GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Tracey Holt
Superior Health Support Systems
Suite 120
1501 W. 6th Ave.
Sault Ste. Marie, MI 49783

April 15, 2025

RE: License #: AS170392423
Investigation #: 2025A0873011
Pennington Home

Dear Ms. Holt:

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.

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 (616) 356-0100.

Sincerely,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(906) 250-9318

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

I. IDENTIFYING INFORMATION

License #:	AS170392423
Investigation #:	2025A0873011
Complaint Receipt Date:	02/11/2025
Investigation Initiation Date:	02/12/2025
Report Due Date:	04/12/2025
Licensee Name:	Superior Health Support Systems
Licensee Address:	Suite 120 1501 W. 6th Ave. Sault Ste. Marie, MI 49783
Licensee Telephone #:	(906) 632-9886
Administrator:	Tracey Holt
Licensee Designee:	Tracey Holt
Name of Facility:	Pennington Home
Facility Address:	665 S. Pleasant Street Pickford, MI 49774
Facility Telephone #:	(906) 647-2380
Original Issuance Date:	04/05/2018
License Status:	REGULAR
Effective Date:	10/05/2024
Expiration Date:	10/04/2026
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff did not allow Resident A privacy for a phone call.	No
Staff refused to use A&D ointment and continued to use Calmoseptine.	Yes
Staff used eyedrops in both eyes instead of one, as prescribed.	No
Additional Findings	No

III. METHODOLOGY

02/11/2025	Special Investigation Intake 2025A0873011
02/12/2025	Special Investigation Initiated - On Site
02/12/2025	Contact - Face to Face Interview with home manager and staff
02/12/2025	Contact - Face to Face Interview with Resident B and C
02/25/2025	Contact - Telephone call received Call from home manager
03/18/2025	Contact - Telephone call made Interview with Caleb Varoni - Admin of Northwoods Home Care and Hospice
03/18/2025	Contact - Document Sent Email requesting physician's orders regarding ointment
03/20/2025	Contact - Telephone call made Call to Winter Cain - SW
04/01/2025	Contact - Telephone call made Interview with Resident A guardian
04/01/2025	Contact - Document Sent Email sent requesting physician's order for ointment

04/02/2025	Contact - Telephone call made Interview with Delores RN
04/02/2025	Contact - Document Sent Email requesting physicians order regarding ointment and eye drops
04/03/2025	Contact - Telephone call made Interview with home manager, requesting physician's orders for ointment and eyedrops
04/03/2025	Contact - Document Received
04/07/2025	Contact - Telephone call made Interview with licensee designee, requesting MAR
04/08/2025	Contact - Telephone call made Interview with HM Ms Carr
04/08/2025	Contact - Telephone call made Interview with Jade Bawks, staff
04/09/2025	Contact - Document Received Received MAR from DON Laura Aikens RN
04/09/2025	Contact - Document Received Received progress notes related to MAR
04/10/2025	Contact – Telephone call made Interview with Kaitlyn Munger, CNA-NWHHH
04/10/2025	Exit Conference
04/14/2025	Contact – Telephone call made Interview with Delores Carruthers
04/14/2025	Contact – Telephone call made Interview with Erin Lash, LPN

ALLEGATION:

Staff did not allow Resident A privacy for a phone call.

INVESTIGATION:

On 1/31/25, I received a document from licensee designee Tracey Holt which included a series of written allegations against the facility from Guardian A. Resident A was not allowed to privately speak to Guardian A over the telephone.
On 2/12/25, I interviewed home manager Kasie Carr at the facility. The incident did not happen as described in document. There was a back and forth between Ms. Carr and Guardian A, but the call was taken off speaker and the phone was given to Resident A. North Woods Home Health and Hospice (NWHHH) social worker Winter Cain was there for the incident.

On 2/12/25, I interviewed staff Riley Schultz at the facility. The phone was put on speaker and given to Resident A. Guardian A realized that she was on speaker and asked to be taken off. Ms. Carr moved the blankets and handed the phone to Resident A.

On 3/20/25, I interviewed NWHHH social worker Winter Cain over the telephone. Resident A was in the living room of the facility when Guardian A called to speak with her. Resident A was in the common area and requested having blankets tucked around her for warmth. When Guardian A called, the phone was put on speaker and placed on Resident A's chest. Guardian A realized she was on speaker during the call and requested she be taken off. Staff told her they did not want to because Resident A had just requested being tucked into the blankets. After a brief back and forth, staff untucked Resident A's arms and handed her the phone. Both parties were being equally rude to one another.

On 4/1/25, I interviewed Guardian A1 over the telephone. Ms. Carr refused to take the phone off speaker to allow Resident A privacy to speak. Eventually the phone was taken off speaker.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:

	(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.
ANALYSIS:	Although the incident could have been handled differently, this incident does not rise to the level of rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff refused to use A&D ointment and continued to use Calmoseptine.

INVESTIGATION:

On 1/31/25, I received a document from licensee designee Tracey Holt which included a series of written allegations against the facility from Guardian A. Staff at the facility refused to stop using a zinc-based ointment instead of the prescribed ointment even when ordered by hospice to do so.

