GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 29, 2020

Shelley Langley
2875 E Richardson Rd
Bad Axe, MI 48413

RE: License #: AM320275971
Investigation #: 2020A0871046
Shady Acres Assisted Living

Dear Mrs. Langley:

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 (989) 732-8062.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM320275971
Investigation #:	2020A0871046
Complaint Receipt Date:	09/11/2020
Investigation Initiation Date:	09/15/2020
Report Due Date:	11/10/2020
Licensee Name:	Shelley Langley
Licensee Address:	2875 E Richardson Rd Bad Axe, MI 48413
Licensee Telephone #:	(989) 269-7658
Administrator:	Shelley Langley
Licensee Designee:	N/A
Name of Facility:	Shady Acres Assisted Living
Facility Address:	2875 E Richardson Bad Axe, MI 48413
Facility Telephone #:	(989) 269-7658
Original Issuance Date:	03/09/2006
License Status:	REGULAR
Effective Date:	10/01/2020
Expiration Date:	09/30/2022
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED

II. ALLEGATION(S)

	Violation Established?
On 09/09/2020, Resident A did not get her pills the night before. Resident A's physician stated it was ordered and the pharmacy indicated 30 tables were delivered on 08/08/2020. It is unknown where the pills went and why they were not available.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/11/2020	Special Investigation Intake 2020A0871046
09/15/2020	Special Investigation Initiated - Telephone Telephone contact with Household Member Kevin Langley
10/16/2020	Inspection Completed On-site Interviewed Licensee Shelly Langley
10/16/2020	Contact - Document Received Received outing log that indicates Resident A was not in the facility in September 2020
10/16/2020	Contact - Document Received Received text message of September 2020's Outing Log
10/19/2020	APS Referral Adult Protective Services (APS referral) through Central Intake to Huron County MDHHS
10/27/2020	Inspection Completed-BCAL Sub. Compliance
10/27/2020	Exit Conference Telephone exit conference with Licensee Shelly Langley

ALLEGATION:

On 09/09/2020, Resident A did not get her pills the night before. Resident A's physician stated it was ordered and the pharmacy indicated 30 tables were delivered on 08/08/2020. It is unknown where the pills went and why they were not available.

INVESTIGATION:

On September 15, 2020, I telephoned Household Member Kevin Langley. Mr. Langley said Resident A's pills come in packets from the pharmacy. Mr. Langley indicated when Resident A left for a few days, she came back with all the pills. Resident A came back on a Tuesday and did not have pills for Wednesday morning.

On October 16, 2020, I conducted an unannounced onsite investigation and interviewed Licensee Shelly Langley. Ms. Langley stated all the medications are delivered on Thursday and Resident A usually goes with a family member for the weekends. Ms. Langley stated when Resident A came back, "none of her pills were popped for seven days." Ms. Langley stated she came back on Wednesday and she should have had enough meds for Wednesday evening and Thursday morning because none of the pills had been popped out.

Ms. Langley said Resident A had a PRN that was discontinued by Huron Behavioral Health Systems. Ms. Langley indicated if a medication is discontinued, it is sent back to the pharmacy. Resident A did not have PRN in the facility.

Ms. Langley said Resident A came back to the facility on September 2, 2020 "to get her stuff." Resident A "did not live here" and was moving out. Ms. Langley stated that on September 2, 2020, she told Resident A's relative to go to the pharmacy to get Resident A's medications and they were "not in my possession." Ms. Langley said no meds were passed to Resident A in September. The last time Ms. Langley saw Resident A was on September 2, 2020 and she spent September with a family member.

On October 16, 2020, I asked Ms. Langley for the August and September *Medication Administration Records* for Resident A. I observed Resident A's *Medication Administration Record* for August and observed that Resident A received her meds through August 25, 2020. The *Medication Administration Record* for September 2020 was not initialed as given and was totally blank. Ms. Langley could not provide a *Medication Administration Record* for the dates August 26 through August 31, 2020.

I also asked Ms. Langley for a copy of the *Resident Register* to see when Resident A moved out of the facility. Ms. Langley did not have the date when Resident A moved out of the facility.

On October 27, 2020, I conducted a telephone exit conference with License Shelly Langley. I advised her what rules she had violated.

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: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Licensee Shelly Langley could not provide Resident A's *Medication Administration Record* from August 26 through August 31, 2020. It is unknown if Resident A received her medications. There is sufficient information to confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14210	**Resident register.**
	A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: **(b) Date of discharge.**
ANALYSIS:	Licensee Shelly Langley did not have the date of discharge for Resident A. There is sufficient evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

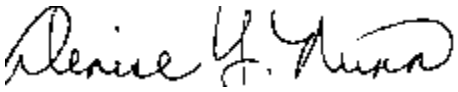
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care medium group home remain unchanged (capacity 1-12).

10/29/2020

Kathryn A. Huber — Date
Licensing Consultant

Approved By:



10/29/2020

Denise Y. Nunn — Date
Area Manager