



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 31, 2026

James Salamon
Blueberry Hill Assisted Living Inc.
PO Box 480762
Los Angeles, CA 90048

RE: License #: AH800398973
Investigation #: 2026A1010025
Blueberry Hill Assisted Living

Dear Licensee:

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 (877) 458-2757.

Sincerely,

A handwritten signature in blue ink that reads "Lauren Wohlfert".

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH800398973
Investigation #:	2026A1010025
Complaint Receipt Date:	02/05/2026
Investigation Initiation Date:	02/06/2026
Report Due Date:	04/07/2026
Licensee Name:	Blueberry Hill Assisted Living Inc.
Licensee Address:	99 Walker Street Lawton, MI 49065
Licensee Telephone #:	(323) 620-4968
Administrator:	Geargina Dreleozis
Authorized Representative:	James Salamon
Name of Facility:	Blueberry Hill Assisted Living
Facility Address:	99 Walker Street Lawton, MI 49065
Facility Telephone #:	(269) 299-6007
Original Issuance Date:	01/24/2023
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	66
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff administered the incorrect medication to Resident A on 01/23/2026.	No
Additional Findings	Yes

III. METHODOLOGY

02/05/2026	Special Investigation Intake 2026A1010025
02/06/2026	Special Investigation Initiated - Letter APS referral made with Centralized Intake
02/06/2026	APS Referral APS referral made with Centralized Intake
02/17/2026	Inspection Completed On-site
02/17/2026	Contact - Document Received Received resident incident report, medication error report, and staff written reprimand
02/18/2026	Contact - Document Received Received staff training document via email from the administrator
03/31/2026	Exit Conference

ALLEGATION:

Staff administered the incorrect medication to Resident A on 01/23/2026.

INVESTIGATION:

On 02/05/2026, the Bureau received the complaint. The allegations read, EMS was dispatched to Blueberry Hill on 1/23/26 after [Resident A] was given the wrong medications. [EMS staff] estimated 8 or 9 medications were administered in error including 2 blood pressure medications, a blood thinner, and Metformin. [Resident A] suffers from low blood pressure and does not have diabetes.”

On 02/06/2026, I made an Adult Protective Services (APS) referral with Centralized Intake.

On 02/17/2026, I interviewed the administrator at the facility. The administrator reported there was a medication error involving Resident A and Resident B on 01/23/2026. The administrator explained Staff Person 1 (SP1) was on the flooring training with SP2 on how to administer resident medications on 01/23/2026. The administrator stated SP2 briefly left SP1 to assist a resident. The administrator said that while SP2 was assisting a resident, SP3 approached SP1 and asked SP1 to administer medication to Resident B. The administrator reported that because SP1 is a new staff person and is training, he is not yet familiar with all the residents in the facility. The administrator stated that as a result, SP1 administered Resident B's medications to Resident A.

The administrator reported SP3 was aware SP1 was still in training and was not yet permitted to administer resident medications independently. The administrator stated SP1 should not have been administering any resident medications at the time of the incident on 01/23/2026. The administrator explained that when SP2 learned the incident occurred, he reported it to her immediately. The administrator said Resident A's vitals were monitored every 15 minutes and her physician was notified. The administrator stated Resident A's blood pressure did drop slightly, therefore Resident A's physician recommended she be transported to the hospital for further evaluation. The administrator reported Resident A was at the hospital for approximately four hours, then she returned to the facility.

The administrator said an incident report was completed and SP3 received a formal written reprimand in her employee record because of the incident. The administrator provided me with a copy of Resident A's incident report dated 01/23/2026 for my review. The *Briefly Describe What Occurred* section of the report read, "Staff took medication for another resident down to activity area to pass medications. When confirming residents name, Resident stated it was her. Resident then proceeded to take medication, however, it was not her medications that she took. She took amlodipine 5mg, duloxetine 60mg, Eliquis 5mg, ezetimibe 10mg, ferrous sulfate 325mg, folic acid 1mg, furosemine 20mg, lisinopril 10mg, metformin 1000mg, metoprolol succ er 50mg, pantoprazole sod 40mg, tizanidine 2mg." The report read Resident A's responsible person and physician were notified.

The administrator reported that in addition to SP3's formal written reprimand, she was permanently removed from administering resident medications. The administrator provided me with a copy of SP3's *Employee Write Up* form for my review. The form was dated 01/23/2026. The *Description of Violation(s)* section of the form read, "had another staff run meds. Medication was administered to wrong resident. The *Plan for Improvement* section of the form read, "Removal from med cart." The form was signed and dated by SP3.

The administrator said a *Medication Error Report Form* was also completed after the incident occurred. The administrator provided me with a copy of this form that was dated 01/23/2026 for my review. The *Describe Error in Detail* section of the form read, "Another residents meds passed to wrong person. The *How could this error*

have been prevented section of the form read, “Take your own medications that you prep to resident.” The form was signed and dated by the administrator. The administrator said the facility’s medication error policy and procedure was followed and appropriate action was taken to prevent further medication errors.

The administrator reported SP3 completed medication administration training before she began administering resident medications. SP3 said the staff medication administration training consists of “classroom training” that includes a competency quiz, followed by on the floor training with staff. SP3 explained that after staff complete the on the floor training with staff, management staff watch the staff person in training successfully complete a resident medication pass before they can administer them independently.

On 02/17/2026, I interviewed Resident A at the facility. Resident A denied concerns regarding staff administering her medications to her. Resident A was unable to recall ever receiving the incorrect medications from staff.

On 02/18/2026, I received a copy of SP3’s *SUPERVISED MEDICATION SIGN – OFF* document via email from the administrator for my review. The document was signed by SP3 and management staff and dated 10/10/2025. This document signified SP3’s medication administration training completion.

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:	The interview with the administrator, along with review of Resident A’s medication error documents revealed Resident A received Resident B’s medications on 01/23/2026. SP3 allowed a staff person in training to administer medications that she had prepared for Resident B. As a result, this medication error occurred. The facility took appropriate corrective action and permanently removed SP3 from administering resident medications.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION:

On 02/17/2026, I observed a bed cane assistive device in use on Resident A's bed. Resident A reported that her friends brought this device into the facility approximately six months ago and "set it up" on her bed. This assistive device was not physician ordered and does not fasten to Resident A's bedframe; therefore, this device poses a safety hazard to Resident A.

On 02/17/2026, the administrator stated she was not aware this device was in use on Resident A's bed. The administrator was informed of the safety hazards associated with this device. The administrator reported that staff have not reported the presence of this device on Resident A's bed.

APPLICABLE RULE	
R 325.1921	Governing bodies, administrators, and supervisors.
	(1) The owner, operator, and governing body of a home shall do all of the following: (b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.
ANALYSIS:	On 02/17/2026, I observed a bed cane assistive device in use on Resident A's bed. This device does not fasten onto the bed frame; it is fastened between the mattress and boxspring. As a result, this assistive device is a safety hazard. The interview with the administrator revealed the device's safety hazards were unknown to staff. Any assistive device placed on a resident's bed must be physician ordered, fastened to the resident's bed frame, and installed per the manufacturer's instruction. Staff must be trained to check the device regularly to ensure the device is secure and no gaps are present. The facility was not in compliance with this rule.
CONCLUSION:	VIOLATION ESTABLISHED

I shared the findings of this report with the facility's authorized representative on 03/31/2026.

IV. RECOMMENDATION

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



03/16/2026

Lauren Wohlfert
Licensing Staff

Date

Approved By:



03/30/2026

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

Date