GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 9, 2026

Sheila Leadbetter
Barrett Regency, Inc.
1318 Maple
Rochester, MI 48307

RE: License #: AS630377781
Investigation #: 2026A0602009
Barrett Regency Inc

Dear Sheila Leadbetter:

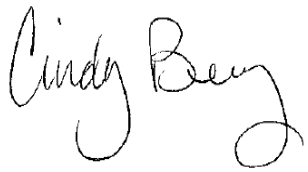
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 972-9136.

Sincerely,



Cindy Berry, Licensing Consultant
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Cadillac Place
3044 West Grand Blvd
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Detroit, MI 48202
(248) 860-4475

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS630377781 |
| | |
| **Investigation #:** | 2026A0602009 |
| | |
| **Complaint Receipt Date:** | 04/22/2026 |
| | |
| **Investigation Initiation Date:** | 04/23/2026 |
| | |
| **Report Due Date:** | 06/21/2026 |
| | |
| **Licensee Name:** | Barrett Regency, Inc. |
| | |
| **Licensee Address:** | 5101 N. Rochester<br>Rochester, MI 48306 |
| | |
| **Licensee Telephone #:** | (248) 494-6719 |
| | |
| **Licensee Designee/ Administrator:** | Sheila Leadbetter |
| | |
| **Name of Facility:** | Barrett Regency Inc |
| | |
| **Facility Address:** | 5101 N. Rochester<br>Rochester, MI 48306 |
| | |
| **Facility Telephone #:** | (248) 494-6719 |
| | |
| **Original Issuance Date:** | 05/10/2016 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 06/07/2025 |
| | |
| **Expiration Date:** | 06/06/2027 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>ALZHEIMERS<br>AGED<br>TRAUMATICALLY BRAIN INJURED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A resided at Barrett Regency for approximately three months in 2025. During her stay, Ativan was administered to her before a prescription was authorized. | No |
| Ms. Leadbetter has not responded to Resident A's family request for a copy of Resident A's resident record. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 04/22/2026 | Special Investigation Intake<br>2026A0602009 |
| 04/22/2026 | Contact – Document received<br>Received emailed documents from Family Member 1 |
| 04/23/2026 | Special Investigation Initiated - On Site<br>Reviewed medication and medication logs |
| 04/23/2026 | Contact - Telephone call received<br>Spoke with the licensee designee while at the facility. |
| 04/27/2026 | Contact - Telephone call received<br>Spoke with Family Member 1 |
| 05/06/2026 | Contact - Document Received<br>Received email from Family Member 1 |
| 05/06/2026 | Contact - Document Sent<br>Status letter sent to Family Member 1 |
| 06/12/2026 | Contact – Telephone call received<br>Spoke with Family Member 1. |
| 06/30/2026 | Contact – Telephone call made<br>Spoke with the pharmacist at CSA Pharmacy. |
| 07/06/2026 | Contact – Telephone call made<br>Call made to Ms. Leadbetter, voicemail full, unable to leave a message. |
| 07/06/2026 | Contact – Telephone call received |

| | |
|---|---|
| | Spoke with Mr. and Mrs. Leadbetter. |
| 07/07/2026 | Contact – Document received<br>Received documents from Ms. Leadbetter. |
| 07/08/2026 | Contact – Telephone call made<br>Message left for Dr. Rica Stamatin requesting a return call. |
| 07/08/2026 | Contact – Telephone call received<br>Spoke with Dr. Rica Stamatin. |
| 07/08/2026 | Exit Conference<br>Message left for Ms. Leadbetter. |
| 07/08/2026 | Contact – Telephone call received<br>Received a message from Ms. Leadbetter stating she was returning my call. |
| 07/08/2026 | Contact – Telephone call made<br>Call made to Ms. Leadbetter, unable to leave a message, voicemail full. |
| 07/09/2026 | APS referral<br>An Adult Protective Services (APS) referral was not made as there were no allegations of abuse or neglect. |
| 07/09/2026 | Contact – Telephone call made<br>Message left for staff member Taryn Aguayo. |
| 07/09/2026 | Contact – Telephone call made<br>Call made to staff member Cathy Rohl, no answer. |
| 07/09/2026 | Exit Conference<br>Held with the licensee designee, Sheila Leadbetter. |

**ALLEGATION:**

**Resident A resided at Barrett Regency for approximately three months in 2025. During her stay, Ativan was administered to her before a prescription was authorized.**

**INVESTIGATION:**

On 4/22/2026 a complaint was received and assigned for investigation alleging that Resident A resided at Barrett Regency for approximately three months in 2025. During her stay, Ativan was administered to her before a prescription was authorized. It was further alleged that Ms. Leadbetter has not responded to a request from Resident A's family for a copy of Resident A's resident record.

