



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 11, 2026

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

RE: License #: AL090281510
Investigation #: 2026A0572046
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.
- 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) 643-7960.

Sincerely,

A handwritten signature in black ink that reads "Anthony Humphrey". The script is cursive and fluid, with the first name "Anthony" and last name "Humphrey" clearly legible.

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 #:	2026A0572046
Complaint Receipt Date:	07/29/2026
Investigation Initiation Date:	07/29/2026
Report Due Date:	09/27/2026
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 #:	(810) 299-1320
Original Issuance Date:	12/05/2007
License Status:	REGULAR
Effective Date:	06/07/2026
Expiration Date:	06/06/2028
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
An untrained staff member improperly managed Resident A's insulin, creating a serious risk of medication error and harm due to missing insulin, incorrect dosing guidance, and inadequate diabetic care.	No
Additional Findings	Yes

III. METHODOLOGY

07/29/2026	Special Investigation Intake 2026A0572046
07/29/2026	APS Referral Referral to APS.
07/29/2026	Special Investigation Initiated - Letter Complainant.
08/17/2026	Inspection Completed On-site Manager, Abbie Card; Manager, Hanna Beagle; Staff, Jayla Garrett; and Resident A.
09/10/2026	Contact – Telephone call made Staff, Brittany Beck
09/10/2026	Contact – Telephone call made Manager, Hanna Beagle
09/10/2026	Exit Conference Licensee Designee, Katie Edwards.

ALLEGATION:

An untrained staff member improperly managed Resident A's insulin, creating a serious risk of medication error and harm due to missing insulin, incorrect dosing guidance, and inadequate diabetic care.

INVESTIGATION:

On 07/29/2026, the local licensing office received a complaint for investigation. A referral will be made to Adult Protective Services (APS).

On 07/29/2026, contact was made with the Complainant. The Complainant initially called me directly and informed me of the concerns. The Complainant was then referred to online complaints in order to appropriately file a complaint.

On 08/17/2026, I made an unannounced onsite at Leighton House Inn, located in Bay County Michigan. Present for an interview were, Administrator, Abbie Card; Licensee Designee, Hanna Beagle; Staff, Jayla Garrett; and Resident A.

On 08/17/2026, I interviewed Manager, Abbie Card regarding the allegation. At the time of the incident, the insulin was supposedly on back order by previous manager, BreAnn DeBoer, but it was never ordered. Abbie Card is not sure how long they were without the insulin, if at all. Abbie Card indicated that Brittany Beck is fully trained on how to properly administer medications.

On 08/17/2026, I interviewed Manager, Hanna Beagle regarding the allegation. Hanna Beagle informed that she just started training for her current position and is kind of out of the loop, but will set up interviews with staff, Resident A, and gather documents for me.

On 08/17/2026, I interviewed Staff, Jayla Garrett regarding the allegation. Jayla Garrett informed that Resident A is on insulin and she was able to tell me the names of the insulin, when Resident A takes them, and the sliding scale. Staff Garrett informed that she heard that Resident A had run out of insulin, but she was not working at the time. According to Jayla Garrett, staff are responsible for ordering the medications and if they are unable to get them, they let the manager know who was BreAnn DeBoer at that time. Staff Garrett had informed BreAnn DeBoer well before they had run out of insulin, but it was never ordered. Staff can order refills from the E-Mars, but Jayla Garrett stated she usually would call the pharmacy directly just to make sure that it's ordered. According to Jayla Garrett, Brittany Beck is fully trained and has been employed for over a year. When Resident A goes on an outing with family, they give them the insulin pen, pen needles, alcohol swabs, lancets, test strips and glucose monitor and copy of units with sliding scale.

On 08/17/2026, I reviewed Staff, Brittany Beck's file. Brittany Beck's file indicates that she is fully trained in all caregiving responsibilities.

On 08/17/2026, I interviewed Resident A regarding the allegation. Resident A informed that staff administers her medications. She is doing well in the home and has no concerns. Staff make sure that she gets her insulin and always does checks to make sure of how much to give her. Resident A was in her bedroom at the time of the interview, sitting in recliner while watching tv and eating her lunch.

