GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 30, 2025

Vashu Patel
Hudson's Country Manor, Inc.
9842 Oakland Dr.
Portage, MI 49024

RE: License #: AL390292582
Investigation #: 2025A0578023
Hudson's Country Manor, Inc.

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,

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 #:	AL390292582
Investigation #:	2025A0578023
Complaint Receipt Date:	04/08/2025
Investigation Initiation Date:	04/08/2025
Report Due Date:	06/07/2025
Licensee Name:	Hudson's Country Manor, Inc.
Licensee Address:	9842 Oakland Dr. Portage, MI 49024
Licensee Telephone #:	(269) 323-9752
Administrator:	Vashu Patel
Licensee Designee:	Vashu Patel
Name of Facility:	Hudson's Country Manor, Inc.
Facility Address:	9842 Oakland Dr. Portage, MI 49024
Facility Telephone #:	(269) 323-9752
Original Issuance Date:	08/29/2008
License Status:	REGULAR
Effective Date:	07/26/2023
Expiration Date:	07/25/2025
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Carbon monoxide levels in this facility were dangerously high after alerting carbon monoxide detectors were ignored by staff for several days.	Yes

III. METHODOLOGY

04/08/2025	Special Investigation Intake 2025A0578023
04/08/2025	Special Investigation Initiated - Telephone
04/10/2025	Inspection Completed On-site
04/10/2025	APS Referral
04/10/2025	Special Investigation Completed On-site -Interview with direct care staff Sarah Ringo and direct care staff Shanice Duckett.
04/10/2025	Contact-Document Reviewed -*Incident Report* dated 01/27/2025.
04/10/2025	Contact-Document Reviewed -*After Visit Summary* for Resident A, dated 02/01/2025.
04/10/2025	Contact-Document Reviewed -*Medication Administration Records* for Resident A, January 2025.
04/10/2025	Contact-Document Reviewed -*Office of Recipient Rights Report of Investigative Findings* dated 03/27/2025.
04/10/2025	Contact-Telephone -With AFC consultant Ondrea Johnson.
05/19/2025	Exit Conference -With licensee designee Vashu Patel.
05/27/2025	Contact-Telephone -Interview with Portage Fire Marshall Steve Tanner, unsuccessful.

ALLEGATION:

Carbon monoxide levels in this facility were dangerously high after alerting carbon monoxide detectors were ignored by staff for several days.

INVESTIGATION:

On 04/08/2025, I received this complaint by email. Complainant reported on 01/25/2025, direct care staff Dani Gritten was doing a final inspection before an inspection by this department. Complainant reported during this inspection; Dani Gritten noticed the carbon monoxide detectors were missing. Complainant reported Dani Gritten asked staff if they knew where the carbon monoxide were located and she was informed these carbon monoxide detectors were moved outside earlier in the day because these carbon monoxide detectors were beeping. Complainant reported that when Dani Gritten put the carbon monoxide detectors back, the carbon monoxide detectors were still beeping. Complainant reported staff contacted the fire marshal who responded to the facility and determined the reason the carbon monoxide detectors were beeping was because carbon monoxide was detected in the facility. Complainant reported one furnace was leaking carbon monoxide and was shut off until a new furnace could be installed on 01/27/2025. Complainant reported the fire marshal did not recommend the evacuation of the residents as there was an additional working furnace that heated all but three resident bedrooms and windows were opened to clear the air in this facility until a recheck of the carbon monoxide levels were acceptable. Complainant alleged a serious risk of harm which could have ultimately resulted in death due to carbon monoxide intoxication or poisoning.

On 04/08/2025, I reviewed the allegations with Integrated Services of Kalamazoo recipient rights director Lisa Smith. Lisa Smith reported the allegations were confirmed with an investigation completed by her agency. Lisa Smith clarified the carbon monoxide detectors were not working correctly in this facility and no immediate actions were taken until the Portage Fire Department responded on 01/25/2025. Lisa Smith reported no residents were injured but an Integrated Services of Kalamazoo medical professional determined residents at this facility were at risk of physical harm including death as a result of the unaddressed carbon monoxide leak.

