GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 24, 2026

Jennifer Herald
Oliver Woods Retirement Village LLC
Suite 200
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL780282845
Investigation #: 2026A1033034
Oliver Woods #3

Dear Ms. Herald:

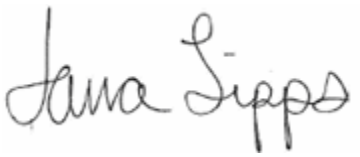
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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) 335-5985.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL780282845
Investigation #:	2026A1033034
Complaint Receipt Date:	05/07/2026
Investigation Initiation Date:	05/07/2026
Report Due Date:	07/06/2026
Licensee Name:	Oliver Woods Retirement Village LLC
Licensee Address:	Suite 200 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(810) 334-8809
Administrator:	Carla LaMarr
Licensee Designee:	Jennifer Herald, Designee
Name of Facility:	Oliver Woods #3
Facility Address:	1330 W. Oliver St. Owosso, MI 48867
Facility Telephone #:	(989) 729-6060
Original Issuance Date:	10/26/2006
License Status:	REGULAR
Effective Date:	08/29/2025
Expiration Date:	08/28/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff members were advised to give Resident A another resident's insulin on 1/19/26 and 4/27/26. **This allegation was entered under the wrong license number and is being investigated under SIR #2026A1033036**	N/A
The facility ran out of oxygen for resident use.	No
The facility is not properly stocked with incontinence briefs for resident use.	No
The facility routinely runs out of resident medications.	No
The direct care staff were asked to conduct a "fire watch" due to the water suppression system not properly functioning. The direct care staff did not know how to conduct a "fire watch".	Yes
Direct care staff, Sierra Woodring, administered resident medications independently prior to completing medication administration training.	No
Additional Findings	Yes

III. METHODOLOGY

05/07/2026	Special Investigation Intake 2026A1033034
05/07/2026	Special Investigation Initiated - Telephone Interview with adult foster care licensing consultant, Bridget Vermeesch.
05/08/2026	APS Referral Denied APS referral.
05/15/2026	Inspection Completed On-site Interviews conducted with Administrator, Carla LaMarr, Assistant Wellness Director, Brandi Harrison, & maintenance director, Alex McLean. Review of direct care staff trainings completed, review of resident records initiated.
05/18/2026	Contact - Document Sent Email correspondence sent to Administrator, Carla LaMarr, requesting additional documentation.
05/21/2026	Contact - Document Received Documents received via email from Administrator, Carla LaMarr.
05/28/2026	Contact - Telephone call made

	Interview conducted with direct care staff, Nicole Chapman via telephone.
05/28/2026	Contact - Document Received Email correspondence received from Administrator, Carla LaMarr.
05/29/2026	Contact - Document Received Email correspondence received from Administrator, Carla LaMarr.
05/29/2026	Contact - Document Received Email correspondence received from direct care staff, Nicole Chapman.
06/04/2026	Contact - Telephone call made Interview conducted via telephone with former direct care staff, Audra Rein.
06/07/2026	Contact - Document Received Email correspondence received from direct care staff, Nicole Chapman.
06/08/2026	Contact - Telephone call made Interview conducted via telephone with direct care staff, Caitlyn Hoskins.
06/08/2026	Contact - Telephone call made Interview conducted with direct care staff, Abigail Harrison, via telephone.
06/09/2026	Contact - Telephone call received Interview conducted with direct care staff, Julie Birge, via telephone.
06/09/2026	Contact - Telephone call made Attempts to interview direct care staff, Sierra Woodring, on 5/28/26 & 6/9/26, via telephone. Voicemail messages left both times. Awaiting response.
06/09/2026	Contact - Document Received Email correspondence received from Administrator, Carla LaMarr.
06/09/2026	Contact - Telephone call made Interview conducted with Citizen 1, via telephone.
06/09/2026	Contact - Telephone call made Interview conducted with Citizen 2, via telephone.

06/22/2026	Exit Conference Conducted via email with licensee designee, Jennifer Herald, and Administrator, Carla LaMarr.

