GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 8, 2026

Linda Rice
United Country Care, Inc.
535 Gilletts Lake Road
Jackson, MI 49201

RE: License #: AS380357952
Investigation #: 2026A0007023
Rice Manor II

Dear Linda Rice:

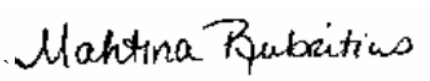
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380357952
Investigation #:	2026A0007023
Complaint Receipt Date:	03/14/2026
Investigation Initiation Date:	03/16/2026
Report Due Date:	05/13/2026
Licensee Name:	United Country Care, Inc.
Licensee Address:	535 Gilletts Lake Road Jackson, MI 49201
Licensee Telephone #:	(517) 531-3005
Administrator:	Linda Rice
Licensee Designee:	Linda Rice
Name of Facility:	Rice Manor II
Facility Address:	PO Box 84 345 S. Union Street Parma, MI 49269
Facility Telephone #:	(517) 800-5791
Original Issuance Date:	06/17/2015
License Status:	REGULAR
Effective Date:	12/17/2025
Expiration Date:	12/16/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 3/13/2026, Robyn Sackrider, DCW, placed the resident medications on the table. Resident A sat at the wrong spot and took Resident B's medications. Resident A is currently hospitalized. Resident A also had a fall that day, and she hit her head, she was checked out regarding that as well.	Yes
Robyn Sackrider, DCW, gave Resident A's medication to Resident B, to replace the medication Resident A took.	Yes

III. METHODOLOGY

03/14/2026	Special Investigation Intake - 2026A0007023
03/16/2026	Special Investigation Initiated - Face to Face contact with Resident A at the hospital.
03/16/2026	Contact - Telephone call received from Teri Miskowski, Assistant Administrator. Discussion.
03/17/2026	APS Referral Received.
03/17/2026	Contact - Document Received Subsequent allegations received.
03/25/2026	Inspection Completed On-site - Unannounced- Face to face contact with Barb Desy, DCW, Resident A, and Resident C.
03/25/2026	Contact - Face to Face contact with Devin Pickett, APS Worker. Discussion.
04/16/2026	Contact - Telephone call received from Linda Rice, Licensee Designee.
04/20/2026	APS Referral Received.
05/07/2026	Contact - Telephone call made to facility. I spoke to Jennifer Dixon, DCW. Discussion.
05/07/2026	Contact - Document Sent - Email to Devin Pickett, APS Worker. Status update requested.
05/08/2026	Contact - Document Received - Email from Devin Pickett, APS Worker. Status update provided.

05/08/2026	Contact - Telephone call made to Linda Rice, Licensee Designee to conduct the exit conference. I requested a return phone call.
05/08/2026	Exit Conference conducted with Linda Rice, Licensee Designee.

ALLEGATIONS:

- **On 3/13/2026, Robyn Sackrider, DCW, placed the resident medications on the table. Resident A sat at the wrong spot and took Resident B's medications. Resident A is currently hospitalized. Resident A also had a fall that day, and she hit her head, she was checked out regarding that as well.**

- **Robyn Sackrider, DCW, gave Resident A's medication to Resident B, to replace the medication Resident A took.**

INVESTIGATION:

As a part of this investigation, I spoke with Teri Miskowski, Assistant Administrator. It was noted that on March 13, 2026, Robyn Sackrider, DCW, left Resident B's medications on the table. Resident A sat in the wrong spot and took Resident B's medications. Emergency services were contacted and Resident A was taken to the hospital. According to Teri Miskowski, Resident A had not been given her evening medications yet. Resident A has been diagnosed with dementia. The incident occurred around 8:00 p.m. There was also an issue as staff noticed Resident A's medications where in a cup in the staff office, the medications were counted, and it was discovered that Robyn Sackrider, DCW had given Resident A's medication (Ativan) to Resident B, since Resident A took his. This was done to replace the medication that was taken.

On March 16, 2026, I spoke with Teri Miskowski, Assistant Administrator. She provided an update regarding Resident A's condition, as she was in the hospital. Teri Miskowski stated that the home manager visited Resident A in the hospital, and physically, Resident A was back to herself. Resident A was not drooling anymore, all of the lab work came back negative, the head scan was good, and there was nothing out of the ordinary with the blood work. They're still waiting for speech to evaluate Resident A. Teri Miskowski informed me that Robyn Sackrider had been removed from passing medications and that she would be retrained. Teri Miskowski stated that Robyn Sackrider had no issues with medication errors before, and she was actually one of their better med passers. She stated that Robyn Sackrider owned up to her mistake. Teri Miskowski stated that she knew this would be a violation, as the direct care worker violated protocols.

