GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 31, 2024

Deborah Pettyplace
The Barton Woods Group, Inc.
9472 Kochville Road
Freeland, MI 48623

RE: License #: AL730317749
Investigation #: 2024A0572045
Barton Woods Assisted Living

Dear Deborah Pettyplace:

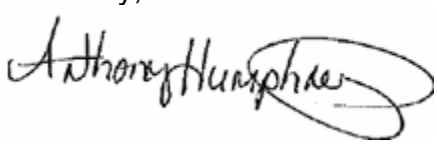
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 643-7960.

Sincerely,



Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL730317749
Investigation #:	2024A0572045
Complaint Receipt Date:	06/03/2024
Investigation Initiation Date:	06/07/2024
Report Due Date:	08/02/2024
Licensee Name:	The Barton Woods Group, Inc.
Licensee Address:	9472 Kochville Road Freeland, MI 48623
Licensee Telephone #:	(989) 695-2014
Administrator:	Rebecca Williams
Licensee Designee:	Deborah Pettyplace
Name of Facility:	Barton Woods Assisted Living
Facility Address:	9472 Kochville Road Freeland, MI 48623
Facility Telephone #:	(989) 695-5380
Original Issuance Date:	10/15/2012
License Status:	REGULAR
Effective Date:	04/15/2023
Expiration Date:	04/14/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
There is concern that staff have not been administering Resident's A Xanax.	Yes
Staff, Quiara Williams was suspected of falling asleep and being under influence while caring for residents.	No

III. METHODOLOGY

06/03/2024	Special Investigation Intake 2024A0572045
06/03/2024	APS Referral APS made the referral.
06/07/2024	Special Investigation Initiated - Telephone Complainant.
06/07/2024	Contact - Document Received Guardian #1
06/10/2024	Inspection Completed On-site Administrator, Rebecca Williams; Resident Care Supervisor, Kelsey Treichel and Direct Care Supervisor, Skylar Arizola.
06/10/2024	Contact - Face to Face Resident B, Resident C and Resident D.
06/11/2024	Contact - Document Received Administrator, Rebecca Williams.
06/18/2024	Contact - Face to Face Resident Care Supervisor, Kelsey Treichel.
06/26/2024	Contact - Telephone call made Resident Care Supervisor, Kelsey Treichel
06/26/2024	Contact - Document Received Direct Care Supervisor, Skyler Arizola.

06/26/2024	Contact - Document Received Administrator, Rebecca Williams.
06/26/2024	Exit Conference Administrator, Rebecca Williams.
07/29/2024	Contact - Face to Face Resident Care Supervisor, Kelsey Treichel
07/29/2024	Contact - Face to Face Dr. Butman's Office.
07/30/2024	Contact - Face to Face Dr. Aaron Smith

ALLEGATION:
There is concern that staff have not been administering Resident's A Xanax.

INVESTIGATION:
On 06/03/2024, the local licensing office received a complaint for investigation. Adult Protective Services (APS) denied their complaint and made the referral to licensing.

On 06/07/2024, I made a call to the Complainant regarding the allegation. The Complainant informed me that the allegation is true as Resident A had a drug screen at the hospital and Xanax medication was not found in Resident A's system. The Complainant sent me a copy of the drug screen dated for 05/31/2024. Resident A is currently in the hospital due to behaviors.

On 06/07/2024, I received a copy of Resident A's drug screen and Resident A tested negative for Benzodiazepine. Benzodiazepine is the Drug Classification for Xanax. The drug screen also states, "This is an unconfirmed test and must not be used for non-medical purposes."

On 06/10/2024, I made an unannounced onsite at Barton Woods Assisted Living, Located in Saginaw County Michigan. Interviewed were, Administrator, Rebecca Williams; Resident Care Supervisor, Kelsey Treichel and Direct Care Supervisor, Skylar Arizola.

