GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 24, 2026

Jennifer Herald
Oliver Woods Retirement Village LLC
Suite 200
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL780258989
Investigation #: 2026A1033036
Oliver Woods #1

Dear Ms. Herald:

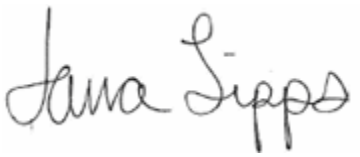
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL780258989
Investigation #:	2026A1033036
Complaint Receipt Date:	05/07/2026
Investigation Initiation Date:	05/07/2026
Report Due Date:	07/06/2026
Licensee Name:	Oliver Woods Retirement Village LLC
Licensee Address:	Suite 200 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(810) 334-8809
Administrator:	Carla LaMarr
Licensee Designee:	Jennifer Herald
Name of Facility:	Oliver Woods #1
Facility Address:	1310 W. Oliver Street Owosso, MI 48867
Facility Telephone #:	(989) 729-6060
Original Issuance Date:	04/16/2004
License Status:	REGULAR
Effective Date:	08/29/2025
Expiration Date:	08/28/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff members are not being adequately trained to perform their job duties.	Yes
Direct care staff, Sierra Woodring, administered resident medications independently prior to completing medication administration training.	No
The facility is not properly stocked with incontinence briefs to provide proper care to all residents.	No
The facility runs out of oxygen and does not have adequate supply for residents requiring oxygen.	No
The facility frequently runs out of resident medications.	Yes
Direct care staff ran out of Resident A's insulin and administered Resident B's insulin to Resident A.	No

III. METHODOLOGY

05/07/2026	Special Investigation Intake 2026A1033036
05/07/2026	Special Investigation Initiated - Telephone Interview conducted with adult foster care licensing consultant, Bridget Vermeesch.
05/08/2026	APS Referral APS, adult services worker, Rebecca Schalow.
05/15/2026	Inspection Completed On-site Interviews conducted with Administrator, Carla LaMarr, Assistant Wellness Director, Brandi Harrison, & maintenance director, Alex McLean. Review of direct care staff trainings completed, review of resident records initiated.
05/18/2026	Contact - Document Sent Email correspondence sent to Administrator, Carla LaMarr, requesting additional documentation.
05/21/2026	Contact - Document Received Documents received via email from Administrator, Carla LaMarr.
05/28/2026	Contact - Telephone call made Interview conducted with direct care staff, Nicole Chapman, via telephone.
05/28/2026	Contact - Document Received

	Email correspondence received from Administrator, Carla LaMarr.
05/29/2026	Contact - Document Received Email correspondence received from Administrator, Carla LaMarr.
05/29/2026	Contact - Document Received Email correspondence received from direct care staff, Nicole Chapman.
06/04/2026	Contact - Telephone call made Interview conducted via telephone with Citizen 3.
06/07/2026	Contact - Document Received Email correspondence received from direct care staff, Nicole Chapman.
06/08/2026	Contact - Telephone call made Interview conducted with direct care staff, Caitlyn Hoskins, via telephone.
06/08/2026	Contact - Telephone call made Interview conducted with direct care staff, Abigail Harrison, via telephone.
06/09/2026	Contact - Telephone call received Interview conducted with direct care staff, Julie Birge, via telephone.
06/09/2026	Contact - Telephone call made Attempts to interview direct care staff, Sierra Woodring, on 5/28/26 & 6/9/26, via telephone. Voicemail messages left both times. Awaiting response.
06/09/2026	Contact - Document Received Email correspondence received from Administrator, Carla LaMarr.
06/09/2026	Contact - Telephone call made Interview conducted with Citizen 1, via telephone.
06/09/2026	Contact - Telephone call made Interview conducted with Citizen 2, via telephone.
06/11/2026	Contact – Telephone call made Interview conducted with Citizen 5, via telephone.
06/11/2026	Contact – Document Sent

	Email correspondence sent to Administrator, Carla LaMarr.
06/21/2026	Contact – Document Received Email correspondence received from Ms. LaMarr.
06/22/2026	Contact – Telephone call made Interview conducted with APS, Rebecca Schalow.
06/22/2026	Contact – Document Received Email correspondence received from Ms. LaMarr.
06/22/2026	Exit Conference Conducted via email with licensee designee, Jennifer Herald, and Administrator, Carla LaMarr.

