GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 10, 2026

Theresa Alvarado
Addie's Acres, LLC
11525 Wood Road
DeWitt, MI 48820

RE: License #: AL190357883
Investigation #: 2026A1029045
Addie's Acres, LLC

Dear Ms. Alvarado:

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 licensee designee 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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

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

I. IDENTIFYING INFORMATION

License #:	AL190357883
Investigation #:	2026A1029045
Complaint Receipt Date:	05/28/2026
Investigation Initiation Date:	05/28/2026
Report Due Date:	07/27/2026
Licensee Name:	Addie's Acres, LLC
Licensee Address:	11633 Wood Road, DeWitt, MI 48820
Licensee Telephone #:	(517) 410-1197
Administrator:	Theresa Alvarado
Licensee Designee:	Theresa Alvarado
Name of Facility:	Addie's Acres, LLC
Facility Address:	11633 Wood Road, DeWitt, MI 48820
Facility Telephone #:	(517) 410-1197
Original Issuance Date:	07/24/2015
License Status:	REGULAR
Effective Date:	01/24/2026
Expiration Date:	01/23/2028
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff members did not administer resident medications as prescribed.	Yes
Resident medications are not locked up securely and are left out accessible to residents.	No
Resident medications are thrown in the trash for disposal.	No

III. METHODOLOGY

05/28/2026	Special Investigation Intake 2026A1029045
05/28/2026	Special Investigation Initiated - Email to complainant
05/29/2026	Contact - Telephone call made to complainant, Savada Wells (left message), Jamie Sailer (left message), Angela E (left message), Eva Khalil, and licensee designee Theresa Alvarado
05/29/2026	Inspection Completed On-site – face to face with Resident A, Resident B, Resident C, Resident D and Savada Wells at Addie's Acres.
06/12/2026	APS Referral made to Centralized Intake
06/16/2026	Contact - Telephone call made to Relative C1, Noah Alvarado, Trinity Falor
07/10/2026	Exit conference with licensee designee Teresa Alvarado

ALLEGATION: Direct care staff members did not administer resident medications as prescribed.

INVESTIGATION:

On 05/28/2026 a complaint was received via Bureau of Community and Health Systems online complaint system alleging that direct care staff members did not administer resident medications as prescribed.

On 05/29/2026, I interviewed Complainant who was unable to identify any specific resident allegedly not receiving medications as prescribed. The complainant stated it may have involved Resident B or Resident C receiving dementia medications but could provide no additional details regarding how medications were improperly administered.

On 05/29/2026, I conducted an unannounced on-site investigation at Addie's Acres and interviewed direct care staff member, whose current role is home manager, Savada Wells. Ms. Wells stated she has been employed since the home opened fifteen years ago and there were currently ten residents. She reported no concerns regarding residents receiving medications inconsistent with their prescriptions and stated all direct care staff are trained in medication administration, with periodic reviews conducted.

I reviewed medication administration records (MAR) for Resident A, Resident B, and Resident C. Upon reviewing the MAR for May 2026 I found the following errors:

Resident A:
05/01/2026: Lubiprostone (Amitaza) 24 mcg – 5 PM dose was not initialed as administered.
05/10/2026: Timolol .5% optic solution not initialed as administered, Tylenol 500 mg (had a red dot but not initialed)
05/17/2026: Preservision (8 PM) was not initialed as administered
05/19/2026: None of the medications during day shift were initialed. All medications except for Lasix / Furosemide, Multivitamin, Azelastine .1% Nasal Spray, Prednisone, did have a "red dot" next to them indicating they prepared by the direct care staff member.
05/20/2026: Multivitamin - 8 AM were not initialed as administered
05/26/2026: Vitamin PM, Preservision (8 PM dose), Azelastine .1% nasal spray, and Timolol .5% opth. solution was not initialed as administered
05/27/2026: Tylenol 500 mg was not initialed as administered.
05/28/2026: Preservision (8 PM dose) was not initialed as administered.

Resident B:
05/01/2026: Seroquel 50 mg, Donepezil 10 mg was not initialed as administered
05/03/2026: Nystatin cream (8 PM dose) was not initialed as administered
05/20/2026: Amoxicillin 500 mg (2 PM dose) was not initialed as administered
05/25/2026 Lisinopril 10 mg was not initialed as administered
05/26/2026: Donepezil 10 mg and Amoxicillin 500 mg was not initialed as administered
05/02/2026, 05/08/2026, 05/18/2026, 05/19/2026, and 05/20/2026 all had a red dot showing the medication Melatonin was prepared but were not initialed by a direct care staff member.

Resident C:
05/01/2026: Simvastatin 40 mg and Metformin not initialed as administered.
05/14/2026-05/28/2026: "NA" documented for Donepezil 10 mg indicating it was not available in the facility.
05/01/2026-05/28/2026: "NA" documented for Ferrous Sulfate 325 mg for daily supplement indicating it was not available in the facility.
05/12/2026, 05/13/2026, 05/25/2026 all had a red dot showing the medication Melatonin was prepared but were not initialed by a direct care staff member.

