GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 16, 2025

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

RE: License #: AL390292582
Investigation #: 2025A0578029
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 #:	2025A0578029
Complaint Receipt Date:	05/06/2025
Investigation Initiation Date:	05/06/2025
Report Due Date:	07/05/2025
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?
Resident A did not receive his prescribed medication for at least six weeks due to the facility waiting for a refill or prescription.	Yes

III. METHODOLOGY

05/06/2025	Special Investigation Intake 2025A0578029
05/06/2025	Special Investigation Initiated - Telephone
05/06/2025	APS Referral
05/07/2025	Contact-Telephone -With Integrated Services of Kalamazoo recipient rights officer Suzie Suchyta.
05/07/2025	Special Investigation Completed On-site -Interview with direct care staff Sarah Ringo.
05/07/2025	Contact-Document Reviewed -Written statement by Sarah Ringo, dated 05/02/2025.
05/07/2025	Contact-Document Reviewed -*AFC Licensing Division Incident/Accident Report*, dated 04/30/2025.
05/07/2025	Contact-Document Reviewed -*AFC Licensing Division Incident/Accident Report*, dated 05/01/2025.
05/07/2025	Contact-Document Reviewed -*Coordination of Care Calls/Text* report for Resident A.
05/11/2025	Contact-Document Reviewed -Resident A's prescription for Mounjaro 10MG (Tirzepatide) 10MG, dated 10/16/2024.
05/11/2025	Contact-Document Reviewed -*Health Care Appraisal* for Resident A, dated 01/24/2025.
05/19/2025	Exit Conference -With licensee designee Vashu Patel.

06/04/2025	Contact-Telephone -Interview with Julie Stinson, medical assistant at Bronson Family Medicine.
06/05/2025	Contact-Document Reviewed -*Medication Administration Records* for Resident A, March 2025, April 2025, May 2025, and June 2025.

ALLEGATION: Resident A did not receive his prescribed medication for at least six weeks due to the facility waiting for a refill or prescription.

INVESTIGATION:

On 05/06/2025, I received this complaint by email. Complainant reported Resident A was sent to the hospital on 04/30/2025 and 05/01/2025 due to blood sugar readings exceeding 500. Complainant alleged during follow up it was discovered Resident A was prescribed a weekly Mounjaro 10MG injection that he had not received for at least six weeks due to the facility waiting for a refill or prescription for his Mounjaro 10MG injection.

On 05/07/2025, I reviewed the details of the allegations with Integrated Services of Kalamazoo recipient rights officer Suzie Suchyta. Suzie Suchyta reported Resident A is prescribed Mounjaro 10GM injections for diabetes management. Suzie Suchyta added the prescription for these Mounjaro 10MG injections expired on 3/21/25. Suzie Suchyta reported Resident A's Mounjaro 10MG injection was finally received at this facility on 04/25/2025 but the Mounjaro 10MG injection for Resident A was still not administered. Suzie Suchyta added that Resident A had gone to ER via ambulance one two separate occasions with blood sugar levels exceeding 500. Suzie Suchyta suspected Resident A's missed administrations of his Mounjaro 10MG injections contributed to Resident A's elevated blood sugar levels.

On 05/07/2025, I completed an unannounced special investigation on-site at this facility and interviewed direct care staff Sarah Ringo regarding the allegation. Sarah Ringo acknowledged that Resident A did not receive his prescribed Mounjaro 10MG injections for several weeks. Sarah Ringo reported contacting the primary care physician for Resident A multiple times to obtain a renewed Mounjaro 10MG injection prescription for Resident A. Sarah Ringo reported when she first contacted Advanced Health pharmacy regarding Resident A's prescriptions, she was informed that a prescription for Resident A's Mounjaro 10MG was never transferred to Advance Health Pharmacy from Resident A's previous pharmacy. Sarah Ringo reported that on 03/19/2025, she spoke with a medical assistant at Resident A's primary care physicians office who reported they could not refill Resident A's prescription but they would send a message to Resident A's primary care physician.

Sarah Ringo reported on 03/21/2025, she contacted Advanced Health Pharmacy regarding Resident A's Mounjaro 10MG injection and she was informed that documentation provided by Resident A's primary care physician was "not sufficient."

Sarah Ringo provided the following written statement, dated 05/02/2025:

> "On 4/30/2025 and 5/1/2025, [Resident A] was sent to the emergency room with a blood sugar of 572 and 502. I reached out to [Resident A's] PCP after 5/1/2025 to make [Resident A] an emergency appointment to find a resolution to his high sugars on 5/2/2025. I received a call from [Guardian A1] stating that [Resident A] not receiving his Mounjaro shot could be the cause of the high sugar. I reached out to [Resident A's] PCP on 3/21/2025 to obtain a new script per pharmacy request and did not hear back. On 3/26/2025 I sat in on an appointment with [Resident A] for nephrology and the doctor instructed [Resident A] to continue taking Mounjaro shot. I explained to him that I had reached out to PCP for a new script and he said that a new one should be sent but that since it was originally prescribed by [Resident A's] PCP they would not be the ones to send the script. I reached out to the pharmacy and was told they had not yet gotten the script. [Resident A] was hospitalized on 4/3/2025 before his next dose was due and did not return to the home until 4/22/2025. I reached out to the PCP again and left a message asking for clarification on whether or not [Resident A] is still to be on the Mounjaro because documentation from the hospital was not clear on whether or not [Resident A] was given it during his stay and I had still not heard back about the script being renewed. I did not receive a response but on 4/25/2025 [Resident A's] Mounjaro was delivered. The pharmacy said that it would have been delivered the previous day however they were out of stock and had to order it. [Resident A] was out of facility for his dose due on 5/1/2025. After speaking with his guardian and PCP it is believed that [Resident A's] blood sugar was high due to him missing that shot."

