GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 7, 2025

Teresa Murray
Murrays Country View
6201 HWY M-35
Gladstone, MI 49837

RE: License #: AH210396377
Investigation #: 2025A1010038
Murrays Country View

Dear Licensee:

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 authorized representative 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 (616) 356-0100.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH210396377
Investigation #:	2025A1010038
Complaint Receipt Date:	03/12/2025
Investigation Initiation Date:	03/13/2025
Report Due Date:	05/11/2025
Licensee Name:	Murray's Country View, LLC
Licensee Address:	3670 Blacksmith 20.5 Ln Gladstone, MI 49837
Licensee Telephone #:	(906) 399-7581
Authorized Representative/ Administrator:	Teresa Murray
Name of Facility:	Murrays Country View
Facility Address:	6201 HWY M-35 Gladstone, MI 49837
Facility Telephone #:	(906) 428-1334
Original Issuance Date:	12/12/2018
License Status:	REGULAR
Effective Date:	04/21/2025
Expiration Date:	07/31/2025
Capacity:	25
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's medications were not administered as prescribed.	No
There is no soap or paper towels in the only bathroom residents are allowed use.	No
Additional Findings	Yes

III. METHODOLOGY

03/12/2025	Special Investigation Intake 2025A1010038
03/13/2025	Special Investigation Initiated - Telephone Message left for the complainant. A telephone call back was requested
03/13/2025	Contact - Document Received interviewed the complainant by telephone
03/27/2025	Inspection Completed On-site Completed via Teams
05/06/2025	Contact – Document received Received Resident A's February 2025 MAR via email
05/07/2025	Exit Conference

ALLEGATION:

Resident A's medications were not administered as prescribed.

INVESTIGATION:

On 3/12/25, the Bureau received allegations from the online complaint system. The complaint read Resident A's prescribed klonopin was to be administered as needed. The facility incorrectly administered Resident A's klonopin twice a day.

On 3/13/25, I interviewed the complainant by telephone. The complainant reported Resident A was at the facility for approximately six days before Resident A was admitted to the hospital. The complainant stated the physician at the hospital said Resident A "had too much klonopin in her system" and that is how is it was known staff administered Resident A's klonopin twice a day when it should have been

administered as needed. The complainant stated because Resident A received klonopin twice a day, Resident A “was weak, unable to walk, and it messed with her mind.”

On 3/27/25, I interviewed the administrator via Teams. The administrator reported Resident A resided at the facility for less than one month. The administrator stated Resident A was transported to the hospital from the facility and her care exceeded what staff at the facility were able to provide. The administrator was unable to recall the exact date Resident A was transported to the hospital. The administrator explained that because Resident A’s care needs exceeded what staff at the facility could provide, Resident A was admitted to another facility after she was discharged from the hospital. The administrator stated Resident A was an amputee, bed bound, could not bear weight, was obese, began to have skin breakdown, and developed Clostridioides Difficile (C. Diff).

The administrator stated Resident A’s medications were administered as prescribed by her physician. The administrator said Resident A wanted control of her medications, however staff at the facility were responsible for Resident A’s medication management and administration. The administrator reported Resident A “wanted her medications when she wanted them, not as prescribed by her physician.”

On 3/27/25, I interviewed Staff Person 1 (SP1) via Teams. SP1’s statements were consistent with the administrator.

On 5/6/2025, I received a copy of Resident A’ February 2025 medication administration record via email for my review. The MAR read Resident A was prescribed “CLONAZEPAM 1 – Pill 2x Day As needed (Anxiety).” The MAR read Resident A was administered this medication at 8:00 am on 2/10/25, 2/11/25, and 2/12/25.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.

ANALYSIS:	The interviews with the administrator, SP1, along with review of Resident A's February 2025 MAR, revealed Resident A's prescribed Klonopin was administered as prescribed. Resident A was not administered Klonopin twice a day while she resided at the facility. There is insufficient evidence to suggest the facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There is no soap or paper towels in the only bathroom residents are allowed use.

INVESTIGATION:

On 3/12/25, the complaint read, "Facility has 2 bathrooms, and they keep the door locked so the residents can't use the clean bathroom the one they let them use they don't have soap and no paper towel."

On 3/13/25, the complainant stated Resident A was provided with her own soap and paper towels because there were none provided in the facility's bathroom that the residents use.

On 3/27/25, the administrator reported all the bathrooms in the facility have soap and paper towels. The administrator stated there is an adequate stock of soap and paper towels stored in the facility to ensure there are always soap and paper towels available in every bathroom in the facility. The administrator said staff at the facility are trained to monitor the soap and paper towel supplies in the bathrooms in the facility to ensure they are always available.

On 3/27/25, I observed the bathrooms in the facility. I observed all the bathrooms were clean and had an adequate supply of soap and paper towels. I observed there was an adequate surplus supply of soap and paper towels in the facility.

APPLICABLE RULE	
R 325.1976	**Kitchen and dietary.**
	(2) The kitchen and dietary area shall be equipped with a lavatory for handwashing. Each lavatory shall have a goose neck inlet and wrist, knee, or foot control. Soap and single service towels shall be available for use at each lavatory.

ANALYSIS:	The interview with the administrator, along with my observation of the bathrooms in the facility, revealed there are soap and paper towels available in all the bathrooms. I observed an adequate surplus supply of soap and paper towels to replenish the bathroom in the facility. There is insufficient evidence to suggest the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 3/17/2025, review of the facility file revealed an updated appointment of administrator form has not been received regarding the facility's change in administrator.

APPLICABLE RULE	
R 325.1913	**Licenses and permits; issuance.**
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.
ANALYSIS:	Review of the facility file revealed an updated appointment of administrator form was not received within 5 business days of the change in designation. As a result, the facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with the facility licensee authorized representative on 5/7/25.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

05/06/2025

Lauren Wohlfert Date
Licensing Staff

Approved By:

05/06/2025

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