GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 20, 2025

Paul Wyman
Retirement Living Management of Lowell, LLC
1845 Birmingham S.E.
Lowell, MI 49331

RE: License #: AL410311105
Investigation #: 2025A0357026
Green Acres Lowell

Dear Mr. Wyman:

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 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,

Arlene B. Smith

Arlene B Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410311105
Investigation #:	2025A0357026
Complaint Receipt Date:	02/20/2025
Investigation Initiation Date:	02/20/2025
Report Due Date:	04/21/2025
Licensee Name:	Retirement Living Management of Lowell, LLC
Licensee Address:	1845 Birmingham S.E. Lowell, MI 49331
Licensee Telephone #:	(616) 897-8000
Administrator:	Venessa Miller
Licensee Designee:	Paul Wyman
Name of Facility:	Green Acres Lowell
Facility Address:	11530 Fulton Street East Lowell, MI 49331
Facility Telephone #:	(616) 987-9115
Original Issuance Date:	07/13/2011
License Status:	REGULAR
Effective Date:	01/23/2024
Expiration Date:	01/22/2026
Capacity:	20
Program Type:	ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not checked on 2nd and 3rd shifts on 02/18-19/2025. They found Resident A deceased on 02/19/2025 at 7am. He was lying face down with significant rigor mortis.	No
On 02/19/2025, Resident A's medication from 02/18/2025, was still in a "med cup" in the medication cart on 02/19/2025.	Yes

III. METHODOLOGY

02/20/2025	Special Investigation Intake 2025A0357026 No report was made to APS because the Resident was deceased.
02/20/2025	Contact - Telephone call received Received a telephone call back from the Administrator, Venessa Miller
02/20/2025	Special Investigation Initiated - Telephone Call made to the Administrator, Venessa Miller, left a message to return my call.
02/24/2025	Inspection Completed On-site
02/24/2025	Contact - Face to Face With Direct Care Staff: Jamin Parrish, Destiny Vanbennekom, Jazzmin Tozer, and Taryn VanNoy. Interview with Venessa Miller, the Administrator.
02/24/2025	Contact - Document Received Charting information on Resident A, Face sheet, February Medication Administration Record, Observations of Resident A, Health Care Appraisal, and his Level of Care Assessment,
02/24/2025	Contact - Face to Face with the Administrator, Venessa Miller.
02/24/2025	Received Resident A's documents: Resident Health Appraisal, Observation Notes, Note from Hospice Nurse, Note from CareLine Physician Service NP, Resident A's Assessment Plan, and his Medication Administration Records.
05/14/2025	Telephone - Call Made to Direct Care Staff, Tabitha Conner. Call to Hospice Sydne Jepson RN, and Mlessis Russell, Supervisor. I

	Called Med Tech, Leah Fhugars. Call to Venessa Miller, and request for Incident/Accident Report on the death of Resident A.
05/14/2025	Document Received: From Venessa Miller, the Incident/Accident Report death of Resident A.
05/20/2025	I conducted a telephone interview with the Licensee Designee Paul Wyman.

ALLEGATION: Resident A was not checked on 2nd and 3rd shifts on 02/18-19/2025. They found Resident A deceased on 02/19/2025 at 7am. He was lying face down with significant rigor mortis.

INVESTIGATION: This complaint was anonymous, so no interview was conducted with the complainant. On 02/20/2025, I conducted an interview with the Administrator, Venessa Miller. We discussed the complaint. She acknowledged that Direct Care Staff, Jaimin Parris, had come to ask her to go with her to Resident A's room because Resident A had fallen. She reported that when she arrived, he was not breathing, and he had no pulse. She stated they immediately contacted his Hospice Nurse, who arrived very soon after their call. She reported there was some pooling of his blood in his abdomen and arms. She had no idea when he had passed. She stated that his head was resting on the side of his bed, and his arms were under his bed and a pillow was resting on his arms. She reported that he was admitted on 11/24/2025 to their facility and he was 90 years old. She also stated that his family did not have an autopsy completed.