Sarah Ringo identified the following timeline:

- 03/26/2025, Resident A attended his nephrology appointment. Staff were informed a message regarding Resident A's Mounjaro 10MG injection prescription refill would be sent to his primary care physician.

- 04/03/2025, Resident A was admitted at a local hospital for psychiatric evaluation. Staff were unsure if Resident A was returning to this facility or if Resident A received his Mounjaro 10MG injections at this hospital.

- 04/21/2025, Resident A returned to this facility.

- 04/22/2025, Staff contacted Resident A's primary care physician. Staff were informed Resident 's scheduled primary care physician appointment was on 04/28/2025, and that a new consent for permission to treat was needed from Resident A's guardian.

- 04/30/2025, Resident A was seen at his primary care physician and Resident A's Mounjaro 10MG injection prescription was not refilled at that appointment.

- 05/01/2025, Resident A's Mounjaro 10MG Injection medication was received by this facility. Sarah Ringo reported staff cannot change when this medication is scheduled to be administered, as it is a once a week medication and was previously administered on Thursdays. Sarah Ringo identified 05/01/2025 as a Friday, indicating that Resident A would not receive this medication until the following Thursday, 05/08/2025.

On 05/07/2025, I reviewed *AFC Licensing Division Incident/Accident Report*, dated 05/01/2025. The *AFC Licensing Division Incident/Accident Report* documented that on 05/01/2025, Resident A's blood sugar was measured at 502, and emergency services were called.

On 05/07/2025, I reviewed *AFC Licensing Division Incident/Accident Report*, dated 04/30/2025. The *AFC Licensing Division Incident/Accident Report* documented that on 04/30/2025, Resident A's blood sugar was measured at 572, and emergency services were called.

On 05/07/2025, I reviewed the *Coordination of Care Calls/Text* report maintained by this facility. The *Coordination of Care Calls/Text* report documented on 02/21/2025, a request for a prescription refill for Resident A's Mounjaro 10MG was made with Resident A's primary care physicians office. The *Coordination of Care Calls/Text* report documented the pharmacy was also contacted to confirm when this prescription was received. The *Coordination of Care Calls/Text* report documented on 03/18/2025, Resident A's primary care physicians' office was contacted regarding the prescription refill of Resident A's Mounjaro 10MG had not been completed. The *Coordination of Care Calls/Text* report documented that a medical assistant reported a message would be conveyed to Resident A's primary physician. The *Coordination of Care Calls/Text* report documented on 04/22/2025, a message was left with the primary care physician for Resident A requesting clarification relating to Resident A's Mounjaro 10MG as "multiple" requests had been made for a refill and if Resident A's Mounjaro 10MG had been discontinued as a prescribed medication.

On 05/11/2025, I reviewed Resident A's prescription for Mounjaro (Tirzepatide) 10MG, dated 10/16/2024. Resident A's Mounjaro 10MG prescription documented that Resident A's Mounjaro 10MG is to be injected subcutaneously "every 7 days." I noted Resident A's prescription for Mounjaro 10MG did not identify the day of the week. Resident A's Mounjaro 10MG prescription was issued by Jody Wertz, PA.

On 05/11//2025, I reviewed the *Health Care Appraisal* for Resident A, dated 01/24/2025. The *Health Care Appraisal* for Resident A documented Resident A is diagnosed with traumatic brain injury, bipolar disorder, developmental disability,

hyperlipidemia, hypertension, major depressive disorder, acute kidney failure, and diabetes type II.

On 06/05/2025, I reviewed the electronic *Medication Administration Records* for Resident A for March 2025, April 2025, May 2025, and June 2025.The electronic *Medication Administration Records* for Resident A documented that Resident A's Mounjaro 10MG was not administered to Resident A on 03/06/2025, 03/13/2025, 03/20/2025, 03/27/2025,04/03/2025, and 04/24/2025 due to Resident A's Mounjaro 10MG not being present in the facility. The electronic *Medication Administration Records* for Resident A documented that Resident A did not receive his Mounjaro 10MG on 05/01/2025 due to Resident A being out of the facility.

On 06/04/2025, I contacted Julie Stinson, medical assistant at Bronson Family Medicine for Jody Wertz, PA. Julie Stinson confirmed Bronson Family Medicine is the primary care physician for Resident A. Julie Stinson reported after reviewing physician notes and triage notes, Resident A's Mounjaro 10MG injection prescription was refilled for 84 dosages on 03/28/2025 and this prescription was electronically sent to Advanced Health Pharmacy the same day. Julie Stinson acknowledged there was one contact from this facility on 04/22/2025 where staff had inquired as to the location of a sleep study for Resident A. Julie Stinson denied any inquiry was made on 04/22/2025 or any other date after 03/28/2025 related to any refills for Resident A's prescribed medications. Julie Stinson acknowledged Resident A has had several emergency room visits related to his blood sugar being in the 300 to 400 range. Julie Stinson added that Resident A's blood sugar is difficult to manager as his guardian is unwilling to restrict his diet or community access, and Resident A will often eat meals at his place of employment as well as at this facility.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Direct care staff Sarah Ringo, Integrated Services of Kalamazoo recipient rights officer Suzie Suchyta, and Bronson Family Medicine medical assistant Julie Stinson, as well as observations made during an unannounced investigation on-site

	and a review of pertinent documentation relevant to this investigation, Resident A did not receive his prescribed Mounjaro 10MG as prescribed for several weeks.
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.

06/09/2025

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Eli DeLeon Date
Licensing Consultant

Approved By:

06/16/2025

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Dawn N. Timm Date
Area Manager