On 06/10/2024, I interviewed Administrator, Rebecca Williams regarding the allegation. Rebecca Williams informed that she heard that Resident A tested negative for Xanax, however; Resident A was being administered the medications that were prescribed by the physician, as needed. Rebecca Williams indicated that the Xanax was either administered by Direct Care Supervisor, Skyler Arizola or

Skylar Arizola observed the med pass. Rebecca Williams informed that the Family Member #1 was accusing them of not administering the medication and then when they said that it's on video, Family Member #1 suggested that the pharmacy must be giving them fake medications. Resident A was not in the home as Resident A was admitted to the hospital due to behavioral issues.

On 06/10/2024, I interviewed Resident Care Supervisor, Kelsey Treichel regarding the allegation. Kelsey Treichel denied the allegation and informed that Direct Care Supervisor, Skyler Arizola was the one who administered the medication.

On 06/10/2024, I interviewed Direct Care Supervisor, Skyler Arizola regarding the allegation. Skyler Arizola informed that this is not true as she personally was the one who administered the medication. Skyler Arizola mixed the medication in applesauce, gave it to Resident A and she walked off but in line to sight, because Resident A won't take the medication if Resident A feels that he's being watched. Once Resident A was done, she went to Resident A, asked if Resident A was finished with his Applesauce and then took the cup. Skyler Arizola indicated that the entire sequence is on video and she can send the video if needed.

On 06/11/2024, I received a video of Direct Care Supervisor, Skyler Arizola in the medication room prepping the medication for Resident A and putting it in a cup of applesauce on 05/30/2024. In a 2nd frame, Skyler Arizola is observed walking down the hallway with the cup in her hand. In the 3rd frame, Skyler Arizola walks into the dining room area where Resident A is sitting and gives Resident A the cup. Skyler Arizola walks out of the frame and Resident A is observed eating the cup of applesauce. As soon as Resident A is finished, Skyler Arizola is seen walking back to Resident A and taking the cup away.

On 06/11/2024, I received a copy of Resident A's Medication Sheet. Resident A is on Alprazolam .25mg twice daily as needed for agitation. Alprazolam is the generic name for Xanax. Resident A was administered Alprazolam on 05/30/2024.

On 06/18/2024, I spoke with Resident Care Supervisor, Kelsey Treichel again regarding the allegation. I informed her that I reviewed the video and asked if anyone explained how Resident A could test negative for a drug after it was taken. Kelsey Treichel informed that this has been their question all along, but nobody has given them an answer. The only thing she can think of is that everyone metabolizes differently and maybe it hadn't fully gotten into Resident A's system that day.

On 07/29/2024, Resident Care Supervisor, Kelsey Treichel was interviewed regarding the Xanax being crushed and placed in applesauce. Kelsey Treichel informed that it was crushed because Resident A would refuse to take the medication and Family Member #1 was upset and told them they need to crush it and put it in applesauce or something. There were no instructions on the label or no doctor's order for the medication to be crushed and placed in applesauce. According to Kelsey Treichel, no staff was offered a drug screen as there was no suspicion that

anyone was taken the medications. Kelsey Treichel also informed that all direct care staff are trained to administer medications and would have access to all medications.

On 07/29/2024, I reviewed the medication record and it indicated that Resident A had been administered Xanax regularly since 05/18/2024.

On 07/29/2024, I went to Resident A's Primary Physician's Office to speak with the Physician or someone who could provide their expertise regarding medications and drug screens results. The reception informed me that Dr. Butman was out of the office and the Clinical Team was too busy to come out to be interviewed.

On 07/30/2024, I went to Covenant Hospital Emergency Room to speak with someone with professional knowledge on how medications work and drug screen results. Dr. Aaron Smith informed that Benzodiazepines do not clear that quickly, especially if its being administered regularly. Typically, these medications are not known for false positives as they are very liable to test. Even with the medication being crushed and mixed with applesauce, the viability will still be the same. In Dr. Aaron Smith's opinion, these medications, although documented as being administered, he does not believe that they are actually being administered.

On 07/30/2024, I held another Exit Conference with Administrator, Rebecca Williams regarding the results of the special investigation. The findings were changed after obtaining additional information. Rebecca Williams did not agree with the results of the investigation.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the interviews, documents received and in my review of the video footage, there is enough evidence to establish a violation of licensing rules. The Direct Care Staff Supervisor personal administered the medication to Resident A and it can be seen on the medication sheet and on video. However; in speaking a medical doctor regarding the medication, he does not believe that it is possible for a person to be administered a Benzodiazepine and the test results are negative.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
Staff, Quiara Williams was suspected of falling asleep and being under influence while caring for residents.