ALLEGATION:

- **The facility ran out of oxygen for resident use.**
- **The facility is not properly stocked with incontinence briefs for resident use.**

INVESTIGATION:

On 5/7/26 I received an online complaint regarding the Oliver Woods #3, adult foster care facility (the facility). The complaint alleged that the facility is not properly stocked with incontinence briefs for resident use. The complaint further alleges that residents have gone without their oxygen tanks due to the facility running out of oxygen. On 5/15/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Administrator, Carla LaMarr, & Assistant Wellness Director, Brandi Harrison, regarding the allegation. Ms. LaMarr and Ms. Harrison reported that there are three residents receiving hospice care at the facility. They reported that there are no residents at the facility who use oxygen. They reported that the hospice provider supplies the incontinence briefs for these residents. They further reported that the remaining residents will have the cost of incontinence briefs factored into their room and board amount. Ms. LaMarr reported that there are four licensed adult foster care facilities on this campus and each facility has a storage room with a supply of incontinence briefs available for resident use. Ms. LaMarr further reported that there is a large storage room in the facility where an overflow supply of briefs is kept for resident use and dispersed to all facilities on the campus. Ms. LaMarr and Ms. Harrison reported that when a resident receives briefs from their hospice provider, the briefs are shipped to the facility, in that resident's name and stored in their resident apartment.

During the on-site investigation on 5/15/26 I conducted a walkthrough of the entire campus. I observed all storage areas where incontinence briefs are stored for resident use. The facility had a large supply of briefs in multiple sizes and variations. During this investigation I asked Ms. LaMarr to provide evidence of briefs being ordered through a durable medical equipment company. Ms. LaMarr provided me with the following documentation:

- Invoice from Medline dated 4/11/26. This invoice was for incontinence briefs and totaled $1870.50.
- Invoice from Medline dated 3/25/26. This invoice was for incontinence briefs and totaled $843.01.
- Invoice from Medline dated 3/10/26. This invoice was for incontinence briefs and totaled $1380.64.

On 6/8/26 I interviewed direct care staff, Abigail Harrison, via telephone, regarding the allegation. Ms. Harrison reported that she has never observed the facility insufficiently supplied with incontinence briefs for resident use.

On 6/9/26 I interviewed direct care staff, Julie Birge, via telephone, regarding the allegation. Ms. Birge reported that she has never had an issue with the facility not being adequately supplied with incontinence briefs for resident use.

On 6/9/26 I interviewed Citizen 1, via telephone, regarding the allegation. Citizen 1 reported that they are a former direct care staff member. Citizen 1 reported that they have not worked at the facility in several months, but they were aware that in December 2025 there were many issues concerning the facility not being properly supplied with incontinence briefs for resident use. Citizen 1 reported that there were residents who required XXXLG size briefs and these were not provided for a period. Citizen 1 reported that there had been a change in leadership at the facility during this period and when this change occurred the person responsible for ordering incontinence briefs and other supplies stopped ordering. Citizen 1 reported that there seemed to be a breakdown in communication about who was tasked with this responsibility and it fell by the wayside. Citizen 1 reported that during this timeframe there were residents who were forced to use a smaller size brief which caused discomfort to those residents.

On 6/9/26 I interviewed Citizen 2 via telephone, regarding the allegation. Citizen 2 reported that during December 2025 and January 2026 there seemed to be an issue with having an adequate supply of incontinence briefs, wipes, and other supplies. Citizen 2 reported that during this period the facility, even the storage rooms were frequently empty and the direct care staff were struggling to find supplies. Citizen 2 reported that this problem was addressed with management but noted that this issue went on for several weeks.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	Based upon interviews conducted and observations made during the unannounced, on-site investigation, it can be determined that there is no substantial evidence to conclude that the facility is not currently being adequately supplied with incontinence briefs for resident use. Citizen 1 and Citizen 2 both verified that there appeared to be an issue with having adequate supplies in December 2025, but this issue appears to be corrected. Ms. LaMarr was able to provide current transactions of a purchase history for these products, and the facility had a large supply of incontinence briefs during the on-site investigation. It was identified that there are currently no residents at the facility who use oxygen tanks for respiratory issues. Therefore, a violation will not be established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility routinely runs out of resident medications.

