GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 15, 2025

Paul Wyman
Retirement Living Management of Mt. Pleasant
1845 Birmingham S.E.
Lowell, MI 49331

RE: License #: AM370379058
Investigation #: 2025A1029055
Green Acres of Mt. Pleasant IV

Dear Mr. Wyman:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated by the licensee designee

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. 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, 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 #:	AM370379058
Investigation #:	2025A1029055
Complaint Receipt Date:	08/26/2025
Investigation Initiation Date:	08/26/2025
Report Due Date:	10/25/2025
Licensee Name:	Retirement Living Management of Mt. Pleasant
LicenseeAddress:	1845 Birmingham S.E., Lowell, MI 49331
Licensee Telephone #:	(616) 897-8000
Administrator:	Paul Wyman
Licensee Designee:	Paul Wyman
Name of Facility:	Green Acres of Mt. Pleasant IV
Facility Address:	1809 E. Remus Road, Mt. Pleasant, MI 48858
Facility Telephone #:	(989) 772-3456
Original Issuance Date:	07/29/2016
License Status:	REGULAR
Effective Date:	01/29/2025
Expiration Date:	01/28/2027
Capacity:	12
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 08/15/2025 direct care staff member Tessa Myers administered liquid Ipratr-Albuterol 0.5mg/3ml solution orally to Resident A and Resident B instead of through a nebulizer.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/26/2025	Special Investigation Intake 2025A1029055
08/26/2025	Special Investigation Initiated – Email to Janelle Baldwin
08/26/2025	APS Referral – APS A. Witucki is already investigating the concerns.
08/26/2025	Contact - Telephone call received from APS Witucki
09/03/2025	Contact - Telephone call made to direct care staff members Tessa Myers (left message) and Anna Kwiecinski
09/04/2025	Contact - Telephone call received from APS Witucki
09/08/2025	Inspection Completed On-site - Face to Face with administrator, Janelle Baldwin and RN Jennifer Guthrie at Green Acres of Mt. Pleasant IV
09/11/2025	Contact - Telephone call made to direct care staff member Tessa Myers
09/16/2025	Contact - Telephone call made to direct care staff member Michelle Parker
09/17/2025	Contact - Document Received - email from Ms. Onweller
09/26/2025	Contact - Telephone call to direct care staff members Josephina Guilds, Gabby Brittain, and licensee designee Paul Wyman
10/07/2025	Contact - Text message received from Ms. Parker.
10/09/2025	Contact – Telephone call to Kathy Onweller, licensee designee Paul Wyman, Alison Witucki
10/14/2025	Exit conference with licensee designee Paul Wyman.

ALLEGATION: On 08/15/2025 direct care staff member Tessa Myers administered liquid Ipratr-Albuterol 0.5mg/3ml solution orally to Resident A and Resident B instead of through a nebulizer.

INVESTIGATION:

On 08/26/2025 a complaint was entered due to a self-reported medication error from Green Acres of Mt. Pleasant IV Regional Consultant Kathy Onweller and administrator, Janelle Baldwin. Ms. Onweller contacted me and informed me on 08/15/2025 direct care staff member Tessa Myers administered liquid Ipratr-Albuterol 0.5mg/3ml solution orally to Resident A and Resident B instead of through a nebulizer. Isabella County Adult Protective Services (APS) Ms. Witucki is also investigating these concerns.

On 08/28/2025 I received a telephone call from APS Ms. Witucki who stated she has an open investigation regarding these concerns. Ms. Witucki stated she is aware that Resident A and Resident B both received their albuterol orally instead of through the nebulizer as prescribed. Ms. Witucki stated she attempted to see Resident B on 08/27/2025 and was notified by Ms. Baldwin that she passed away on 08/24/2025. Ms. Witucki stated direct care staff member Ms. Myers was a new employee as of 08/12/2025 and was not proficient in medications after a couple days of medication training before she was sent to administer medications on her own. Ms. Witucki stated at this point Ms. Myers had only observed the albuterol being administered one time. Ms. Witucki stated Ms. Myers informed her she did not know until a week later what occurred after speaking with direct care staff member Gabby Brittain who informed Ms. Myers that she made an error. Ms. Brittain then informed another unknown direct care staff member who notified administrator Ms. Baldwin. Ms. Witucki stated both residents were receiving hospice services.