On 02/24/2025, I conducted a face-to-face meeting with Direct Care Staff, Jaimin Parrish. She reported that she worked 1st shift on 02/19/2025, which is 6:00 AM to 2:00 PM. She said she did the med count with 3rd, shift which was all good. She stated that they start with getting residents up for breakfast. She stated that Resident A did not want to be bothered, and he did not get up until 10:00AM and he had said to them to peek through the window to check on him. She said he seemed to be "normal" when she last seen on Monday, 02/17/2025. She reported that she was passing medications on this day, 02/19/2025, and Resident A was her last resident to pass meds too. She stated that Resident A is very independent. She stated that he was scheduled for a haircut that day at 9:45. She said she went to get him up and to administer his one medication, 81 mg aspirin. She was unsure of the time. She said she knocked at his door, but he did not answer her. She went in and called him by his name and put the cup with the aspirin on the counter. She reported that she did not turn on the light, and she turned around she saw him on the floor. She said she ran to get Vanessa Miller, the Administrator. She reported that it looked like he was using his walker because one foot was caught under his walker which was next to his bed. She said he was lying on his abdomen, with his neck cocked upward next to his bed. She said he was right up next to this bed. She stated that his pillow was lying on his fore arms, and his arms were under his bed. She said when Ms. Miller

and she returned to his room they knew he was gone. She reported that he was receiving Hospice Care. She said she immediately called his Hospice Nurse. She said she was told that a nurse was on her way. She stated that she saw his med cup from the day before, sitting on the counter. She stated that later she and two other staff destroyed the medication she had intended to administer him.

On 02/24/2025, I conducted a face-to-face interview with Direct Care Staff, Destiny Vanbennekom. She reported that she worked as a Med Tech on 02/18/2025 on 1st. shift. She said she went to administer Resident A's morning AM medication and sat his med cup on the counter, because Resident A was sleeping. She thought it was around 10:00 AM. She said she checked him again at 11:00 AM and he was still sleeping. She reported that at noon his Hospice nurse came to see him. She said she asked Resident A if he wanted to go to lunch and he declined. She stated that she brought his lunch tray to him, time unknown. She reported that he had told her, 'I'm perfectly fine, I'm perfectly asleep, and I don't want to be bothered.' She said she observed Resident A at 2:00 PM and he was fine, and the nurse told her to let him sleep. In the past she said his daughter also told her he likes to sleep so let him sleep. She reported that she did not work on 02/19/2024, therefore she did not have firsthand knowledge about him on that day. She stated that she did not administer his aspirin, and she left it in his room in the med cup on the counter and she charted that she had administered his Aspirin. Ms. Vanbennekom confirmed she had observed Resident A on 02/18/2025, at 10:00AM., and at 11:00 AM, and she brought his lunch to him, time undetermined, and observed him again at 2:00PM. This was a total of four times she had observed him.

On 02/24/2025, Ms. Miller provided me with Resident A's Medication Administration Record for 02/2025 and Ms. Vanbennekom had charted that she had administered Resident's Aspirin EC 81 MG Tablet at 10/26/2025 at 10:26 AM. Ms. Vanbennekom acknowledged that she did not administer Resident A's prescribed Aspirin, but she had charted she had administered his Aspirin.

On 02/24/2025, I conducted a face-to-face interview with Direct Care Staff, Jazzmin Plotts, and she reported she worked 2nd shift on 02/18/2025 from 2:00 to 10:00 PM. She reported she worked as a Med Tech that shift and passed resident medications between 3:00 and 4:00 PM. She stated that Resident A does not have any scheduled medications at those times. She said they do check and change every resident before dinner between 4:00 and 5:30pm. She said Taryn Vannoy, Direct Care Staff, went in to see Resident A before dinner. She reported that he had refused his dinner. Ms. Plotts reported Resident A is very independent and can go to the bathroom on his own. She also stated that he is very stubborn. She stated that no one checks on Resident A at night because he does not want anyone to check on him. She said they make rounds and check on everyone, but she did not believe that 3rd shift had checked on him on 02/18-19/2025, for the reason she had just stated.