On 4/22/2026, I received and reviewed invoices and copies of prescriptions (CSA Pharmacy and Express Scripts) from Resident A's Family Member 1 for the medication she received when she resided at the facility, as well as text messages exchanged between Family Member 2 and Ms. Leadbetter. The invoice from CSA Pharmacy dated 3/01/2025 – 5/31/2025 documents that a prescription for Ativan 0.5 mg was billed on 3/19/2025 and the electronic prescription for this medication was dated 3/19/2025. The invoice from Express Scripts invoice dated 1/01/2025 – 12/29/2025 lists Lorazepam (Ativan) as being filled on 3/19/2025. According to the text messages reviewed, Ms. Leadbetter informed Family Member 2 that the doctor ordered 0.5 mg of Ativan as needed and the dates it was administered in March 2025 (3/3/2025, 3/4/2025, 3/5/2025, 3/6/2025, 3/15/2025 and 3/18/2025). There were several text messages exchanged between Ms. Leadbetter and Family Member 2 regarding Resident A receiving Ativan during this time.

On 4/23/2026, I conducted an unannounced on-site investigation at which time I spoke with staff member, Tywanna Peoples. Ms. Peoples called the licensee designee, Sheila Leadbetter, while on-site. I spoke with Ms. Leadbetter by telephone and informed her of the allegations. She stated she was unable to come to the home as she was out of town and would not return until 4/27/2026. Ms. Leadbetter denied the allegations and went on to state that she has a court hearing scheduled for 5/07/2026 regarding this matter. She stated that Dr. Rica Stamatin prescribed Resident A Ativan, and the medication was received from CSA pharmacy. When the medication arrived at the home (exact date unknown), there was only one blister pack of medication delivered. The following week the pharmacy sent out two additional blister packs. She said the medication was sent out in two deliveries because there was a discrepancy between the prescribing doctor and the pharmacy. Ms. Leadbetter stated she was unaware of the details regarding the discrepancy. I informed Ms. Leadbetter that I needed to review each resident's medications and their medication logs.

On 4/27/2026 I spoke with Resident A's Family Member 1. Family Member 1 stated she has concerns about Resident A being given Ativan prior to the prescription being written. The prescription was written on 2/28/2025. It was not filled until 3/19/2025, but was administered prior to 3/19/2025. She went on to state that once Resident A moved out of the facility, her Ativan and Haldol were not sent to the new facility. I informed Family Member 1 that this was investigated in Special Investigation Report #2025A060217 and would not be re-investigated.

During a previous investigation (Special Investigation Report #2025A0602017), Ms. Leadbetter provided copies of Resident A's medication logs for the months of 2/2025, 3/2025, 4/2025, and 5/2025 along with a handwritten prescription (from Dr. Rica Stamatin) dated 2/28/2025 for Ativan 0.5 mg three times daily as needed. The medication logs documented that Resident A received Ativan 0.5 mg on 3/3/2025, 3/4/2025, twice on 3/5/2025, twice on 3/6/2025, 3/15/2025, 3/16/2025, 3/18/2025, 4/18/2025, 5/9/2025, 5/11/2025, 5/12/2025, 5/22/2025 and 5/23/2025 with the reason for administration documented as agitation and/or behavior.

On 6/30/2026 I spoke with the pharmacist at CSA Pharmacy. She stated she received a prescription for Resident A on 3/19/2025 for Ativan 0.5 mg three times daily as needed with no refills. She went on to state that this was the only Ativan prescription she received for Resident A. The prescription was submitted to the insurance company and filled the same day it was received (3/19/2025).

On 7/06/2026 I spoke with Mr. and Mrs. Leadbetter by telephone. They stated they were not happy that another complaint was opened, as they thought the allegations had already been addressed in special investigation #2025A0602017. Mr. Leadbetter again stated they are in the middle of a court case with Resident A's family, as the family has not paid Resident A's past due bill. He went on to state there was information left out of the previous investigation that could have "exonerated" he and his wife. I assured Mr. and Mrs. Leadbetter that my role here is only to investigate allegations of alleged adult foster care licensing rule violations. Ms. Leadbetter agreed to provide documentation regarding the allegations.

