



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 17, 2026

Pamela Hurley
Innovative Lifestyles, Inc.
PO Box 1258
Clarkston, MI 48347

RE: License #: AS630074810
Investigation #: 2026A0605029
Kurtz Home

Dear Pamela Hurley:

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:

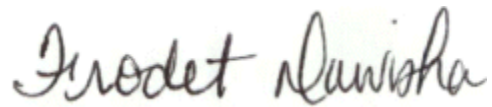
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

The issuance of a six-month provisional license was previously recommended in special investigation report #2026A0605018 dated 06/08/2026, which remains in effect. You submitted documentation agreeing to the issuance of a provisional license on 06/25/2026 and the 1st provisional was issued effective 06/25/2026.

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 (248) 972-9136.

Sincerely,

A handwritten signature in dark ink, reading "Frodet Dawisha". The signature is written in a cursive, flowing style. The word "Frodet" is written in a larger, more prominent script, while "Dawisha" follows in a similar but slightly smaller script. The ink is dark and the background is white.

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3044 W. Grand Blvd
2nd Floor Annex, Ste 2-730
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630074810
Investigation #:	2026A0605029
Complaint Receipt Date:	07/27/2026
Investigation Initiation Date:	07/27/2026
Report Due Date:	09/25/2026
Licensee Name:	Innovative Lifestyles, Inc.
Licensee Address:	Suite 1 5490 Dixie Hwy Waterford, MI 48329
Licensee Telephone #:	(248) 931-2061
Administrator/Licensee Designee:	Pamela Hurley
Name of Facility:	Kurtz Home
Facility Address:	1499 Kurtz Road Holly, MI 48442
Facility Telephone #:	(810) 373-6123
Original Issuance Date:	01/15/1997
License Status:	1ST PROVISIONAL
Effective Date:	06/25/2026
Expiration Date:	12/24/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 07/14/2026, Resident A's 12PM and 2PM medications were not passed as the pills were still in the blister pack.	Yes

III. METHODOLOGY

07/27/2026	Special Investigation Intake 2026A0605029
07/27/2026	Special Investigation Initiated - Letter Email to Oakland County Office of Recipient Rights (ORR) Katie Garcia
07/29/2026	Contact - Face to Face Attempted to conduct on-site investigation but no one was home
07/29/2026	Contact - Telephone call made With licensee designee Pamela Hurley regarding allegations
07/30/2026	Contact - Document Received Email from Pamela Hurley
08/11/2026	Inspection Completed On-site Conducted scheduled on-site investigation
08/25/2026	Contact - Telephone call made Discussed allegations with direct care staff (DCS)
09/08/2026	APS Referral Adult Protective Services (APS) referral was made
09/08/2026	Contact - Document Received APS denied the referral
09/08/2026	Contact – Telephone call made Discussed allegations with area supervisor Michelle Bailey, program director Tonya Tyree, and previous home manager Lashonda Marve

09/17/2026	Exit Conference Conducted exit conference with licensee designee Pam Hurley with my findings
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ALLEGATION:

On 07/14/2026, Resident A's 12PM and 2PM medications were not passed as the pills were still in the blister pack.

INVESTIGATION:

On 07/27/2026, intake #211709 was assigned for investigation based on an incident report (IR) submitted by Kurt Home regarding direct care staff (DCS) Jennifer Vilders did not administer medications to Resident A on 07/14/2026.

On 07/27/2026, I reviewed the IR dated 07/14/2026 completed by LaShonda Marve-Austin. According to the IR, LaShonda returned to work from being off for a couple of days and saw that the 12PM and 2PM medications were not administered for Resident A by DCS Jennifer Vilders. Jennifer called LaShonda stating that the medications were not passed so when LaShonda checked the blister packs, she discovered that Jennifer was correct and that Jennifer was the individual that should have passed the medications on 07/14/2026.

On 07/29/2026, I attempted an unannounced on-site visit, but no one was home.

On 07/29/2026, I contacted licensee designee Pamela Hurley who advised that the home manager LaShonda Marve was not home as she had taken the residents out. There are only two residents at this home. She will email me both their July 2026 medications logs and blister packs.

On 07/30/2026, I received an email from Pamela Hurley with both Resident A and Resident B July 2026 medication logs and pictures of their blister packs.

I reviewed Resident A's medication logs and pictures of his blister packs and found the following errors:

- **Phenytoin SOD Ext 100MG:** take one capsule three times a day was not administered at 12PM on 07/14/2026, but DCS initials JV (Jennifer Vilders) was on the medication log.
- **Divalproex SOD Dr 250MG:** take one tab by mouth three times per day was not administered at 2PM on 07/14/2026, but DCS initials JV (Jennifer Vilders) was on the medication log.
- **Acetaminophen 500 MG:** take two tablets by mouth three times a day was not administered at 2PM on 07/14/2026, but DCS initials JV (Jennifer Vilders) was on the medication log.

I reviewed Resident B's medication logs and there were no medication errors.

I also reviewed the in-service completed on 07/17/2026 with DCS Jennifer Vilders on medication administration based on the medication error on 07/14/2026 that was completed by Michelle Bailey, area supervisor.

On 08/11/2026, I conducted an on-site investigation at this group home. Present was current home manager Dosha Mitchell and DCS Brandon Wolverton. Dosha stated that LaShonda Marve-Austin was demoted from home manager as of 08/01/2026, Dosha has been the home manager of this home. She heard that DCS did not administer medications to Resident A, and because of that this DCS was written up and then sent to refresher medication training. There are currently four residents at this group home.