ALLEGATION:

- **Direct care staff members are not being adequately trained to perform their job duties.**
- **Direct care staff, Sierra Woodring, administered resident medications independently prior to completing medication administration training.**

INVESTIGATION:

On 5/7/26 I received an online complaint regarding the Oliver Woods #1, adult foster care facility (the facility). The complaint alleged that the direct care staff members are not receiving adequate training to perform assigned tasks. The complaint further alleged that direct care staff, Sierra Woodring, was administering resident medications prior to completing her medication administration training.

On 5/15/26 I conducted an unannounced, on-site investigation at the facility. I spoke with Administrator, Carla LaMarr, and Assistant Wellness Director/direct care staff, Brandi Harrison, regarding direct care staff training records. Ms. LaMarr and Ms. Harrison reported that they keep direct care staff training records through the Relias training system online. They reported that when a direct care staff member is hired there is a training checklist that the team works with the new hire on completing and there is a check-off process for when the new hire completes certain tasks. They reported that this check-off sheet is a paper copy and kept in the direct care staff paper file. Ms. LaMarr and Ms. Harrison reported that they have recently had a disgruntled employee who they believe has gone through the employee files and shredded these training sheets. They reported that many direct care staff orientation training sheets are now missing. Ms. LaMarr and Ms. Harrison denied that Ms. Woodring ever administered medications prior to completing medication administration training. I requested to review the complete direct care staff list for the facility. This facility is located on a campus that houses four licensed adult foster care facilities. The direct care staff are usually cross trained at each facility and able to cover shifts in all facilities. I requested to review

thirteen direct care staff training records. I observed the following when reviewing these files:

- The following direct care staff do not have a current cardiopulmonary resuscitation certification:
    - Corey Miller
    - Julie Birge
    - Sierra Woodring
    - Emily Clark
    - Corney Emerson
    - Mercedes Finnagin
    - Nicole Chapman
        - I spoke with Ms. LaMarr, via email, on 5/28/26, about the missing CPR certifications for these direct care staff members. She reported that this is accurate information and that they are scheduled to take a new CPR course on 6/14/26.
- Sierra Woodring Medication Administration Training record was completed and dated 4/27/26-4/28/26.
- The files did contain documentation of all other required trainings.

During the on-site investigation on 5/15/26 I requested to review the *Medication Administration Records* (MARs) for eight residents. I was provided these records via email from Ms. LaMarr on 5/21/26. I observed the following information on the MARs reviewed:

- Sierra Woodring's signature did not appear on any of the provided MARs as someone who administered medications during the month of April 2025.

On 5/28/26 and 6/9/26 I made attempts to interview Ms. Woodring, via telephone. Voicemail messages were left both days and no response was received.

On 5/28/26 I interviewed Ms. Chapman via telephone regarding the allegation. Ms. Chapman reported that Ms. Woodring was in the middle of her medication administration training and had not yet been cleared to administer medications independently when direct care staff, Shelly Teal, requested that she administer medications in one of the other licensed adult foster care facilities located on this campus. Ms. Chapman reported that she could not recall the exact date when this occurred, but she knew it happened in April 2026.

On 6/8/26 I interviewed direct care staff, Caitlyn Hoskins, via telephone regarding the allegation. Ms. Hoskins reported that she has received all training to work at the licensed adult foster care facilities on this campus. She reported that she has never observed a direct care staff member administering medications prior to completing their medication administration training.

On 6/8/26 I interviewed Abigail Harrison, via telephone, regarding the allegation. Ms. Harrison reported that she feels she completed all required trainings prior to providing

independent care to the residents at the facility. She reported that she has never observed untrained direct care staff members administering resident medications.

