GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 27, 2025

Carol DelRaso
Briarwood Assisted Living
620 Ely St.
Allegan, MI 49010

RE: License #: AH030293792
Investigation #: 2025A1028042
Briarwood Assisted Living

Dear Carol Del Raso:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH030293792
Investigation #:	2025A1028042
Complaint Receipt Date:	03/12/2025
Investigation Initiation Date:	03/12/2025
Report Due Date:	05/11/2025
Licensee Name:	Ely Street Opco LLC
Licensee Address:	4500 Dorr Street, Toledo, OH 43615
Licensee Telephone #:	(419) 247-2800
Administrator:	Judy Finnie
Authorized Representative:	Carol DelRaso
Name of Facility:	Briarwood Assisted Living
Facility Address:	620 Ely St., Allegan, MI 49010
Facility Telephone #:	(269) 673-9536
Original Issuance Date:	06/10/2008
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	55
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility staff are not providing showers or assistance with eating in accordance with the service plan.	Yes
Resident A was administered too much insulin causing Resident A to be sent to the hospital.	No
Additional Findings	No

III. METHODOLOGY

03/12/2025	Special Investigation Intake 2025A1028042
03/12/2025	Special Investigation Initiated - Letter
03/12/2025	APS Referral APS made referral to HFA department.
03/18/2025	Contact - Face to Face Interviewed the facility administrator at the facility.
03/18/2025	Contact - Face to Face Interviewed Employee 1 at the facility.
03/18/2025	Contact - Face to Face Interviewed Resident A's family member at the facility
03/18/2025	Contact - Document Received Received requested documentation from the administrator.

This investigation will only address allegations pertaining to potential violations of the rules and regulations for Homes for the Aged (HFA).

ALLEGATION:

Facility staff are not providing showers or assistance with eating in accordance with the service plan.

INVESTIGATION:

On 3/12/2025, the Bureau received the allegations through the online complaint system.

On 3/12/2025, Adult Protective Services (APS) made referral to Homes for the Aged (HFA) through Centralized Intake.

On 3/18/2025, I interviewed the facility administrator at the facility who reported Resident A is not neglected and that the staff follow the service plan. The administrator reported Resident A receives at minimum two showers per week in accordance with the service plan. Resident A does not refuse showers and if Resident A were to need an additional shower during the week due to an incontinence accident or other incident, staff would provide Resident A with that shower. The administrator reported Resident A's family member comes to the facility every day during lunch time and assists Resident A with eating. Staff have offered assistance during the lunchtime meal, but Resident A's family member insisted on feeding Resident A. The facility provides Resident A assistance with eating for all other meals. The facility administrator reported the service plan and level of care was explained to the family member and Resident A's family several times since Resident A was admitted to the facility on 2/14/2025. Resident A's family member and family were also informed that the facility is not a medical facility and therapy, and nursing services are provided via third-party home health to Resident A. The administrator reported the family member continues to demonstrate some difficulty understanding the level of care the facility can and cannot provide in accordance with the facility's license, but the facility continues to conference with them and the physician to ensure care. The administrator reported Resident A demonstrated a decline in mobility and function due to [their] diagnosis of Parkinson's disease with Resident A requiring assistance with all care. The facility conferenced with Resident A's physician to obtain physical therapy (PT) and occupational therapy (OT) services due to Resident A's demonstrated decline. The administrator reported Resident A continues to demonstrate difficulty with eating, so the facility requested the physician prescribe an order for a speech pathologist to evaluate and treat along with a swallow study. Home health nursing was also requested by the facility due to Resident A's decline in mobility and development of a pressure sore on [their] bottom. The administrator reported Resident A is on a rotation schedule as recommended by the physician to prevent further pressure sores and that home health nursing continues to monitor and treat the pressure sore. The administrator provided me with the requested documentation for my review.

On 3/18/2025, I interviewed Employee 1 at the facility whose statement was consistent with the administrator's statement.