Resident A was sitting on the couch watching TV wrapped up in a blanket. He did not want to be interviewed.

Resident B was watching TV in his bedroom. He was interviewed regarding the allegations. He stated he always takes his medications and had no concerns to report.

Resident C was also watching TV, and he too did not want to be interviewed.

Resident D was sleeping during this visit.

I interviewed DCS Brandon Wolverton regarding the allegations. Brandon has been working for this corporation for about seven months. He does not know anything about Resident A's medications not being passed in July as he was not working for this home. He recently began working at this home on 08/01/2026. He had no information to provide regarding the allegations.

I reviewed all the residents' medications and saw that Brandon passed everyone's meds but had not initialed any of the medication logs. Brandon stated he became distracted by helping one of the residents, so I had him simulate a medication pass, which he did properly. He initialed the medication logs in front of me. Dosha agreed to complete an in-service with Brandon on initialing the medication logs at the time the medications were administered. She will email the in-service to me.

On 08/25/2026, I interviewed DCS Jennifer Vilders regarding the allegations. On 07/14/2026, Jennifer stated that she went to administer medications to Resident A and saw that a pill prior to 07/14/2026 was not passed, so she popped that pill out on 07/14/2026 and passed it to Resident A at 12PM and again at 2PM. She could not recall what date it was that the pill was in the blister pack she had popped out but stated she did not pop 07/14/2026 even though she administered Resident A's medications on that day. Jennifer denied she did not pass Resident A's medications on 07/14/2026 and stated, "I always pass medications to all the residents." She called the home manager LaShonda Marve-Austin and told her what happened that she went to pass Resident A's medications and did not pop the 14th pill out but instead popped out the pill of

another date. Jennifer has completed medication administration training and follows the six rights of medication administration. She always checks the blister pack to the residents' names and information twice, then pops the pill out of the blister pack after checking the label to the medication log, then she passes the medication to the resident, watches the resident take the medication and then initials the medication log. She will be going to refresher medication training tomorrow 08/26/2026.

On 09/08/2026, I interviewed previous home manager LaShonda Marve-Austin regarding the allegations. LaShonda stated after this medication error, she was removed as the home manager and Pamela Hurley brought in Dosha Mitchell as the new home manager. LaShonda stated that there were two days that Resident A's medications were not passed on 07/07/2026 12PM and on 07/14/2026 12PM and 2PM, both by DCS Jennifer Vilders. She took pictures of the blister pack showing that there was a pill in the blister pack on 07/07/2026 and texted me the picture. In addition, she was off from 07/14/2026-07/17/2026, so when she returned to work and was made aware of Resident A not receiving his medications again on 07/14/2026, she wrote an IR and reported this to management and that is when she was demoted. She was told that she should have been auditing the medication logs even when she was off, which she stated would have been impossible since she was not working.

On 09/08/2026, I interviewed Tonya Tyree, the program director, regarding the allegations. On 07/07/2026 and 07/14/2026, DCS Jennifer Vilders was working 8AM-4PM both days. She is the staff that did not administer the medications to Resident A. She was written up for this medication error and has been through refresher medication training. Tonya has been auditing the medication logs/medications so far and there have not been any errors.

On 09/08/2026, I interviewed Michelle Bailey, the area supervisor, regarding the allegations. Michelle was unaware of the medication not being passed on 07/07/2026 but was aware of the medication not being passed on 07/14/2026, which resulted in DCS Jennifer Vilders being written up and had to retake medication administration training. On a weekly basis, the program director Tonya Tyree has been conducting audits of all residents' medications and there has not been any errors thus far. They will continue to audit medications.

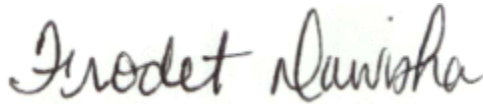
On 09/17/2026, I conducted the exit conference via telephone with licensee designee Pamela Hurley with my findings. Ms. Hurley stated that since this incident, they have been conducting medication audits weekly at this group home. Also, they have terminated DCS Jennifer Vilders and in-serviced all other staff on ensuring medication is being administered and initialed at the time of medication administration. She agreed to submit a corrective action plan.

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 on my investigation and review of Resident A's medications, Resident A was not administered his medications, Phenytoin SOD Ext 100MG (07/07/2026 at 12PM and on 07/14/2026 12PM and 2PM), Divalproex SOD Dr 250MG (07/14/2026 at 2PM), and Acetaminophen 500 MG (07/14/2026 at 2PM) as prescribed.
CONCLUSION:	VIOLATION ESTABLISHED

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: (b) Complete an individual medication log that contains all of the following: (v) Initials of the individual who administered the medication at the time given.
ANALYSIS:	Based on my investigation and review of Resident A's medications, DCS Jennifer Vilders initialed the medication log for Phenytoin SOD Ext 100MG (07/07/2026 at 12PM and on 07/14/2026 12PM and 2PM), Divalproex SOD Dr 250MG (07/14/2026 at 2PM), and Acetaminophen 500 MG (07/14/2026 at 2PM) when these medications were not administered to Resident A as they were still in their blister packs.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

I recommended the issuance of a 1st provisional license in special investigation report #2026A0605018, dated 06/08/2026. Contingent upon receiving an acceptable corrective action plan, the recommendation for a provisional license remains in effect.

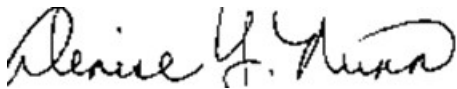


09/17/2026

Frodet Dawisha
Licensing Consultant

Date

Approved By:



09/17/2026

Denise Y. Nunn
Area Manager

Date