GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 24, 2025

Therese Fulgham
Sensations
511 E. Shepherd
Charlotte, MI 48813

RE: License #: AH230303551
Investigation #: 2025A1021041
Sensations

Dear Therese Fulgham:

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 authorized representative 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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 4890

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH230303551
Investigation #:	2025A1021041
Complaint Receipt Date:	02/28/2025
Investigation Initiation Date:	03/04/2025
Report Due Date:	04/30/2025
Licensee Name:	AWL Companies LLC
Licensee Address:	511 E.Shepherd Street Charlotte, MI 48813
Licensee Telephone #:	(520) 307-1196
Administrator/ Authorized Representative:	Therese Fulgham
Name of Facility:	Sensations
Facility Address:	511 E. Shepherd Charlotte, MI 48813
Facility Telephone #:	(517) 543-8101
Original Issuance Date:	03/03/2011
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	39
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A ran out of medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/28/2025	Special Investigation Intake 2025A1021041
03/04/2025	Special Investigation Initiation-On Site
03/24/2025	Exit Conference

ALLEGATION:

Resident A ran out of medication.

INVESTIGATION:

On 02/28/2025, the licensing department received an anonymous complaint with allegations Resident A ran out of medication. The complainant alleged staff person 1 (SP1) received the medication on 02/14/2025, put the medication in a locked drawer, and did not notify staff the medication was received from the pharmacy. The complainant alleged Resident A ran out of the medication for 48 hours.

On 03/04/2025, I interviewed authorized representative Therese Fulgham at the facility. Authorized representative reported to her knowledge; that SP1 was getting ready to leave for the weekend and put the medication in a locked drawer. Authorized representative reported staff members did not know the medication was in the locked drawer and could not administer the medication. Authorized representative reported on Monday, staff members notified management, and the medication was found and administered to Resident A. Authorized representative reported she is on call 24/7 and no staff members contacted her or SP1 about the missed medications. Authorized representative reported when there is a missed medication, staff members can call the pharmacy, the hospice company, or management to inquiry about the medication. SP1 reported that she is not certain if the hospice or the pharmacy were contacted. Authorized representative reported all medication technicians can input medications when medications are delivered by the pharmacy.

On 03/04/2025, I interviewed SP1 at the facility. SP1 reported on 02/14/2025, pharmacy delivered the medication to the facility at approximately 5:00pm, which is late for a delivery. SP1 reported she did not know that Resident A needed the medications, and she placed the medications in the locked drawer in her office. SP1 reported she is on call 24/7 and no staff members called her to inquire about the medication. SP1 reported on 02/17/2025, when she arrived at work, staff members inquired about the medication and the medication was able to be administered. SP1 reported if there is a missing medication, staff members can call the pharmacy, the hospice company, or management to inquire about the medication. SP1 reported she is not certain if anyone was contacted.

On 03/04/2025, I interviewed SP2 at the facility. SP2 reported Resident A was scheduled Haldol for anxiety. SP2 reported Resident A had recently switched to this medication from Ativan. SP2 reported Resident A's hospice company called in a new prescription as the prescription had no refills on it. SP2 reported on 02/14-02/17, the facility did not have the Haldol medication. SP2 reported hospice was contacted to inquiry about the medication. SP2 reported the hospice company authorized the facility to switch the order to Ativan as the facility had a stock of Ativan for Resident A. SP2 reported Resident A was very anxious the entire weekend. SP2 reported on 02/17/2025, SP1 was questioned about the medication, and it was found to be placed in a locked drawer. SP2 reported there is no policy in place when medication is not available. SP2 reported that the pharmacy, hospice, or management can be contacted.

On 03/04/2025, I interviewed Elara Care hospice nurse Emily Stock at the facility. Ms. Stock reported Haldol was ordered on 02/14/2025. Ms. Stock reported the facility contacted the on-call nurse on 02/17/2025 at 2:37am inquiring about the prescription. Ms. Stock reported the on-call nurse authorized the facility to administer Ativan until the Haldol medication was received. Ms. Stock reported typically the on-call nurse can check the pharmacy delivery status, however, the call came in when the pharmacy was closed. Ms. Stock reported later in the day on 2/17/2025, she learned of the situation and the medication was found to be placed in a locked drawer.

I reviewed facility documentation for Resident A. The documentation read,

"Spoke with Elara caring triage nurse Shawnaci over the phone. She has requested an emergency fill on (Resident A)'s Haldol. She has instructed me to pass the one tablet that is left for her 3:30pm passing and hopes the refill will be here by 7:30pm passing.
Called hospice spoke with Melissa RN to activate Ativan 0.5mg 2 tabs every 4hrs prn to see if that helps calm her nerves any. She has been up quite a bit, screaming as loud as possible and very demanding more than usual."

I reviewed Resident A's medication administration record (MAR). The MAR revealed Resident A was prescribed Haldol 1mg with instructions to administer one tablet

every four hours. The MAR revealed Resident A did not receive this medicaiton on 02/16/2025 at 7:30pm, 02/17/2025 at 12:15am, 3:30am, 7:30am.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Interviews conducted and review of documentation revealed Resident A did not receive Haldol 1mg medication as prescribed on 02/16/2025-02/17/2025 even though the medication was in the possession of the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

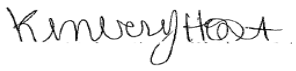
INVESTIGATION:

Interviews conducted with authorized representative, SP1 and SP2 revealed the facility does not have a policy for staff to follow when a resident runs out of medication.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Review of facility policies revealed the facility does not have a policy for staff members to follow when a resident runs out of medications. There is no clear direction on the appropriate person to contact or the appropriate procedure to follow.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



03/05/2025

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Kimberly Horst Date
Licensing Staff

Approved By:

03/21/2025

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section