



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 17, 2025

Vashu Patel
Hudson Country Manor Inc.
10900 James Way
Portage, MI 49002

RE: License #: AL390412381
Investigation #: 2025A0578050
Hudson's Country Manor

Dear Vashu Patel:

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 that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

A handwritten signature in black ink, appearing to read "Eli DeLeon". The signature is fluid and cursive, with a long horizontal stroke at the end.

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390412381
Investigation #:	2025A0578050
Complaint Receipt Date:	08/25/2025
Investigation Initiation Date:	08/27/2025
Report Due Date:	10/24/2025
Licensee Name:	Hudson Country Manor Inc.
Licensee Address:	10900 James Way Portage, MI 49002
Licensee Telephone #:	(269) 718-9040
Administrator:	Vashu Patel
Licensee Designee:	Vashu Patel
Name of Facility:	Hudson's Country Manor
Facility Address:	9842 Oakland Drive Portage, MI 49024
Facility Telephone #:	(269) 718-9040
Original Issuance Date:	08/05/2025
License Status:	TEMPORARY
Effective Date:	08/05/2025
Expiration Date:	02/04/2026
Capacity:	19
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 08/14/2025, Resident A demonstrated symptoms of a urinary tract infection and was ordered a urinalysis, but this urinalysis was not completed. It is unclear whether Resident A ever received treatment for her urinary tract infection.	Yes

III. METHODOLOGY

08/25/2025	Special Investigation Intake 2025A0578050
08/25/2025	APS Referral
08/25/2025	Special Investigation Initiated - Face to Face
08/25/2025	Contact-Documentation Reviewed- <i>AFC Licensing Division Incident Report</i> for Resident A, dated 08/20/2025.
08/25/2025	Special Investigation Completed On-site- Interview with direct care staff Sarah Ringo.
09/03/2025	Contact-Documentation Reviewed- <i>After Visit Summary</i> for Resident A, Bronson Methodist Hospital. dated 08/06/2025.
09/03/2025	Contact-Documentation Reviewed- <i>Notes from Care Team</i> for Resident A, dated 08/11/2025.
09/03/2025	Contact-Documentation Reviewed- <i>Notes from Care Team</i> for Resident A, dated 08/14/2025.
09/03/2025	Contact-Documentation Reviewed- <i>Notes from Care Team</i> for Resident A, dated 08/20/2025.
09/03/2025	Contact-Documentation Reviewed- Cephalexin 500MG prescription for Resident A.
10/14/2025	Contact-Telephone- With Integrated Services of Kalamazoo recipient rights officer Suzie Suchyta.
10/16/2025	Exit Conference with licensee designee Vashu Patel.

ALLEGATION: On 08/14/2025, Resident A demonstrated symptoms of a urinary tract infection and was ordered a urinalysis, but this urinalysis was not completed. It is unclear if Resident A ever received treatment for her urinary tract infection.

INVESTIGATION:

On 08/25/2025, I received this complaint through LARA-BCHS-Complaints@michigan.gov. Complainant alleged on 8/14/25, Resident A was reporting painful urination and direct care staff suspected that Resident A had a urinary tract infection. Complainant alleged Resident A was not receiving any treatment for this urinary tract infection. Complainant reported Resident A was taken to a lab on 08/14/2025 to complete a UTI test. Complainant alleged that on 08/20/2025, home manager Sarah Ringo had followed up with Resident A's primary care physician and was informed there was no order for a UTI test and the UTI test for Resident A had not been completed. Complainant added it is unknown if Resident A is receiving any treatment for a urinary tract infection at this time.