On 6/9/26 I interviewed direct care staff, Julie Birge, regarding the allegation. Ms. Birge reported that she has never witnessed untrained direct care staff members administering medications to residents at the facility. She reported that she feels she received all required trainings.

On 6/9/26 I interviewed Citizen 1 via telephone regarding the allegation. Citizen 1 reported that they have no knowledge regarding the allegation that direct care staff were allowed to administer medications prior to completing medication administration training.

On 6/9/26 I interviewed Citizen 2 via telephone regarding the allegation. Citizen 2 reported that they have no knowledge of information pertaining to direct care staff being allowed to administer medications prior to completing medication administration training.

On 6/5/25, Special Investigation #2025A1033029 cited a rule violation of Rule R400.15204(3)(c) regarding direct care staff qualifications and training requirements. The citation identified that five direct care staff members did not have current documentation of completed cardiopulmonary resuscitation training in their employee files. The CAP submitted on 6/17/25 identified that direct care staff would be trained and competent in cardiopulmonary resuscitation and a copy of this certification would be place in direct care staff files. Adult foster care home rules were updated and promulgated on 11/3/2025 and Rule R 400.15204 is equivalent to Rule R 400.629(5)(c).

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(5) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be trained and competent in all of the following areas before performing assigned tasks independently: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation, which includes a hands-on demonstration as part of the training.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases including recognizing signs of illness.** **(h) Food safety, which includes food storage, preparation, distribution, and serving in a safe manner.** **(i) Nutrition and special diets.**

ANALYSIS:	Based upon interviews conducted with Ms. LaMarr and Ms. Harrison as well as review of employee files, it can be determined that there were seven out of 13 files that were missing documentation of current cardiopulmonary resuscitation certifications. Based on this information a violation has been established.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2025A1033029 Rule 204(3)(c), AND CAP SUBMITTED 6/17/25].**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Based upon interviews conducted with Ms. LaMarr, Brandi Harrison, Ms. Chapman, Abigail Harrison, Ms. Birge, Ms. Hoskins, Citizen 1, and Citizen 2, as well as review of Ms. Woodring's medication administration training and eight resident MARs, it can be determined that there is not adequate evidence to conclude that Ms. Woodring administered medications at the facility prior to completing her medication administration training. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **The facility is not properly stocked with incontinence briefs to provide proper care to all residents.**
- **The facility runs out of oxygen and does not have adequate supply for residents requiring oxygen.**

INVESTIGATION:

On 5/7/26 I received an online complaint regarding the facility. The complaint alleged that the facility is not properly stocked with incontinence briefs for resident use. The complaint further alleged that there have been residents who have run out of their oxygen tanks due to direct care staff oversight. On 5/15/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. LaMarr & Brandi Harrison regarding the allegation. Ms. LaMarr and Ms. Harrison reported that there are four residents receiving hospice care at the facility. They reported that the hospice provider supplies the incontinence briefs for these residents. They further reported that the remaining residents will have the cost of incontinence briefs factored into their room

and board amount. Ms. LaMarr reported that there are four licensed adult foster care facilities on this campus and each facility has a storage room with a supply of incontinence briefs available for resident use. Ms. LaMarr further reported that there is a large storage room in one of the licensed facilities where an overflow supply of briefs is kept for resident use and dispersed to all facilities on the campus. Ms. LaMarr and Ms. Harrison reported that when a resident receives briefs from their hospice provider, the briefs are shipped to the facility, in that resident's name, and stored in their resident apartment.

Ms. LaMarr and Ms. Harrison reported that there are four residents in the facility who utilize oxygen tanks as part of their care plan. These residents were identified as Residents C, D, E, & F. They reported that there has never been an issue with these residents running out of oxygen at the facility. Ms. LaMarr reported that an issue did occur at one of the other licensed adult foster care facilities on the campus with a resident of that licensed setting running low on her portable oxygen tanks. Ms. LaMarr reported that a training was completed with all direct care staff members regarding this issue and how to know when to reorder oxygen tanks. Ms. LaMarr further clarified that the resident in question was not out of oxygen, she still had her oxygen concentrator which plugs into the wall outlet. She reported that new portable oxygen tanks were ordered and delivered the same day that her tank ran out of oxygen. Ms. LaMarr reported that the direct care staff training related to reordering oxygen tanks was completed on 5/13/26.