On 04/10/2025, I reviewed the *Incident Report* relating to the allegations and completed by direct care staff Dani Gritten and dated 01/27/2025. The *Incident* Report documented the following:

> "I (Dani Gritten) came into the office on Saturday and was doing the final inspections for our State of Michigan audit for Monday and noticed we had carbon monoxide detectors missing. I (Dani Gritten) asked staff on shift if they knew where they were and they said they moved them outside earlier in the day to see if they would stop beeping. I put them back up at about 1:30 PM and they

were going off. We contacted the fire marshal and he came out and said there was carbon monoxide detected and we opened all the windows to clear the air. RW Lapine came to investigate and determined the furnace was bad and shut it off and will be back on Monday to do an install on a new furnace. The fire Marshall did not recommend evacuating the residents because we still have a working furnace that heats all but three bedrooms and they are satisfied with the results of the recheck of carbon monoxide."

On 04/10/2025, I completed an unannounced investigation on-site and interviewed direct care staff Sarah Ringo regarding the allegations. Sarahe Ringo reported serving as the home manager for this facility and clarified direct care staff Dani Gritten was the former home manager for this facility. Sarah Ringo reported she could not recall all the details of the allegations, but she reported being contacted by direct care staff regarding the carbon monoxide detectors making an alarm noise on 01/25/2025. Sarah Ringo reported staff were unsure what to do and had contacted direct care staff Dani Gritten and Dani Gritten instructed staff to call Sarah Ringo. Sarah Ringo reported she had to "google" what to do when a carbon monoxide alarm goes off and then called the fire marshal and licensee designee, Vashu Patel. Sarah Ringo reported when the fire marshal arrived, they had a device to detect carbon monoxide leaks, and it was determined that one of the furnaces in the facility was leaking carbon monoxide. Sarah Ringo reported the fire marshal informed them that evacuation was not necessary as the carbon monoxide levels were at an acceptable level after opening the windows of the facility and that a new furnace was scheduled to be installed on 01/27/2025. Sarah Ringo acknowledged the weather was cold at this time but clarified that residents waited in the running facility vans while the facility was inspected by the fire marshal. Sarah Ringo reported this fire marshal was from the Portage Police Department but could not identify them by name. Sarah Ringo confirmed a new furnace was installed at this facility.

While at the facility, I interviewed direct care staff Shanice Duckett regarding the allegations. Shanice Duckett reported the carbon monoxide alarms in this facility began going off when contractors had begun replacing the floors in this facility, which Shanice Duckett identified as a Friday but could not recall the specific date. Shanice Duckett reported the following Tuesday; she had observed three carbon monoxide detectors on a desk near the front entrance of the facility. Shanice Duckett reported she asked who had removed the carbon monoxide detectors and she reported Dani Gritten did but acknowledged that she did not directly observe Dani Gritten removing these carbon monoxide detectors. Shanice Duckett reported it was suspected the batteries needed to be replaced in all of the carbon monoxide detectors as they continued to make alarm noises. Shanice Duckett reported Dani Gritten suspected the carbon monoxide detectors needed to be "reset", so they were taken outside. Shanice Duckett reported one carbon monoxide detector was placed in the facility shed, another was placed in a facility van, and another was placed in a snowbank outside the facility. Shanice Duckett reported none of the staff knew how to respond to the carbon monoxide alarms. Shanice Duckett reported she was unsure when the carbon monoxide detectors were returned to the facility, but

reported it was the same day the Portage Fire Department had come to the facility and determined a furnace was leaking carbon monoxide. Shanice Duckett reported Dani Gritten was in a rush to get groceries and put the carbon monoxide detectors back in the facility. Shanice Ducket reported Dani Gritten commented that if the carbon monoxide detectors went off during the inspection by this department, Dani Gritten would suggest this was a new problem. Shanice Duckett reported she then called direct care staff Sarah Ringo, who was the assistant manager at the time for additional guidance. Shanice Duckett reported this was when Portage Fire Department was contacted and inspected the facility for carbon monoxide leaks. Shanice Ducket reported that collectively, the carbon monoxide detectors have been going off in this facility for over a week but less than two weeks. Shanice Duckett reported having headaches while working at this facility. Shanice Duckett reported Resident A also reported to direct care staff that she was having headaches and took PRN medications because of this pain. Shanice Ducket reported Resident A was examined at a local hospital due to concerns regarding carbon monoxide exposure but Resident A was not diagnosed with any medical concerns related to carbon monoxide. Shanice Duckett denied that any other residents had expressed any headaches or discomfort the day Portage Fire Department had determined a carbon monoxide leak on 01/25/2025, or in the days leading up to 01/25/2025.