On March 16, 2026, I made face to face contact with Resident A. I observed her sleeping. Hospital staff informed me that she was hollering out about five minutes prior to my visit and must had just gone to asleep.

I reviewed an incident report, dated March 13, 2026, and the following was noted: Robyn Sackrider, DCW, documented that at 5:00 p.m., Resident A was in her RR (Riser Recliner). Robyn Sackrider walked to the kitchen to check on the food. She heard a loud crash and Resident A started yelling for help. Resident A was on the floor with her head against the door jam. Her walker was the right way, directly ahead of her. Robyn Sackrider got Resident A to sit up, and she checked her for bleeding, then she stood her up. She then assisted and walked Resident A to her room and checked her over for any bumps or bruises. Resident A had a bump on her head by the crown of her neck. Staff followed up with management, and Resident A's family. The family member asked that staff conduct 15-minute checks on Resident A and to watch for a concussion.

I reviewed another incident report, dated March 13, 2026, and the following was noted: Robyn Sackrider, DCW, documented that at 8:00 p.m., "I was not following protocol, when doing 8:00 p.m. medications. I sat down another resident's p.m. medications at his seat and walked away to get another resident. When walking back, [Resident A] had sat down at his spot and already taken meds."

I reviewed an incident report, dated March 13, 2026, and Jennifer Dixon, DCW & Manager, documented that she received a call from staff, who informed that Resident A had taken another resident's medications. The staff left the medication on the table and walked away. Jennifer Dixon came from the other house and called 911. Resident A was sitting in the living room when she arrived and said hi to staff. Jennifer Dixon went into the medication room to copy Resident A's MARS and Resident A's medications were set up on the counter, in the med cup. Jennifer Dixon also copied Resident B's mediations and blacked out the resident's name and case number. When the paramedics arrived, Jennifer Dixon informed them of what occurred and provided them with the information she copied. Resident A told the emergency personnel that she was taking her medications that were sitting on the table for her. Resident A was slurring her works and she was very drowsy. It was also noted that when staff contacted Jennifer Dixon, she asked her why she left pills on the table, unattended to begin with.

As a part of this investigation, I reviewed a subsequent complaint, and the following information was noted:
This complaint was received on March 17, 2026: "[Resident A] is currently not getting up at all but was previously walking unassisted. Resident A needs assistance with her ADLs. Resident A is diagnosed with a fall and altered mental status. Resident A is her own decision maker. Resident A resides in an adult foster home. On 03/13/2026 Resident A was given another patient's medication on top of her own medications. Resident A was given Klonopin that is not prescribed to her in an unknown amount along with her own prescribed Ativan medication. This made Resident A fall and hit her head. Resident A is also on blood thinners and hitting her head is dangerous. Resident A is currently at the hospital. Resident A is still having issues with her altered mental status. Resident A's speech is garbled. Resident A

knows what she wants to say but cannot get the words out." There was a caregiver with Resident A when she first went to the hospital; however, Resident A no longer has anyone with her and is she is being admitted to the hospital.

On March 25, 2026, I made face to face contact with Barb Desy, DCW, Resident A and Resident C. Barb Desy informed me that she was not at the facility when the incident occurred. She informed me that Resident A had returned from the hospital. I observed Resident A walking to her room, utilizing a walker. Staff informed me that Resident A was talking now.

I interviewed Resident A. She informed me that she had not recently been in the hospital. She informed me that she took medications but did not confirm that she had taken the wrong medication. Resident A reported that she was feeling "okay."

I followed up with DCW Barb Desy, and she stated that they're monitoring Resident A closely, as she has periods of weakness. I observed Barb Desy, and she was very attentive to the residents.

On March 25, 2026, I made face to face contact with Devin Pickett, APS Worker. He is investigating the allegations; he made face to face contact with Resident A at the hospital. He also has to conduct a staff interview, but he thinks this was a mistake.

On April 16, 2026, I received a phone call from Linda Rice, Licensee Designee. She stated that Resident A had a fall on April 15, 2026, around 9:00 p.m. Resident A was not complaining of any pain. She does have some bruising. Resident A is walking fine and there is no swelling; however, the doctor is going to have X-Rays completed just to be sure there are not any issues.