During the on-site investigation on 5/15/26 I conducted a walkthrough of the entire campus. I observed all storage areas where incontinence briefs are stored for resident use. The facility had a large supply of briefs in multiple sizes and variations. During this investigation I asked Ms. LaMarr to provide evidence of briefs being ordered through a durable medical equipment company. Ms. LaMarr provided me with the following documentation:

- Invoice from Medline dated 4/11/26. This invoice was for incontinence briefs and totaled $1870.50.
- Invoice from Medline dated 3/25/26. This invoice was for incontinence briefs and totaled $843.01.
- Invoice from Medline dated 3/10/26. This invoice was for incontinence briefs and totaled $1380.64.

On 6/8/26 I interviewed Abigail Harrison, via telephone, regarding the allegation. Ms. Harrison reported that she has never observed the facility insufficiently supplied with incontinence briefs for resident use. She reported no issues with residents running out of oxygen at the facility.

On 6/8/26 I interviewed direct care staff, Caitlyn Hoskins, regarding the allegation. Ms. Hoskins reported that she has no knowledge of the facility being in short supply of incontinence briefs or residents running out of oxygen. She reported to the best of her knowledge these issues have not occurred.

On 6/9/26 I interviewed Ms. Birge, via telephone, regarding the allegation. Ms. Birge reported that she has never had an issue with the facility not being adequately supplied with incontinence briefs for resident use. Ms. Birge reported that to her knowledge, no residents have ever run out of their oxygen.

On 6/9/26 I interviewed Citizen 1 via telephone, regarding the allegation. Citizen 1 reported that they have not worked at the facility is several months, but they were aware that in December 2025 there were many issues concerning the facility not being properly supplied with incontinence briefs for resident use. Citizen 1 reported that there were residents who required XXXLG size briefs and these were not provided for a period. Citizen 1 reported that there had been a change in leadership at the facility during this period and when this change occurred the person responsible for ordering incontinence briefs and other supplies stopped ordering. Citizen 1 reported that there seemed to be a breakdown in communication about who was tasked with this responsibility and it fell by the wayside. Citizen 1 reported that during this timeframe there were residents who were forced to use a smaller size brief which caused discomfort to those residents. Citizen 1 had no information on any residents running out of their oxygen tanks at the facility.

On 6/9/26 I interviewed Citizen 2 via telephone, regarding the allegation. Citizen 2 reported that during December 2025 and January 2026 there seemed to be an issue with having an adequate supply of incontinence briefs, wipes, and other supplies. Citizen 2 reported that during this period the facility, even the storage rooms were frequently empty and the direct care staff were struggling to find supplies. Citizen 2 reported that this problem was addressed with management but noted that this issue went on for several weeks. Citizen 2 had no reported information on residents running out of oxygen tanks.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	Based upon interviews conducted and observations made during the unannounced, on-site investigation, it can be determined that there is no substantial evidence to conclude that the facility is not currently being adequately supplied with incontinence briefs for resident use. Citizen 1 and Citizen 2 both verified that there appeared to be an issue with having adequate supplies in December 2025, but this issue appears to be corrected. Ms. LaMarr was able to provide current transactions of a purchase history for these products, and the facility had a large supply of incontinence briefs during the on-site investigation. There was no evidence of residents at this facility running out of oxygen tanks presented during this investigation. Therefore, a violation will not be established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **The facility frequently runs out of resident medications.**
- **Direct care staff ran out of Resident A's insulin and administered Resident B's insulin to Resident A.**

INVESTIGATION:

On 5/7/26 I received an online complaint regarding the facility. The complaint alleged that residents are missing medications due to the facility running out of medications to administer. This complaint also identified that residents who take insulin were running out of their insulin supply. Further, there was an allegation that Resident A ran out of her insulin on 1/19/26 and 4/27/26 and direct care staff were advised by management to administer Resident B's insulin to Resident A.