While at the facility, I reviewed additional details relating to the allegations with Sarah Ringo. Sarah Ringo acknowledged that Resident A was examined at a local hospital after Resident A had made complaints of having a headache when the Portage Fire Marshall responded and there were concerns that Resident A might have carbon monoxide poisoning. Sarah Ringo reported Resident A was discharged with no medical conditions related to carbon monoxide poisoning but Resident A received a pacemaker during the same emergency room visit due to a low heart rate. Sarah Ringo reported this low heart rate was suspected to be the reason for Resident A's complaint of headache. Sarah Ringo denied that Resident A had utilized her PRN medications for pain prior to 01/25/2025. Sarah Ringo denied the carbon monoxide detectors had been alerting the staff to a carbon monoxide leak for almost two weeks and clarified that it might have been a few days.

On 04/10/2025, I reviewed the *After Visit Summary* for Resident A, dated 02/01/2025 and completed at Bronson Hospital. The *After Visit Summary* for Resident A documented Resident A was examined for "dizziness." The *After Visit Summary* for Resident A documented that a CT abdomen angiogram was completed on Resident A. The *After Visit Summary* documented Resident A underwent a surgical procedure to receive a pacemaker. The *After Visit Summary* included follow-up appointments and reasons to contact the Bronson Cardiology Office relating to Resident A's pacemaker. The *After Visit Summary* for Resident A did not document any medical conditions related to carbon monoxide poisoning.

On 04/10/2025, I reviewed the electronic *Medication Administration Records* for Resident A for January 2025. The electronic *Medication Administration Records* for Resident A documented that Resident A is prescribed Tramadol 50MG PRN and

Tylenol Extra Strength 500MG PRN for pain. I noted the Medication Administration Record for Resident A documented that Resident A was not administered Tramadol 50MG PRN or Tylenol Extra Strength 500MG PRN in January 2025.

On 04/10/2025, I reviewed the details of the allegations with AFC licensing consultant Ondrea Johnson. Ondrea Johnson acknowledged conducting an inspection at this facility on or around 01/27/2025 but denied being aware of the allegations. Ondrea Johnson clarified the Bureau of Fire Services was aware of the carbon monoxide related event at this facility.

On 04/10/2025, I reviewed the *Office of Recipient Rights Report of Investigative Findings* provided by Integrated Services of Kalamazoo and dated 03/27/2025. The *Office of Recipient Rights Report of Investigative Findings* interviewed direct care staff Ebony Hawkins and direct care staff Joyce McCoy, who confirmed that direct care staff Dani Gritten had removed carbon monoxide detectors on 01/25/2025 which was alerting to carbon monoxide in the air at this facility. The *Office of Recipient Rights Report of Investigative Findings* determined Dani Gritten's act of commission placed residents at this facility at risk of physical harm, including death, as identified by an Integrated Services of Kalamazoo medical professional.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based upon my investigation, which consisted of interviews with direct care staff Sarah Ringo, direct care staff Shanice Duckett and Integrated Services of Kalamazoo recipient rights director Lisa Smith, as well as observations made during an unannounced investigation on-site and a review of pertinent documentation relevant to this investigation, direct care staff did not act in a manner that attended to the personal need for protection and safety of residents when carbon monoxide detectors alerting staff to the presence of carbon monoxide were ignored and removed from this facility. A medical professional with Integrated Services of Kalamazoo determined this inaction exposed residents in this facility to a risk of serious harm including death.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based upon my investigation, which consisted of interviews with direct care staff Sarah Ringo, direct care staff Shanice Duckett and Integrated Services of Kalamazoo recipient rights director Lisa Smith, as well as observations made during an unannounced investigation on-site and a review of pertinent documentation relevant to this investigation, carbon monoxide detectors in this facility were not maintained for the health, safety, and well-being of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/28/2025

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Eli DeLeon Date
Licensing Consultant

Approved By:

05/30/2025

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Dawn N. Timm Date
Area Manager