I reviewed the medications for Residents A and B and confirmed they were available in the facility and matched current physician orders. I also reviewed Resident C's medication list and physician orders dated 05/14/2026, which listed Donepezil and Ferrous Sulfate as current medications; however, both medications were not available in the home at the time of the inspection.

There was a sheet posted in the medication room called, "RED DOT METHOD" OF MED ADMINISTRATION with the following instructions:
· "Pull each med & verify correct:
Resident, Drug & purpose, Dose, Route, Time
· Place RED DOT on med sheet in correct space for Resident, Med, Date & Time BEFORE PULLING NEXT MED
· If med not available, place "NA" in correct space for Resident, Med, Date & Time
- *Notify TL and/or Admin + Pharmacy*

· If med has 10 or fewer doses left,
- *Notify TL and/or Admin + Pharmacy*

· Watch resident take meds
· After resident takes med (by shift end) initial med sheet in correct space for Resident, Med, Date & Time
(Sign bottom of med sheets if not done)
*· If resident REFUSES med, place **"R"** in correct space for Resident, Med, Date & Time & notify TL and/or Administrator"*

I interviewed Residents A, C, and D at Addie's Acres. Resident A stated that staff do a good job administering her medications, though they are occasionally "a little late." Resident C reported she takes "too many medications" and that her daughter manages them. She stated she discontinued one medication due to stomach discomfort but could not recall the name. Resident C also stated she wishes she could take medication for memory loss but is not currently doing so. Resident D reported no medication related concerns.

On 06/16/2026, I interviewed Relative C1, who manages all of Resident C's medications because Resident C uses a different pharmacy. Relative C1 stated she previously used the facility's primary pharmacy but switched back to Walgreens due to various issues. She reported she is working with MSU Neurology to adjust Resident C's medications and requested that Resident C discontinue Donepezil due to gastrointestinal side effects however she has not yet obtained a discontinue order. Relative C1 also reported that she purchases Ferrous Sulfate over the counter and needs to bring it to Addie's Acres but has not yet done so. She stated she will work on obtaining the discontinue order and providing the supplements soon.

On 05/29/2026, I interviewed former direct care staff member Eva Khalil, who reported her last day of employment was 05/28/2026. Ms. Khalil stated she had no concerns that residents were receiving medications they were not prescribed. She reported that they use paper MARs, all direct care staff members are trained in medication administration, and no residents had ever expressed medication-related concerns to her.

On 06/16/2026, I interviewed direct care staff member Trinity Falor. Ms. Falor stated she has never observed residents receiving medications that were not prescribed. She reported that medication changes are communicated by Ms. Wells. Ms. Falor works first shift and stated most medications are straightforward but is unsure of second shift's practices. She acknowledged blanks on the MAR due to the facility's "red dot" system, which indicates a medication was administered but may not be initialed by direct care staff members because they forget to document after placing a red dot but reported no concerns regarding dementia medications for Residents B or C. Ms. Falor also reported an incident in which Relative C1 was upset that Resident C ran out of medication. She stated that because Relative C1 uses Walgreens instead of the facility's usual pharmacy, delays sometimes occur in obtaining Resident C's medications. Ms. Falor had no information regarding Relative C1's concerns about specific medications.

On 07/10/2026, I completed an exit conference with licensee designee Ms. Alvarado. Ms. Alvarado stated that direct care staff have gained a better understanding of the facility's "red dot" medication documentation method, and she has been retraining direct care staff members on an ongoing basis. She reported that they will sometimes place a red dot on the MAR but fail to return and initial the medication, leaving uncertainty as to whether it was administered since a red dot only indicates the medication was pulled for administration. She stated that medication records are being reviewed regularly to ensure proper documentation. Ms. Alvarado reported that she will include documentation of retraining on medication administration with the *Corrective Action Plan*. She also stated she is considering requiring all residents to use the same pharmacy to reduce medication availability issues and ensure consistency in medication management.

This is a repeat violation from SIR 2026A0466014 dated 03/13/2026, in which a violation was established for failure to follow physician orders. In that investigation, prescribed hydration packets and Ensure supplements were not documented as administered on Resident A's MAR on 12/04/2025, 12/09/2025, 12/22/2025, 12/25/2025, 12/27/2025, 12/28/2025, 12/29/2025, 12/30/2025, and 12/31/2025. Ms. Alvarado submitted a *Corrective Action Plan* stating that Addie's Acres leadership would reinforce medication documentation during staff orientation and review documentation semi-annually with all current staff.