On 5/8/26 I received email correspondence from Adult Protective Services, Adult Services Worker, Rebecca Schalow, regarding the allegations. Ms. Schalow reported that she had conducted an on-site inspection at the facility on 5/6/26 and provided written dictation of interviews conducted on this date. I observed the following in these notes.

- Face to face interviewed Ms. Schalow conducted with Resident A on 5/6/26. Resident A reported that she is insulin dependent. Resident A reported that she has run out of her insulin on one or two occasions at the facility but has not gone without insulin. Resident A could not provide the dates of these occurrences. Resident A reported that she is not certain how the situation was resolved but feels they must have taken one of her doses and split it into two doses to get her through until her insulin arrived from the pharmacy.
- Face to face interview with Ms. LaMarr and Brandi Harrison on 5/6/26. They reported that Resident A ran out of insulin on 1/19/26 and 4/27/26. They reported that on 1/19/26 Resident A's insulin pen was found in the medication refrigerator

and on 4/27/26 the insulin was found in the medication cart. It was further reported that neither of these insulin medications were located prior to direct care staff, Nicole Chapman, administering another resident's insulin to this resident on both dates. It was not disclosed which resident's insulin was used by Ms. Chapman for Resident A.

On 5/15/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. LaMarr and Brandi Harrison regarding the allegation. Ms. LaMarr reported that there have not been any issues with residents at the facility running out of their medications to her knowledge. Ms. Harrison reported no concerns about this occurring as well.

Ms. LaMarr reported that she was aware of a complaint that direct care staff had administered another resident's insulin to Resident A. She reported that Adult Foster Care Licensing Consultant, Julie Elkins, investigated this allegation a couple months ago. Ms. LaMarr reported that this allegation was not substantiated in Ms. Elkins' report.

During the unannounced, on-site investigation I requested to review the MARs for eight residents for the month of April 2026. Ms. LaMarr provided these MARs for my review via email on 5/21/26. I conducted a walkthrough of the facility and observed where resident medications are stored. I reviewed the insulin supply on hand for Resident A, Resident B, and Resident G. Each residents' insulin was available at the facility for administration on this date.

I reviewed the eight MARs provided by Ms. LaMarr. I did not observe any concerning areas that would identify a problem with missing medications. I reviewed Resident A's MAR for the month of April 2026 and noted that Resident A's insulin on 4/27/26 was administered by direct care staff, Angel DeVincent.

On 5/28/26 I interviewed Ms. Chapman via telephone regarding the allegation. Ms. Chapman reported that there are frequently residents who do not receive timely refills on their medications. Ms. Chapman reported that she had documentation of residents who were missing medications and she would email this documentation to this consultant. Ms. Chapman reported that on 1/19/26 she contacted Citizen 3 regarding Resident A being out of her Basaglar insulin. Citizen 3 is a former direct care staff/Wellness Director for the facility. Ms. Chapman reported that Citizen 3 advised her to go to the neighboring licensed facility and use Citizen 4's Lantus insulin for Resident A. Ms. Chapman reported that she told Citizen 3 that she felt this was illegal. She reported that Citizen 3 told her that she must administer Citizen 4's medication if Resident A was out of her own insulin supply. Ms. Chapman reported that she did administer Resident A, Citizen 4's insulin on 1/19/26. Ms. Chapman further reported that Resident A ran out of her Lantus insulin on 4/27/26. She reported that Brandi Harrison was called and it was reported to her that the Lantus was out of stock for Resident A. Ms. Chapman reported that Ms. Harrison instructed Citizen 5 (who is a former direct care staff member) to administer Resident B's insulin to Resident A on this date. Ms.

Chapman reported that Citizen 5 did administer Resident B's insulin to Resident A on 4/27/26.

