GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 26, 2023

Lauren Gowman
Sheldon Meadows Assisted Living Center
4482 Port Sheldon
Hudsonville, MI 49426

RE: License #: AH700236945
Investigation #: 2024A1028002
Sheldon Meadows Assisted Living Center

Dear Lauren Gowman:

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,

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 #:** | AH700236945 |
|---|---|
| | |
| **Investigation #:** | 2024A1028002 |
| | |
| **Complaint Receipt Date:** | 09/28/2023 |
| | |
| **Investigation Initiation Date:** | 10/02/2023 |
| | |
| **Report Due Date:** | 11/28/2023 |
| | |
| **Licensee Name:** | Sheldon Meadows Living Ctr. LLC |
| | |
| **Licensee Address:** | 950 Taylor Ave., Grand Haven, MI 49417 |
| | |
| **Licensee Telephone #:** | Unknown |
| | |
| **Administrator:** | Loren Duemler |
| | |
| **Authorized Representative:** | Lauren Gowman |
| | |
| **Name of Facility:** | Sheldon Meadows Assisted Living Center |
| | |
| **Facility Address:** | 4482 Port Sheldon, Hudsonville, MI 49426 |
| | |
| **Facility Telephone #:** | (616) 662-8191 |
| | |
| **Original Issuance Date:** | 02/01/1998 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 07/31/2023 |
| | |
| **Expiration Date:** | 07/30/2024 |
| | |
| **Capacity:** | 129 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | Violation Established? |
|---|---|
| Resident A does not receive medications on time. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 09/28/2023 | Special Investigation Intake<br>2024A1028002 |
| 10/02/2023 | Special Investigation Initiated - Letter |
| 10/02/2023 | APS Referral<br>APS referral made to Centralized Intake. |
| 10/04/2023 | Contact - Face to Face<br>Interviewed facility Admin/Loren Duemler at the facility. |
| 10/04/2023 | Contact - Face to Face<br>Interviewed staff/Ashley Hall at the facility. |
| 10/04/2023 | Contact - Face to Face<br>Interviewed Resident A at the facility. |
| 10/04/2023 | Contact - Document Received<br>Received Resident A's record from Admin/Loren Duemler. |
| 10/04/2023 | Inspection Completed On-site<br>On-site inspection completed due to special investigation. |

**ALLEGATION:**

**Resident A does not receive medications on time.**

**INVESTIGATION:**

On 9/28/2023, the Bureau received the allegations through the online complaint system.

On 10/2/2023, a referral was made to Adult Protective Services (APS) through Centralized Intake.

On 10/4/2023, I interviewed facility administrator, Loren Duemler, at the facility who reported Resident A has an authorized representative in place but makes [their] own decisions and is [their] own person. Upon admittance to the facility, Resident A was insistent on using their own pharmacy which is an outside provider. Ms. Duemler reported due to the pharmacy being an outside provider, there have been issues with prescriptions being sent to the facility in a timely manner. The facility follows up on all of Resident A's prescriptions, but there still continues to be an issue with the pharmacy providing Resident A's medications in a timely manner due to either the pharmacy awaiting medication shipment and/or Resident A's physician not submitting prescriptions and orders in a timely manner. Ms. Duemler also reported the facility has explained to Resident A and [their] authorized representative that all vitamins that enter the facility still require a physician's order. Ms. Duemler reported that Resident A did miss medications recently due to the medication being on order from the pharmacy and due to the medication being shipped late from the pharmacy due to the physician's order being late. Resident A was informed of the medications being out and that the facility was waiting on the pharmacy to fill the medication orders. Ms. Duemler reported any time a medication is not in the medication cart and/or is getting low, the medication tech on duty reports this to the supervisor and it is to be documented in the medication administration record (MAR). Ms. Duemler reported Resident A has been encouraged to switch to the facility pharmacy to help prevent medication shortages and delays, but Resident A does not want to switch. Ms. Duemler reported the facility continues to monitor Resident A's medications to help prevent shortages and the facility communicates regularly with Resident A's physician and pharmacy to try and prevent medication delays. Ms. Duemler provided me Resident A's record for my review.

On 10/4/2023, I interviewed Employee A whose statement was consistent with Ms. Duemler's statements.

On 10/4/2023, I interviewed Resident A at the facility who reported [they] have missed medication due to the facility care staff not providing it in a timely manner and/or not providing at all. Resident A reported [they] communicate with facility staff about the medication issues but are told the facility is waiting on physician orders or the pharmacy to deliver. Resident A confirmed they use an outside pharmacy and do not want to use the facility pharmacy to save money. Resident A confirmed [they] were recently made aware that [they] were informed all medications entering the facility must have a physician's order in place.

