GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 29, 2026

Carol DelRaso
Paden Road Opco LLC
Suite 200
7297 Nemco Way
Brighton, MI 48116

RE: License #: AH590339564
Investigation #: 2026A1041008
Lakeview Terrace Assisted

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

Tammie Daniels

Tammie Daniels, Licensing Staff
Bureau of Community and Health Systems

enclosure

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

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AH590339564 |
| | |
| **Investigation #:** | 2026A1041008 |
| | |
| **Complaint Receipt Date:** | 05/28/2026 |
| | |
| **Investigation Initiation Date:** | 05/28/2026 |
| | |
| **Report Due Date:** | 07/27/2026 |
| | |
| **Licensee Name:** | Paden Road Opco LLC |
| | |
| **Licensee Address:** | 4500 Dorr Street<br>Toledo, OH 43615 |
| | |
| **Licensee Telephone #:** | (419) 247-2800 |
| | |
| **Administrator:** | Erin Evans |
| | |
| **Authorized Representative/** | Carol DelRaso |
| | |
| **Name of Facility:** | Lakeview Terrace Assisted |
| | |
| **Facility Address:** | 9494 Paden Road<br>Lakeview, MI 48850 |
| | |
| **Facility Telephone #:** | (616) 464-1564 |
| | |
| **Original Issuance Date:** | 07/16/2014 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/01/2026 |
| | |
| **Expiration Date:** | 07/31/2027 |
| | |
| **Capacity:** | 38 |
| | |
| **Program Type:** | AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Medications given to Resident A were not documented. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 05/28/2026 | Special Investigation Intake<br>2026A1041008 |
| 05/28/2026 | Special Investigation Initiated - Telephone<br>Telephone interview with Complainant |
| 06/03/2026 | Contact - Face to Face<br>Onsite Investigation |
| 06/29/2026 | Exit Conference |

## ALLEGATION:

**Medications given to Resident A were not documented.**

**INVESTIGATION:**

On 05/28/2026, the department received the allegations through the online complaint system.

On 05/28/2026, I interviewed the complainant by phone. The complainant alleged that on 05/24/2026, Resident A fell and was taken to the emergency department. The complainant alleged that when the facility was contacted to verify which medications had been given after the fall, staff could not do so because the medications were not documented in the medication administration record.

On 06/03/2026, I interviewed the facility Administrator, Erin Evans, at the facility. The Administrator reported that on 05/24/2026, Resident A fell and hurt her wrist. The Administrator reported that Resident A's relative, Relative A1, took Resident A to the emergency department (ED) for evaluation. The Administrator reported that Relative A1 called the facility from the ED to clarify which pain medications had been given after the fall. The Administrator reported that when she checked Resident A's electronic medication administration record (MAR), no pain medications were

documented. The Administrator reported that she then spoke with Employee 1, who had passed Resident A's medications that day. The Administrator reported that Employee 1 told her he gave Resident A Aspirin immediately after the fall and Tylenol later. The Administrator reported that she could not provide clarification to Relative A1 or the ED because the medications Employee 1 described were not documented in the MAR. The Administrator reported that due to this finding, Employee 1 was immediately removed from the medication cart and was currently not permitted to pass medications until medication re-training could be completed. The Administrator reported that Employee 1's retraining was not completed yet.

On 06/03/2026, I interviewed Employee 1 at the facility. Employee 1 reported that after Resident A went to the ED on 05/24/2026, the Administrator asked him which medications had been given to Resident A and he told her. Employee 1 reported that he gave Resident A both Aspirin and Acetaminophen after the fall. Employee 1 reported that he thought he had documented this in the electronic MAR but "*it didn't take,"* which he believed was a system error. Employee 1 reported that he was not removed from the medication cart on 05/24/2026 and had not received any retraining. Employee 1 reported that the last time he passed medications was "*today."*

On 06/03/2026, I reviewed Resident A's MAR from 05/24/2026 through 06/03/2026. Review revealed that Resident A had Aspirin 325 mg and Acetaminophen 650 mg prescribed every 6 hours as needed for pain; neither medication was marked as given on 05/24/2026; Employee 1 passed Resident A's other medications on 05/24/2026; and Employee 1 passed Resident A's medications on 05/28/2026, 06/02/2026, and 06/03/2026.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1932** | **Resident medications.** |
| | **(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following:**<br>**(b) Complete an individual medication log that contains all of the following information:**<br>**(iv) The time when the prescribed medication is to be administered and when the medication was administered.**<br>**(v) The initials of the individual who administered the prescribed medication.**<br>**(vii) A record of the reason for administration of a prescribed medication that is on an as-needed basis.** |

| | |
|---|---|
| **ANALYSIS:** | Review of Resident A's MAR and the interview with Employee 1 revealed that the pain medications reportedly given on 05/24/2026 were not documented in the MAR therefore, the facility is not in compliance with this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## ADDITIONAL FINDINGS:

### INVESTIGATION:

On 06/03/2026, I reviewed Resident A's service plan which revealed the facility is responsible for managing Resident A's medications.

Review of Resident A's current MAR revealed the following instructions for as-needed pain medications:

- *"ASPIRIN TAB 325MG TAKE 1 TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR PAIN".*
- *"ACETAMINOPHEN TAB 650MG TAKE 1 TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR PAIN…".*

There were no instructions guiding staff on when to use one pain medication over the other, which could lead to administration based on staff judgment rather than the physician's intended use.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1932** | **Resident medications.** |
| | **(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed healthcare professional.** |
| **ANALYSIS:** | Review of Resident A's MAR revealed that, because the physician's order only directed staff to administer the medications for pain without specifying when to use one medication versus the other, the facility did not provide staff with the necessary guidance to ensure the medications were administered in accordance with the prescribing physician's intended use. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

On 06/03/2026, I reviewed the facility's information on record with the department including the name of the Administrator. While onsite, it was noted that the Administrators name did not match the department's records.

During interview, the Administrator reported that she began the role on January 4, 2026, and the former Administrator was no longer at the facility. The Administrator reported that she was unsure if the Authorized Representative reported the change to the department.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1913** | **Licenses and permits; general provisions.** |
| | **(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.** |
| **ANALYSIS:** | The facility did not fulfill the requirement to report the change in Administrator to the department within 5 business days therefore, the facility is not in compliance with this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Tammie Daniels 06/22/2026

Tammie Daniels Date
Licensing Staff

Approved By:

06/25/2026

_____

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