On 02/24/2025, I conducted a face-to-face interview with Direct Care Staff, Taryn VanNoy and she confirmed that she worked 2nd shift on 02/18/2025 and she worked

with Ms. Plotts. She reported that she observed Resident A and said he was really tired, and he was in his bed sleeping. She said she saw him at 4:30 and 5:00PM. She reported that she asked the kitchen staff to save him a plate. She said she went to check on him again (time unknown) and his door was locked, and she could not get in because she did not have a key. She thought this was around 8:00 PM. and she thought he might still be sleeping. She said aids do not have keys to resident's rooms. She reported that if he needed help, he would pull his call light and, on her shift, he had not pulled his call light on 02/18/2025. She reported that he had used his call light in the past. She said his blinds were closed on the window. She went on to say that Resident A would get very mad if you checked on him because he was a light sleeper and when you checked on him, he would wake up. She said he could lock his door himself. She reported that she asked the staff (no names provided) on the 3rd shift to check on Resident A during their shift because he had been sleeping so much. She said that Venessa Miller, the Administrator, had called her about 10:00 AM on 02/19/2025, to ask her questions and then she had sent her a text message that Resident A had passed. On 2nd shift on 02/18/2025, Direct Care staff Taryn VanNoy observed Resident A two times at 4:30 and 5:00 PM.

On 02/24/2025, Ms. Miller provide a copy of Resident A's. "Level of Care Assessment." Typed on this form was the following: (State approved assessment form in place of formally OCAL 3265)." This form was completed by Jennifer Springer, Resident Care Coordinator on 12/02/2024. The form stated that Resident A was independent with showering, and with hygiene, dressing and undressing, Falls: no falls in the last two years, Mobility: by self with 4 wheeled walker, Independent with eating, Staff to administer his medications, Orientation (Memory, Judgement): Mild impairment some confusion and forgetfulness, Pain Management: No pain, Skin Integrity: preventive skin care, Communication: family to manage his finances, Mood: no mood issues, Socialization-reminders, Behavior: no behavioral issues or concerns. Nonsmoker, Laundry: weekly laundering, House Keeping: weekly housekeeping, Transportation: family to arrange or provide, Hobbies/Special Interest: watches TV mysteries, daily activities. Medical or Dental follow-ups-none at this time. Upon review of Resident A's Level of care assessment there was nothing noted in his plan where staff were required to check on Resident A. The staff administered his medication once a day and they answered his call light when he pressed it for help.

On 02/24/2025, Ms. Miller provide me with a copy of Resident A's Health Care Appraisal dated 12/04/2025 completed by Morgan Kochajda-Watkins NP. His Diagnoses were listed as follows: "Lung mass, bladder cancer, Alz Dementia, and Neuropathy." General appearance "appears in no distress, well groomed. Mental / Physical Status and limitations," "short term memory loss, daughter provides correctios to history." Mobility: "He uses cane and walker."

On 02/24/2025. Venessa Miller, Administrator provided copies of Resident A's "Observations," which were typed notes. I reviewed the notes. On 02/18/2025, at 1:00 PM the note read "*Observation for Resident A. Patient seen for routine visit with*

hospice RN. Patient is sleeping on arrival and unhappy to be woken up. Full assessment not completed. Patient is resting comfortably in bed with no signs of dyspnea. No concerns at this time. Will follow up next week. Sydne Jepson RN." Resident A was assessed by Gentiva Hospice Nurse. Sydne Jepsen RN on 2nd shift.