INVESTIGATION:
On 06/10/2024, I interviewed Resident B regarding the allegation. Resident B informed that Staff were working almost 24 hours days and were getting tired due to workers quitting all at once, but never seen any staff sleeping on the job.
On 06/26/2024, I interviewed Resident C regarding the allegation. Resident C informed that all of Resident C's needs are being and has never seen any staff sleep on the job.

On 06/26/2024, I interviewed Resident D regarding the allegation. Resident D informed that there are some good staff at the facility, and they help Resident D needs to be met. Most of the time, staff are able to assist right away, but sometimes they are busy with other residents. Resident D denies observing any staff sleeping on the job.

On 06/26/2024, I contacted Resident Care Supervisor, Kelsey Treichel regarding the allegation. Kelsey Treichel informed that Quiara Williams works 3rd shift and they have never heard of anything like this regarding her. Kelsey Treichel indicated that Family Member #1 came into the office and said that Staff, Kristina Martinez appeared to be kind of off and that someone needs to check on her. When she went to go check on Kristina Martinez, she was giving a resident a shower, appeared to be alert and completing all of her shift duties. The facility has a "No Sleep" policy. She denied that they conduct random drug screens on staff. Staff, Kristina Martinez has not worked at the facility for over a month.

On 06/26/2024, I contacted Direct Care Supervisor, Skyler Arizola regarding the allegation. Skylar Arizola informed that she has never had a complaint about Quiara Williams doing this, but there was one regarding Kristina Marinez. Skylar Arizola stated, "Kristina Martinez was never observed sleeping or being under the influence by our staff. When (Resident A's Family Member #1) came down and said that she thought we should check on her for nodding off, Kelsey (Treichel) went down to find her and see what was going on and she was giving another resident a shower." Skyler Arizola informed that she had spoken to Kristina Martinez several times in person that day, providing hand over hand care with residents and never suspected her of being under the influence and no reprimands were given as there wasn't a reason to give any.

On 06/26/2024, I contacted Administrator, Rebecca Williams regarding the allegation. Rebecca Williams stated, "I was aware of a comment that (Resident A's Family Member #1) made to Kelsey (Treichel) in reference to Kristina (Martinez) "needing to be checked on". Kelsey (Treichel) went and followed up immediately to find her giving a resident a shower. She completed all her tasks and responsibilities as well. There was zero indication of any problems with her during shift. Skyler (Arizola) also assisted her throughout the day and saw nothing to be concerned with. This wasn't even a true complaint, but rather a comment she felt like she needed to be checked on. No discipline was needed because nothing was found."

On 06/26/2024, I received Barton Woods Assisted Living Sleeping Policy. It indicates that staff are to report all policy violations, including sleeping on the job. A substantiated violation of sleeping on the job is grounds for immediate dismissal.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the interviews of Residents and management, there is not enough evidence to establish a rules violation. Resident B, C and D all denied ever seeing any staff sleeping on the job. In speaking with Administrator, Rebecca Williams; Resident Care Supervisor, Kelsey Treichel and Direct Care Supervisor, Skylar Arizola, they all indicated that Kelsey Treichel went to check on the staff member and she was showering another resident and completing all of her daily work duties.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 06/26/2024, I held an Exit Conference with Administrator, Rebecca Williams regarding the results of the special investigation.

On 07/30/2024, I held another Exit Conference with Administrator, Rebecca Williams regarding the results of the special investigation. The findings were changed after obtaining additional information. Rebecca Williams did not agree with the results of the investigation.

IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this large adult foster care group home, pending the receipt of an appropriate corrective action plan (Capacity 1-20).

07/30/2024

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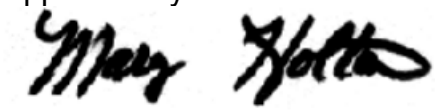
Anthony Humphrey Date
Licensing Consultant

Approved By:



07/31/2024

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Mary E. Holton Date
Area Manager