



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 26, 2026

Jennifer Herald
Oliver Woods Retirement Village LLC
Suite 200
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL780314126
Investigation #: 2026A1033013
Oliver Woods #4

Dear Ms. Herald:

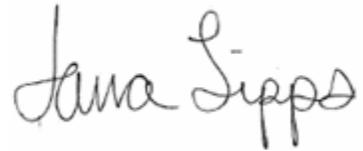
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 335-5985.

Sincerely,

A handwritten signature in cursive script that reads "Jana Lipps". The signature is written in a dark ink and is positioned below the word "Sincerely,".

Jana Lipps, 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 #:	AL780314126
Investigation #:	2026A1033013
Complaint Receipt Date:	01/21/2026
Investigation Initiation Date:	01/21/2026
Report Due Date:	03/22/2026
Licensee Name:	Oliver Woods Retirement Village LLC
Licensee Address:	Suite 200 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(810) 334-8809
Administrator:	Carla LaMarr
Licensee Designee:	Jennifer Herald, Designee
Name of Facility:	Oliver Woods #4
Facility Address:	1340 W. Oliver Street Owosso, MI 48867
Facility Telephone #:	(989) 729-6060
Original Issuance Date:	04/02/2012
License Status:	REGULAR
Effective Date:	10/02/2024
Expiration Date:	10/01/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility is understaffed.	No
On 1/15/26 an unidentified resident did not receive her blood pressure medication as prescribed.	Yes
Direct care staff, Jesssica Walker, is administering medications and is not trained to administer medications.	No

III. METHODOLOGY

01/21/2026	Special Investigation Intake 2026A1033013
01/21/2026	Special Investigation Initiated - Telephone Interview conducted with Complainant, via telephone.
01/21/2026	APS Referral- Denied APS referral.
01/26/2026	Inspection Completed On-site- Interviews conducted with Administrator, Carla LaMarr, direct care staff/Operations Specialist, Audra Rein, direct care staff, Allen Kaczorowski, direct care staff, Nicole Decker, direct care staff/Wellness Team Supervisor, Jessica Walker. Review of resident records initiated.
02/19/2026	Contact – Document Sent- Email correspondence sent to Administrator, Carla LaMarr, and Licensee Designee, Jennifer Herald.
02/23/2026	Contact – Document Received- Email received from Ms. LaMarr.
02/25/2026	Exit Conference Conducted via email with licensee designee, Jennifer Herald, and Administrator, Carla LaMarr.

ALLEGATION: The facility is understaffed.

INVESTIGATION:

On 1/21/26 I received an online complaint regarding the Oliver Woods #4, adult foster care facility (the facility). The complaint alleged that the facility is understaffed. There were not any additional details provided regarding this complaint. On 1/21/26 I interviewed Complainant, via telephone. Complainant reported that direct care staff, Jessica Walker, completes the direct care staff schedule for the facility and does not

schedule enough people to cover each shift. Complainant reported that the facility is usually staffed with two direct care staff for personal care, supervision, protection of the residents and one direct care staff for medication administration. Complainant reported that direct care staff members are pulled from the facility to cover breaks in one of the other three licensed adult foster care facilities all located on the same campus. There are four licensed adult foster care facilities on this campus.

On 1/26/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Administrator, Carla LaMarr, regarding the allegation. Ms. LaMarr reported that the facility is staffed with two to three direct care staff on each shift. She reported that sometimes there are three direct care staff when they have a direct care staff scheduled just for medication administration. She reported that sometimes the third direct care staff who is scheduled for medication administration may be responsible to administer medications at more than one of the licensed adult foster care facilities on this campus, but this happens on third shift (10pm – 6:30am). She further reported that this individual also covers lunch breaks between the four licensed facilities on third shift. Ms. LaMarr reported that the facility is never with less than two direct care staff members at all hours of the day and night. Ms. LaMarr reported that there are two residents, Resident A and Resident B, who require two direct care staff members to assist with personal care, transfers, and/or mobility.