The next note was dated 02/18/2025, at 8:45 PM and it read as follows: *"Resident seen by CareLine Physician Services NP today. No concerns no new orders at this time. NP noted resident appeared to be sleeping the majority of the day today which is a change from her last visit. NP stated to continue to monitor & to notify her of anything new."* The note was written by Jeffifer Springer Resident Care Coordinator.

The next note was dated 02/19/2025 at 10:30 AM by Venessa Miller, which read: *"Resident was observed on the floor in his bedroom with his upper body against the side of the bed by Med Tech Jaimin when she went to administer his AM medication. Resident was not breathing and had no pulse. Gentiva Hospice was notified. Hospice notified daughter. Medcure Body Donation had been contacted by Hospice to pick up resident."*

The next note was dated 02/19/2025, a 11:51 AM. "(*Resident A) was discharged from the system. Discharge Reason: Deceased. Notes: Deceased passed away on Gentiva Hospice."*

On 02/24/2025, I conducted a face-to-face interview with Venessa Miller, the Administrator. She was certain the staff had checked on Resident A on all shifts. She explained that he did not want to be disturbed, and he had yelled at many staff if they came into his room while he was sleeping. She reported that he had told staff to look through his window to check on him. She stated that he was adamant that they should not wake him up. She stated that Resident A's daughter had also told the staff to let him sleep and to not wake him up. She confirmed that Direct Care Staff, Jaimin Parrish, came to her immediately on 02/19/2025 when she realized he was on the floor. She described the same details as Ms. Parrish. I asked her about staff not having a key and she reported that they all knew where the keys were on the med cart. She stated that all the staff had to do was ask the med passer and they would have gotten the keys for them.

On 05/14/2024, I conducted a telephone interview with Direct Care Staff, Tabitha Conner. She confirmed that she worked 3rd. shift starting on 02/18-19/2025. She reported that she had been trained by many staff and the training included that staff were to check on Resident A by looking through the window of his room which faces the hallway. She continued and said the staff never went into his room. She said he was very independent, and he woke easily. She started to work in the facility in March 2025. She said she saw that his door was open a bit on 02/18/2025, and she could barely see in, but she could see he was sleeping in his bed, no time noted. She did not remember the time she checked on him, but it was during her shift. She reported that they do not check on residents on a regular basis. She stated that after

Resident A had passed, they changed their policy and now were instructed to check on residents every two hours. On 02/24/2024, Ms. Miller provided me with a copy of Resident A's Task/Charting Information. This document read: "Scheduled For 02/18/2025 @ 10:00PM. Charted on: 02/18/2025 @ 10:59." This document showed that Direct Care Staff, Tabitha Conner, had charted on 02/18/2025 @ 10:59 "had completed a visual check on every resident."

Direct Care Staff, Tabitha Conner confirmed that she did see Resident A asleep in his bed between 10:00PM and 10:59PM., on 02/18/2025.

On 05/14/2025, I conducted an interview with the Registered Nurse Sydne Jepson, from Gentiva Hospice. Her supervisor, Melissa Russell, was also on the call. She said she saw him the day before and he was sleeping a lot. She explained that she was called by the home staff between 9:30 and 10:00 AM. When she arrived, she reported that Resident A was not breathing and had no pulse. He was lying on the floor. She said she found that he still had warm parts of his body. She said he had his pants on but no shirt. She said the pillow was under his head. She had no idea when he passed, and she did not know what had caused his death. She said he did not have a bedrail on his bed. She was not suspicious of any neglect. She stated that Resident A had a DNR on record. She stated that she has had many patients in this facility, and she had only seen good care.

A heath care professional had seen Resident A on 02/18/2025. Gentiva Hospice, Sydne Jepson RN saw him on 02/18/2025 at 1:00 PM evidenced by her written Observation Note on Resident A and her verbal testimony. There was also a note written by Jennifer Springer, Resident Care Coordinator, that Resident A was seen by CareLine Physician Services NP on 02/18/2025, at 8:45PM. Direct Care Staff, Taryn VanNoy verbally testified that she had brought Resident A, his lunch tray, on 02/18/2025, with no time noted. She confirmed she had observed Resident A on 02/18/2025 at 4:30 and 5:00 PM. She went back to check on him around 8:00PM but his door was locked, and she did not have a key.

