GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 6, 2026

Connie Clauson
Assured Care Assisted Living, LLC
Suite 203
3196 Kraft Ave SE
Grand Rapids, MI 49512

RE: License #: AL110283729
Investigation #: 2026A0790012
The Willows Assisted Living #4

Dear Mrs. Clauson:

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 (616) 356-0100.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
gillr@michigan.gov
(517)980-1433

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL110283729
Investigation #:	2026A0790012
Complaint Receipt Date:	12/23/2025
Investigation Initiation Date:	12/23/2025
Report Due Date:	01/22/2026
Licensee Name:	Assured Care Assisted Living, LLC
Licensee Address:	Suite 203 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Connie Clauson
Licensee Designee:	Connie Clauson
Name of Facility:	The Willows Assisted Living #4
Facility Address:	3440 Niles Road St. Joseph, MI 49085
Facility Telephone #:	(269) 428-0715
Original Issuance Date:	12/11/2007
License Status:	REGULAR
Effective Date:	09/18/2024
Expiration Date:	09/17/2026
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident went without prescribed medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/23/2025	Special Investigation Intake 2026A0790012
12/23/2025	Special Investigation Initiated - Telephone I called the Complainant to ensure the allegations were accurate and comprehensive.
12/30/2025	APS Referral is not necessary because the allegations do not meet assignment criteria for Adult Protective Services (APS). The allegations concern licensing rule violations and not abuse and/or neglect of a vulnerable adult.
12/30/2025	Inspection Completed On-site I interviewed Resident A, direct care staff member (DCSM) Janaeah Hill, and administrator Nora Ramirez.
01/06/2026	Inspection Completed-BCAL Sub. Compliance
01/06/2026	Corrective Action Plan Requested and Due on 01/22/2026
01/08/2026	Exit Conference with licensee designee Connie Clauson.

ALLEGATION:

Resident went without prescribed medications.

INVESTIGATION:

On 12/23/25, I reviewed a Michigan Department of Licensing and Regulatory Affairs / Bureau of Community and Health Systems Online Complaint Form dated 12/22/25. The complaint indicated that on 12/17/25, Resident A was at the emergency room.

The complaint indicated that Resident A often gets a yeast infection under her breasts and normally gets an antifungal medication that is used to decrease the fungal infection. The complaint indicated Resident A ran out of her antifungal medication several days ago.

The complaint indicated Resident A was then seen by the nurse practitioner (NP) Angela Carder-Sokolowski who ordered the antifungal medication and Norco to help with the feelings of pain that Resident A was experiencing. Resident A waited several hours but no medications were called in. Resident A was in so much pain that it was decided she should be taken to the emergency room to receive medical treatment.

The complaint further indicated that Resident A's family took Resident A to the emergency room at Corewell Health Lakeland Hospitals – St. Joseph Hospital for treatment of a painful rash and urinary tract infection. While Resident A was at the emergency room, the pharmacy called and let Resident A's family know they could not fill the prescription for Norco that Resident A's NP Angela Carder-Sokolowski wrote because the NP allegedly did not have the authority to prescribe the medication.

On 12/23/25, I called the Complainant to confirm the allegations were accurate and comprehensive.

On 12/29/25, I interviewed quality and compliance associate Patricia Krumrie from Region IV Area Agency on Aging (AAA). Ms. Krumrie indicated she was informed that Resident A's Nystatin cream ran out while at the Adult Foster Care (AFC) facility and direct care staff members (DCSMs) did not bother to refill it.

Ms. Krumrie stated she was informed that Family Member A1 came into town to visit Resident A and immediately took Resident A to the emergency room at Corewell

Health Lakeland Hospitals – St. Joseph Hospital because Resident A was in so much pain from the rash under her breasts.

Ms. Krumrie said she was informed the NP Angela Carder-Sokolowski who sees Resident A at the facility prescribed her Norco to treat the pain but did not have the authority to prescribe the drug.

Ms. Krumrie said she was informed Resident A required medical treatment and pain medication at the emergency room to treat the rash.

I conducted an unannounced onsite investigation on 12/3025. I interviewed Resident A. Resident A appeared competent and able to recall previous incidents in great detail.

Resident A explained that on 12/17/25, she did not have any of her family members visit her at the facility. Resident A stated she personally requested she be transported to the emergency room at Corewell Health Lakeland Hospitals – St. Joseph Hospital because she was experiencing an extreme amount of pain. She said family members did meet her at the emergency room. Resident A stated that the nurse practitioner (NP) Angela Carder-Sokolowski who sees her at the facility prescribed Norco for the pain but DCSMs informed her they were not able to receive the medication from the pharmacy until the next day. Resident A said she knew she would be unable to endure the amount of pain she was in until the next day and knew she had to be seen at the emergency room immediately. She stated she required immediate medical attention.

Resident A said she was able to get the pain medication she needed at the emergency room and returned to the facility within a few hours. She stated she was suffering from a painful infection, but it has been healing up since returning from the emergency room and she is feeling much better.

Resident A stated everything is going well at the facility overall. She said she feels she receives good care at the facility for the most part.

Resident A stated she is well aware and knows all of her prescribed medications. She said she knows when she does not receive a prescribed medication and when she receives a medication she is not prescribed. She said both of these types of medication errors have occurred since living at the facility. Resident A could not provide specific incidents or timeframes for these alleged medication errors occurring.

