GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 29, 2026

Shequita Brown
1961 Reynolds
Muskegon, MI 49440

RE: License #:	AF610417971
Investigation #:	2026A0356028
	Organic Care

Dear Ms. Brown:

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

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF610417971
Investigation #:	2026A0356028
Complaint Receipt Date:	03/11/2026
Investigation Initiation Date:	03/11/2026
Report Due Date:	05/10/2026
Licensee Name:	Shequita Brown
Licensee Address:	1961 Reynolds Muskegon, MI 49440
Licensee Telephone #:	(870) 635-3599
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Organic Care
Facility Address:	1961 Reynolds St. Muskegon, MI 49442
Facility Telephone #:	(870) 635-3599
Original Issuance Date:	11/21/2023
License Status:	REGULAR
Effective Date:	05/21/2024
Expiration Date:	05/20/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Former Direct Care Worker (DCW) Heather Duncan was physically aggressive with Resident A.	Yes
Staff did not administer resident medications as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/11/2026	Special Investigation Intake 2026A0356028
03/11/2026	APS Referral Denied.
03/11/2026	Special Investigation Initiated - Telephone Casey Olson, HW, ORR
03/24/2026	Inspection Completed On-site
03/24/2026	Contact - Face to Face Resident's A&B, DCW's Deandra Robinson and Meagan Frost.
03/24/2026	Contact - Document Received MARs reviewed, IR's reviewed.
03/26/2026	Contact - Telephone call received Casey Olson, Health West, Office of Recipient Rights.
03/26/2026	Contact - Document Received IR from C. Olson, HW, ORR.
04/14/2026	Contact-Telephone call received Licensee Shequita Brown.
04/27/2026	Contact-Telephone call made Heather Duncan, former DCW, Tammy Hegedus, Shoreline Guardianship Services, Relative #1, Sarah (Cunningham) Wilson, Health West RN.
04/29/2026	Exit conference, Shequita Brown, Licensee

ALLEGATION: Former Direct Care Worker (DCW) Heather Duncan was physically aggressive with Resident A.

INVESTIGATION: On 03/11/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported on 03/09/2026, Resident A went into the common area and DCW Heather (Duncan) was upset about this, so she grabbed a spray water bottle and sprayed Resident A in the face. Resident A got up and cried and went to her room. The complainant reported there are two spray bottles, one has bleach with water, and the other one is just water. Heather (Duncan) was asked if there were any chemicals in the water that had been sprayed onto Resident A's eyes and Heather denied there was. Resident A did not need any medical attention due to this incident, and she did not complain of any pain in her eyes.

On 03/24/2026, I conducted an unannounced inspection at the facility with Licensing Consultant, Natasha Grew. Ms. Grew and I interviewed DCW's Meagan Frost, Deandra Robinson and Resident A. Without any questions asked, Resident A stated Ms. Duncan pushed her down the steps and she sustained bruising to her lower back due to falling down the steps. Resident A stood up and showed Ms. Grew and I her back. Ms. Grew and I observed a red mark on Resident A's lower back right hip area. Ms. Robinson showed Ms. Grew and I a picture of the injury when it was fresh, and there was a large red mark on Resident A's lower back right hip area and the red mark extended in a line across the lower part of Resident A's back. Ms. Robinson and Ms. Frost stated this was unusual for Resident A to fall on her own. Ms. Robinson and Ms. Frost stated that while Resident A is blind, and bumps into things in the facility, she does not fall and poses no fall risk. Resident A stated again that Ms. Duncan pushed her down the back steps in the facility, she fell and that is how she sustained the red marks on her back. Ms. Robinson and Ms. Frost stated Resident A's fall on the back steps occurred on a Sunday and prior to the spraying of the unknown substance to Resident A's eyes. Ms. Robinson and Ms. Frost stated Ms. Duncan knew there were chemicals in the spray bottle(s).

Ms. Robinson and Ms. Frost stated Resident A did not go to the doctor for the spray in the eyes nor did they call the nurse at Health West, but Resident A did go to the doctor for the fall. Ms. Robinson and Ms. Frost stated the doctor took pictures of the bruising on Resident A's lower back and added it to her file. Ms. Robinson and Ms. Frost stated Resident A's fall on the back steps occurred on a Sunday prior to the spraying of Resident A's eyes. Ms. Robinson and Ms. Frost stated Ms. Duncan worked first shift and then changed to third shift when the incidents took place.