On 1/26/26 during the unannounced, on-site investigation at the facility I interviewed direct care staff/Operations Specialist, Audra Rein, regarding the allegation. Ms. Rein reported that the facility is staffed with two to three direct care staff per shift. She reported that the facility is never staffed with less than two direct care staff members. Ms. Rein reported that there are two residents, Resident A and Resident B, who require a two direct care staff members to assist with personal care, transfers, and/or mobility. Ms. Rein reported that she feels the staffing levels are sufficient for the needs of the current residents.

During the unannounced, on-site investigation, I interviewed direct care staff, Allen Kaczorowski, regarding the allegation. Mr. Kaczorowski reported that he has worked at the facility for about two years. He reported that primarily his shifts occur at another licensed adult foster care facility on the same campus, but he does pick up shifts at the facility. He was working at the facility on this date. Mr. Kaczorowski reported that he feels the staffing levels are adequate at the facility. He reported that the majority of the 20 residents only require a one person assist with personal care, transfers, and mobility. He reported that there are two residents who require two direct care staff members to assist with these areas. Mr. Kaczorowski reported that there are typically two direct care staff scheduled at the facility and there are times when three direct care staff are scheduled.

During the unannounced, on-site investigation, I interviewed direct care staff, Nicole Decker, regarding the allegation. Ms. Decker reported she believes the staffing levels are adequate at the facility. She reported that Resident B requires a two direct care staff members to assist with mobility, transfers, and/or personal care. She reported that most

of the residents require one direct care staff member to assist and some are independent in their care needs and just require verbal reminders. She reported that each shift has at least two to three direct care staff scheduled. Ms. Decker reported that this feels adequate based on the needs of the current residents.

During the on-site investigation on 1/26/26 I interviewed direct care staff/Wellness Team Supervisor, Jessica Walker, regarding the allegation. Ms. Walker reported that she completes the scheduling for all four licensed adult foster care facilities on the campus. She reported that she also fills in as a direct care staff member when staffing requires. Ms. Walker reported that she feels the staffing levels at the facility are adequate based on the current resident assessment plans. She reported that each shift is scheduled to have at a minimum, two direct care staff members. She reported that staffing levels never fall below two direct care staff, even when direct care staff breaks and lunches are being covered.

During the on-site investigation on 1/26/26, I reviewed the following documentation:

- *Service Plan Report*, for Resident A, dated 3/20/25. On page two, under section, *Evacuation/Emergency Assistance*, it reads, “Resident requires assistance of 2 or more staff with evacuation.”
- *Service Plan Report*, for Resident B, dated 2/20/25. This document did not indicate a need for two direct care staff members to assist with mobility, transfers, and/or personal care.
- Direct care staff schedules for the month of January 2026 were reviewed for the facility. Each shift demonstrated at least two direct care staff members scheduled, routinely.

APPLICABLE RULE	
R 400.633	Staffing requirements.
	<p>(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following:</p> <p>(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.</p> <p>(b) 12 residents for small group and family homes.</p>

ANALYSIS:	Based upon the interviews conducted and documentation reviewed it can be determined that there is not adequate evidence to suggest the facility is not currently being staffed with adequate personnel. All parties interviewed, including Complainant, reported that there are at least two direct care staff members scheduled at all times. It was further identified that there are shifts and times when there are three direct care staff members scheduled. Based upon interviews conducted and documentation reviewed, it was determined that there are potentially two residents who require a two direct care staff to assist with mobility, transfers, and/or personal care. The other residents appear to be higher functioning and require less assistance from direct care staff with mobility, transfers, and personal care. Due to a lack of available evidence, a violation will not be cited at this time.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: On 1/15/26 an unidentified resident did not receive her blood pressure medication as prescribed.

INVESTIGATION:

On 1/21/26 I received an online complaint regarding the facility. The complaint alleged on 1/15/26 the residents did not receive their blood pressure medication as prescribed. The complaint does not cite a specific resident or direct care staff member responsible for medication administration on this date. On 1/21/26 I interviewed Complainant, via telephone. Complainant reported that Ms. Walker was administering medications at the facility on 1/15/26 due to the facility being limited on staffing on this date. Complainant reported that a direct care staff member (name not disclosed) observed that several residents had high blood pressure readings on 1/16/26 and assumed this was due to residents not receiving their blood pressure medication as prescribed on 1/15/26. Complainant reported that Ms. Rein was aware that blood pressure medications were not administered on 1/15/26. Complainant did not have any identifying information for which residents did not receive their scheduled blood pressure medication.

