



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 30, 2026

Thomas Ostrom
350 S. Marketplace Blvd.
Delta Twp., MI 48917

RE: License #: AH230418409
Investigation #: 2026A1021024
The Courtyard at Delta

Dear Thomas Ostrom:

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 authorized representative 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 "Kimberly Horst".

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH230418409
Investigation #:	2026A1021024
Complaint Receipt Date:	02/19/2026
Investigation Initiation Date:	02/20/2026
Report Due Date:	04/21/2026
Licensee Name:	Delta Assisted Living LLC
Licensee Address:	Ste. 605 101 N. Wacker Drive Chicago, IL 60606
Licensee Telephone #:	(312) 623-0884
Administrator:	Joseph Marlow
Authorized Representative:	Thomas Ostrom
Name of Facility:	The Courtyard at Delta
Facility Address:	350 S. Marketplace Blvd. Delta Twp., MI 48917
Facility Telephone #:	(517) 459-9225
Original Issuance Date:	01/14/2025
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	90
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A received incorrect medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/19/2026	Special Investigation Intake 2026A1021024
02/20/2026	Special Investigation Initiated - Telephone Left message with administrator
02/20/2026	Contact - Telephone call made interviewed administrator
02/23/2026	Contact - Document Received received Resident A's documents
02/24/2026	Contact - Telephone call made interviewed Remedi Senior Care
02/26/2026	Contact-Telephone call made Interviewed staff person 1 (SP1)
03/30/2026	Exit Conference

The APS reporting source had allegations that Resident A is not provided with bedrails. This allegation was investigated under SIR 2026A1010003.

ALLEGATION:

Resident A received incorrect medication.

INVESTIGATION:

On 02/19/2026, the licensing department received a complaint with allegations from Adult Protective Services (APS) that on or around 10/31/2025, staff members attempted to overdose Resident A on Depakote medication. The APS reporting source alleged that this also occurred in February 2026.

APS did not open this complaint for investigation.

On 02/20/2026, I interviewed facility administrator Joseph Marlow by telephone. The administrator reported no knowledge of any issues with Depakote medication. The administrator reported that the order has been changed a few times since September 2025.

I reviewed Resident A's medication administration record (MAR) for October 2025. The MAR read,

“10/01/2025-10/17/2025: Depakote 500mg: 2 tablets by mouth two times a day”

10/19/2025-10/31/2025: Depakote 500mg: 1 tablet by mouth one time a day in morning

10/18/2025-10/31/2025: Depakote 500mg: give 2 tablets in evening

10/20/2025-10/31/2025: Depakote 500mg: give 2 tablets by mouth one time a day at bedtime.”

On 02/24/2026, I interviewed Remedi Senior Care Pharmacy by telephone. The pharmacist reported that Resident A had the following medication orders for Depakote:

09/01/2025-09/08/2025: Depakote 500mg: Take one tablet by mouth every morning

09/08/2025-11/14/2025: Depakote 500mg: Take two tablets by mouth two times a day

10/17/2025: Depakote 500mg: Take one tablet by mouth every morning

On 02/25/2026, I obtained prescriptions from the pharmacy for the Depakote medication. The orders read,

“09/08/2025: Depakote 500mg: Take two tablets twice a day by oral route.

10/17/2025: Depakote 500mg: Take one tablet PO q AM and 2 tablets PO q HS”

On 02/26/2026, I interviewed staff person 1 (SP1) by telephone. SP1 reported that she began her role at the facility a few months ago. SP1 reported that the physician that wrote for this medication is no longer Resident A's physician. SP1 reported that when the new medication order was obtained on 10/17/2025, the medication order from 09/08/2025 should have been removed but it was not. SP1 reported that the evening Depakote bedtime dose was to be held and that staff may have documented refused on Resident A's MAR as floor staff are unable to put hold on the MAR. SP1 reported no knowledge that this communication on holding the medication was documented. SP1 reported that she met with Resident A in February and this medication order is now changed.

APPLICABLE RULE	
R 325.1932	Resident medications.
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Interviews conducted and review of documentation revealed Resident A's Depakote 500mg medication order changed in October 2025. Review of Resident A's MAR revealed the medication orders were not correctly transcribed and therefore the medication was not offered as prescribed by the licensed health care professional.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's October, November, and February MAR revealed the following:

October 2025:

Depakote 500mg morning dose: refused four times between 10/19-10/31

Depakote 500mg evening dose: refused 12 times between 10/18-10/31

Depakote 500mg bedtime dose: refused 12 times between 10/20-10/31

November 2025:

Depakote 500mg morning dose: refused 26 times between 11/01-11/30

Depakote 500mg evening dose: refused 24 times between 11/01-11/30

Depakote 500mg bedtime dose: refused 24 times between 30 times between 11/01-11/30

I reviewed facility med pass history report. The report revealed some of these medication refuses the facility nurse was notified and other times the nurse was not notified. There was no documentation that the physician was notified of these refusals.

APPLICABLE RULE	
R 325.1932	Resident medications.

	<p>(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following:</p> <p>(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.</p>
ANALYSIS:	Review of Resident A's MAR revealed Resident A repeatedly refused the Depakote medication and the physician was not notified.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



02/26/2026

Kimberly Horst
Licensing Staff

Date

Approved By:



03/30/2026

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

Date