INVESTIGATION:

On 5/7/26 I received an online complaint regarding the facility. The complaint alleged that residents are missing medications due to the facility running out of medications to administer. This complaint also identified that residents who take insulin were running out of their insulin supply. On 5/15/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. LaMarr and Brandi Harrison regarding the allegation. Ms. LaMarr reported that there have not been any issues with residents at the facility running out of their medications to her knowledge. Ms. Harrison reported no concerns with this occurring as well.

During the unannounced, on-site investigation I requested to review the MARs for eight residents for the month of April 2025. Ms. LaMarr provided these MARs for my review via email on 5/21/26. I did not see any concerns regarding residents not having medications to administer documented on these MARs. I conducted a walkthrough of the facility and observed where resident medications are stored. I reviewed the insulin supply on hand for Residents A & B.

On 5/28/26 I interviewed Ms. Chapman via telephone regarding the allegation. Ms. Chapman reported that there are frequently residents who do not receive timely refills on their medications. Ms. Chapman reported that she had documentation of residents who were missing medications and she would email this documentation to this consultant. She could not provide a specific resident name at the facility who ran out of medications.

On 5/29/26 I received email correspondence from Ms. Chapman regarding the allegation. Ms. Chapman provided the following documentation for my review:

- *Med Pass Exceptions*, 2/1/26-5/8/26, for Resident C. I observed the following:
    - *Melatonin 3MG, not administered on 2/1/26, 2/2/26 due to "Awaiting Med Arrival From Pharmacy."*
    - *Five medications were marked as not administered on 2/20/26 due to "Resident Refused".*

On 6/8/26 I interviewed Abigail Harrison, via telephone, regarding the allegation. Ms. Harrison reported that she has not experienced residents running out of their prescribed medications at the facility.

On 6/9/26 I interviewed Ms. Birge via telephone regarding the allegation. Ms. Birge reported that she has never observed a resident run out of their medication at the facility. She has no knowledge of this occurring.

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:	Based upon interviews conducted with Ms. LaMarr, Brandi Harrison, Abigail Harrison, Ms. Birge, and Ms. Chapman, as well as documentation reviewed during this investigation, it can be determined that there is not a preponderance of evidence to suggest that there is a current problem with the facility managing and maintaining medications on-site for the current residents. The eight MARs I reviewed for this investigation were all from April 2025 and there were no concerns identified. Abigail Harrison and Ms. Birge reported no identified issues with residents currently running out of medications at the facility. The document provided by Ms. Chapman identified two missed doses of Resident C's Melatonin, on 2/1/26 & 2/2/26, due to "Awaiting Med Arrival from Pharmacy" and medications refused by the resident on 2/20/26. There were not any recent or prolonged issues identified with Resident C's medications. Due to this, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The direct care staff were asked to conduct a "fire watch" due to the water suppression system not properly functioning. The direct care staff did not know how to conduct a "fire watch".

INVESTIGATION:

On 5/7/26 I received an online complaint regarding the facility. The complaint alleged that on 12/18/25 the direct care staff were asked to conduct 15-minute checks due to the fire suppression system being off. The complaint alleges that the direct care staff were not familiar with this protocol and did not know what this directive entailed.

On 5/15/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Administrator, Carla LaMarr, and Assistant Wellness Director, Brandi Harrison, regarding the allegation. I asked Ms. LaMarr and Ms. Harrison to describe the process in place for when the facility has a malfunctioning fire suppression system, identifying the question as, what responsibilities do direct care staff have when the fire suppression system is not properly functioning. Ms. LaMarr reported that the protocol at the facility is to contact the maintenance staff and they will take the lead in addressing the issue, identifying the problem, and report any repairs needed to Brigade Fire Protection services for repair. Ms. Harrison agreed with Ms. LaMarr's statements regarding this process. I inquired whether there was any other step direct care staff should follow through on when the fire suppression system is not functioning properly. Both Ms. LaMarr and Ms. Harrison stated that they were unaware of any other steps for the direct care staff to take other than contacting the maintenance staff. Ms. LaMarr reported that she is unaware of any recent time when the fire suppression system was not properly functioning at the facility.

