



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2025

Connie Clauson
Hume Home of Muskegon
1244 W Southern Avenue
Muskegon, MI 49441-2271

RE: License #: AH610236822
Investigation #: 2025A1028068
Hume Home of Muskegon

Dear Connie Clauson:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in cursive script that reads "Julie Viviano".

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH610236822
Investigation #:	2025A1028068
Complaint Receipt Date:	06/20/2025
Investigation Initiation Date:	06/20/2025
Report Due Date:	08/20/2025
Licensee Name:	The Hume Home of Muskegon
Licensee Address:	1244 W Southern Ave. Muskegon, MI 49441
Licensee Telephone #:	(616) 285-0573
Authorized Representative/Administrator:	Connie Clauson
Name of Facility:	Hume Home of Muskegon
Facility Address:	1244 W Southern Avenue Muskegon, MI 49441-2271
Facility Telephone #:	(231) 755-1715
Original Issuance Date:	01/01/2000
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	34
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
From May 2025 to June 2025, Resident A was not administered anxiety and blood pressure medications in accordance with physician orders.	No
Additional Findings	Yes

III. METHODOLOGY

06/20/2025	Special Investigation Intake 2025A1028068
06/20/2025	Special Investigation Initiated - Letter
06/20/2025	APS Referral
07/02/2025	Contact - Face to Face Interviewed Employee 1 at the facility.
07/02/2025	Contact - Face to Face Interviewed Employee 2 at the facility.
07/02/2025	Contact - Face to Face Interviewed Employee 3 at the facility.
07/02/2025	Contact - Document Received Received requested documentation from Employee 1 and Employee 2.

ALLEGATION:

From May 2025 to June 2025, Resident A was not administered anxiety and blood pressure medications in accordance with physician orders.

INVESTIGATION:

On 6/20/2025, the Bureau received the allegations through the online complaint system.

On 7/2/2025, I interviewed Employee 1 at the facility who reported no knowledge of Resident A not receiving anxiety or blood pressure medications on 5/8/2025, 5/16/2025, or 5/21/2025. Employee 1 reported Resident A should have been administered medications in accordance with physician orders. Employee 1 also reported Resident A becomes very anxious during medication administration and has demonstrated some confusion with medication administration, but Resident A is [their] own person and makes [their] own decisions. However, Employee 1 reported knowledge that on 6/17/2025, Resident A went to the hospital due to not feeling well and demonstrating dizziness. It was alleged at the hospital that Resident A may have been given a double dose of blood pressure medication. However, Employee 1 reported there was no evidence this occurred because the medication cart and record were audited by the facility once the allegation was made and all Resident A's medications were correctly accounted for. Employee 1 reported Resident A was administered medication in accordance with the physician orders. Employee 1 provided the requested documentation for my review.

On 7/2/2025, I interviewed Employee 2 at the facility who reported Resident A has an emergency contact and a case worker, but Resident A is considered [their] own person and makes [their] own decisions. Employee 2 reported Resident A has a history of demonstrated anxiety and [they] have demonstrated a recent history of increasing anxiety with some intermittent confusion. Employee 2 reported the alleged medication issues in May 2025 were addressed by the prior facility administrator with Resident A and Resident A's caseworker. Employee 2 reported there were care conferences completed between facility administration and staff, the case worker, and Resident A to ensure timely and correct medication administration for Resident A. All staff also received multiple re-training and re-education sessions on medication administration policies and procedures to ensure skill and competency. Employee 2 also confirmed that Resident A went to the hospital on 6/17/2025 due to demonstrating dizziness and not feeling well and that it was alleged at the hospital Resident A received a double dose of blood pressure medication. Employee 2 reported it was later discovered that Resident A told hospital staff that [they] think they were administered blood pressure medication twice. Employee 2 reported due to this allegation, Resident A's medication administration record (MAR) and medication count were verified and there was no evidence Resident A received a double dose of blood pressure medication. Employee 2 provided additional requested documentation for my review.

