GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 6, 2025

Khurram Shahzad
New Hope White Lake, LLC
3678 Prairie Creek Lane
Saginaw, MI 48603

RE: License #: AH630406127
Investigation #: 2025A1019053
New Hope White Lake Senior Living Community

Dear Licensee:

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.

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) 335-5985.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630406127
Investigation #:	2025A1019053
Complaint Receipt Date:	05/08/2025
Investigation Initiation Date:	05/09/2025
Report Due Date:	07/07/2025
Licensee Name:	New Hope White Lake, LLC
Licensee Address:	450 S Williams Lake Rd White Lake, MI 48386
Licensee Telephone #:	(551) 998-1221
Administrator:	Shannon Snapp
Authorized Representative:	Khurram Shahzad
Name of Facility:	New Hope White Lake Senior Living Community
Facility Address:	450 S Williams Lake Rd White Lake, MI 48386
Facility Telephone #:	(248) 886-6700
Original Issuance Date:	01/27/2023
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	117
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Narcotic pain medications are not being given.	Yes
Residents have skin breakdown from not being changed.	No
Additional Findings	No

III. METHODOLOGY

0/5/08/2025	Special Investigation Intake 2025A1019053
05/08/2025	Comment Complaint was forwarded to LARA from APS, APS is not investigating the allegations
05/09/2025	Special Investigation Initiated - Letter Emailed administrator requesting information/documentation.
05/21/2025	Inspection Completed On-site
05/27/2025	Inspection Completed BCAL Sub. Compliance

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged or did not provide enough information for the allegations to be investigated. Therefore, only identifiable items pertaining to homes for the aged provisions of care were considered for investigation.

ALLEGATION: Narcotic pain medications are not being given.

INVESTIGATION:

On 5/8/25, the department received a complaint alleging that day shift staff are not properly administering and/or documenting narcotic pain medication. The complaint also alleged that staff are not administering morphine to a female resident who has been crying out in pain. The complaint did not provide names of residents this is

alleged to have occurred with or dates this is alleged to have occurred on. Due to the anonymous nature of the complaint, additional information could not be obtained.

On 5/21/25, I conducted an onsite inspection. I interviewed administrator Shannon Snapp at the facility. The administrator provided a current resident roster which listed 55 residents. The administrator reported that there are several residents who are prescribed narcotic medication, and she provided two binders, one for assisted living and one for memory care, which included controlled substance use records for all residents receiving narcotics. The administrator reported that she is unaware of narcotics not being passed properly or inaccurate documentation of narcotics. The administrator explained that only shift supervisors are permitted to pass narcotic medications and staff are expected to count all narcotics before and after every shift; those counts are also kept in the binders.

While onsite, I reviewed the controlled substance records, narcotic count sheets and medication administration records (MAR) for five residents for the previous 7 weeks (4/1/25-5/21/25). The following observations were made:

- Staff documented on Resident A's MAR that he received PRN or "as needed" lorazepam twice on 5/12/25, but the controlled substance use record only listed the medication was administered once. In follow up correspondence, the administrator reported that this was a documentation error on the controlled substance use record. Additional documentation errors were observed on 5/16/25 for this same medication, as staff documented incorrect times of three administrations and failed to document one of the administrations entirely.

- No discrepancies were observed in Resident B's records.

- Staff documented on Resident C's MAR that he received a scheduled dose of alprazolam daily for the entire timeframe reviewed, but the controlled substance use record listed the medication as administered twice on 4/23/25, not at all on 4/24/25, twice on 5/18/25 and not at all on 5/19/25. In follow up correspondence, the administrator reported that this was a documentation error on the controlled substance use record, and the medication was given as prescribed on 4/23/25, 4/24/25, 5/18/25, and 5/19/25.

- Staff documented on Resident D's MAR that she received a fentanyl patch on 4/5/25 but the controlled substance use record did not include that administration. In follow up correspondence, the administrator reported that this was a documentation error on the controlled substance use record and confirmed that the medication was given as prescribed. Resident D is ordered to receive tramadol twice daily. Staff documented on Resident D's MAR that she received tramadol only once on 5/4/25 and three times on 5/25/25. In follow up correspondence, the administrator reported that this was a

documentation error on the controlled substance use record and confirmed that the medication was given as prescribed on 5/4/25 and 5/5/25.

- No discrepancies were observed in Resident E's records.

Regarding morphine, the administrator reported that Residents A, B and C are the only residents who are prescribed morphine. Residents A, B, and C are all male; no females residents are prescribed morphine. Based on the lack of information provided in the complaint, it cannot be determined who the complainant was referring to for this portion of the allegation.