On 5/29/26 I received email correspondence from Ms. Chapman regarding the allegation. Ms. Chapman provided the following documentation for my review:

- *Med Pass Exceptions*, 2/1/26-5/8/26, for Resident G. I observed the following:
  - Astepro 205.5MCG is marked as "Awaiting Med Arrival From Pharmacy" from 2/13/26-2/19/26.
  - MG Gluconate 250MG is marked as "Awaiting Med Arrival From Pharmacy" from 2/13-2/15/26.
- *Med Pass Exceptions*, 2/1/26-5/8/26, for Resident D. I observed the following:
  - All missed doses had an appropriate notation of either, "Out of Facility" or "Withheld Per Dr/RN Orders".
- *Med Pass Exceptions*, 2/1/26-5/8/26, for Resident H. I observed the following:
  - Medication doses that were missed were marked with "Resident Refused".
- *Med Pass Exceptions*, 2/1/26-5/8/26, for Resident I. I observed the following:
  - Lorazepam 0.5MG was marked as "Awaiting Med Arrival From Pharmacy" on 2/15/26-2/16/26.
  - Preservision CaP AREDS 2 is marked as "Awaiting Med Arrival From Pharmacy" on 3/4/26.
  - Donepezil 5MG is marked as "Awaiting Med Arrival From Pharmacy" on 3/5/26-3/9/26.
- *Med Pass Exceptions*, 2/1/26-5/8/26, for Resident C. I observed the following:
  - Hydrocodone 5-325MG is marked "Awaiting Med Arrival From Pharmacy" on 3/8/26-3/10/26.
- *Med Pass Exceptions*, 2/1/26-5/8/26, for Resident F. I observed the following:
  - Albuterol is marked as "Awaiting Med Arrival From Pharmacy" on 2/18/26.
- *Med Pass Exceptions*, 2/1/26-5/8/26, for Resident A. I observed the following:
  - Basaglar 100Unit is marked "Awaiting Med Arrival From Pharmacy" on 2/7/26-2/9/26.
  - Melatonin 5mg is marked "Awaiting Med Arrival From Pharmacy" on 2/19/26.
  - Trazodone is marked "Awaiting Med Arrival From Pharmacy" on 2/19/26.
  - Incruse Elpt Inh 62.5MCG is marked "Awaiting Med Arrival From Pharmacy" on 2/20/26.
  - Lantus Solos Inj 100ML is marked "Awaiting Med Arrival From Pharmacy" on 2/22 & 2/23/26.
- *Med Pass Exceptions*, 2/1/26-5/8/26, for Resident J. I observed the following:
  - Loperamide 2MG is marked "Awaiting Med Arrival From Pharmacy on 2/25/26.
  - The other missed administrations are noted with "Resident Refused" or "Out of Facility".

On 6/4/26 I interviewed Citizen 3 regarding the allegation. Citizen 3 is a former direct care staff member for the facility. Citizen 3 was previously in a management position with the facility. Citizen 3 reported that she has not worked at the facility in a couple

months but previously she was aware that there were some issues with residents' medications not being refilled in a timely manner. Citizen 3 could not recall specific residents or resident names for this investigation. When questioned about Resident A running out of insulin, Citizen 3 reported that she is aware there is an allegation that she advised direct care staff to administer another resident's mediation to Resident A. Citizen 3 denied this claim. She reported that this could not be possible as the two residents do not even use the same brand of insulin. She reported that she does not recall the names of the residents, but she was questioned about this previously. She reported that she did receive a telephone call from a direct care staff member noting they felt a resident was out of her medication because they could not find the insulin. Citizen 3 reported that she advised this direct care staff member where in the facility to locate the insulin as it is refrigerated in a locked refrigerator and not found in the medication cart. Citizen 3 reported that the insulin was found on this date and the medication was administered correctly to her knowledge. Citizen 3 could not recall when this occurred, which direct care staff member she spoke with, or which residents were involved.