Ms. Frost stated that Resident A kept stating, "don't spray me in the eyes" and she (Ms. Frost) did not know what Resident A was talking about until Resident B told her what had happened. Ms. Frost stated that Resident B told her that Ms. Duncan sprayed Resident A in the eyes with a spray bottle. Ms. Frost stated Resident A did not report this and never said anything about it. Ms. Frost stated she did not see any

redness to Resident A's eyes; no discharge and no indication of bleach sprayed into her eyes and that is why they did not seek medical treatment.

Ms. Grew and I asked Resident A about the allegation and Resident A stated Ms. Duncan sprayed her in the eyes with something that "burnt." Resident A stated that after Ms. Duncan sprayed her in the eyes, she (Resident A) got angry, stated it was painful, but she did not tell anyone.

On 03/24/2026, Ms. Grew and I interviewed Resident B in her room. Resident B stated she was up late at 10:00-11:00p.m. on 03/08/2026 because Ms. Duncan failed to administer her (Resident B's) evening medications, so she was up playing games. Resident B stated at midnight (03/08/2026-03/09/2026), Resident A went into the kitchen asking for a snack and Ms. Duncan told Resident A "no, you already had a snack" and then Ms. Duncan began to clean the house. Resident B stated Ms. Duncan told Resident A to go to her room and then Ms. Duncan sprayed Resident A "right in the eyes" with the spray bottle she was holding. Resident B stated she said to Ms. Duncan, "hey, is that water?" and Ms. Duncan said, "yea, it's just water." Resident B stated Resident A went to her room and got her sunglasses, put them on and sat down in the chair in the living room.

Ms. Frost stated Resident B came to her on 03/09/2026 at 4:00p.m. and told her about Ms. Duncan spraying Resident A in the eyes with the spray bottle. Ms. Frost stated Resident B reported the same information that she relayed to Ms. Grew and I.

On 03/24/2026, I reviewed the IR (Incident Report) dated 03/09/2026, written by Ms. Frost. The IR documented the following information, *'(Resident B) stated last night around midnight, when (Resident A) came up from her room and sat in her chair, Heather (Duncan) told her she was cleaning. Heather then went into the kitchen, grabbed a spray bottle, walked up to (Resident A) and sprayed her in the face. (Resident B) stated (Resident A) began crying and went back down to her room. A short time later (Resident A) returned upstairs wearing her sunglasses. Staff had noticed (Resident A) repeatedly saying, "don't spray me in the eyes," which prompted further questioning today, 03/09/2026. (Resident B) reported that she asked Health (Duncan) on 03/08/2026 if the bottle contained chemicals, and Heather told her (Resident B) it was water. However, the only clear spray bottle that was found contains a bleach solution. This raises concern that (Resident A) may have been sprayed in or near the face with a bleach mixture. (Resident A) never stated any pain or irritation of the eye. Staff did not notice that (Resident A's) eyes were irritated at anytime on 03/09/2026. Heather (Duncan) was already terminated at about 1:30p.m. on 03/09/2026, before (Resident B) told staff case worker and Meagan (Frost) about this incident about 3:40p.m. on 03/09/2026.'*

On 03/26/2026, I interviewed Casey Olson, Health West, Office of Recipient Rights Officer via telephone. Ms. Olson stated she is investigating the same allegations and had conducted an interview with Resident A. Ms. Olson stated Resident A reported that Ms. Duncan pushed her down the steps and sprayed her in the eyes, it burned

and it “smelled like perfume.” Ms. Olson had Resident A smell the different spray bottles that were in the facility used for cleaning and Resident A picked the spray bottle with bleach in it stating that one smelled like perfume to her and that is what Ms. Duncan sprayed in her eyes. Ms. Olson stated she concluded that Ms. Duncan sprayed Resident A in the eyes with the bleach water spray bottle.

On 04/14/2026, I interviewed Shequita Brown, Licensee via telephone. Ms. Brown stated that Resident A throws herself down and could have gotten the bruises on her back from doing that. Ms. Brown stated she does not believe Ms. Duncan pushed Resident A down on the steps. Ms. Brown stated she and Relative #1 have witnessed Resident A do this before so she (Ms. Brown) cannot confirm that incident was at the hands of staff.

Ms. Brown stated Resident A reported to her that Ms. Duncan had sprayed her in the face with “perfume, it burned” so she put her sunglasses on so Ms. Duncan would not spray her in the face/eyes anymore. Ms. Brown stated Resident A was saying “don’t spray me” and she had never said anything like that before, then Resident B reported to Ms. Frost what she had witnessed, and it made more sense. Ms. Brown stated she and Ms. Olson asked Resident A to smell the bottles. One had Lysol cleaner in it and the other had bleach. Resident A smelled the Lysol spray bottle and said no, then she smelled the bleach spray bottle and said yes, that was the one. Ms. Brown stated Resident A did not complain of her eyes burning nor did she say anything about this incident occurring until Resident B reported it on 03/09/2026. Ms. Brown stated Ms. Duncan was terminated immediately.