On 08/25/2025, I reviewed an *AFC Licensing Division Incident Report* for Resident A, dated 08/20/2025 and related to the allegations. The *AFC Licensing Division Incident Report* for Resident A documented that on 08/14/2025, Resident A was taken by direct care staff to Bronson of Woodbridge for urinalysis according to a physician's order. The *AFC Licensing Division Incident Report* for Resident A documented that on 08/20/2025, direct care staff Sarah Ringo had followed up with the ordering physician's office as a prescription for antibiotics for Resident A had not been received. The *AFC Licensing Division Incident Report* for Resident A documented that urinalysis results for Resident A were never received by her physician's office. The *AFC Licensing Division Incident Report* for Resident A documented that medical staff at the primary care physician's office for Resident A had called Sarah Ringo to inform her that Resident A's bloodwork was processed but never for urinalysis. The *AFC Licensing Division Incident Report* for Resident A documented that Sarah Ringo had commented that Resident A had been "complaining" of symptoms since last week. The *AFC Licensing Division Incident Report* for Resident A documented that Resident A's primary care physicians' office would be documenting the missed bloodwork and sending a new order for urinalysis for Resident A.

On 08/25/2025, I interviewed direct care staff Sarah Ringo regarding the allegations. Sarah Ringo reported on 08/06/2025, Resident A was brought to her primary care physician's office for a routine examination. Sarah Ringo reported Resident A's symptoms of increased verbal aggression and delusional speech were attributed to a possible urinary tract infection, as Resident A is prone to urinary tract infections due to her medications and her fluid restrictions. Sarah Ringo reported a urinalysis for Resident A was ordered and completed that same day. Sarah Ringo reported on 08/11/2025, she had called Resident A's primary care physicians office to report that Resident A was still experiencing symptoms of a urinary tract infection, such as

increased urination and burning. Sarah Ringo added that she had not received any kind of prescribed antibiotic for Resident A as of 08/11/2025, despite Resident A completing a urinalysis on 08/06/2025. Sarah Ringo reported the medical assistant for Resident A's primary care physician's office had reported Resident A's urinalysis was received but not processed for a urinary tract infection by the laboratory and was no longer available. Sarah Ringo reported an additional order for a urinalysis for Resident A was obtained and attempts were made to collect Resident A's urine at this facility but were unsuccessful. Sarah Ringo reported calling Resident A's primary care physician's office to report an increase in symptoms that were similar to a urinary tract infection for Resident A but Resident A's primary care physician was unwilling to prescribe an antibiotic for Resident A since Resident A is allergic to antibiotics until the urinary tract infection could be confirmed. Sarah Ringo reported multiple attempts at obtaining a urine sample from Resident A at the facility were unsuccessful until Resident A was taken to Bronson at Woodbridge to complete her urinalysis.

Sarah Ringo reported that she communicated with Resident A's primary care physician on 08/20/2025 that Resident A's symptoms had worsened, and that Resident A was experiencing burning urination, early dementia signs, and repeating questions a short time later after being answered. Sarah Ringo reported informing Resident A's primary care physician about the trouble they were having obtaining an uncontaminated urine sample from Resident A. Sarah Ringo reported Resident A was taken the same day to a laboratory to obtain an uncontaminated urine sample. Sarah Ringo reported this resulted in obtaining a prescription for antibiotics for Resident A which was delivered on 08/22/2025 and ordered for five days. Sarah Ringo identified Resident A's prescribed antibiotic as Keflex, 500MG, four times a day for five days.

Sarah Ringo reported that between 08/06/2025 when Resident A first demonstrated symptoms and reporting pain, and between 08/20/2025, she was the only direct care staff that was following Resident A's condition and reporting it to Resident A's primary care physician. Sarah Ringo reported not working on one of the days during 08/14/2025 and 08/20/2025. Sarah Ringo reported this was because she currently did not have an assistant manager but was in the process of hiring an assistant manager.

While at the facility, I interviewed Resident A regarding the allegations. Resident A reported living at this facility for almost twenty years. Resident A reported that she recently wasn't feeling well but was doing better now. Resident A acknowledged experiencing painful urination when she wasn't feeling well but clarified that she no longer has this pain. Resident A denied having any additional concerns.

On 09/03/2025, I reviewed an *After Visit Summary* for Resident A, dated 08/06/2025 and provided by Bronson Methodist Hospital. The *After Visit Summary* for Resident A documented that Resident A visited the office of Dr. Eric Shay in relation to

dysuria, or painful urination. The *After Visit Summary* for Resident A documented Resident A was prescribed a urinalysis with reflex microscopy and an ECG.