On 6/8/26 I interviewed Ms. Hoskins regarding the allegation. Ms. Hoskins reported that she is not aware of residents running out of their medications. She reported that she usually does not administer medications which gives her limited knowledge of the medications available in the medication cart.

On 6/8/26 I interviewed Abigail Harrison, via telephone, regarding the allegation. Ms. Harrison reported that she has not experienced residents running out of their prescribed medications at the facility.

On 6/9/26 I interviewed Ms. Birge via telephone regarding the allegation. Ms. Birge reported that she has never observed a resident run out of their medication at the facility. She has no knowledge of this occurring.

On 6/9/26 I interviewed Citizen 1 regarding the allegations. Citizen 1 reported that they did not directly observe another direct care staff member administer another resident's insulin to Resident A, but they were aware of the allegation. Citizen 1 reported that there was a lot of talk amongst the direct care staff that Citizen 3 had issued a verbal directive to administer another resident's insulin to Resident A in January 2026. Citizen 1 did not know which direct care staff member it was or the exact date of the occurrence. Citizen 1 reported, "[Citizen 3] was always pushing staff to do things we weren't comfortable doing."

On 6/9/26 I interviewed Citizen 2 regarding the allegation. Citizen 2 reported that she is aware of the rumors that Citizen 3 advised a direct care staff member to administer another resident's insulin to Resident A. Citizen 3 reported that she did not observe this firsthand. She reported that she did not know which direct care staff member was given this directive.

On 6/11/26 I interviewed Citizen 5 via telephone regarding the allegation. Citizen 5 confirmed that they are a former direct care staff member for the facility. Citizen 5 confirmed that they were trained in medication administration and did administer medications at the facility. Citizen 5 denied the allegation that she was instructed by Brandi Harrison to administer another resident's insulin to Resident A on 4/27/26. Citizen 5 reported that she had no knowledge of any direct care staff member being instructed to administer another resident's medication to a different resident. Citizen 5 reported that she did observe resident medications to be missing from the medication cart while she worked at the facility. She reported that there were medications that required refills and sometimes a medication would be missing for one to two days before it was refilled in the medication cart. Citizen 5 was asked twice during this interview about the administration of Resident A's insulin. Both times she reported that she had no knowledge of this ever occurring at the facility.

During this investigation I reviewed Ms. Elkin's special investigation report, which was about Ms. LaMarr and direct care staff being requested to administer one resident's insulin to another resident. This special investigation report, #2026A0466020, was written for a different licensed adult foster care facility on this campus and referred to a different direct care staff member and three different residents. Ms. Elkins found no violation in the conclusion of her report.

On 6/11/26 I sent email correspondence to Administrator, Carla LaMarr, requesting information on missing medications noted on the Med Pass Exceptions documents supplied by Ms. Chapman. On 6/21/26 Ms. LaMarr responded to this email with the requested information. Ms. LaMarr copied licensee designee, Jennifer Herald, on this communication. I observed the following information in this email:

- Ms. LaMarr reported that Resident G's Astepro medication was refilled by the pharmacy on 2/12/26 but was not received at the facility until 2/19/26. She reported that several attempts were made by direct care staff to communicate with the pharmacy about the missing medication. She noted that these communications are documented on the Med Pass Exceptions report. I reviewed the report and found one documented entry from direct care staff, Allen Kaczorowski, on 2/17/26 which reads, "This is stated to be filled on the 12th. I will call later today on this as clearly something is wrong on their end." The rest of the missed doses just state, "Awaiting Med Arrival From Pharmacy".
- Ms. LaMarr reported that Resident I's Donepezil medication documented as not being administered from 3/5/26-3/9/26 the direct care staff contacted the pharmacy and doctor for a new script on 3/5/26. I reviewed the Med Pass Exceptions Report which did not identify that the direct care staff had made efforts to obtain a new script from the pharmacy/physician.
- Ms. LaMarr reported that Resident C's Hydrocodone medication was missed from 3/8/26-3/10/26 because it required a new script. She reported that the refill request was submitted to the physician on 3/9/26.
- Ms. LaMarr reported that Resident A's missing Basaglar medication was reordered on 2/7/26 and 2/9/26. She reported that Mr. Kaczorowski had made contact with the pharmacy and they reported to Mr. Kaczorowski that this

medication had been sent to the facility but it was not received. She reported that there is documentation of these contacts in the medication exceptions report. I reviewed this report and noted documentation from Mr. Kaczorowski on 2/8/26 stating, “Pharmacy claimed in system they sent it but we do not have it. I will contact them tomorrow to have it sent out.” He also documented on 2/9/26, “Calling today to figure out why we haven’t received yet as they claim it was filled in the MAR.”

