GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 2, 2026

Karen Goreta
Karen's Helping Hands
2232 Ford
Wyandotte, MI 48192

RE: License #: AS820417019
Investigation #: 2026A0116031
Marigold Manor

Dear Ms. Goreta:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820417019
Investigation #:	2026A0116031
Complaint Receipt Date:	05/18/2026
Investigation Initiation Date:	05/22/2026
Report Due Date:	07/17/2026
Licensee Name:	Karen's Helping Hands
Licensee Address:	4425 High Street Ecorse, MI 48229
Licensee Telephone #:	(313) 282-6158
Administrator:	Karen Goreta
Licensee Designee:	Karen Goreta
Name of Facility:	Marigold Manor
Facility Address:	31704 Marigold Drive Brownstown Township, MI 48173
Facility Telephone #:	(734) 795-5073
Original Issuance Date:	07/15/2024
License **Status:**	REGULAR
Effective Date:	01/15/2025
Expiration Date:	01/14/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Staff, Courtney Smith, initialed Resident A's 8:00 p.m. Klonopin as given. However, after home managers review of the medication and medication administration record, she confirmed the medication was not administered.	Yes

III. METHODOLOGY

05/18/2026	Special Investigation Intake 2026A0116031
05/18/2026	APS Referral Received.
05/22/2026	Special Investigation Initiated - On Site Interviewed home manager, Alyssa Amy, Resident A and reviewed Resident A’s medication and medication administration record.
05/22/2026	Contact - Telephone call made Interviewed staff, Courtney Smith.
05/22/2026	Inspection Completed-BCAL Sub. Compliance
06/01/2026	Contact - Telephone call received Licensee designee, Karen Goreta.
06/01/2026	Exit Conference Licensee designee, Karen Goreta.
06/02/2026	Referral - Recipient Rights Made.

ALLEGATION:

Staff, Courtney Smith, initialed Resident A's 8:00 p.m. Klonopin as given. However, after home managers review of the medication and medication administration record, she confirmed the medication was not administered.

INVESTIGATION:

On 05/22/26, I conducted an unscheduled onsite inspection and interviewed home manager, Alyssa Amy, Resident A and reviewed his clonazepam (generic for Klonopin) 2mg tablets (bubble pack) and his medication administration record (MAR). Ms. Amy reported that this is a new medication that was prescribed to Resident A on 05/08/26 due to an escalation in his behavior. Ms. Amy reported that the error occurred on the evening of 05/11/26. She reported that on the morning of 05/12/26 when she completed the morning narcotic medication count, she observed the tablet was still in the bubble pack, the MAR was not initialed, but the homes internal narcotic count sheet was initialed by Ms. Smith as if the medication had been administered at 8:00 p.m. as prescribed. Ms. Amy reported that is how she caught the error.

Ms. Amy reported that she addressed the matter with staff, Courtney Smith, who admitted being distracted by Resident A as he was demanding his medication early. Ms. Amy reported she informed licensee designee, Karen Goreta, of the medication error and has registered Ms. Smith for medication refresher training. Ms. Amy reported that right after the error she had other staff shadow Ms. Smith for a few medication passes before she returned to passing medications independently.

Ms. Amy reported that she reviewed all of Resident A's other prescribed medications and the counts for them were all accurate.

I interviewed Resident A and he reported that he takes medications three times per day and the staff administer them. Resident A was not aware that one of his prescribed medications had not been given on 05/11/26. Resident A reported that he likes his home and the staff and reported that they take good care of him and his housemates. Resident A was neatly dressed and groomed and no concerns noted.

I reviewed Resident A's 2 mg clonazepam bubble pack and to date the count was accurate and matched the narcotic count sheet and MAR. The MAR was not initialed for 05/11/26 for the 8:00pm dose of clonazepam.

On 05/22/26, I interviewed staff, Courtney Smith, and she reported that she did not administer Resident A's 8:00 p.m. dose of clonazepam. Ms. Smith reported that Resident A was bombarding her and demanding that she give him his medication at 7:30 p.m. and other residents were also asking her questions. Ms. Smith admitted that she was distracted by this and never dispensed or administered the clonazepam to Resident A. Ms. Smith reported that she has been in the field over 10 years and knows what to do. She accepted responsibility for her actions and reported that she will be completing a medication refresher training and will be more focused when passing medications.

On 06/01/26, I interviewed licensee designee, Karen Goreta, and conducted the exit conference. Ms. Goreta reported that once Ms. Amy informed her of the medication

error, she completed an emergency staff meeting and reiterated the importance of following the 6 rights of medication and focusing while preparing and administering medication. Ms. Goreta reported that she is over the excuses that Ms. Smith is giving and reported that there is no plausible explanation for the error. Ms. Goreta reported that Ms. Smith has completed the medication refresher training.

I informed Ms. Goreta of the findings of the investigation and rule cited. Ms. Goreta reported an understanding and reported she would submit an acceptable corrective action plan upon receipt of the report.

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 on the findings of the investigation, which included interviews with home manager, Alyssa Amy, staff, Courtney Smith, licensee designee, Karen Goreta, and review of Resident A's MAR and clonazepam bubble pack, there is a preponderance of evidence to substantiate the allegation that Resident A's 2 mg clonazepam tablet was not given as prescribed by his physician. Staff, Courtney Smith, did not administer Resident A's 8:00 p.m. dose of clonazepam on 05/11/26.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/02/26

Pandrea Robinson
Licensing Consultant

Date

Approved By:

06/02/26

Ardra Hunter
Area Manager

Date