On 09/10/2026, I interviewed Staff, Brittany Beck regarding the allegation. Staff Beck informed that when she came on shift in the morning, Resident A's Family Member #1 came to pick her up, but she was out of insulin. Staff Beck was not aware of her being out because she did not work the previous day. Brittany Beck contacted the

previous Manager, BreAnn DeBoer and she informed her that they must be on back order. BreAnn told her that Resident A had her insulin the day before, so she had just run out. Brittany Beck stated that BreAnn DeBoer borrowed insulin from Turner House Inn so that Resident A could have some insulin to take with her. Brittany Beck was able to the name insulins that Resident A is on, the dosages and sliding scale. Brittany Beck stated that she is properly trained to administer medications. Brittany Beck indicated that Resident A's Family Member #1, very rudely stated, "Do you guys have monthly diabetic trainings?" Brittany Beck said that she informed her that they have monthly training on various topics, so no they do not have monthly diabetic training. Staff Beck believed this prompted the family to think that she did not have any diabetic training, because it's not done monthly. There was another issue that took place on 07/18/2026 in which she took Resident A's blood sugar, and the electronic MARs states to give 10 units regardless of the levels. Resident A's son, who is also diabetic, told her not to give her any insulin unless it was over 100. Brittany Beck showed the son what it says on the electronic MARs, so he knows that she was following what is prescribed. Brittany Beck then contacted Manager, BreAnn DeBoer and then the MARs were changed to reflect this.

On 09/10/2026, I contacted Licensee Designee, Katie Edwards regarding a question regarding the allegation. I wanted to know if it was possible for the electronic MARs to be changed so quickly after Staff, Brittany Beck shared with Manager, BreAnn DeBoer that the son did not want Resident A to be administered the 10 units unless it was over 100. Katie Edwards informed that they do have Team Health as their providers, which consists of a Medical Director and a Nurse Practitioner who are available by phone when not in-house. If there was a change, BreAnn DeBoer would have contacted one of them for that to be changed so quickly.

On 09/10/2026, I reviewed orders from 05/02/2026 and it states to inject 10 units subcutaneously with meals for diabetes mellitus. I then reviewed orders from 07/18/2026 and it states to inject 10 unit subcutaneously with meals for diabetes mellitus, hold if BG less than 100.

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 on my interview with staff and review of Resident A's file, there is not enough evidence to establish a licensing rules violation. According to staff and the records that I reviewed, Staff, Brittany Beck is trained to administer medications to

	residents. I also reviewed orders and Brittany Beck followed the orders in the electronic MARs.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

Resident A was out of insulin and Manager, BreAnn DeBoer borrowed some from the licensed rehabilitation center that shares the same physical location.

INVESTIGATION:

On 09/10/2026, I interviewed Staff, Brittany Beck regarding an allegation. She informed that when she came on shift in the morning, Resident A's Family Member #1 came to pick her up, but she was out of insulin. She was not aware of her being out because she did not work the previous day. Brittany Beck contacted the previous Manager, BreAnn DeBoer, and she informed her that they must be on back order. BreAnn told her that Resident A had her insulin the day before, so she had just run out. Brittany Beck says that BreAnn DeBoer borrowed insulin from Turner House Inn so that Resident A could have some insulin to take with her, so it wasn't missed.

On 08/17/2026, I reviewed Resident A's MARs. The MARs did not show any missed insulin injections.

On 09/10/2026, I held an exit conference with Licensee Designee, Katie Edwards regarding the results of the special investigation. Katie Edwards agreed that if medications were borrowed from another area and/or another resident, then it would be an adult foster care rule violation.

APPLICABLE RULE	
R 400.675	Resident medications.
	(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on my interview with Staff, and review of Resident A's file, there is enough to establish a licensing rules violation. Resident A was going on an outing with family but was out of insulin. Staff informed the Manager that Resident A was out of insulin, so some insulin was borrowed from the Turner House Inn Rehabilitation. In review of the records, there was no insulin missed during that time.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

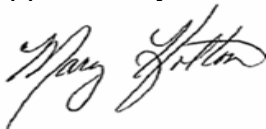


09/10/2026

Anthony Humphrey
Licensing Consultant

Date

Approved By:



09/11/2026

Mary E. Holton
Area Manager

Date