On 1/26/26, during the unannounced, on-site investigation I interviewed Ms. LaMarr regarding the allegation. Ms. LaMarr reported that she had no knowledge of resident medications that were not administered on 1/15/26.

On 1/26/26, during the unannounced, on-site investigation, I interviewed Ms. Rein regarding the allegation. Ms. Rein reported that she has no knowledge of resident blood pressure medications not being administered as prescribed on 1/15/26. She reported that on 1/23/26 at 8:45am it was identified that Resident C's blood pressure was higher than usual. She reported that Resident C's physician was consulted and a new blood

pressure medication, Amlodipine, was ordered. She reported that there was not a concern that Resident C's blood pressure medication was not administered, but rather that the dosage was not strong enough. Ms. Rein reported that once the Amlodipine was prescribed and started to be administered, Resident C's blood pressure returned to a safe reading.

During the unannounced, on-site investigation on 1/26/26, I interviewed Ms. Decker, regarding the allegation. Ms. Decker reported that she has no knowledge about resident blood pressure medications not being administered as prescribed on 1/15/26.

During the unannounced, on-site investigation on 1/26/26, I interviewed Ms. Walker regarding the allegation. Ms. Walker reported that she is trained to administer medications and that she has administered medications at the facility. She reported that she is not aware of failing to administer any resident medication, including blood pressure medications.

During the unannounced, on-site investigation I reviewed the following documentation:

- *Medication Administration Records (MAR)*, for all current residents at the facility for the month of January 2026. I observed the following:
 - The *MAR* for Resident A did not contain signatures for any of Resident A's 8am medications on 1/15/26. The *MAR* listed the following medications for high blood pressure that were not initialed as being administered on 1/15/26.
 - Losartan Pot Tab 25mg. Take 2 tablets by mouth every day for hypertension. This medication was scheduled for administration at 8am and was not initialed as being administered on 1/15/26.
 - Metoprol Suc Tab 25mg ER. Take 1 tablet by mouth every day for hypertension. This medication was scheduled for administration at 8am and was not initialed as being administered on 1/15/26.
 - The *MAR* for Resident C listed the following medications that were not signed for and contained no explanation for why the medication was not signed for on 1/15/26.
 - Furosemide Tab 20mg. Take 1 tablet by mouth every day. This medication was scheduled for administration at 11am and was not initialed as being administered on 1/15/26.
 - Metoprol Suc Tab 100mg ER. Take 1 + ½ tablets by mouth every morning. This medication was scheduled for administration at 11am and was not initialed as being administered on 1/15/26.
 - Resident C's *MAR* contained the task, Check Blood Pressure and Pulse. This task is scheduled for 8am and 5pm daily. On 1/15/26 under the 8am timeslot there are no entries to indicate that a direct care staff member checked Resident C's blood pressure at this time. On 1/15/26 at 5pm Resident C's blood pressure was recorded as 153/98. On 1/16/26 at 8am Resident C's blood pressure was recorded at 183/105 and at 5pm on 1/16/26 it was recorded at 184/98. By 1/17/26 the readings were as follows, 8am 151/83, 5pm

138/84. From 1/17/26 through 1/22/26 Resident C's systolic blood pressure reading fluctuated between 108 and 166. On 1/23/26 Resident C's blood pressure was recorded at 8am as 183/100.

- The *MAR* also contained the notation. Blood Pressure: "Obtain blood pressure. Report any systolic blood pressure reading above 180 or diastolic blood pressure reading above 90. Report any systolic blood pressure reading below 90. Report any change greater than 15 points from resident normal reading average if HR is also greater than 100."
- Amlodipine Tab 2.5mg. Take 1 tablet by mouth every day: Hold if systolic blood pressure is less than 110. This medication was added to the *MAR* on 1/23/26. This medication is documented as being administered on 1/23/26-1/26/26.

On 2/19/26 I sent email correspondence to Ms. LaMarr and licensee designee, Jennifer Herald. I inquired why Resident A and Resident C's *MARs* on 1/15/26 do not contain any initials for medications scheduled for administration at 8am while the other resident *MARs* reviewed contain the initials of direct care staff Rachelle Sprague for 8am medications on this date. I also inquired whether direct care staff members consulted Resident C's physician/medical provider on 1/16/26 when it was recorded that her blood pressure reading was 183/105 at 8am and 184/98 at 5pm.

