GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 24, 2025

Jennifer Herald
Glen Abbey Assisted Living
445 North Lotz Road
Canton, MI 49512

RE: License #: AH820372250
Investigation #: 2025A1027037
Glen Abbey Assisted Living

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated by the home for the aged authorized representative.

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.

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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 241-1970
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820372250
Investigation #:	2025A1027037
Complaint Receipt Date:	03/11/2025
Investigation Initiation Date:	03/11/2025
Report Due Date:	05/10/2025
Licensee Name:	Lotz Road Opco LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(419) 247-2800
Administrator:	Sarah Molner
Authorized Representative:	Jennifer Herald
Name of Facility:	Glen Abbey Assisted Living
Facility Address:	445 North Lotz Road Canton, MI 49512
Facility Telephone #:	(734) 981-9224
Original Issuance Date:	07/21/2017
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	64
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff did not administer insulin according to the prescription from the licensed healthcare professional.	Yes
Additional Findings	No

III. METHODOLOGY

03/11/2025	Special Investigation Intake 2025A1027037
03/11/2025	Special Investigation Initiated - On Site
03/14/2025	Inspection Completed-BCAL Sub. Compliance
03/24/2025	Exit Conference Conducted by email with Jennifer Herald and Sarah Molner

ALLEGATION:

Staff did not administer insulin according to the prescription from the licensed healthcare professional.

INVESTIGATION:

On 3/11/2025, the Department received an anonymous complaint stating that someone overheard a conversation among staff in which it was mentioned that a resident had run out of insulin, and another employee proposed using a different resident's insulin pen.

On the same day, I conducted an on-site inspection at the facility and interviewed the staff.

Administrator Sarah Molner and Employee #1 both denied that any resident had run out of insulin. Employee #1 clarified that both Residents A and B received insulin, but they were different types. Employee #1 further explained that on 3/9/2025, Employee #2 informed her that Resident A was running low on insulin. However, Employee #1 also mentioned that Resident A's authorized representative needed to approve her insulin prescription due to a $70 copay.

The Administrator reviewed the files for Residents A and B, confirming that Resident A's Lantus insulin had been delivered on 3/8/2025 at 10:00 PM. I reviewed the records, and they aligned with the Administrator's statements.

Employee #1 explained that Resident A's insulin was stored in her own refrigerator, as per her family's preference. However, Employee #1 speculated that the insulin was placed medication refrigerator where other insulins were typically stored, which could have caused Employee #2 to think the supply was running low.

Employee #1 spoke highly of Employee #2, calling her a very good medication technician and expressing no concerns about her medication administration practices. Employee #1 also explained that two staff members were required to sign off together on insulin administration. Medication technicians were trained to administer only medications prescribed to the resident. They underwent a medication administration class where policies were reviewed, followed by shadowing a skilled medication technician, and being observed while administering medications. Employee #1 confirmed that she observed staff administering medications and signed off on them before allowing them to work independently.

The Administrator mentioned that a monthly training session was scheduled for 3/20/2025, which would include topics related to medication administration.

During my on-site inspection, I reviewed the March 2025 Medication Administration Records (MARs) for Residents A and B. The records showed that Resident A was prescribed Novolog three times daily and Lantus at bedtime, while Resident B was prescribed Basaglar twice daily. The MARs indicated that staff witnessed and signed off on each other's medication administration. I also observed that Resident A had eight Novolog pens and one Lantus pen, while Resident B had four Basaglar pens, two of which were nearly empty. All pens lacked a date they were opened.

Further review of the March 2025 MARs revealed that Resident A's medications were administered according to the physician's orders. However, Resident B's MAR indicated that she was prescribed Basaglar to inject 8 units subcutaneously every 12 hours, with instructions to hold the insulin if the blood glucose was less than 100. Staff had initialed the 7:00 AM doses on the following dates as administered, even though the blood glucose was less than 100: 3/2/2025, 3/3/2025, 3/5/2025, and 3/8/2025.

A review of the home's medication administration final observation checklist for staff revealed that staff were trained in the five rights of medication administration, including administering injectable medications, and were required to date newly opened containers.

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:	Although there was insufficient evidence to confirm that staff administered insulin not prescribed to a resident, it was confirmed that Resident B received insulin outside the parameters of the licensed healthcare professional's orders. Additionally, the insulin pens were not dated in accordance with the home's training policies. As a result, a violation of this rule was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remains unchanged.

03/14/2025

Jessica Rogers Date
Licensing Staff

Approved By:

03/24/2025

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