During the unannounced investigation on 5/15/26 I interviewed Maintenance Manager, Alexander McLean, regarding the allegation. I asked Mr. McLean what the protocol is at the facility for direct care staff to follow when the fire suppression system is not properly functioning. Mr. McLean reported that the direct care staff should notify himself or another maintenance staff member and they will assess the situation. He reported that if the system requires repair, he will contact Brigade Fire Protection to service the system. He further reported that the direct care staff will be put on a "fire watch" until the system is functioning correctly. He reported that this includes doing 15-minute checks of the facility to ensure there is not a fire or potential for a fire and assuring the welfare of the residents. Mr. McLean reported that a few months ago there was an instance when the facility was placed under a "fire watch" due to the fire suppression system being turned off. He reported that the system was not faulty on that date, but they did turn it off and had the direct care staff conduct a fire watch for a period of about ten hours. Mr. McLean was asked on what date this occurred but reported that he was not certain as a permanent record of this event was not detailed in writing.

During my interview with Mr. McLean, Ms. LaMarr and Ms. Harrison were present in the room. Ms. LaMarr reported that she was aware of what a "fire watch" entails and forgot to mention this process during the interview she gave this consultant prior to Mr.

McLean's interview. Mr. McLean, Ms. LaMarr, and Ms. Harrison reported that the direct care staff do complete an online fire safety training and noted that this training addresses the process of a "fire watch".

On 5/21/26 Ms. LaMarr sent email correspondence regarding the allegation. She provided a PowerPoint presentation regarding the quarterly fire safety training conducted with direct care staff members at the facility. I observed the following in this presentation:

- The training is titled *Quarterly Safety Training*. On the first page it states, "All staff must attend one of these sessions once annually".
- Under the section, *Fire Safety*, the following outline is provided for topics to address:
    - R.A.C.E/P.A.S.S.
    - Fire Panel
    - Fire Extinguisher
    - Fire Pull Stations
    - Overview of fire procedure: Shelter in place, horizontal, vertical evacuation
    - Fire Prevention
    - Fire Response Plan – smoke compartments
    - Evacuation Maps
- I did not see a section devoted to "Fire Watch" protocol.

Ms. LaMarr reported that the direct care staff are trained quarterly in fire safety issues through:

- Two staff meetings per month
- Monthly fire drills
- Maintaining documentation of signed logs from the attended direct care staff meetings. These logs are saved in the Life Safety and Inspections binder at the facility.

On 5/28/26 I interviewed direct care staff, Nicole Chapman, regarding the allegation. Ms. Chapman reported on 12/18/25 the fire suppression system at the facility was not functioning properly and the direct care staff were instructed by Administrator, Carla LaMarr, through a text message to the direct care staff group chat to conduct "15-minute checks" due to this issue. Ms. Chapman reported that the direct care staff working on this date were not aware of what was expected of them and had not been trained on how to conduct "15-minute checks" at the facility. Ms. Chapman reported that there are four licensed adult foster care facilities on this campus and two of the facilities were ordered to conduct a fire watch on 12/18/25. She reported that both licensed facilities had an issue with their fire suppression systems on 12/18/25 and direct care staff in both facilities were requested to conduct "15-minute checks" on this date. Ms. Chapman reported that she could send this consultant a screenshot of the text message exchange from Ms. LaMarr.

On 5/29/26 I received email correspondence from Ms. LaMarr providing documentation of Ms. Chapman's completed direct care staff trainings as well as the direct care staff schedule for December 2025. I observed the following information:

- Ms. Chapman completed her *Fire Safety: Fire Prevention* training on 4/6/26.
- Ms. Chapman completed, *Fire Safety: Types of Fire Extinguishers*, training on 3/13/26.
- She completed, *Workplace Emergencies and Natural Disasters*, training on 3/13/26.
- The direct care staff schedule for 12/18/25 listed the following direct care staff working between 5pm and 6am the following morning:
    - Brooke Rhodes, 2pm to 10:30pm
    - Robyn Hunt, 2pm to 10:30pm
    - Caitlyn Hoskins, 2pm to 10:30pm
    - Danielle Cheadle, 2pm to 10:30pm
    - Paul Bowman, 2pm to 10:30pm
    - Joanna Hoop, 2pm to 10:30pm
    - Savannah Lowry, 10pm to 6:30am
    - Brooke Rhodes, 10pm to 6:30am

On 6/7/26 I received email correspondence from Ms. Chapman. Ms. Chapman provided a photograph of a screenshot image of the group text exchange from Ms. LaMarr to the direct care staff members on 12/18/25. The text message reads, "Buildings three and four the fire suppression system has been turned off. You will have to do checks every 15 minutes and maintenance will reevaluate in the morning if you have any questions feel free to reach out to me." I could see Ms. LaMarr's profile photograph next to the text in this group chat, indicating this message came from Ms. LaMarr's telephone.