On 7/2/2025, I interviewed Employee 3 at the facility whose statement was consistent with Employee 1's statement and Employee 2's statement.

On 7/3/2025, I reviewed the requested documentation which revealed the following:

- Resident A requires assistance with bathing, dressing, grooming, personal hygiene, toileting.
- Resident A uses a walker for mobility and can transfer independently.
- Resident A is alert and oriented x 3.

- The facility manages meals, housekeeping, and medication administration for Resident A.
- On 5/16/2025, Resident A saw the physician for evaluation and treatment of shortness of breath and panic attack.
- On 5/21/2025, Resident A saw the physician for evaluation and treatment of shortness of breath and anxiety reaction.
- On 6/11/2025, Resident A saw the physician for evaluation and treatment of numbness with prior diagnoses of hypertension, shortness of breath, and left-sided weakness.
- On 6/17/2025, Resident A saw the physician for evaluation and treatment of dizziness and generalized weakness with prior diagnoses of dizziness and COPD exacerbation.
- Evidence of care conferences with facility administration, Resident A, and Resident A's caseworker in May 2025 pertaining to the alleged medication administration errors.
- Evidence the facility provided staff multiple sessions of re-education and re-training on medication administration procedures and medication administration record documentation procedures.
- Evidence that during the daily staff meeting on 7/2/2025, review of correct medication administration procedures and protocols was completed with staff.
- I reviewed the May 2025 MAR which revealed medication administration record entry errors which made it difficult to determine if Resident A received medication in accordance with physician orders or not.
- I reviewed the June 2025 MAR which revealed no medication administration record entry errors. There is also no evidence that Resident A received a double dose of blood pressure medication on 6/17/2025.

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:	<p>It was alleged that May 2025 to June 2025, Resident A was not administered anxiety and blood pressure medications in accordance with physician orders.</p> <p>While medication administration errors occurred in May 2025, the facility took action to address and correct the medication administration errors along with Resident A's and the caseworker's concerns. The June 2025 MAR demonstrates compliance with medication administration and MAR documentation. There is also no evidence to support that Resident A was given a double dose of blood pressure medication on 6/17/2025.</p> <p>However, there is evidence the facility has provided and continues to provide routine education and training to staff that administer medications to ensure competency and skill during all resident medication administration. Due to the facility taking action to address the alleged May 2025 and June 2025 medication errors for Resident A, the facility demonstrated action to become compliant with the rule. Also, no medication errors for Resident A were found in the June 2025 medication record, which also supports facility compliance with the rule. No violation found.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

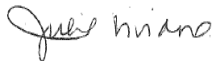
On 7/2/2025, medication was observed in an administration cup on top of the medication cart in the medication room with no staff present or supervising. The doors to the medication room were left open with no staff observed in the room as well. The medication sat unattended on top of the medication cart for ten minutes until a staff member entered the room and took the medication off the cart to administer to a resident residing on the main hallway. The medication was easily accessible to anyone in the facility.

I conferenced with Employee 1 and Employee 2 prior to exiting the facility to inform [them] of the observed unattended medication that was easily accessible to anyone in the facility. Employee 1 and Employee 2 reported it would be addressed immediately with the staff member and all other staff as well to correct the error and prevent it going forward.

APPLICABLE RULE	
R 325.1932	Resident medications.
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: (a) Be trained in the proper handling and administration of the prescribed medication.
ANALYSIS:	Medication was observed in an administration cup on top of the medication cart. Staff responsible for the medication cart were not in the medication room and the doors to the medication room were left open and easily accessible to anyone in the facility. The medication was observed to be left on top of the medication cart for ten minutes prior to staff retrieving it for administration. The medication was easily accessible to anyone in the facility, and this presents a risk to all residents in the facility. Violation found.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend that the license remains the same.



7/9/2025

Julie Viviano
Licensing Staff

Date

Approved By:



08/05/2025

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

Date