APPLICABLE RULE	
R 325.1932	**Resident's medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(i) The name of the prescribed medication.** **(ii) The prescribed required dosage and the dosage that was administered.** **(iii) Label instructions for use of the prescribed medication or any intervening order.** **(iv) The time when the prescribed medication is to be administered and when the medication was administered.** **(v) The initials of the individual who administered the prescribed medication.**
ANALYSIS:	While there is no evidence to suggest that residents did not receive their prescribed narcotic medication as the complaint alleged, review of medication administration records and controlled substance count logs revealed occurrences where the records were inconsistent, demonstrating that staff made several documentation errors when recording the medication administrations.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents have skin breakdown from not being changed.

INVESTIGATION:

The complaint alleged “A lot of the residents have skin break down from not being changed.” The complaint did not provide names of residents who are alleged to have skin breakdown due to staff not changing their briefs. Due to the anonymous nature of the complaint, additional information could not be obtained.

The administrator reported that there is currently one resident, Resident E, who has an open area to her buttocks. The administrator reported that Resident E moved into the facility with the wound and that facility staff, and the visiting nurse practitioner have been monitoring it regularly. The administrator reported that the wound has not advanced to the point of requiring wound care through an outside home care vendor. The administrator reported that Resident E does wear incontinence briefs that staff assist in changing, however she is not on a toileting schedule. The administrator reported that Resident E does have some cognitive limitations but can verbalize her needs. The administrator reported that there are times when Resident E will change her brief on her own and there are times when Resident E refuses to allow staff to assist her.

While onsite, I was provided Resident E’s service plan and progress note documentation addressing her skin breakdown. In the toileting section, Resident E’s service plan read “*Provide [Resident E] with supervision and offer guidance with toileting needs. [Resident E] wears pull-up, change as needed*.” A progress note dated 5/20/25 read “[Nurse practitioner] was at bedside today. Ativan was refilled, the pressure ulcer was stable, and the color was darkening.” A progress note dated 5/14/25 read “*Resident continues to refuse to get into bed, to be turned ever [sic] two hours. Small open area, TX Triad wound paste to buttocks per MAR. Writer spoke to [Nurse Practitioner] R/T getting pro-stat 30ML QD ordered for wound healing. Writer spoke to daughter about a cushion for her chair, resident refuses to use it. Daughter aware of POC and agrees.*” A progress note dated 4/22/25 read “[*Nurse Practitioner] was at bedside today, R/T skin check on buttocks. Breakdown is unchanged and unavoidable, with difficulty complying with pressure injury precautions. The daughter is aware of POC and agrees.*” A progress note dated 4/1/25 read *“[Nurse Practitioner] was at the bedside today R/T skin check unchanged breakdown, unavoidable, difficulty complying with pressure injury precautions to the buttoks [sic]. [Nurse Practitioner] stated to continue with current orders. No new orders at this time. The daughter is aware of POC and agrees.”* Additional progress notes dated 3/19/25, 3/11/25, 2/25/25, 2/11/25, 1/27/25 and 1/20/25 all speak to Resident E’s refusal to allow care staff to assist in brief changes. A progress note dated 5/20/25 from the nurse practitioner read:

> *Patient seen and examined. Patient observed in chair, in no acute distress. Patient’s participation in HPI is limited due to cognitive status. Able to answer simple questions. Calm and cooperative at time of exam. Denies pain at this*

time, no grimacing no guarding. No c/o shortness of breath or dyspnea. Wounds to buttocks assessed, bilateral buttocks with dark purple discoloration. Small open area to left buttock. Redness, excoriation. No gross s/s/ infection. Continue triad cream. Discussed pressure injury prevention precautions. Further skin breakdown is likely unavoidable related to cognitive limitations, noncompliance with repositioning and turning despite nursing encouragement. Prostat ordered to optimize nutritional status. Patient prefers to sit in chair most of day and night.

Additionally, I observed on Resident E's MAR that facility staff documented administering the triad paste to Resident E twice daily for the entire duration of the timeframe reviewed.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(1) A home shall provide a resident with necessary assistance with personal care such as, but not limited to, care of the skin, mouth and teeth, hands and feet, and the shampooing and grooming of the hair as specified in the resident's service plan.
ANALYSIS:	Attestations from the administrator, combined with review of progress note documentation reveal that Resident E has had ongoing skin breakdown issues on her buttocks. Outside medical personnel documented that the breakdown is "unavoidable" given Resident E's cognitive status and care noncompliance. Review of medication administration records demonstrate that staff are applying cream to the affected areas as ordered. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

05/29/2025

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

06/06/2025

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