On 6/8/26 I interviewed direct care staff, Caitlyn Hoskins, regarding the allegation. Ms. Hoskins reported that she works at the facility. She reported that she was working on 12/18/25 when the "fire watch" was requested for the facility. Ms. Hoskins reported that she was not aware of what a "fire watch" consisted of and had never been trained to this protocol previously. She reported that she did complete her fire safety orientation when she was hired at the facility about a year ago. She reported that the direct care staff working on 12/18/25 were requested to conduct 15-minute checks on all residents due to the fire suppression system being turned off. She reported that Mr. McLean advised her how to proceed with these checks on this date.

On 6/8/26 I interviewed direct care staff, Abigail Harrison, via telephone regarding the allegation. Ms. Harrison reported that she does not recall working on 12/18/25 when the direct care staff were asked to conduct a "fire watch" due to the fire suppression system being turned off. She reported that she knows what a "fire watch" consists of as she has previously worked in nursing homes. She reported that she did complete her fire safety training at the facility and believes that the concept of a "fire watch" was addressed in this training. She reported that the management at the facility provide regular refreshers in fire safety and do so either by walking through the facility and quizzing direct care staff or in monthly direct care staff meetings. Ms. Harrison reported feeling confident

performing 15-minute checks of the facility and residents for the purposes of a “fire watch”.

On 6/9/26 I interviewed direct care staff, Julie Birge, via telephone regarding the allegation. Ms. Birge reported that she has worked at the facility for about eleven months. She reported that she did recall a date in December 2025 when the direct care staff were requested to conduct 15-minute checks on the residents at the facility. Ms. Birge reported that she was scheduled to provide care at another licensed facility on this campus on this date and that facility was also under a “fire watch” protocol. Ms. Birge reported that this was a new protocol for her and she had not been asked to do this before. She reported that she was told that the “system” was down and not working. She reported that she assumed this meant the call light system for the residents. Ms. Birge was not aware that the “system” referred to was the fire suppression system. Ms. Birge reported that she has completed fire safety training but does not recall a section of the training that focused on “fire watch” and direct care staff responsibilities during a “fire watch”. Ms. Birge reported that the fire safety training she has completed mostly focuses on fire drills. Ms. Birge reported that she did conduct 15-minute checks on the residents when she was requested to complete this task. She reported that this was done until the direct care staff were advised the system was back up and running properly.

On 6/9/26 I received email correspondence from Ms. LaMarr. Ms. LaMarr had been requested to supply the Relias training records for the direct care staff noted to be on the direct care staff schedule on 12/18/25 from 5pm through 6am the next morning. I observed the following information in reviewing these training records:

- Brooke Rhodes Relias transcript identifies she has completed the following fire safety trainings:
    - Fire Safety: Fire Prevention, 1/30/25
    - Fire Safety: Types of Fire Extinguishers, 1/30/25
- Robyn Hunt Relias transcript:
    - Fire Safety: Types of Fire Extinguishers, 12/2/25
- Caitlyn Hoskins Relias Transcript:
    - Fire Safety: Fire Response Plans, 3/4/26
    - Fire Safety: Fire Prevention, 1/8/26
    - Fire Safety: Types of Fire Extinguishers, 11/6/25
    - Fire Safety: RACE & PASS, 9/28/25
    - Fire Safety: 7/1/25
- Danielle Cheadle Relias Transcript:
    - Zero trainings completed
- Paul Bowman Relias Transcript:
    - Training record requested and not provided
- Joanna Hoop Relias Transcript:
    - Zero trainings completed
- Savannah Lowry Relias Transcript:
    - Fire Safety: Types of Fire Extinguishers, 12/2/25