Ms. Carr stated this issue likely arose because NWHHH often gives verbal orders but will not fax the actual physician's order for quite some time. Resident A was prescribed Calmoseptine ointment by her primary care physician when she was admitted to the facility. When Resident A was admitted to hospice in November 2024, the hospice physician prescribed A & D ointment. Both ointments were used, however, staff noticed that when the A & D ointment was used, Resident A's skin deteriorated.

Guardian A stated facility staff were told by Ms. Carruthers to stop using Calmoseptine because it made Resident A's skin condition worse. Staff were to use A & D ointment. Ms. Carr refused to use A & D ointment and directed staff to continue using Calmoseptine.

On 4/2/2025, I interviewed NWHHH registered nurse Delores Caruthers. After the A & D ointment was prescribed by the hospice physician in January, Ms. Caruthers repeatedly asked Pennington staff to stop using the Calmoseptine ointment.

On 4/8/25, I interviewed employee Jade Bawks. Ms. Bawks questioned why both ointments were used but staff never received a discontinue order from Resident A's primary care physician to stop using the Calmoseptine. When asked to use A & D exclusively, Ms. Bawks complied.

On 4/9/25, I interviewed Superior Heath Support Systems director of nursing Laura Aikens through email. The reason the Calmoseptine and A & D were used simultaneously is because there was never a doctor's order to stop using the Calmoseptine.

On 4/9/25, I reviewed Resident A's medication administration record (MAR). During January and February, A & D was administered several times per day while Calmoseptine was administered less frequently. According to the facility's progress notes, the use of Calmoseptine ceased during March due to nurse's order. However, according to the MAR, Calmoseptine was applied several times in March.

On 4/10/25, I interviewed NWHHH certified nursing assistant Kaitlyn Munger over the telephone. Around February 2025, Ms. Carruthers asked Pennington staff to stop using the Calmoseptine ointment and use A & D exclusively. Ms. Kaitlyn noticed Calmoseptine's continued use when she showered Resident A. Calmoseptine is a white paste and its use was obvious on the skin, as opposed to A & D, which is clear. While showering Resident A, Ms. Munger tried to clean the area of the Calmoseptine and skin breakage occurred. The continued use of Calmoseptine may have worsened Resident A's skin condition. Ms. Munger reported this to Ms. Carruthers and Ms. Carr and noted that only A & D should be used on Resident A's skin. Ms. Carr told her that she doesn't care what the doctors say because she knows what works and what doesn't. Eventually, facility staff stopped using Calmoseptine and used A & D ointment exclusively and Resident A's condition improved.

On 4/14/25, I interviewed Ms. Carruthers over the telephone. Ms. Carruthers never saw the discontinuation order for Calmoseptine but heard that it was sent to Pennington.

On 4/14/25, I interviewed Erin Lash, LPN affiliated with Resident A's primary care physician's office, by telephone. An order to discontinue Calmoseptine for Resident A was faxed to Pennington 1/16/25.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist.

ANALYSIS:	Resident A's primary care physician faxed an order to discontinue Calmoseptine in January of 2025. However, the facility staff continued to administer the medication until March.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff used eyedrops in both eyes instead of one, as prescribed.

INVESTIGATION:

On 1/31/25, I received a document from licensee designee Tracey Holt which included a series of written allegations against the facility from Guardian A. Resident A was prescribed eye drops that were to be used for only 5 days and used in only one eye. Instead, staff continued to use the eye drops for over 30 days, and in both eyes.

On 4/1/25, I interviewed Guardian A who confirmed the information written in her complaint. Staff Jade Bawks was the one who Guardian A saw administer the eye drops into both eyes.

On 4/8/25, I interviewed Ms. Bawks over the telephone. The eyedrop antibiotic prescription was for 5 days and only for the left eye. Staff received a further order later in January to continue using the medication in the left eye. It is not true that the medication was used in both eyes. There was an incident in which Guardian A was at the facility with Ms. Bawks where they observed Resident A's right eye seemed to be showing similar discharge to the left eye. It was discussed that they could put some of the eye drops into the right to see if it helped. Guardian A, also Resident A's durable power of attorney, gave consent to this.

On 4/9/25, I reviewed Resident A's MAR which showed the drops being used for the recommended time frame and ordered to be only used in the left eye. I reviewed both physician's orders to confirm the time frame.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be

	labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	There is not enough evidence to determine the eye drops were used in any way other than how and when they were prescribed or what was consented to by Resident A's durable power of attorney.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 4/10/25, I explained the findings of this report to licensee designee Tracey Holt. She accepted the findings and reported she may share the report with Guardian A.

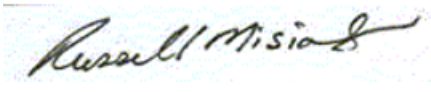
IV. RECOMMENDATION

Contingent upon approval of a corrective action plan, I recommend no changes to the status of this license.

4/14/25

Garrett Peters — Date
Licensing Consultant

Approved By:



4/14/25

Russell B. Misiak — Date
Area Manager