On 09/03/2025 I interviewed direct care staff member Anna Kwiecinski. Ms. Kwiecinski stated she was informed of this incident after Resident A passed through third hand information that on 08/15/2025 Resident A and Resident B had albuterol poured into their mouths instead of administered through the nebulizer. Ms. Kwiecinski stated she spoke with Ms. Brittain about these concerns on 08/22/2025 and the concerns were reported to administration at that time.

On 09/08/2025 I completed an unannounced on-site investigation at Green Acres of Mt. Pleasant IV and interviewed administrator, Janelle Baldwin. Ms. Baldwin stated Ms. Myers started her employment on 8/11/2025 and the first date working with residents was 08/13/2025. Ms. Baldwin stated on her second day, 08/15/2025 Ms. Myers was administering medications and she made the error of administering albuterol orally instead of through the nebulizer for Resident A and Resident B. Ms. Baldwin stated she is the one who made the decision Ms. Myers could administer medications on 08/15/2025 despite having one day of medication training and no prior experience as a direct care staff member because she did not realize she did not have prior experience until the investigation started. Ms. Baldwin stated she was informed by the previous home manager, Ms. Parker that Ms. Myers had prior experience. Ms. Baldwin stated

she could not recall if another direct care staff member had called in but stated she made the decision stating "if she's comfortable then she can do meds". Ms. Baldwin stated she was also there until 8 PM on 08/15/2025 and Ms. Myers called her with some other medication questions but not regarding albuterol. Ms. Baldwin stated she realized after the investigation started that Ms. Myers only had two days shadowing Ms. Brittain and Ms. Guilds and that she had never administered medications independently. Ms. Baldwin stated after she found out about the error a week later on 08/22/2025, Ms. Myers was removed from administering medications at that time. Ms. Baldwin stated on the Medication Administration Record (MAR) it documented that the albuterol was supposed to be given through the nebulizer and I confirmed this by reviewing the August 2025 MAR for Resident A and Resident B. Ms. Baldwin stated Ms. Myers informed her she did not realize that she made an error until she was speaking with Ms. Brittain about it on 08/22/2025. Ms. Baldwin stated another direct care staff member reported it to her and she did not receive the information first hand from Ms. Myers until she spoke with her. Ms. Baldwin stated both Resident A and Resident B were receiving Hospice services and both residents passed away within a week of this incident. Ms. Baldwin stated neither family requested an autopsy but that RN Guthrie and Regional Manager spoke with the coroner Michelle Fox, D-ABMDI who did not have concerns this error contributed to either resident's death.

On 9/8/2025 I interviewed RN Jennifer Guthrie. RN Guthrie stated she was informed on 08/22/2025 that there were medication errors for Resident A and Resident B because Ms. Myers did not use the nebulizer for albuterol rather the albuterol was administered orally. RN Guthrie stated after this incident she observed Resident A and Resident B and did not notice any change in either Resident A or Resident B's condition. RN Guthrie stated both residents were receiving visits from hospice during this time. RN Guthrie stated she is the coordinator for health needs of the facility but was not working on the day of this incident and did not find out about the error until a week later when an unknown direct care staff member reported it to her. RN Guthrie stated this concern was not first hand so she instructed the staff member to report the concerns to Ms. Baldwin. RN Guthrie stated on 08/25/2025 she discussed concerns with Ms. Baldwin and she confirmed the error did occur.

