GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 1, 2025

Katie Edwards
Wood Care VIII, Inc.
910 S Washington Ave
Royal Oak, MI 48067

RE: License #: AL090281510
Investigation #: 2025A0572035
Leighton House Inn

Dear Katie Edwards:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL090281510
Investigation #:	2025A0572035
Complaint Receipt Date:	05/05/2025
Investigation Initiation Date:	05/06/2025
Report Due Date:	07/04/2025
Licensee Name:	Wood Care VIII, Inc.
Licensee Address:	910 S Washington Ave Royal Oak, MI 48067
Licensee Telephone #:	(810) 299-1320
Administrator:	Katie Edwards
Licensee Designee:	Katie Edwards
Name of Facility:	Leighton House Inn
Facility Address:	6700 Westside Saginaw Rd Bay City, MI 48706
Facility Telephone #:	(989) 667-9800
Original Issuance Date:	12/05/2007
License **Status:**	REGULAR
Effective Date:	06/07/2024
Expiration Date:	06/06/2026
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On or about 04/29/2025, while in rehab, Resident A never received dinner. Resident A was told they ran out of food.	No
Resident A has been given Resident A's roommates medication and taken it.	Yes
Pills were found on the floor and an insulin pen on the table.	Yes
Buspirone medication was ordered late, Resident A went 4 days without Buspirone Medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/05/2025	Special Investigation Intake 2025A0572035
05/06/2025	Special Investigation Initiated - Letter Complainant.
05/07/2025	Contact - Document Received Complainant.
05/13/2025	Inspection Completed On-site Home Manager, Sara Schram; Med Supervisor, Jody Bannister; Staff, Stella Payne; Staff, Lillian Wilson; Resident A and Resident B.
06/26/2025	Inspection Completed-BCAL Sub. Compliance
06/27/2025	Exit Conference Licensee Designee, Katie Edwards

ALLEGATION:
On or about 04/29/2025, Resident A never received dinner. Resident A was told they ran out of food.

INVESTIGATION:
On 05/06/2025, I contacted the Complainant regarding the allegation. The Complainant informed that this allegation occurred in the same building as Leighton House, but it was in the Rehabilitation side of the building. The Complainant was

informed that I didn't have jurisdiction to investigate the allegation in the Rehabilitation Center. I advised the Complainant on where to make the referral.

Resident A was in Rehab on or around 04/29/2025 to 05/02/2025. Resident A was not in a licensed AFC Home during that time period.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on information given to me from the Complainant, this allegation occurred outside of my jurisdiction. Resident A was in Rehab on or around 04/29/2025 to 05/02/2025 and was not in a licensed AFC Home during that time period.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- Resident A was given Resident A's roommates medication and taken it.
- Pills were found on the floor and an insulin pen on the table.
- Buspirone medication was ordered late, Resident A went 4 days without Buspirone Medication.

INVESTIGATION:

On 05/06/2025, I contacted the Complainant regarding the allegation. The Complainant indicated that staff are very careless with medications. They have given Resident A Resident B's medication and left Resident A's insulin pen on the table in March 2025. They didn't order several of Resident A's medications in March 2025 and the complainant knew this because they were not on the bill. When the Complainant asked about it, the Complainant was told Resident A had "Back-stock". In the Complainant's opinion, back-stock can only be from not being given the medications properly.

On 05/13/2025, I made an unannounced onsite at Leighton House Inn, located in Bay County Michigan. Interviewed were, Home Manager, Sara Schram; Med Supervisor, Jody Bannister; Staff, Stella Payne; Staff, Lillian Wilson; Resident A and Resident B.

On 05/13/2025, I interviewed the Home Manager, Sara Schram regarding the allegations. Sara Schram said that she was informed of this issue and it would have

occurred before she began her employment at the facility. Resident A went to the hospital on 04/18/2025 and a family member found two pills on the floor. The two pills were Zoloft and Bymex. Resident A was on both of those medications, so it is believed to be Resident A's pills. Sara Schram is unsure if the pills were left for Resident A to take and was knocked over or if Resident A took the pills and spat them out. In regard to Resident A taking Resident B's medication, this was something that Sara Schram also had heard about. Staff Schram heard about this from Resident A's Suitemate (Resident B). There is no record of this occurring, but Resident B is aware of what medication Resident B takes. Resident B does not have dementia and is not known to make up stories. Since Sara Schram has come on board, they have discussed in monthly staff meetings the importance of when administering medications, staff are not to just leave the residents alone with their medications. They are to watch them take it before leaving. Regarding insulin pens being left on the table, she has not heard anything in regard to that. Resident A takes two different types of insulin and she has never seen any just laying around on the table. Resident A ran out of Buspirone and went without from 03/31/2025 to 04/03/2025. There is no way to make the medications automatically delivered once they become low, so they have to order them. Family Member #1 believes that it is more medications, but it wasn't. Family Member #1 believes that it is more because of the billing statement, but the billing statement does not coincide with when they put the order in.

On 05/13/2025, I reviewed Resident A's medication administration record and all but one medication appeared to be administered as prescribed. During the time period of 03/31/2025 to 04/03/2025 Resident A's Buspirone was not given.

On 05/13/2025, during my onsite, I went into Resident A's and Resident B's bedrooms. I did not notice any loose medications on the floor. I also did not observe any loose medications in the common areas of the home.

