



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 4, 2026

Benjamin McKinnon
The Manor at Glacier Hills Home for the Aged
1200 Earhart
Ann Arbor, MI 48105

RE: License #: AH810236789
Investigation #: 2026A1019030

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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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,

A handwritten signature in blue ink, appearing to read "Elizabeth Gregory-Weil".

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH810236789
Investigation #:	2026A1019030
Complaint Receipt Date:	04/22/2026
Investigation Initiation Date:	04/24/2026
Report Due Date:	06/22/2026
Licensee Name:	Glacier Hills Inc.
Licensee Address:	1200 Earhart Rd. Ann Arbor, MI 48105
Licensee Telephone #:	(734) 769-6410
Administrator:	LeAnn Pennington
Authorized Representative:	Benjamin McKinnon
Name of Facility:	The Manor at Glacier Hills Home for the Aged
Facility Address:	1200 Earhart, Ann Arbor, MI 48105
Facility Telephone #:	(734) 769-6410
Original Issuance Date:	09/11/2000
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	116
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A missed a dose of medication.	Yes
Additional Findings	No

III. METHODOLOGY

04/22/2026	Special Investigation Intake 2026A1019030
04/24/2026	Special Investigation Initiated - Telephone Telephone interview with complainant.
04/24/2026	Contact - Document Sent Requested documentation from administrator.
04/27/2026	Contact - Document Received All requested documentation has been provided by licensee.
04/27/2026	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A missed a dose of medication.

INVESTIGATION:

On 4/22/26, the department received a complaint that staff failed to administer a dose of medication to Resident A. On 4/24/26, a phone interview was conducted with the complainant. The complainant reported that on 4/22/26, staff failed to administer a dose of his Farxiga. The complainant reported that the resident is supposed to receive the medication "upon rising" and that staff had failed to administer the medication to Resident A prior to him leaving the facility for lunch with family that afternoon.

I requested Resident A's medication administration record (MAR). The MAR read that Resident A is prescribed Farxiga and instructed "*TAKE 1 TABLET BY MOUTH ONCE DAILY*". I observed that on 4/22/26, staff documented that the Resident was not administered the medication and cited the reason for the missed dose as "*OUT OF FACILITY*". The MAR listed the scheduled time that Resident A is to receive the medication as "*UR*". Review of the facility's medication policy reads "*The physician's*

order for a given medication will be written as an upon rising and/or prior to bed administration time. Upon Rising = UR: Medication administered between 6:00 am and 10:00 am.” The MAR indicate that staff documented the attempted medication administration at 1:45pm, which is well past the designated time for “upon rising”.

When questioned about this, Employee 1 stated:

To Note when the resident admitted, the family was choosing to bring medications in from another pharmacy, not the pharmacy the facility works with for delivery. Due to situations when the medications were running out, the family was picking and choosing what meds to have filled by our recommended pharmacy Pharma script, that delivers directly to the community. I have included when they authorized Pharma script to fill certain medications. There were multiple times we were communicating with family about medications needing to be refilled from these outside pharmacies...

Resident A’s MAR noted “NOTIFY [RELATIVE A] 4 DAYS BEFORE MEDS RUN OUT”. Employee 1 went on to state that Resident A had run out of the medication on the morning of 4/22/26, and that the resident’s physician and family were notified that day. Employee 1 reported that same day, Resident A’s family authorized the facility to fill the medication via the contracted pharmacy, Pharmascript. Employee 1 reported that the medication was delivered to the facility on 4/22/26 around 2:00pm, but Resident A was out of the facility with his family and it could not be administered at that time. Per Resident A’s MAR, he was administered the medication as prescribed the following day.

APPLICABLE RULE	
R 325.1932	Resident’s medications.
	(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed healthcare professional.
ANALYSIS:	Resident A ran out of his Farxiga medication on 4/22/26. While facility staff provided notification of the medication running out to Resident A’s family and physician that same day, they did not give enough notice so that the medication could be obtained prior to running out. As a result, Resident A missed a dose of the medication. Based on this information, the allegation is substantiated.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



04/27/2026

Elizabeth Gregory-Weil
Licensing Staff

Date

Approved By:



05/04/2026

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

Date