On 7/07/2026, I received documents from Mrs. Leadbetter regarding Resident A's care while residing in the facility. I reviewed a handwritten prescription written by Dr. Rica Stamatin on 02/28/25 for Ativan 0.5 mg tablet (take three times daily as needed) for Resident A, as well as notes from Dr. Stamatin dated 2/28/2025 and 3/19/2025. According to the notes dated 2/28/2025, Dr. Stamatin saw Resident A on this date as a new patient. It was noted that Resident A presented with restlessness and agitation while in the home and was taking Xanax. A handwritten prescription for Ativan 0.5 mg (to be taken three times a day as needed) was given to the caregiver. It was further noted if the anti-anxiety medication was not enough to control the episodes of agitation and anxiety, consideration would be made to increase the dose of Ativan to 1 mg. According to Dr. Stamatin's notes dated 3/19/2025, he spoke with the pharmacy for clarification regarding an Ativan script given on 2/28/2025. There were no details documented regarding exactly what needed to be clarified.

On 7/08/2026 I spoke with Dr. Rica Stamatin by telephone. I specifically asked Dr. Stamatin if he recalled writing a prescription for Ativan for Resident A when she resided at Barrett Regency Inc and if there were any issues with the pharmacy pertaining to the prescription. Dr. Stamatin stated he did not recall, as it had been well over a year since he last saw her. He agreed to look at his notes and get back with me but could not give a timeframe as to when this would occur.

On 07/09/26, Ms. Leadbetter stated the handwritten prescription (dated 2/28/2025) she received for Resident A's Ativan 0.5 mg was picked up by the pharmacy, and the medication was delivered to the home on 3/3/2025. She said she has no control or input as to when the pharmacy submits the prescriptions to the insurance company for payment.

| **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 information gathered through the investigation, there is insufficient information to conclude that Resident A was given Ativan 0.5 mg (three times daily as needed) prior to a prescription being authorized. I received and reviewed a prescription written for Resident A by Dr. Rica Stamatin dated 2/28/2025 for Ativan 0.5 mg (three times daily as needed). I also received and reviewed invoices from Express Scripts and CSA Pharmacy documenting that a prescription for Ativan 0.5 mg was processed on 3/19/2025. While there are discrepancies noted between the date the prescription was written on 2/28/25 and the date the pharmacy notes it was filled and submitted to the insurance company on 3/19/25, Resident A did have a prescription on file for Ativan when it was administered from 3/03/25-3/18/25.The licensee designee, Sheila Leadbetter, stated that the prescription was filled and delivered to the home on 3/03/25. Resident A's prescribing physician, Dr. Stamatin, was unable to confirm or deny if there were any issues with the pharmacy regarding a prescription he wrote for Resident A for Ativan, as it had been over a year since he last saw her. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Ms. Leadbetter has not responded to Resident A's family request for a copy of Resident A's file.**

**INVESTIGATION:**

On 5/6/2026, I received and reviewed a screenshot of a text message dated 6/4/2025 from Resident A's family member requesting a copy of Resident A's file. I received and

reviewed a copy of a receipt from the United States Postal Service (dated 3/26/2026) regarding a certified letter that was addressed to Ms. Leadbetter from Resident A's family. The letter was returned to the sender and listed as unclaimed. I also received and reviewed a copy of an email (dated 4/1/2026) addressed to Ms. Leadbetter from Resident A's family requesting a copy of Resident A's file. According to Resident A's Family Member 1, they have not received a response from Ms. Leadbetter regarding their request.