On 09/03/2025, I reviewed the *Notes from Care Team* for Resident A, dated 08/11/2025 and provided by the primary care physician for Resident A. The *Notes from Care Team* for Resident A documented that Sarah Ringo had called and reported that a clean urine specimen for Resident A could not be obtained as Resident A defecates every time she urinates. The *Notes from Care Team* for Resident A documented that Sarah Ringo reported Resident A was experiencing burning and frequent urination. The *Notes from Care Team* for Resident A documented that Sarah Rngo requested a prescription for an antibiotic for Resident A. The *Notes from Care Team* for Resident A documented that on 08/12/2025, Sara Ringo was called back and instructed to take Resident A to Bronson at Woodbridge so that a specimen could be collected from Resident A.

On 09/03/2025, I reviewed the *Notes from Care Team* for Resident A, dated 08/14/2025 and provided by Bronson Hospital. The *Notes from Care Team* for Resident A documented that staff at Resident A's primary care physicians' office could not locate any testing results for Resident A in *Epic* or on *Care Everywhere*. The *Notes from Care Team* for Resident A documented that staff from Resident A's primary care physicians' office had called Sarah Ringo regarding the missing results and was informed by Sarah Ringo that Resident A still needed to go to Bronson at Woodbridge to complete Resident A's urinalysis and this visit would occur on 08/14/2025.

On 09/03/2025, I reviewed the *Notes from Care Team* for Resident A, dated 08/20/2025. The *Notes from Care Team* for Resident A documented that Sarah Ringo had called inquiring about the results of Resident A's urinalysis, as Sarah Ringo reported Resident A's confusion and burning with urination had "worsened."

The *Notes from Care Team* for Resident A documented that staff from Resident A's primary care physicians office had called the lab and was informed that Resident A's specimen was not received and there were no notes related to this specimen, The *Notes from Care Team* for Resident A documented the urinalysis for Resident A was not processed as ordered and the order was removed without requesting a new order for a urinalysis for Resident A. The *Notes from Care Team* for Resident A documented that a Patient Safety Report was completed for Resident A and that Sarah Ringo was notified and informed that Resident A could not be treated without getting the results of Resident A's urinalysis as Resident A has allergies to medications. The *Notes from Care Team* for Resident A documented that Sarah Rngo confirmed that Resident A would be brought to Bronson at Woodbridge for testing that same day and that an Incident Report would be completed to document the "delay in care."

On 09/03/2025 I reviewed the prescribed medications for Resident A, including a prescription for Cephalexin 500MG, QID, dated 08/20/2025. Resident A's

prescriptions for Cephalexin 500MG was electronically sent to Advance Health Pharmacy.

On 10/14/2025, I reviewed the details of the allegations with Integrated Services of Kalamazoo recipient rights officer Suzie Suchyta. Suzie Suchyta reported reviewing the allegations with a medical consultant for Integrated Services of Kalamazoo, who reported, “there is serious risk of physical harm when a UTI is not treated for 14 days after initial symptoms are detected. Risk varies but if an aggressive bacterium is involved the infection can spread to the kidneys and could lead to sepsis which could cause death.” Suzie Suchyta reported for these reasons, she was establishing a violation of Resident A’s rights.

APPLICABLE RULE	
R 400.15310	Resident health care.
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Resident A and direct care staff Sarah Ringo, as well as observations made during an unannounced investigation on-site and a review of pertinent documentation relevant to this investigation, Resident A had recurring painful urination, confusion, and memory loss related to a urinary tract infection that was first addressed on 08/06/2025. A prescribed medication to address Resident A’s urinary tract infection was not obtained by this facility until 08/20/2025, and this medication was not delivered to the facility until 08/22/2025. While a medical appointment and multiple telephone consultations occurred to address Resident A’s changes in physical condition, such as her suspected urinary tract infection, Resident A endured painful and frequent urination for over 14 days with no immediate care or emergency relief provided.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on temporary status.



10/17/2025

Eli DeLeon
Licensing Consultant

Date

Approved By:



10/17/2025

Dawn N. Timm
Area Manager

Date