GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 19, 2022

Jeffrey Shepard
Elder Ridge Manor II, LLC
PO Box 518
Stockbridge, MI 49285

RE: License #: AL330380274
Investigation #: 2022A0584004
Elder Ridge Manor II, LLC

Dear Mr. Shepard:

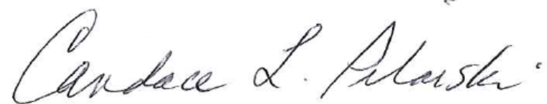
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,



Candace Pilarski, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-8967

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330380274
Investigation #:	2022A0584004
Complaint Receipt Date:	11/23/2021
Investigation Initiation Date:	11/24/2021
Report Due Date:	01/22/2022
Licensee Name:	Elder Ridge Manor II, LLC
Licensee Address:	4101 Oakley Road Stockbridge, MI 49285
Licensee Telephone #:	(517) 851-7501
Administrator:	Jenny Flores
Licensee Designee:	Jeffrey Shepard
Name of Facility:	Elder Ridge Manor II, LLC
Facility Address:	4101 Oakley Road Stockbridge, MI 49285
Facility Telephone #:	(517) 851-7501
Original Issuance Date:	04/06/2017
License **Status:**	REGULAR
Effective Date:	10/05/2021
Expiration Date:	10/04/2023
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Concern owner has been giving Resident A Ativan from another resident's expired script.	Yes

III. METHODOLOGY

11/23/2021	Special Investigation Intake 2022A0584004
11/24/2021	Special Investigation Initiated - Telephone With Gene Mellen, Ingham County DHHS, Adult Protective Services worker
11/24/2021	APS Referral Gene Mellen stated he received an APS referral of the allegations
12/03/2021	Contact - Document Sent Email to Jenny Flores, administrator
12/27/2021	Contact - Face to Face With Jeff Shepard, Licensee Designee
12/27/2021	Exit Conference Face to face with Jeff Shepard, licensee designee
12/27/2021	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Concern owner has been giving Resident A Ativan from another resident's expired script.

INVESTIGATION:

On 11/24/2021, Sabrina McGowan, licensing consultant, contacted Gene Mellen, Adult Protective Services worker from the Ingham County Department of Health and Human Services. Ms. McGowan stated that Mr. Mellen told her that he did receive a referral regarding Resident A at the facility receiving expired medication. Ms. McGowan stated Mr. Mellen interviewed licensee designee, Jeffrey Shepard regarding the allegation. Ms. McGowan stated Mr. Mellen told her he would not be

substantiating any allegations due to Resident A not being harmed and the medication that was given was the same dose and strength as the medication Resident A should be taking.

On 12/27/2021, I conducted a face-to-face interview with Jeffrey Shepard, licensee designee for Elder Ridge home. Mr. Shepard stated Resident A is a relative of the family and currently receiving services from PACE. Mr. Shepard stated Resident A is visited by an assigned nurse from PACE who is responsible for renewing and ordering medications. Mr. Shepard stated the assigned nurse is also responsible for agreeing to medication changes. Mr. Shepard stated Resident A had a severe behavior that caused him to be sent to Sparrow Hospital for evaluation during last summer. Mr. Shepard stated while Resident A was at Sparrow Hospital, the doctors there prescribed a medication called Risperidone. Mr. Shepard stated for the 10 weeks Resident A was on Risperidone, he was basically falling asleep all day, would not eat and lost 50 pounds of weight. Mr. Shepard said that during this time, there was a change in the psychiatric doctors at PACE and he reported to the assigned nurse that he was instructed by the guardian to stop the medication since it was causing the severe lethargy and weight loss. Mr. Shepard stopped the medication per the guardian's orders and said the PACE nurse was not in agreement with that change despite the major physical changes reported and exhibited by Resident A while on Risperidone. Mr. Shepard stated the guardian "refused" the medication on Resident A's behalf and the guardian called the nurse to inform her they were going to cease. Mr. Shepard stated this was done after a couple of months of communicating with PACE and "begging" them to discontinue the Risperidone for Resident A due to the adverse effects it caused. Mr. Shepard said that Resident A's mental health and behavioral issues still needed to have some sort of medical help so the after a visit with the new PACE psychiatrist, Resident A was prescribed Lorazepam as a PRN. Mr. Shepard said that after Risperidone was stopped, Resident A was returning to his old self, able to ambulate and communicate without issues.

Mr. Shepard said there has been a history of medication counts and errors from delivery of the medications for the PACE recipients. Mr. Shepard stated that sometimes, resident medication was sent in 15 day supply and other times in 30 day supply. Mr. Shepard reported that issue as well, but it was not corrected. Mr. Shepard said in November 2021, Resident A's Lorazepam was starting to get low and he informed the assigned nurse on four different occasions that the medication required a reorder. Mr. Shepard stated the assigned nurse told him each time the medication was ordered and would be arriving within a few days. Mr. Shepard said the assigned PACE nurse visited Resident A every Thursday where she was informed face-to-face the medication did not arrive and more medication was needed. Mr. Shepard also stated he had two text messages that he sent in two weeks (the last one being around November 22, 2022) reporting that Resident A's medication was not received and more was needed. Mr. Shepard said that he told the assigned nurse that he needed a new prescription for Resident A's Lorazepam medication because in over two weeks the medication has not arrived even though

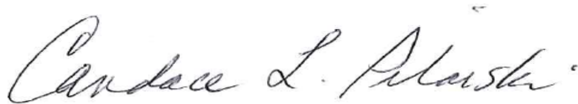
the nurse told him it was ordered.   Mr. Shepard said the nurse told him she would fax over a prescription but he did not receive it. Mr. Shepard stated he did have some extra pills of Lorazepam in the same dosage strength that was left over for from another resident that he had not destroyed. Mr. Shepard said Resident A was exhibiting a behaviors indicative of negative episode so Mr. Shepard decided to use the other resident's Lorazepam medication for Resident A.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions. **(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:** **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.** **(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.** **(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.**

NALYSIS:	Licensee designee Jeffrey Shepard knowingly dispensed another resident's Lorazepam medication to Resident A. Mr. Shepard did not take any reasonable precaution to ensure this prescription medication was not used by a resident for whom it was not prescribed. Licensee designee Jeffrey Shepard also discontinued Resident A's Risperidone medication without a physician's order. Consequently, Mr. Shepard did not dispense this medication per the label instructions and Mr. Shepard also modified the prescription without a physician's order. Lastly, Mr. Shepard did not properly dispose of the previous resident's Lorazepam medication after it was no longer required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receiving an acceptable corrective action plan, I recommend no change in the status of this license.



1/10/2022

Candace Pilarski Date
Licensing Consultant

Approved By:

01/19/2022

Dawn N. Timm Date
Area Manager