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:	Interviews were conducted with Complainant, direct care staff members Ms. Khalil, Ms. Falor, and Ms. Wells, Resident A, Resident C, and Resident D, Relative C1, and licensee designee Teresa Alvarado and the review of the May 2026 *Medication Administration Records* (MARs) for Residents A, B, and C. A detailed review of the MARs identified documentation errors and missing medications, demonstrating that residents were not consistently receiving medications as prescribed. Interviews confirmed that Resident C's medications were not consistently available due to delays in obtaining medications from an outside pharmacy.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SIR # 2026A0466014 DATED 03/13/2026. CAP COMPLETED.]**

ALLEGATION: Resident medications are not locked up securely and are left out accessible to residents.

INVESTIGATION:

On 05/28/2026 a complaint was received via Bureau of Community and Health Systems online complaint system with concerns that direct care staff members are not locking up resident medications and they are left out accessible to residents.

On 05/29/2026, I interviewed Complainant, who reported observing an inhaler left on a table on one occasion, stating that another resident could have accessed it.

On 05/29/2026, I interviewed direct care staff member Eva Khalil. Ms. Khalil reported she has never observed medications left unsecured, except for Tylenol that had previously been left on the counter. She stated there is a separate medication room that remains locked.

On 05/29/2026 I completed an unannounced on-site investigation at Addie's Acres and interviewed direct care staff member Ms. Wells. Ms. Wells reported that medications are stored in a dedicated medication room and a locked cupboard, and she has never observed medications left out or accessible to residents. I did not observe any unlocked medications that were accessible to residents.

While on-site, I interviewed licensee designee, Ms. Alvarado, by phone. She stated all medications are always locked and that she has never observed an inhaler or other medications left out. Ms. Alvarado stated all medications are required to stay in the locked cabinet at all times unless they are administered by the direct care staff members.

On 05/29/2026, I interviewed Resident A, Resident C, and Resident D. All three residents reported they had not observed medications left out in the facility. Resident C

reported that a long time ago she found a pill on the floor but immediately gave it to a direct care staff member.

On 06/16/2026, I interviewed Relative C1, who stated she has never observed medications left out and confirmed that medications are stored in a dedicated, locked room.

On 06/16/2026, I interviewed direct care staff member Trinity Falor. Ms. Falor stated she has never observed medications left unsecured and reported that all medications remain locked at all times.

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 interviews with staff members Ms. Khalil, Ms. Wells, and Ms. Falor, as well as licensee designee Ms. Alvarado, all reported that medications are stored in a locked medication room with secured cupboards and are not left accessible to residents. Residents A, B, and D also reported they had not observed unsecured medications. Although Complainant alleged seeing an inhaler left out on one occasion, no additional witnesses corroborated this claim, and no unsecured medications were observed during the on-site investigation. Relative C1 also confirmed that medications are kept locked.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident medications are thrown in the trash for disposal.

INVESTIGATION:

On 05/28/2026 a complaint was received via Bureau of Community and Health Systems online complaint system with concerns that resident medications are thrown in the trash for disposal.

On 05/29/2026, I completed an unannounced on-site investigation and I interviewed direct care staff member Ms. Wells. Ms. Wells stated that she disposes of medications by mixing them with coffee grounds prior to placing them in the trash. She reported that discontinued narcotic medications awaiting disposal are stored locked in Ms. Alvarado's office until Ms. Alvarado takes them to an authorized drop-off location. Ms. Wells also reported that, in the past, medications have been taken to the police department for proper disposal. Ms. Wells was able to show me a cabinet where they are stored securely.

On 05/29/2026, I also interviewed Resident A, Resident C, and Resident D. None of the residents were aware of how medications are disposed of and all denied ever seeing medications placed in the trash.

On 05/29/2026, I interviewed direct care staff member Ms. Khalil. Ms. Khalil reported that when narcotics need to be disposed of, they are given to Ms. Wells or, at times, collected by the Hospice RN. She stated that all medications at Addie's Acres are kept locked and that she is not directly involved in the disposal process.

On 06/16/2026, I interviewed direct care staff member Ms. Falor. Ms. Falor stated that when medications require disposal following a resident's passing, she refers the matter to Ms. Wells. Ms. Falor stated when there are Hospice comfort care medications for a resident then then Hospice will typically dispose of the medications after they are deceased. Ms. Falor stated most discontinued medications are non-narcotic prescriptions that simply run out.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident or expired must be properly disposed of.
ANALYSIS:	Based on interviews with direct care staff members Ms. Khalil, Ms. Wells, and Ms. Falor all reported that medication disposal procedures are followed and that medications remain secured until properly disposed of. Ms. Wells demonstrated the locked storage area where discontinued medications are kept until taken to an authorized drop-off location. Residents A, B, and C reported no concerns and indicated they have not observed medications disposed of improperly or placed in the trash.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

_____07/10/2026_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

07/10/2026

_____

Dawn N. Timm
Area Manager

Date