On 7/9/2026 Ms. Leadbetter stated on 2/26/2026 a copy of Resident A's resident file was submitted to the judge during a small claims court hearing. Copies were made of the documents and were provided to the family during that hearing.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.687** | **Resident admission and discharge policy; house rules; change of residency; provision for resident records.** |
| | (10) A licensee shall provide copies of resident records when requested by the resident and resident's designated representative. A fee that is charged for copies of resident records must not be more than the cost to make copies. |
| **ANALYSIS:** | Based on the information received during the investigation, there is sufficient information to determine that Resident A's family was not provided a copy of Resident A's resident records.<br><br>According to Resident A's Family Member 1, a text message was sent to Ms. Leadbetter on 6/4/2025, a certified letter (returned to sender as unclaimed) was sent to Ms. Leadbetter on 3/26/2026, and an email was sent to Ms. Leadbetter on 4/1/2026 requesting a copy of Resident A's resident records.<br><br>Although Ms. Leadbetter stated she provided a copy of Resident A's record to the court on 2/26/2026 and a copy was given to Resident A's family during that hearing, additional requests were made by the family on 3/26/2026 and 4/1/2026 after the date of the court hearing.<br><br>Resident A's Family Member 1 state they still have not received a copy of Resident A's resident record. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 4/23/2026, at the time of the unannounced onsite investigation, Ms. Peoples unlocked the medication cabinet and provided the current (4/2026) medication administration records (MARs) for Resident B, Resident C, Resident D, Resident E, and Resident F. I did not observe any medication or MARs belonging to Resident A. On 4/20/2026 there was no staff signature on the MAR for Resident C's medication, Omeprazole 40 mg (1capsule by mouth every day). Resident D's medication, Levothyroxine 75 mcg (1 tablet by mouth every morning 8 am) appeared to have been popped out of the blister pack beginning 4/22/2026 through 4/30/2026. The medication was placed back into the blister pack and taped closed. I observed two of these same pills contained in the 4/25/2026 spot in the blister pack. It was documented on the MAR that Resident D's medication, Quetiapine Fumarate 25 mg (1 tablet by mouth twice daily for 30 days), was discontinued on 4/12/2026 and increased to three times daily on this same date. There were no staff initials documented on the MAR on 4/19/2026 and 4/20/2026 for the 8 pm dosage. I did not observe anything documented on the MAR providing an explanation for the missed doses. I further observed a small container with a screw on cap in the medication cabinet containing five pills with Resident D's name labelled on the outside of the container. Ms. Peoples stated the pills belonged to Resident D and that Resident D was hospitalized as of 4/21/2026. On 4/23/2026 I observed Haloperidol Oral Solution USP (concentrate) 2 mg/ml in the medication cabinet. There was no resident name or dosage visible on the box as the label had been partially removed. The prescription had an expiration date of 9/21/2026.

On 7/8/2026 I left a message for the licensee designee Sheila Leadbetter requesting a return call so that an exit conference could be conducted.

On 7/9/2026, I received a call from the licensee designee, Sheila Leadbetter, and conducted the exit conference by telephone. I informed Ms. Leadbetter of the investigative findings and recommendation documented in this report. Ms. Leadbetter stated that she will address the issue of her employees failing to sign resident MARs when medication is administered. Ms. Leadbetter stated the Haloperidol Oral Solution USP (concentrate) 2 mg/ml in the medication cabinet was prescribed by a hospice physician/nurse and should have been removed from the cabinet. She agreed to submit a corrective action plan addressing these violations upon receipt of this report.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.675** | **Resident medications.** |
| | (2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. |

| | |
|---|---|
| | Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents. |
| **ANALYSIS:** | Based on the information obtained during the investigation, there is sufficient information to determine that some of Resident D's medication was not kept in the original pharmacy container.<br><br>On 4/23/2026 I observed a clear small container with a screw on cap in the medication cabinet containing five pills with Resident D's name labelled on the outside of the container. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **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:<br>(b) Complete an individual medication log that contains all of the following:<br>(v) Initials of the individual who administered the medication at the time given. |
| **ANALYSIS:** | Based on the information obtained during the investigation, there is sufficient information to determine that staff did not initial Resident C and Resident D's MAR at the time medication was given.<br><br>On 4/23/2026, I observed no staff initials on Resident C's MAR for the medication, Omeprazole 40 mg (1capsule by mouth every day) on 4/20/2026 and I did not observe an explanation documented on the MAR for the lack of signatures.<br><br>On 4/23/2026, I observed no staff initials on Resident D's MAR for the medication Quetiapine Fumarate 25 mg (1 tab by mouth three times daily) on 4/19/2026 and 4/20/2026 for the 8 pm dosage. I did not observe and explanation documented on the MAR for the lack of signatures. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| APPLICABLE RULE | |
|---|---|
| **R 400.675** | **Resident medications.** |
| | (7) Prescription medication that is no longer required by a resident or expired must be properly disposed of. |
| **ANALYSIS:** | Based on the information obtained during the investigation, there is sufficient information to determine that medication for an unknown resident was being stored in the medication cabinet.<br><br>On 4/23/2026, I observed Haloperidol Oral Solution USP (concentrate) 2 mg/ml in the medication cabinet. The resident's name and dosage was not visible as the label was partially removed. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

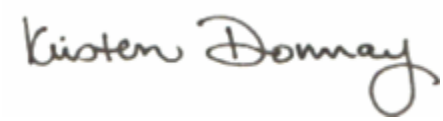
## IV. RECOMMENDATION

Contingent upon receipt of a corrective action plan, I recommend no change to the status of the license.

7/08/2026

Cindy Berry Date
Licensing Consultant

Approved By:



WOC Area Manager for 07/08/2026

Denise Y. Nunn Date
Area Manager