On 10/4/2023, I reviewed Resident A's record which revealed the following:

- Requires assist with bathing, dressing, per-care, and toileting.
- Independent with eating, grooming, and oral care.
- Requires assist with transfers.

- Independent with use of power scooter for mobility.
- Does not require checks or supervision and can leave building independently and unsupervised.
- Facility manages meals, housekeeping, laundry, and medication management.

I reviewed Resident A's medication administration record (MAR) from July 2023 which revealed the following:

- Resident A was to take 2 capsules of 100mg of Gabapentin by mouth three times daily. The MAR is blank on 7/25/2023 for 12:00pm and 8:00pm. However, there is a discrepancy because the MAR notes show it was signed by staff as being given.
- Resident A was to take 510gm OTC Miralax Powder with 4-8oz of juice or water by mouth once nightly. The MAR is blank on 7/25/2023. It cannot be determined if Resident A was administered the medication or not and/or if Resident A refused the medication or not.

I reviewed Resident A's medication administration record (MAR) from August 2023 which revealed facility communication with the pharmacy about Resident A's medications being on order and/or the facility awaiting medication delivery from the pharmacy. There is also evidence of Resident A refusing medication.

I reviewed Resident A's medication administration record (MAR) from September 2023 which revealed facility communication with the pharmacy about Resident A's medications being on order and/or the facility awaiting medication delivery from the pharmacy. There is also evidence of Resident A refusing medication.

| **APPLICABLE RULE** | |
| --- | --- |
| **R 325.1932** | **Resident medications.** |
| | **(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.** |

| ANALYSIS: | It was alleged Resident A did not receive medications in a timely manner. Interviews, onsite investigation, and review of documentation reveal Resident A uses an outside pharmacy which results in a delay of medication being delivered to the facility in a timely manner. There is evidence of communication between the facility and Resident A's pharmacy concerning medication shortages and delay. There is also evidence of Resident A refusing medications intermittently.<br><br>However, there is a discrepancy in Resident A's MAR for July 2023. Resident A was to take 2 capsules of 100mg of Gabapentin by mouth three times daily. The MAR is blank on 7/25/2023 for 12:00pm and 8:00pm medication administration times, but the MAR notes show it was signed by staff as being given. It cannot be determined if Resident A was administered the medication or not and/or if Resident A refused the medication or not.<br><br>Also, the MAR is blank on 7/25/2023 for Resident A's medication administration of 510gm OTC Miralax Powder to be given with 4-8oz of juice or water by mouth once nightly. It cannot be determined if Resident A was administered the medication or not and/or if Resident A refused the medication or not. Therefore, the facility is in violation. |
|---|---|
| CONCLUSION: | **VIOLATION ESTABLISHED** |

**Additional Findings:**

On 10/4/2023, Resident A reported they do not receive showers twice a week as provisioned in the service plan. Resident A reported they inform staff [they] missed the scheduled shower and staff "do not do anything about it" or provide a make up shower.

On 10/4/2023, Ms. Duemler reported Resident A is to receive two showers per week per the service plan and Resident A has expressed to her that [they] do not always receive them in a timely manner. Ms. Duemler reported Resident A is offered and/or provided showers twice per week but will refuse showers at times if [they] do not think staff are strong enough to assist during a transfer into the shower appropriately. Ms. Duemler reported staff are to document provision of showers to ensure appropriate care.

On 10/4/2023, I reviewed Resident A's record and notes which revealed the following:

- Resident A refusing toileting assistance from third shift staff on 8/7/2023.

- On 9/26/2023, Resident A reported facility care staff did not use gait belt during transfer. Use of the gait belt during transfer and/or mobility with Resident A is documented in the service plan.
- On 9/13/2023, Resident A *slapped care staff member on the hand due to care staff member grabbing a product Resident A was trying to ask for. Resident A aggressively asked [care] staff member what her problem was and if she was new.*
- No evidence of Resident A refusing showers.
- No evidence of staff documenting provision of showers for Resident A.

| **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 no 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:** | It was alleged Resident A does not receive showers twice a week per the service plan and/or does not receive showers in a timely manner. Interview, onsite investigation, and review of documentation reveal Resident A has refused care from third shift staff on 8/7/2023 and demonstrated aggressive behavior towards staff on 9/13/2023 as well. However, there is no evidence to support Resident A refuses showers and there is no evidence to support staff provide showers as provisioned in the service plan or in a timely manner. It cannot be determined that staff provide Resident A showers twice per week and/or in a timely manner due to the lack of documentation within the record. Therefore, the facility is in violation. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remain the same.

10/26/2023

Julie Viviano Date
Licensing Staff

Approved By:

12/20/2023

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