On 05/14/2025, I conducted a telephone interview with Leah Fhugars, Med Tech. She confirmed that she worked 3rd shift starting on 02/18-19/2025. She stated that she did not check on Resident A because the aid on her shift checks on the residents. She stated that she has worked in Green Acres facilities on the same campus for 12 years. She stated that it was the practice to not wake Resident A up while he was sleeping, and they were told to look through the window of his room to check on him. She said his room was dark and they could not see into his room. She was unaware if Direct Care Staff, Tabitha Conner, had checked on Resident A during the 3rd shift. I asked her if any staff from 2nd shift had asked her to check on Resident A because he was sleeping so much, and she said no one said anything to her.

On 05/14/2025, I spoke by telephone with Venessa Miller, and I asked if they had completed an Incident/Accident Report (IR) and she said they had, and she would

send it to me. I asked her when staff were required to check on each resident during the night and she they had not been checking on residents regularly but changed it to checks every two hours after Resident A's death.

On 05/14/2025. I received and reviewed the IR. The IR read as follows: Date 02/19/2025, at 10:32AM. Resident A was observed on the floor next to his bed not breathing and no pulse. Action taken: "Hospice was called as well as 'On Call.' Hospice nurse provided postmortem care and confirmed time of death. DPOA and funeral home notified by the hospice nurse. Hospice Death. Physician's diagnosis: Malignant neoplasm of Bladder." This document was signed by Jaimin Parrish and Venessa Miller on 02/19/2025.

From all the documentation I reviewed and the interviews with staff, Resident A was checked between 10:00PM and 10:59PM on 02/18/2025 by 3rd shift staff Tabitha Conner. He was not checked on again until approximately 10:30AM on 02/19/2025, by Direct Care Staff, Jaimin Parrish when she discovered him on the floor by his bed and he was deceased on 02/19/2025.

Venessa Miller, the Administrator, checked Resident A and he was not breathing, and had no pulse at 10:32AM. Sydne Jepson RN from Gentiva Hospice, confirmed the death of Resident A at 11:00 AM on 02/19/2025, which was noted on the Incident/Accident Report dated 02/19/2025. She reported that Resident A's daughter had chosen not to have an autopsy performed for Resident A.

On 05/20/2025, I conducted a telephone exit conference with the Licensee Designee, Paul Wayman and he agreed with my findings.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It was alleged that Resident A was not checked on during 2nd and 3rd shifts on 02/18-19/2025. Upon conducting interviews with Direct Care Staff, Taryn VanNoy, stated Resident A would get very mad if you checked on him because he was a light sleeper and when you checked on him, he would wake up. Leah Fhugars Med Tec stated it was the practice to not wake Resident A up while he was sleeping. Destiny Vanbennekom, reported that he had told her, 'I'm perfectly fine, I'm perfectly asleep, and I don't want to be bothered.' Jaimin Parrish stated that Resident A did not want to

	be bothered, and he did not get up until 10:00AM and he had said to them to peek through the window to check on him. Med Tech Jazzmin Plotts said Resident A is very independent and can go to the bathroom on his own, very stubborn and no one checks on Resident A at night because he does not want anyone to check on him. Tabathia Conner reported the staff never went into his room because he said he was very independent, and he woke easily. Vanessa Miller, the Administrator, explained that he did not want to be disturbed, and he had yelled at many staff if they came into his room while he was sleeping. She reported that he had told staff to look through his window to check on him. She stated that he was adamant that they should not wake him up during the night. Upon my review of Resident A's 'Level of Care Assessment,' Health Care Appraisal, and any other documentation, there was an absence of any documentation requiring staff to check on Resident A at any certain intervals. The Hospice nurse Sydne Jepson RN did not express any concern regarding the care of Resident A received at the home, and stated the facility provides good care. Durning this investigation I did not find any evidence that the staff had not provided Resident A with of his personal needs, protection and safety during his time in the facility. They reported they answered his call lights, administered his medications, encouraged him, provided any help he requested, and did not wake him up during the nighttime or when he was sleeping at his request. His Level of Care Assessment did not require staff to check on him with any assigned times. Therefore, there is not a rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: On 02/19/2025 Resident A's medications from 02/18/2025 were still in a "med cup" in the medication cart.