On 6/9/26 I interviewed Citizen 1 via telephone regarding the allegations. Citizen 1 is a former direct care staff member of the facility. Citizen 1 reported that they worked at the facility for a period of around eight to ten months. They reported that the training they received was “terrible”. Citizen 1 reported that the direct care staff members were “briefed” in fire safety training. They could not recall whether the fire suppression system was discussed in the fire safety training they received. Citizen 1 reported that they primarily worked first shift. When asked about the fire suppression system being turned off on 12/18/25. Citizen 1 reported that they were not working at the facility when this occurred. Even though the direct care staff schedule had Citizen 1 listed as working at the neighboring licensed adult foster care facility on this date from 10pm to 6:30am. Citizen 1 reported that they overheard complaints from direct care staff who did work during the period that the fire suppression system was turned off. They reported that these direct care staff members were frustrated because they did not feel they were provided with adequate training to understand what they were supposed to do in the event of a fire watch. They reported that they were told to conduct 15-minute checks on the residents during this period.

On 6/9/26 I interviewed Citizen 2 via telephone regarding the allegation. Citizen 2 reported that they were a previous direct care staff member at the facility. They reported that their primary shift at the facility was second shift. Citizen 2 reported that the quality of the direct care staff training was lacking. They reported that a new hire is put on the floor providing resident care as soon as possible. Citizen 2 reported that most of the trainings are completed on the computer and it is up to the direct care staff to make time to complete these trainings in between providing personal care assistance to residents. When asked if Citizen 2 received fire safety training they reported, “a little bit”. They stated that they did walk around the facility with the maintenance manager, and he demonstrated where fire panels were located and fire extinguishers. Citizen 2 reported that the maintenance manager stated to always call him if there were any emergencies. Citizen 2 reported they do not remember being trained to the facility protocol for when the fire suppression system is turned off and not functioning correctly. They reported that they were working at the facility on 12/18/25 when the fire suppression system was turned off. Citizen 2 reported that the direct care staff were instructed to conduct 15-minute safety checks on all residents during the period the fire suppression system was off. They reported that this was new information to them on this date and they were not aware of this protocol before this date.

APPLICABLE RULE	
R 400.619	**Emergency preparedness plan.**
	(7) A licensee shall ensure that all staff are instructed and retrained quarterly per calendar year, and new staff on hire, with respect to their duties and responsibilities under the emergency preparedness plan, on the operation of the fire alarm and other fire protection equipment. A record of the instruction must be maintained for 2 years.

ANALYSIS:	Based upon the interviews conducted and documentation reviewed during this investigation it can be determined that there is substantial evidence to identify that the direct care staff have not been adequately trained in all aspects of the facilities fire safety protocol. When interviewed, Ms. LaMarr & Brandi Harrison could not identify the process of a “fire watch” until reminded by Mr. McLean of this protocol and the process to follow. Ms. Chapman, Ms. Birge, Citizen 1, Citizen 2, & Ms. Hoskins, all reported that they feel the process of a “fire watch” was never discussed during their orientation or regular fire safety trainings. They all appeared to have vague understanding of their responsibilities during a “fire watch”. The training records provided identified that Ms. Chapman did not have fire safety training completed until after 12/18/26. Danielle Cheadle, and Joanna Hoop did not have any documentation of fire safety training, however, were scheduled on the direct care staff schedule on this date and during the time frame of the requested “fire watch”. During the interviews conducted the common theme presented was that Mr. McLean understands the fire safety protocols and procedures to follow, and the direct care staff relies on Mr. McLean’s knowledge. The direct care staff should have a competent level of knowledge regarding these systems to provide for the safety of the residents. Based on this information, a violation has been established as it appears the direct care staff and Administrator require further training pertaining to fire safety protocols and the mechanics of the fire safety system at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff, Sierra Woodring, administered resident medications independently prior to completing medication administration training.

INVESTIGATION:

On 5/7/26 I received an online complaint regarding the facility. The complaint alleged that direct care staff, Sierra Woodring, was administering resident medications prior to completing her medication administration training.

On 5/15/26 I conducted an unannounced, on-site investigation at the facility. I spoke with Ms. LaMarr and Brandi Harrison regarding the allegation. Ms. LaMarr and Ms. Harrison denied that Ms. Woodring ever administered medications prior to completing medication administration training. I requested to review Ms. Woodring’s medication administration training record. Ms. LaMarr provided this document. I observed that

Sierra Woodring Medication Administration Training record was completed and dated 4/27/26-4/28/26.

