



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
ACTING DIRECTOR

January 11, 2024

Jason and Jessica Taylor  
3773 Hudson Road  
Osseo, MI 49266

RE: License #: AM300276139  
Investigation #: 2024A1032008  
Somewhere in Time

Dear Jason and Jessica Taylor:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 1/10/24, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

A handwritten signature in black ink, appearing to read "Dwight Forde".

Dwight Forde, Licensing Consultant  
Bureau of Community and Health Systems  
Unit 13, 7th Floor  
350 Ottawa, N.W.  
Grand Rapids, MI 49503

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AM300276139
<b>Investigation #:</b>	2024A1032008
<b>Complaint Receipt Date:</b>	11/03/2023
<b>Investigation Initiation Date:</b>	11/07/2023
<b>Report Due Date:</b>	01/02/2024
<b>Licensee Name:</b>	Jason and Jessica Taylor
<b>Licensee Address:</b>	3773 Hudson Road, Osseo, MI 49266
<b>Licensee Telephone #:</b>	(517) 286-5407
<b>Administrator:</b>	N/A
<b>Licensee Designee:</b>	Put a name in here
<b>Name of Facility:</b>	Somewhere in Time
<b>Facility Address:</b>	3773 Hudson Rd., Osseo, MI 49266
<b>Facility Telephone #:</b>	(517) 523-2621
<b>Original Issuance Date:</b>	06/12/2006
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	01/25/2023
<b>Expiration Date:</b>	01/24/2025
<b>Capacity:</b>	12
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident A was not properly supervised taking medication.	Yes
Additional Findings	No

## III. METHODOLOGY

11/03/2023	Special Investigation Intake 2024A1032008
11/07/2023	Special Investigation Initiated - On Site
01/10/2024	Exit Conference

### ALLEGATION:

**Resident A was not properly supervised taking medication.**

### INVESTIGATION:

On 11/7/23, I interviewed Resident A in the home. Resident A stated that she had a medical issue several months ago but that her medication had been stabilized. I asked her about what the staff members do when medications are passed. She explained that the staff observe her take the medication given to her.

I observed two months' worth of medication administration records (MAR) and there did not appear to be any discrepancies.

I interviewed employee Katie Querbach in the home. Ms. Querbach stated that she is trained to pass medications and has worked in a variety of assisted living settings. She described making sure the right medication is given to the right resident at the right time through the right route. Ms. Querbach provided documentation that showed that Resident A's Keppra levels are currently within normal range.

Ms. Querbach reported that based on her experience, Resident A is starting to show signs of dementia. She described Resident A experiencing sundowning, becoming inexplicably rude to other residents, and freezing in place for several seconds and losing track of time.

I interviewed licensee Jessica Taylor in the home. Ms. Taylor acknowledged that in the past, when dispensing medications, they would leave the medication on the table for Resident A to take, because she felt that Resident A was someone who would reliably take her medication, but upon reflection, it was possible several months ago, that Resident A was not actually taking her medications, resulting in low levels of Keppra in Resident A's system. Ms. Taylor reported that Resident A's issues with her medication levels occurred during June through July.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<p><b>(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:</b></p> <p><b>(a) Be trained in the proper handling and administration of medication.</b></p>
<b>ANALYSIS:</b>	Based on my interviews, as well as noted changes in Resident A's medication levels, it was established that Resident A was not receiving proper doses of her medication, due to not being properly supervised during medication administration.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 1/10/23, I conducted an exit conference with licensee Jason Taylor. I reviewed my findings and Mr. Taylor agreed with the conclusions reached. He provided an acceptable corrective action plan.

#### **IV. RECOMMENDATION**

I recommend no change to the status of this license. Jason Taylor provided an acceptable corrective action plan.



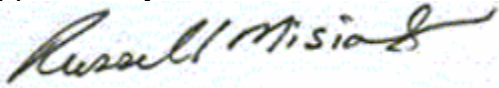
1/11/24

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Dwight Forde  
Licensing Consultant

Date

Approved By:



1/11/24

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Russell B. Misiak  
Area Manager

Date