INVESTIGATION: On 02/24/2025, I conducted a face-to-face interview with Direct Care Staff, Destiny Vanbennekom. She reported that she worked as a Med Tech on 02/18/2025 on 1st. shift. She reported she secured Resident A's medication, Aspirin and put the medication in the medication cup. She said she went to administer Resident A's morning AM medication and sat his med cup on the counter, because Resident A was sleeping, and she thought it was around 10:00 AM. She said she checked him again at 11:00 AM and he was still sleeping. She reported that at noon

his Hospice nurse came to see him. She said she asked him if he wanted to go to lunch and he declined. She stated that she brought his lunch tray to him, time unknown. She said she observed Resident A at 2:00 PM and he was fine, and the Hospice nurse told her to let him sleep. In the past she said his daughter also told her he likes to sleep so let him sleep. She stated that she did not administer his Aspirin, and she left it in his room in the med cup on the counter and charted that she had administered his Aspirin. Ms. Vanbennekom confirmed she had observed Resident A on 02/18/2025, at 10:00AM., and at 11:00 AM, and brought his lunch to him, time undetermined, and observed him again at 2:00PM. This was a total of four times she had observed Resident A, and she acknowledged that she did not administer his prescribed Aspirin at any of those times. She denied that she left Resident A's medication of Aspirin in the med cart but acknowledged the medication was left in his room.

On 02/24/2025, Ms. Miller provided me with Resident A's Medication Administration Record for February 2025, and Ms. Vanbennekom had charted that she had administered Resident A his Aspirin EC 81 MG Tablet at 10/26/2025 at 10:26 AM. I asked Ms. Vanbennekom if she had documented that she had administered Resident A's medication, Aspirin, and she acknowledged that she did not administer Resident A's prescribed Aspirin, but she charted she had administered his Aspirin on their computer for administration of medications.

On 02/24/2025, I conducted an interview with Direct Care Staff, Jaimin Parrish. She reported that on 02/19/2025 she saw Resident A's med cup sitting on the counter from the day before, 02/18/2025.

On 05/20/2025, I conducted a telephone exit conference with the Licensee Designee, Paul Wayman and he agreed with my findings.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Direct Care Staff, Destiny Vanbennekom reported that she worked as a Med Tech on 02/18/2025 on 1st. shift and sat Resident A's med cup on the counter, because Resident A was sleeping, and she thought it was around 10:00 AM. She acknowledged that she did not administer his prescribed Aspirin, and she left the medication in the medication cup in Resident A's room. She acknowledged that she charted that she had administrated his prescribed Aspirin. On 02/24/2025, Direct Care Staff, Jaimin Parrish reported that she saw Resident A's med cup on the counter from 2/18/25.

	During this investigation it was confirmed by Med Tech, Destiny Vanbennekom did not administer Resident A's prescribed medication of Aspirin on 02/18/2025 even though she charted that she had administered the medication. She also acknowledged that she left the medication in the medication cup in Resident A's room on 02/18/2025. Therefore, there is a violation of the rule because Ms. Vanbennekom did not administer Resident A's prescribed medication on 02/18/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the Licensee Designee provide an acceptable plan of correction and the complaint be closed.

Arlene B. Smith 05/20/2025

Arlene B. Smith Date
Licensing Consultant

Approved By:

Jerry Hendrick 05/20/2025

Jerry Hendrick Date
Area Manager