On 04/28/2026, I conducted an exit conference with Licensee, Shequita Brown via telephone. Ms. Brown stated she and staff did not know about this incident until the following day and at that point, Resident A never told them her eyes burned. She did not complain about pain so they did not call the Health West on call nursing or take Resident A to see her primary care doctor. Ms. Brown stated she and staff wrote an IR and sent it to Health West immediately to notify recipient rights and the case manager. Ms. Brown stated she understood the information, analysis, and conclusion of this applicable rule and will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	It was alleged that on 03/09/2026, DCW Heather Duncan sprayed Resident A in the face with a water spray bottle that was possibly filled with cleaning solution.

	Based on my investigative findings, there is a preponderance of evidence to show that on the evening of 03/08/2026-03/09/2026, Ms. Duncan used a spray bottle with a bleach solution in it to spray at or in Resident A's face/eyes, therefore a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff did not administer resident medications as prescribed.

INVESTIGATION: On 03/11/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported Heather (Duncan) was terminated from her job due to failing to pass medication to the residents.

On 03/24/2026, I conducted an unannounced inspection at the facility with Licensing Consultant, Natasha Grew. Ms. Grew and I interviewed DCW's Meagan Frost and Deandra Robinson who stated Resident A would not take her medications from Ms. Duncan and they were not aware if she missed medications because of that, but Ms. Duncan was terminated for failing to administer Resident B's medications. Ms. Frost stated she talked to Resident B's legal guardian, Tammy Hegedus, about Resident B's medications. Ms. Frost stated that Ms. Hegedus requested Ms. Frost take Resident B's medications to school on 03/09/2026 and administer the missed medications from the evening before (03/08/2026). Ms. Frost stated she signed the medications out for 03/08/2026 on 03/09/2026 and took them to Resident B's school and administered them to her at 11:30a.m. on 03/09/2026 when they were due for administration on 03/08/2026 at 4:00p.m.

On 03/24/2026, Ms. Grew and I interviewed Resident B in her room. Resident B stated at 8:00p.m. on 03/08/2026, Ms. Duncan passed medication and called Resident B downstairs to the medication room. Resident B stated she was waiting for Ms. Duncan to pass her evening medications, and she got water but ended up waiting "hours" for Ms. Duncan to pass her medications and she never did. Resident B stated she ended up being up late, and at 10:00-11:00p.m. on 03/08/2026 she was up playing games on her gaming system with her boyfriend because she never got the medications that she takes prior to bedtime. Resident B stated that is when she witnessed the incident in the previous allegation, then she called her guardian, Tammy Hegedus to report that she had not been given her medications. Resident B stated the only time she missed her medications was on 03/08/2026.

On 03/24/2026, I reviewed the MAR (medication administration record) for Resident B for the month of March 2026 (to date). The MAR documented the following:

- On 03/08/2026, Escitalopram Tab 10mg, take 1 tablet by mouth every evening, 4:00p.m. signed with the initials MF (Meagan Frost) and the date 03/09/2026 was documented in the signature box for 03/08/2026.
- On 03/08/2026, Escitalopram Tab 5mg, take 1 tablet by mouth every evening (take with 10mg tablet for total daily dose 15mg), 4:00p.m. signed with the initials MF (Meagan Frost) and the date 03/09/2026 was documented in the signature box for 03/08/2026.
- On 03/08/2026, Guanfacine Tab 1mg ER, take 1 tablet by mouth every evening, 4:00p.m. signed with the initials MF (Meagan Frost) and the date 03/09/2026 was documented in the signature box for 03/08/2026.
- On 03/08/2026, Paliperidone tab ER 1.5mg, take 1 tablet by mouth every evening, signed with the initials MF (Meagan Frost) and the date 03/09/2026 was documented in the signature box for 03/08/2026.
- Vienva, there is no dosage or instructions on the MAR, this medication is a form of oral contraceptive administered once daily. There are no staff initials on the MAR showing the medication was administered on 03/06/2026.
- On 03/19/2026, the following medications are not documented as administered on the MAR, Benzoyl Peroxide Gel 10%, apply topically to affected area(s) on skin once daily, 8:00a.m., Cetirizine Tab 10mg, take 1 tablet by mouth daily, 8:00a.m., Clindamycin SOL 1%, apply topically to affected area(s) of the skin once daily, 8:00a.m., Vitamin D3 25MCG Cap (1000 IU), take 1 capsule by mouth daily with food, 8:00a.m.