During the on-site investigation, I received the following documentation:

- *AFC Incident / Accident Report* for Resident A
    - Explain what happened: Upon investigation, on 08/25/2025 employee Tessa Myers states she administered albuterol .5 - 3 mg/ 3 ml solution orally instead of via nebulizer.
    - Action taken by staff: Above medication error was not reported until 08/22/2025. [Resident A] passed away under Hospice care on 08/21/2025.
    - Corrective measures taken to remedy and or prevent recurrence: Employee was removed from medication administration duties on 08/22/2025 when alleged medication error was reported to administrator. Employee states package said to give orally. Packaging of vials state "for

oral inhalation only". Employee removed from medication administration duties on 08/22/2025.

- *Medication error discrepancy report* - Resident B was given medication via the wrong route because an investigation dated 8/25/25 found employee stated albuterol solution was given orally versus via nebulizer as prescribed. Ms. Baldwin was notified on 08/22/2025. Provider was notified from Care Team Hospice on 8/25/25. Designated representative / guardian notified 08/25/2025 approximately 3:00 PM.
- Resident A and Resident B's August 2025 MAR which includes the following Ipratr / Albuterol. Instill 3 ml vial via nebulizer three times daily for SOB.

On 09/11/2025 I interviewed direct care staff member Ms. Myers. Ms. Myers stated that she was on her third day of work on 08/15/2025 after two days of shadowing other direct care staff members administer medications, she was assigned to administer medications by Ms. Baldwin. Ms. Myers stated she gave Resident A and Resident B the albuterol incorrectly because she remembered it was taken orally so she had them drink it. Ms. Myers stated she did not remember it was supposed to be through the nebulizer. Ms. Myers stated the first day she was shadowing, she observed Ms. Brittain do this but when it was time to do this, she did not remember about the nebulizer. Ms. Myers stated she did not tell Ms. Baldwin she wasn't comfortable with medications yet because she was worried about her job and she felt like she did not have a choice because they did not have anyone else. Ms. Myers stated she now knows that they would have figured out something else and assigned someone else to administer medications. Ms. Myers stated she did not realize initially she made an error but a few days later she was discussing the medications with direct care staff member Ms. Brittain who informed her she did it wrong. Ms. Myers stated even after realizing this she still did not inform Ms. Baldwin of the error but another direct care staff member Ms. Davis was informed by Ms. Brittain and she notified Ms. Baldwin. Ms. Myers stated she admitted to the medication error on 08/22/2025 to Ms. Baldwin.

On 09/26/2025 I interviewed direct care staff member Gabby Brittain. Ms. Brittain stated both Resident A and Resident B were prescribed to receive albuterol with the nebulizer which was how she trained Ms. Myers to administer the medication while shadowing. Ms. Brittain stated she showed her how to put the albuterol in the nebulizer machine and to have the residents breathe it in for ten minutes. Ms. Brittain stated she trained Ms. Myers on this process one time. Ms. Brittain stated Ms. Myers was brand new and may not have retained it because there was so much to learn. Ms. Brittain stated when she started her employment she was a direct care staff member and then worked her way up to medications but they did not do this with Ms. Myers. Ms. Brittain stated after the incident both Resident A and Resident B seemed to act the same however there health was declining and hospice was involved. Ms. Brittain stated she did not tell management about this but instead she told another direct care staff member Jen Davis who then told Ms. Baldwin on 08/22/2025.

On 09/26/2025 I interviewed licensee designee Paul Wyman. Mr. Wyman stated he was aware of the medication error where Resident A and Resident B received their

albuterol orally instead of through the nebulizer. Mr. Wyman stated due to this medication error caused by Ms. Myers which has prompted him to revamp the training process companywide to make sure there is enough medication training before direct care staff members administered medications.