During the course of this investigation, I reviewed a subsequent complaint, and the following information was noted:
This complaint was received on April 20, 2026: "On 03/13/2026, [Resident A] fell and hit her head resulting in a knot on the back of her head. [Resident A] was subsequently monitored by AFC staff at 15-minute intervals after the fall at the request of [Resident A's] family, as [Resident A] was not exhibiting any signs of negative effects from hitting her head. Later the same day, Robyn was passing out medications. Robyn left another resident's medications at a spot where they typically sit. [Resident A] sat at the spot containing the other resident's medications [Loratadine (10 mg tablet), Lorazepam (.5 mg), and Clozapine (300 mg)] and took them. [Resident A] had not been given her medications yet. AFC staff called for an ambulance. [Resident A] started slurring her words approximately 20 minutes later. [Resident A] was sent to Henry Ford Hospital and admitted for observation and testing. [Resident A's] blood work and medical tests at the hospital all checked out fine. It is not known if there was a determination as to what caused [Resident A's] symptoms."

During this investigation, I reviewed an incident report dated March 13, 2026, and the following information was noted: “Chantal Copeland, DCW, documented that at 10:00 p.m., she arrived for her 10:00 p.m. shift and went to sign in the med book and noticed a dixie cup, which was taped up and had a clear med cup with medications inside it. There was also a note that said “[Resident A’s] medications.” After looking at the medications, Chantal Copeland noticed that the medication count did not seem correct, so she reached out to Jennifer Dixon, Manager, and she came over to the facility and reviewed the medications with her; it was noted that a Lorazepam (for Ativan) was missing from Resident A’s medications. They searched but could not find the medication.

Jennifer Dixon, Manager also completed an incident report and documented that on March 14, 2026, at 7:00 a.m., staff contacted her to tell her that there was medication in a cup, taped up and they were Resident A’s medications from (3/13/2026) at 8:00 p.m. The staff also asked that Jennifer Dixon stop over at the facility and complete a controlled med count with her, as she believed the count was off. They completed the controlled count together and it was correct; but they discovered that staff from 03/13/26 put Resident A’s medication (Tramadol) back into the medication bubble pack and taped it. Resident A’s Ativan was not in the cup or in the bubble pack. The medications in the cup, that was taped, were all of Resident A’s 8:00 p.m. medications for 03/13/2026. Jennifer Dixon asked staff (that worked on 03/13/2026) where Resident A’s 8:00 p.m. Ativan was (that was popped from the bubble pack), and she stated that since Resident A took his (Resident B’s) medications, she gave him Resident A’s Ativan that she popped to replace what Resident A took, when she took his medication.

I reviewed the medication logs for Resident A and Resident B. It was noted that they both were prescribed Lorazepam Tab 0.5 MG (for Ativan). Resident A was prescribed the medication three times daily and Resident B was prescribed the medication once daily. It was also noted that staff initialed the MAR, documenting that Resident B received his prescribed medications on March 13, 2026.

On May 7, 2026, I spoke with Jennifer Dixon, DCW. She stated that she was at the big house (Rice Manor- AL380007070), when she received the call regarding Resident A taking the other resident’s medications. I inquired about the staff at Rice Manor, as she documented that she left that facility to assist at Rice Manor II, and she stated that Megan Beck was the other direct care staff there on duty with her that day.

On May 8, 2026, Devin Pickett, APS, informed me that this appeared to be an isolated incident, the licensee acted quickly, and the allegations were not substantiated. He also informed me that Resident A was treated and is now well.

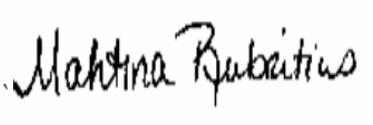
On May 8, 2026, I conducted the exit conference with Linda Rice, Licensee Designee. We discussed the investigation and my recommendations. She concurred with the established violations and agreed to submit a written corrective action plan.

She also informed me that Robyn Sackrider left her employment and no longer works for the licensee.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based upon my investigation which consisted of an on-site investigation, review of relevant documents, interviews with staff and APS, it's concluded that there is a preponderance of the evidence to support the allegations that Robyn Sackrider left Resident B's medications on the table and Resident A took the medications that were prescribed for another resident (Resident B). There is also a preponderance of the evidence to support the allegations that Robyn Sackrider did not ensure that the medication (Ativan), which was prescribed for Resident A, did not go to any other person other than who it was prescribed for, as she then administered Resident A's medication to Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains the same.



5/8/2026

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Mahtina Rubritius Date
Licensing Consultant

Approved By:

05/08/2026

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Dawn N. Timm Date
Area Manager