On 03/24/2026, I reviewed the MAR for Resident A for the month of March 2026 (to date). The MAR documented the following:

- Divalproex Tab 250mg, take 1 tablet by mouth twice daily, do not crush, chew, or split (8:00a.m./2:00p.m.) is not signed as administered at 8:00a.m. on 03/03/2026.
- Divalproex Tab 250mg, take 1 tablet by mouth twice daily, do not crush, chew, or split (8:00a.m./2:00p.m.) is not signed as administered at 2:00p.m. on 03/23/2026.
- Jardiance Tab 10mg, take 1 tablet by mouth every morning, 8:00a.m. on 03/03/2026 is not signed as administered.
- Pioglitazone Tab 15mg, take 1 tablet by mouth once daily, 8:00a.m. on 03/03/2026 is not signed as administered.
- Sertraline Tab 100mg, take 1 tablet by mouth twice daily, 8:00a.m. on 03/03/2026 is not signed as administered.
- Sertraline Tab 100mg, take 1 tablet by mouth twice daily, 8:00p.m. on 03/09/2026 is not signed as administered.
- Celecoxib Cap 100mg, take 1 tablet by mouth twice daily, 8:00p.m. on 03/09/2026 is not signed as administered.
- Tylenol PM, take 2 tablets by mouth every night at bedtime as needed for sleep, max of 4 grams Apap/24hr from all sources, 8:00p.m. on 03/09/2026 is not signed as administered.

- Lidocaine DIS 5% patch, apply topically to affected area once daily, on 12 hours, off 12 hours, 8:00a.m. on 03/08/2026 is not signed as administered.
- Quetiapine tab 150mg ER, take 1 tablet by mouth every night at bedtime, 8:00p.m. on 03/09/2026 is not signed as administered.

On 03/24/2026, I reviewed the MAR for Resident C, D & E for the month of March 2026. The MARs showed resident medications were signed as administered as prescribed by the medical professional.

On 04/28/2026, I conducted an exit conference with Shequita Brown, Licensee, via telephone. Ms. Brown stated she will retrain staff on the importance of documenting the administration of medications and submit an acceptable corrective action plan. Ms. Brown stated she understood the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	The complainant reported DCW Heather Duncan failed to pass medication to the residents. Upon review of Resident A, B, C, D & E's MARs, several medications are not documented as administered to Resident A and B during the month of March 2026. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

INVESTIGATION: On 03/11/2026, the complainant reported Ms. Duncan, DCW grabbed a spray water bottle and sprayed Resident A in the face. Resident A did not need any medical attention due to this incident, and she did not complain of any pain in her eyes.

On 03/24/2026, Ms. Robinson and Ms. Frost stated Resident A did not go to the doctor for the spray in the eyes nor did they call the nurse at Health West. Ms. Frost stated she did not see any redness to Resident A's eyes; no discharge and no indication of bleach sprayed into her eyes and that is why they did not seek medical treatment.

On 03/24/2026, Resident A stated Ms. Duncan sprayed her in the eyes with something that “burnt.” Resident A stated that after Ms. Duncan sprayed her in the eyes, she (Resident A) got angry, stated it was painful, but she did not tell anyone.

On 03/24/2026, The IR dated 03/09/2026, written by Ms. Frost did not document that medical care was sought for Resident A after she was sprayed in the eyes with an unknown substance, possibly bleach water.

On 04/27/2026, I interviewed Sarah Wilson, RN, Health West via telephone. Ms. Wilson stated no one from the facility placed a call to the Health West online nursing center for directions on resident care nor did staff follow up with a doctor visit after this incident.

On 04/28/2026, I conducted an exit conference with Shequita Brown, Licensee, via telephone. Ms. Brown stated she will submit an acceptable corrective action plan and understands that even though they did not find out about the incident until the following day and Resident A did not exhibit signs of injury, seeking professional advice is the best course of action and the rule. Ms. Brown stated she understands the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(2) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Staff at the facility did not follow up or seek medical advice from the on-call Health West nurses nor did they seek professional medical care from a doctor for Resident A when it was discovered that Resident A had been sprayed in the face/eyes with a cleaning solution. A violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

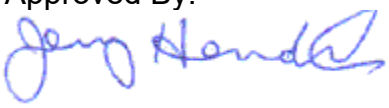
IV. RECOMMENDATION

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

04/29/2026

Elizabeth Elliott Date
Licensing Consultant

Approved By:



04/29/2026

Jerry Hendrick Date
Area Manager