9/15/2025.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	It was alleged that Resident A was not administered medication in accordance with physician orders resulting in hospitalization. Interviews and review of documentation revealed there are blank entries in the September 2025 medication administration record. Due to the blank entries, it cannot be determined if Resident A received medications in accordance with physician orders or if Resident A refused medications. It also cannot be determined why Resident A's 300mg of Lithium Carbonate was not reordered in a timely manner to prevent a shortage of the medication and/or why the medication order was not checked on in a timely manner when the facility did not receive any return communication from the physician or pharmacy after requesting the refill on 9/12/2025. Due to the facility's noncompliance of medication administration rules, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

On 10/27/2025, when reviewing Resident A's medication administration record (MAR), several blank entries were observed in the record with no corresponding documentation to determine if Resident A received the medications in accordance with physician orders or not. I emailed the facility administrator requesting additional clarification.

On 10/30/2025, the facility administrator reported via email that the blank entries in the MAR document that Resident A refused medications, however, there is no further documentation in the MAR stating that Resident A refused medications on 9/9/2025, 9/14/2025, and 9/15/2025.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(vi) A record if the resident refuses to accept prescribed medication and notification as required in subdivision (c) of this subrule.** **(c) Contact the appropriate licensed health care professional when the prescribed medication has not been administered in accordance with the label instruction, an order from a health care professional, medication log, or a service plan.**
ANALYSIS:	During review of Resident A's September 2025 medication administration record, multiple blank entries were observed in the record. When questioned about the blank entries, the facility administrator reported *the blank entries are when [Resident A] refused the medication.* However, there is no corresponding information in the record documenting that Resident A refused medication on 9/9/2025, 9/14/2025, and 9/15/2025 or that the physician was contacted by facility staff about Resident A's refusals of medications. The MAR was not completed in accordance with the rule; therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Viviano

10/30/2025

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Julie Viviano Date
Licensing Staff

Approved By:

11/26/2025

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section