

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA DIRECTOR

May 8, 2025

Aerica Swanson-Hurt Unforgettable Memory Care 5504 New Meadow Dr Ypsilanti, MI 48197

> RE: License #: AS810405517 Investigation #: 2025A0575031

> > **Unforgettable Memory Care**

Dear Ms. Swanson-Hurt:

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.

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) 284-9720.

Sincerely,

Jeffrey J. Bozsik, Licensing Consultant

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Bureau of Community and Health Systems

(734) 417-4277

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

I. IDENTIFYING INFORMATION

License #:	AS810405517
Investigation #:	2025A0575031
Complaint Receipt Date:	04/29/2025
Complaint Receipt Bate.	0-1/20/2020
Investigation Initiation Date:	04/29/2025
Report Due Date:	05/29/2025
Licensee Name:	Unforgettable Memory Care
Licensee Address:	5504 New Meadow Dr Ypsilanti, MI 48197
Licensee Telephone #:	(734) 657-0802
Administrator:	Aerica Swanson-Hurt
Licensee Designee:	Aerica Swanson-Hurt
Name of Facility:	Unforgettable Memory Care
Facility Address:	5504 New Meadow Dr Ypsilanti, MI 48197
Facility Telephone #:	(734) 657-0802
Original Issuance Date:	05/03/2022
License Status:	REGULAR
Effective Date:	05/03/2023
Expiration Date:	05/02/2025
Capacity:	6
Program Type:	AGED; ALZHEIMERS

II. ALLEGATION(S)

Violation Established?

The medication(s) for Residents A and B are not being given properly.	Yes
The medication administration records for Residents A and B are not properly recorded.	Yes
Resident A's medication was not provided to day program staff.	Yes

III. METHODOLOGY

04/29/2025	Special Investigation Intake-2025A0575031
04/29/2025	Special Investigation Initiated – Telephone with complainant
04/29/2025	APS Referral
04/30/2025	Contact - Telephone call made-(a) complainant; (b) Rosalyn Otting, Hometown Pharmacy Pharmacist
04/30/2025	Inspection Completed- On-site-interviews with: (a) Aerica Swanson-Hurt; (b) Resident B
04/30/2025	Inspection Completed-BCAL Sub. Compliance
04/30/2025	Corrective Action Plan Requested and Due
04/30/2025	Exit Conference with Aerica Swanson-Hurt
05/02/2025	Contact- Document received-complainant information about Resident B

ALLEGATION:

The medication(s) for Residents A and B are not being given properly.

INVESTIGATION:

On 04/29/2025, an APS referral was received.

Resident A, who has no guardian, was not interviewed because he was out of the facility and he has dementia.

On 4/30/2025, Resident B, who has no guardian, was interviewed but since she is totally blind, she could only guess, not credibly answer questions about medications she is prescribed and administered by the staff.

On 4/30/2025, I interviewed Aerica Swanson-Hurt, licensee designee. She stated that since Resident A is a respite resident, admitted on 1/15/2025, she does not order any refills of his medications. She stated that of Resident A's medications, the two in question are both eye drops and neither were administered until the start date of 4/24/2025. However, since both were listed on the March 2025 medication administration record (MAR), she stated that she documented as if they were administered, although she stated that no medications were administered to Resident A.

On 4/30/2025, I interviewed Aerica Swanson-Hurt. She stated that of Resident B's medications in question, three are eye drops and one is eye ointment. She stated that eye ointment is prescribed four times a day, one of which is at midnight when she is asleep. Aerica Swanson-Hurt stated that she would not wake up Resident B to administer her eye ointment. She also stated that she did not administer Resident B's eye ointment on Saturday and Sunday at noon, (she is at a day program at noon during the week) as prescribed. Finally, she stated that when Resident B was discharged from hospitalizations in January, February and April of 2025, the hospital provided her with Resident B's medications, so she did not need to order more medication refills which made it look like she wasn't administering Resident B's medications when she was completing the medication administration record.

On 4/30/2025, I interviewed the complainant. She stated that Resident A is not a respite resident and is a permanent resident of this facility. She stated that just because Aerica Swanson-Hurt did not call for medication refills does not mean they will automatically be refilled, or she will be contacted by the prescribing medical doctor or the pharmacist. She further stated that Resident B was seen at the University of Michigan Kellogg Eye Center, and they found that her intraocular eye pressure had increased. This finding led her to conclude that Resident B's eye drops were not being administered as prescribed.

On 5/02/2025, I received a document from the complainant detailing the office notes from Michigan Medicine Ophthalmology regarding Resident B's eyesight status. The resulting lab results and office notes indicated to the complainant that Aerica Swanson-Hurt was not administering Resident B's eye drops as prescribed by the medical doctor.

On 4/30/2025, Aerica Swanson-Hurt provided Resident B's eye ointment product information that stated that extended (greater than ten days) use of this eye ointment

product may cause increased intraocular eye pressure. Resident B has been prescribed this medication since November 2024.

On 4/30/2025, I interviewed Rosalyn Otting, pharmacist, during my interview with the complainant. She stated that Resident A and B's prescriptions for eye drops are not refilled automatically like medication in pill form. She stated that Aerica Swanson-Hurt had to call in to refill the eye drop prescriptions.

APPLICABLE RULE		
R 400.14312	Resident medications.	
	(2) Medication shall be given, taken, or applied pursuant to label instructions.	
ANALYSIS:	By her own admission, Aerica Swanson-Hurt did not administer Resident A or B's medications pursuant to label instructions.	
CONCLUSION:	VIOLATION ESTABLISHED	

ALLEGATION:

The medication administration records for Residents A and B are not properly recorded.

INVESTIGATION:

On 4/30/2025, I interviewed Aerica Swanson-Hurt, licensee designee. She stated that since Resident A is a respite resident, admitted on 1/15/2025, she does not order any refills of his medications. She stated that of Resident A's medications, the two in question are both eye drops and neither were administered until the start date of 4/24/2025. However, since both were listed on the March 2025 medication administration record (MAR), she documented as if they were administered, although in fact none were administered to Resident A.

On 4/30/2025, I interviewed Aerica Swanson-Hurt. She stated that of Resident B's medications in question, three are eye drops and one is eye ointment. She stated that eye ointment is prescribed four times a day, one of which is at midnight when she is asleep. Therefore, Aerica Swanson-Hurt stated that she would not wake up Resident B to administer her eye ointment. She also stated that she did not administer Resident B's eye ointment on Saturday and Sunday at noon, (she is at a day program at noon during the week) as prescribed.

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: v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	By her own admission, Aerica Swanson-Hurt did not accurately complete the medication log for Resident A or Resident B.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident B's medication was not provided to day program staff.

INVESTIGATION:

On 4/30/2025, I interviewed Aerica Swanson-Hurt. She stated that of Resident B's medications in question, three are eye drops, and one is eye ointment. She stated that eye ointment is prescribed four times a day, one of which is at noon while she is at the day program. She stated that she did not provide the day program staff with Resident B's medication and assumed that they were administering it to her.

APPLICABLE RULE	
R 400.14312	Resident medications.
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, alternatively, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.

ANALYSIS:	By her own admission, Aerica Swanson-Hurt did not assure that Resident B or, alternatively, the person who assumes responsibility for Resident B when she's at the day program, has her medication to administer.
CONCLUSION:	VIOLATION ESTABLISHED

On 4/30/2025, I conducted an exit conference with Aerica Swanson-Hurt.

IV. RECOMMENDATION

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

Jeffrey J. Bozsik	Date: 5/2/2025

Licensing Consultant

Approved By:

Ardra Hunter Date: 5/8/2025

Area Manager