On 6/22/26 I interviewed APS, Rebecca Schalow, via telephone regarding the allegation. I confirmed the content of the documentation she provided to me on 5/8/26 regarding her interview conducted on-site with Ms. LaMarr and Brandi Harrison on 5/6/26. I inquired of Ms. Schalow if the documentation of this interview was accurate, stating that Ms. LaMarr and Ms. Harrison reported understanding that Ms. Chapman had administered another resident’s insulin medication to Resident A on 1/19/26 and 4/27/26. Ms. Schalow reported that Ms. LaMarr and Ms. Harrison both acknowledged that on these dates Resident A’s insulin was not found by the direct care staff for administration and by the time someone did locate Resident A’s insulin at the facility, Ms. Chapman had already administered someone else’s insulin to Resident A. Ms. Schalow reported that neither Ms. LaMarr nor Ms. Harrison acknowledged giving Ms. Chapman the verbal directive to administer another resident’s insulin to Resident A, but they both acknowledged that Ms. Chapman did administer another resident’s insulin on these dates.

On 6/22/26 Ms. LaMarr provided, via email, Resident A’s MAR for January 2026. I reviewed this MAR. I observed that Resident A’s Basaglar insulin is noted as being administered by direct care staff, Nicole Decker, on 1/19/26.

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 upon interviews conducted and documentation reviewed it can be determined that there is adequate evidence to indicate that there have been several dates and times when residents of the facility have gone without their prescribed, routine medications, for days at a time. When I requested that Ms. LaMarr clarify why these medications were not present at the facility she reported for Resident A, Resident C, Resident G, and Resident I that each had medications that ran out at the facility and were either ordered or requested a refill from the provider on the day or days after they ran out. Resident routine medications should be reordered prior to medication stock being depleted at the facility to ensure smooth transitions and allow for no disruptions in the medications administered to residents. Whether there is a communication barrier with the pharmacy or the direct care staff are not planning ahead to reorder medications, this has been identified as an area needing improvement. Based on this information collected a violation is being established.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 the interviews conducted and documentation reviewed during this investigation there is not adequate evidence to determine that the direct care staff have administered another resident's insulin to Resident A. It was reported that on 1/19/26, Ms. Chapman, was instructed by Citizen 3 to administer another resident's insulin to Resident A. However, Ms. Chapman's name does not appear on the MAR on 1/19/26 as the direct care staff who administered the medication rather Ms. Decker's name is listed. Furthermore, Citizen 3 denied giving this directive to Ms. Chapman. It was also reported that on 4/27/26 Citizen 5 was requested by Brandi Harrison to administer another resident's insulin to Resident A. However, Citizen 5 adamantly denied these allegations and Ms. Harrison denied giving this directive. Ms. Chapman states that these allegations are factual but there is not evidence to make this conclusion. Ms. Schalow reported that Ms. LaMarr and Ms. Harrison admitted that Ms. Chapman did administer another resident's insulin on 1/19/26 and 4/27/26 to Resident A, but the MARs do not present this as factual. Ms. Chapman's name does not appear on either MAR as administering the insulin to Resident A on these dates. Citizen 1 and Citizen 2 reported that they overheard rumors of this occurring, but neither had an eyewitness account of the situation. Based on a lack of concrete evidence a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

6/22/26

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Jana Lipps Date
Licensing Consultant

Approved By:

06/24/2026

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Dawn N. Timm Date
Area Manager