Resident A denied running out of the antifungal medicated cream she was prescribed to alleviate the infection she had acquired on her chest under her breasts. She explained that NP Ms. Carder-Sokolowski had prescribed the same antifungal medication in powder form and had told Resident A that it would work much better than the cream for her. Resident A said Ms. Carder-Sokolowski was

correct in her assumption and the antifungal medication in powder form has worked much better. Resident A denied running out of the prescribed antifungal medication in cream or powder form.

On 12/30/25, I interviewed DCSM Janaeah Hill. Ms. Hill stated that she has worked at the facility for more than a year and has been trained to properly administrator medication(s). She said that she normally administers the residents' medications when on shift.

Ms. Hill stated that Resident A has never ran out of her antifungal medicated cream nor antifungal medicated powder.

Ms. Hill said Resident A has run out of prescribed medications in the past. She stated that she believes the medication errors have mainly occurred because of the pharmacy not filling the prescriptions in a timely manner.

Ms. Hill assisted me with conducting a thorough review of Resident A's *medication administration record (MAR)* and current prescriptions for the month of 12/25, and comparing Resident A's *MAR* with the medications available at the facility for Resident A.

I found two medication errors. I found that Resident A was prescribed Gemtesa 75 MG Tablet orally (by mouth) once daily. Resident A had not received Gemtesa since 12/28/25 and there was no evidence indicating that a DCSM or administrator had requested a refill from the pharmacy.

I found a second medication error. I found that Resident A was prescribed Meclizine 25 MG Tablet orally twice daily. Resident A had not received Meclizine since 6/9/25. I was later informed this medication had been discharged (D/C) on 10/21/23. There was no evidence showing that Resident A's prescription for Meclizine had been D/C in Resident A's *MAR* and according to the records Resident A was receiving the medication until 6/9/25.

On 12/30/25, I interviewed administrator Nora Ramirez. Ms. Ramirez stated that they have had issues with Resident A not complying with her doctor's orders, and with requests made by Ms. Ramirez and DCSMs to help DCSMs better care for Resident A.

Ms. Ramirez stated that Resident A refused to take Tylenol for pain. Ms. Ramirez admitted that Resident A had run out of Norco over the weekend recently. Ms. Ramirez said Resident A missed one morning dose of Norco and refused to take Tylenol which she was also prescribed for pain instead. She said Resident A has only run out of Norco on this one occasion and because it occurred on the weekend, they were not able to get it immediately filled. Ms. Ramirez stated this incident led to Resident A requesting to be transported to the emergency room on 12/17/25. Ms.

Ramirez said the DCSM responsible for not ordering Resident A's Norco medication was disciplined.

Ms. Ramirez explained that Resident A's primary care physician (PCP) Areceli Mesiona Brucal just up and quite in 6/25. She said it has been difficult for her and DCSMs to get the pharmacy to refill all of Resident A's previous prescriptions from Dr. Brucal, as well as transition to Resident A receiving care and her prescriptions from NP Angela Carder-Sokolowski. Ms. Ramirez stated they also have issues when multiple doctors, including Resident A's PCP and Neurologist, are simultaneously prescribing medications.

Ms. Ramirez confirmed that Ms. Carder-Sokolowski can prescribe Norco. She said the issue was that the Norco was prescribed on a weekend and they had issues with the pharmacy filling the prescription timely.

Ms. Ramirez said Resident A sometimes refuses to shower, refuses to take her prescribed Norco before showering to reduce pain, and refuses to allow DCSMs to administer her prescribed antifungal medicated powder where she is infected. She stated DCSMs have been attempting to administer the powder three times daily as prescribed, but Resident A has refused at times.

Ms. Ramirez completed an internal investigation attempting to discover what had occurred to cause the medication errors. She admitted the medication errors did happen and she would take steps to ensure they would not continue to occur going forward.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with the Complainant, Ms. Krumrie, Resident A, Ms. Hill, and Ms. Ramirez there was sufficient evidence found indicating that Resident A did not receive medications prescribed to her on several occasions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 12/30/25, during an unannounced onsite investigation, I found no evidence demonstrating that contact was made with Resident A's licensed health care professional or the appropriately licensed health care professional who prescribed the medications when medication errors occurred.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(f) Contact the resident's licensed health care professional or the appropriately licensed health care professional who prescribed the medication when a medication error occurs.**
ANALYSIS:	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with the Complainant, Ms. Krumrie, Resident A, Ms. Hill, and Ms. Ramirez there was sufficient evidence found indicating that contact was not made with Resident A's licensed health care professional or the appropriately licensed health care professional who prescribed the medications when medication errors occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/8/26, I conducted an exit conference / interview with licensee designee Connie Clauson. Ms. Clauson was informed of the outcome of this special investigation and did not dispute the findings. Ms. Clauson was asked to provide an acceptable Corrective Action Plan (CAP) within the required timeframe and agreed to do so.

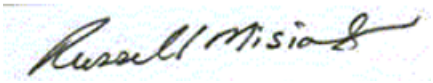
IV. RECOMMENDATION

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

1/8/26

Rodney Gill — Date
Licensing Consultant

Approved By:



1/22/26

Russell B. Misiak — Date
Area Manager