During the on-site investigation on 5/15/26 I requested to review the *Medication Administration Records* (MARs) for eight residents. I was provided these records via email from Ms. LaMarr on 5/21/26. I observed the following information on the MARs reviewed:

- Sierra Woodring's signature did not appear on any of the provided MARs as someone who administered medications during the month of April 2026.

On 5/28/26 and 6/9/26 I made attempts to interview Ms. Woodring, via telephone. Voicemail messages were left both days and no response was received.

On 5/28/26 I interviewed Ms. Chapman via telephone regarding the allegation. Ms. Chapman reported that Ms. Woodring was in the middle of her medication administration training and had not yet been cleared to administer medications independently when direct care staff, Shelly Teal, requested that she administer medications at the facility. Ms. Chapman reported that she could not recall the exact date when this occurred but she knew it happened in April 2026.

On 6/8/26 I interviewed Ms. Hoskins via telephone regarding the allegation. Citizen 1 reported that she has received all training to work at the licensed adult foster care facilities on this campus. She reported that she has never observed a direct care staff member administering medications prior to completing their medication administration training.

On 6/8/26 I interviewed Abigail Harrison, via telephone, regarding the allegation. Ms. Harrison reported that she feels she completed all required trainings prior to providing independent care to the residents at the facility. She reported that she has never observed untrained direct care staff members administering resident medications.

On 6/9/26 I interviewed direct care staff, Julie Birge, regarding the allegation. Ms. Birge reported that she has never witnessed untrained direct care staff members administering medications to residents at the facility.

On 6/9/26 I interviewed Citizen 1 via telephone regarding the allegation. Citizen 1 reported that they have no knowledge regarding the allegation that direct care staff were allowed to administer medications prior to completing medication administration training.

On 6/9/26 I interviewed Citizen 2 via telephone regarding the allegation. Citizen 2 reported that they have no knowledge of information pertaining to direct care staff being allowed to administer medications prior to completing medication administration training.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Based upon interviews conducted with Ms. LaMarr, Brandi Harrison, Ms. Chapman, Abigail Harrison, Ms. Birge, Ms. Hoskins, Citizen 1 & Citizen 2, as well as review of Ms. Woodring's medication administration training and eight resident MARs, it can be determined that there is not adequate evidence to conclude that Ms. Woodring administered medications at the facility prior to completing her medication administration training. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the investigation I reviewed eight MARs provided via email from Ms. LaMarr on 5/21/26. I observed the following information on these MARs:

- Resident D, Resident E, Resident F, & Resident G all have the abbreviation, "U-SA" on their MARs where a direct care staff signature would normally be recorded.
- On 5/28/26 & 5/29/26 I had email correspondence with Ms. LaMarr to clarify what "U-SA" stands for on these MARs. Ms. LaMarr reported that this indicates when a resident is "self-administering" their own medications. I requested to review the medical orders authorizing these residents to self-administer and inquired how these medications are being stored.
- Ms. LaMarr provided the self-administration orders for each resident.
- Ms. LaMarr reported the following regarding storage of medications:
    - "[Resident D] stores his meds at bedside and was provided a lock box but refused to use it."
    - "[Resident E] has her meds locked in her apartment in a cabinet in a locked box."
    - "[Resident F] Was also provided a lock box and stores at bedside."
    - "[Resident G] Family puts in med reminders for her weekly and these are not stored in a locked cabinet. Wellness will ask family to consider."
- Ms. LaMarr was reminded that all resident medications need to be stored in a locked cabinet or drawer.

On 6/10/26 I interviewed Adult Services Worker with Adult Protective Services, Rebecca Schalow, regarding the allegations. Ms. Schalow reported that she made a visit to Resident D this week and his medications were sitting out in his apartment and not stored in a locked container.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	Based on the information gathered during this investigation a violation has been established. There are at least two residents, Resident D and Resident G, who self-administer their medications, store their medications in their resident apartments, and these medications are not being stored in a locked container.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the current status of the license is recommended at this time.

6/22/26

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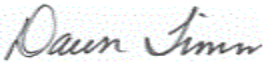
Jana Lipps Date
Licensing Consultant

Approved By:



06/24/2026

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Dawn N. Timm Date
Area Manager