On 05/13/2025, I interviewed Med Supervisor, Jody Bannister, regarding the allegations. Jody Bannister just started her position with the company on 01/31/2025. Jody Bannister witnessed two pills on the floor of Resident A's bedroom and does not know how they got there. It was either from the day Resident A went to the hospital or the day after Resident A's hospital visit. They have now been re-educating staff during staff meetings on how to properly administer medications. Staff have gotten better at this, and it appears that things were laxed previously. In regard to Resident A being administered Resident B's medications, she is unaware of this situation. Jody Bannister also is unaware of insulin pens being left on the table in Resident A's bedroom. In regard to running out of medications, Jody Bannister informed that they use MedWiz Pharmacy which sends them the medications in a bubble pack. Their system does not flag them when they need a new prescription. When they get down to the last blue line of medications, that is when they are supposed to re-order the medications. However, when they order, they'll wait maybe a couple days and then call the pharmacy for a refill of the medication. That's when they find out that the doctor has to write a new script which

requires the physician's signature. The medication usually arrives the same day or the next day. If staff order medication there is nothing alerting them that a new script is needed, which can cause a med not to be ordered timely.

On 05/13/2025, I interviewed Staff Stella Payne regarding the allegations. Staff Payne has been working for the company since February 2025. Staff Payne has not heard about an incident involving Resident A being given Resident B's medication. Staff Payne also never heard or witnessed anything regarding insulin being left on a table in Resident A's bedroom or medication being found on the floor. Staff Payne only knows that there are times when Resident A doesn't want to take Resident A's medications. Staff Payne is unaware of Resident A running out of medications because she is not a med passer.

On 05/13/2025, I interviewed Staff, Lillian Wilson regarding the allegations. Staff Wilson started working for the company in March 2025. Staff Wilson did not hear about Resident A being given the incorrect medications. Staff Wilson has been passing medications for approximately 10 years, so she is very comfortable with administering medications. Resident A can get fussy about taking medications at times. Staff are required to watch the residents take their medications. Lillian Wilson never knew about any pills being found on the floor. In regard to Resident A running out of medications, Lillian Wilson believes that it is a pharmacy issue because staff are ordering the medications timely. After a couple days, if it doesn't show up, then they let management know and management are on the phones immediately to get the scripts ordered. The Med Supervisor is working on a system to ensure that meds are ordered timely.

On 05/13/2025, I interviewed Resident A regarding the allegation. Resident A informed that Resident A was given Resident B's medication before but does not remember who gave it to them or when it happened, due to memory loss. Resident A does not remember medications being found on the floor or insulin pens being left on the table. Resident A informed that staff now watch Resident A take its medications. Resident A stated, "I don't know what my medications look like. I just assumed that they are giving me the correct meds." Resident A does not know if medications have ever been ordered late. As far as Resident A knows, Resident A gets Resident A's medications on time every day and denied not receiving medication for a period of 4 days.

On 05/13/2025, I interviewed Resident B regarding the allegation. Resident B informed maybe a month or so ago, staff brought in medication to Resident B's bedroom to administer, but it didn't look like Resident B's medications. Resident B went and asked its suitemate (Resident A) if they had taken their medications and Resident A said, "Yes". Resident B told Resident A, "I think you took mine because I have yours here." Resident B does not remember who passed them the wrong medication but says that they don't think that that staff person still works there. Resident B pushed the call light, and the staff came to assist. Resident B told the staff of the mix-up. The staff then gave Resident B the correct medication. Resident

B is not sure if Resident A was given the right medication. Resident B has not noticed any other medication issues. Resident B never observed any insulin laying on the table but also doesn't take insulin either. Resident B has never observed insulin in Resident A's bedroom either. Resident B has never observed medications laying on the floor. Resident B's medications have always been ordered timely. Resident B informed that staff now stay and watch them take their medications. Staff use to say, "Here's your pills", then leave."

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on my interviews with Resident A, Resident B and staff, there is enough evidence to establish a rule violation. During my interviews, I determined that Resident A had taken Resident B's medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**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:	Based on interviews with staff and The Complainant, there is enough evidence to support a licensing rules violation. The Home Manager informed me that a family member found two of Resident A's pills on the floor next to Resident A's bed. They confirmed that they were Resident A's medications by reviewing Resident A's medication administration record.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15305	**Resident medications.**
	(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 to the provision of the act.
ANALYSIS:	Based on my interviews with staff and review of the medication administration record, there is enough evidence to support a rules violation. Staff did not refill medications that needed a new prescription. Resident A went 4 days without medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION
On 05/13/2025, I interviewed Home Manager, Sara Schram. Resident A went to the hospital on 04/18/2025 and a family member found two pills on the floor. The two pills were Zoloft and Bymex. Resident A was on both of those medications, so it is believed to be Resident A's pills. Since Sara Schram has come on board, she has discussed in monthly staff meetings the importance of when administering medications, Staff are not to just leave the residents alone with their medications. Staff must watch the residents take their meds before leaving them.

On 05/13/2025, I interviewed Resident A regarding the allegation. When ask if staff watch them taking their medication, Resident A replied, "They watch us take our medications now".

On 05/13/2025, I interviewed Resident B regarding the allegation. Resident B informed that staff now stay and watch them take their medications. Staff use to say, "Here's your pills", then leave."

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking or applying of prescription medications shall be supervised by licensee, administrator, or direct care staff.

ANALYSIS:	Based on my interviews with Resident A, Resident B and staff, there is enough evidence to establish a rule violation. During my interviews, it was determined that staff were not administering medication properly. Staff would leave the medications with the residents and not observe them taking the medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/27/2025, an exit conference was held with Licensee Designee, Katie Edwards. I informed Katie Edwards of the results of this special investigation.

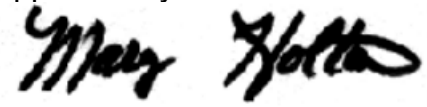
IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this large adult foster care group home, pending the receipt of an acceptable corrective action plan (capacity 13-20)

07/01/2025

Anthony Humphrey — Date
Licensing Consultant

Approved By:



07/01/2025

Mary E. Holton — Date
Area Manager