On 2/23/26 I received email correspondence from Ms. LaMarr in response to the email I had sent to her on 2/19/26. Ms. LaMarr reported that she does not have an explanation as to why Resident A and Resident C's *MARs* for 1/15/26 do not contain any initials of direct care staff for 8am medications being administered. She further stated that the computer system only holds notes entered by direct care staff for 30 days and she is no longer able to obtain these records. Ms. LaMarr further reported that Ms. Rein contacted Resident C's physician on 1/16/26 to discuss her high blood pressure readings. Ms. LaMarr attached the following notes from the electronic resident record regarding these contacts:

- 1/16/26, 845am, entered by Audra Rein, reads, "Blood pressure reading was elevated and reading higher than the parameters set by doctor. Doctor notified and staff instructed to give morning medications and recheck blood pressure in 2 hours. Staff to call doctor back if blood pressure remains higher than set parameters."
- 1/16/26, 12pm, entered by Audra Rein, reads, "Blood pressure reading 158/78. No need to call doctor back at this time. Staff instructed to continue with medication regime as ordered by doctor."
- 1/16/26, 5:30pm, entered by Audra Rein, reads, "BP 184/98 per Brianna Hunt who contacted this nurse. Doctor notified and instructed staff to give evening medications and re check blood pressure in 2 hours and call doctor back if blood pressure is above 180/90. Staff notified."
- 1/16/26, 7:30pm, entered by Audra Rein, reads, "Staff called and reported blood pressure is reading at 170/76. No further need to call doctor."

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based upon interviews conducted and documentation reviewed it can be determined that there is sufficient evidence to conclude that both Resident A and Resident C were not administered their morning medications on 1/15/26. The <i>MARs</i> reviewed for these residents lacked direct care staff signatures identifying that the medications had been administered. Resident C's blood pressure reading was not recorded at 8am as ordered to be done. Resident C's blood pressure was then elevated the following day. Ms. LaMarr reported that she was uncertain why the direct care staff did not sign the <i>MAR</i> indicating Resident A and Resident C's medication had been administered. Since there is no way to prove that the medications for Resident A and Resident C were administered on 1/15/26 a violation is being established.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.675	Resident medications.
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: (b) Complete an individual medication log that contains all of the following: (v) Initials of the individual who administered the medication at the time given.
ANALYSIS:	The medication administration records reviewed for Resident A and Resident C were missing signatures of direct care staff members for prescribed morning medications on 1/15/26. As a result, a violation has been established.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Direct care staff, Jesssica Walker, is administering medications and is not trained to administer medications.

INVESTIGATION:

On 1/21/26 I received an online complaint regarding the facility. The complaint alleged that Ms. Walker has been administering medications and she is not trained to administer medications.

On 1/26/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. LaMarr and Ms. Rein regarding the allegation. They reported that Ms. Walker has been trained to administer medications. Ms. LaMarr provided documentation of Ms. Walker's medication training. This document was titled, Medication Administration Observation, dated 11/19/25, and signed by Helen Sheets. The document had multiple checklists that were marked as completed, indicating Ms. Sheets had signed off on Ms. Walker's ability to administer medications correctly. On 1/26/26 during the unannounced, on-site investigation, I interviewed Ms. Walker. Ms. Walker reported that she had been trained to administer medications. She reported that her primary job is scheduling direct care staff, and she is not required to administer medications on a routine basis. She reported that she is confident in administering medications when required.

APPLICABLE RULE	
R 400.675	Resident medications.
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: (a) Be trained in the proper handling and administration of medication.
ANALYSIS:	Based upon interviews conducted and documentation reviewed it can be determined that Ms. Walker has been trained in medication administration. Therefore, a violation will not be established at this time.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

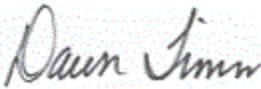


2/26/26

Jana Lipps
Licensing Consultant

Date

Approved By:



02/26/2026

Dawn N. Timm
Area Manager

Date