On 10/09/2025 I interviewed APS Witucki and she stated she substantiated for the medication errors for Resident A and Resident B. Ms. Witucki stated when she spoke to Ms. Baldwin she was also informed they were going to revamp their training process moving forward. Ms. Witucki stated Ms. Baldwin was also labeled as a perpetrator on the APS case for neglect because she made the decision to have Ms. Myers administering medications without adequate training.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 08/15/2025 Both Resident A and Resident B were administered their albuterol solution using the incorrect route after direct care staff member Ms. Myers administered the albuterol to Resident A and Resident B orally by pouring it into their mouth to drink instead of via nebulizer as prescribed. Ms. Baldwin completed an *AFC Incident / Accident Report* and *Medication Error / Discrepancy report* on the incident once she was notified on 08/22/2025. Ms. Myers stated she was shown how to do this via the nebulizer but forgot at the time of administering the medication which led to her making the error. Ms. Myers did not realize she made this error until she was discussing this with another direct care staff member Ms. Brittain.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 09/08/2025 I completed an unannounced onsite investigation at Green Acres of Mt. Pleasant IV and interviewed administrator, Janelle Baldwin. Ms. Baldwin stated Ms. Myers started her employment on 08/11/2025 and the first date working was 08/13/2025. This error occurred on her second day, 08/15/2025 and there was no one shadowing her because she was administering medications independently. Ms. Baldwin stated before this occurred they were supposed to have at least three days shadowing a direct care staff member experienced in medication administration. Ms. Baldwin stated a shorter time shadowing was approved if that employee had previous medication administration experience. Ms. Baldwin stated this is what occurred with Ms. Myers however she did not have prior experience, which she did not realize until after the error

occurred. Ms. Baldwin stated Ms. Myers should not have been allowed to administer medications independently because her previous position was retail and she did not have prior experience. Ms. Baldwin stated she made the decision that "if she's comfortable then she can do meds" and was here until 8 PM In case she had questions. Ms. Baldwin stated when the investigation started, that is when she realized Ms. Myers only had two days of training before administering the medications alone, which she confirmed was not enough. Ms. Baldwin had no documentation other than the days listed on the staffing schedule with "Tr (for training) written in that Ms. Myers had been trained. There was no documentation for Ms. Myers medication administration training and her orientation checklist and medication administration training was dated 08/16/2025.

On 09/08/2025 I interviewed RN Jennifer Guthrie. RN Guthrie stated she's not in charge of the medication administration training because once a new direct care staff member starts they are trained with an experienced direct care staff member. RN Guthrie stated she does not know what part of the training teaches about using the nebulizer for albuterol. RN Guthrie stated as a result of this error the training process is going to change and now the new direct care staff members are required to have thirty days on the floor working as a direct care staff member, five days with someone in each building, and then they have a medication observation checklist which will be completed. RN Guthrie stated there will also be a medication administration test and they will continue to have ongoing medication training such as the one coming up with Hometown Pharmacy on 9/18/2025.

During the on-site investigation, I received the following documentation:

- *Orientation List for Medications* showing Ms. Myers was trained in preparation and distribution of medications on 08/16/2025.

On 09/11/2025 I interviewed Ms. Myers who stated she did not feel like she was proficient in administering medications when this incident occurred because she only shadowed two times and it was only her third day working when this occurred. Ms. Myers stated she did not sign off on medication administration training until 08/16/2025.

On 09/26/2025 I interviewed licensee designee Paul Wyman. Mr. Wyman stated they are revamping the training policies companywide as a result of this error.

On 10/09/2025 I spoke to Ms. Onweller who stated there was a meeting with administrators to determine what the training requirement should be for administering medications because they are going to revamp their training policies. Ms. Onweller stated she does have some direct care staff members who do not administer medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (a) Be trained in the proper handling and administration of medication.
ANALYSIS:	Ms. Myers was not trained in medication administration adequately before this error occurred. I was able to review her training record showing she was trained on medication administration on 08/16/2025 and this error occurred on 08/15/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Jennifer Browning _____10/14/2025_____

Jennifer Browning
Licensing Consultant
Date

Approved By:

Dawn Timm 10/15/2025

_____

Dawn N. Timm
Area Manager
Date