On 3/18/2025, I interviewed Resident A's family member at the facility who confirmed [they] come every day at lunch time to assist Resident A with eating. The family member reported the facility assists Resident A will all other meals. The family member also confirmed that Resident A receives two showers per week and that home health nursing is monitoring and treating Resident A's pressure sore.

Resident A was present during the interview but was unable to participate in the interview due to demonstrated limited speech and communication difficulties.

I observed the family member assisting Resident A with the lunch time meal. No concerns were noted.

On 3/20/2025, I reviewed the requested documentation which revealed the following:

- Resident A requires assistance with dressing, toileting, personal hygiene, grooming, bathing, transfers, and mobility.
- Resident A receives two showers per week at minimum.
- Resident A requires medication administration assistance.
- Resident A is receiving home health PT and OT services to address mobility and activities of daily living.
- Resident A is being monitored and treated for a pressure sore by home health nursing.
- An order was requested for speech therapy to evaluate and treat Resident A due to Resident demonstrating difficulty with eating and speaking.
- The service plan reads that Resident A *is independent with all tasks related to dining without reminders from staff.*

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

ANALYSIS:	It was alleged facility staff are not providing showers or assistance with eating in accordance with the service plan. Interviews, onsite investigation, and review of documentation reveal the following: • Resident A is receiving two showers per week at minimum. • Resident A receives assistance with meals. However, despite staff and Resident A's family member confirming Resident A receives assistance with eating, Resident A's service plan shows Resident is *independent with all tasks related to dining.* Resident A is not independent with tasks related to eating or dining and requires assistance from staff with all meals. There is a discrepancy between staff statements, the family member's statement, and onsite observation of Resident A completing the lunch time meal with assistance. Resident A's service plan shows Resident A as independent with eating and dining tasks, which Resident A is not. Therefore, the facility is in violation because the service plan does not match the level of care being provided to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was administered too much insulin causing Resident A to be sent to the hospital.

INVESTIGATION:

Prior to this complaint being received by the department, the facility alerted the department of the medication administration error pertaining to Resident A's insulin on 2/18/2025. The staff member realized they administered too much insulin to Resident A and immediately alerted the shift supervisor. The facility took immediate action and alerted Resident A's physician and family with Resident A being sent to the hospital for further evaluation and treatment immediately. The facility removed the staff member that committed the medication administration error from medication administration duties immediately. The staff member was provided with re-education, re-training, and a written corrective action in [their] file as well. The staff member was not allowed to return to medication administration duties until all re-education and re-training was completed. The facility also provided all care staff re-education and re-training on medication administration to ensure staff competency. The facility provided the department all documentation pertaining to the medication

administration error along with a written corrective action plan on 2/20/2025 due to the medication administration error.

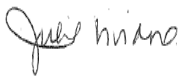
On 3/18/2025, the administrator confirmed the staff member was re-educated, re-trained, and received a written corrective action for the medication administration error. The administrator also reported all care staff were re-educated and re-trained during the recent in-service meeting last week to ensure staff competency; and that continued education, and training will occur regularly during in-service meetings.

On 3/18/2025, Resident A's family member reported [they] were alerted about the medication administration error, and that Resident A was sent to the hospital for evaluation and treatment. The family member reported that is the only concern [they] have had about medication administration for Resident A.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	It was alleged Resident A was administered too much insulin causing Resident A to be sent to the hospital. While the medication administration occurred on 2/18/2025, the facility took immediate action to ensure Resident A's health and safety. Resident A's physician and family were alerted immediately, and Resident A was sent immediately to the hospital. The facility also removed the staff member that committed the error from medication administration duties immediately with the staff member receiving re-education, re-training, and a written corrective action. The facility also provided all staff re-education and re-training on the importance of correct medication administration. The facility took appropriate action to address the situation for immediate resident care and implemented a corrective action plan to ensure that a similar situation does not occur again. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend the status of this license remain the same.



3/20/2025

Julie Viviano Date
Licensing Staff

Approved By:

03/27/2025

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