GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 31, 2023

Clarence Rivette
DeWitt ALC, LLC
3520 Davenport Avenue
Saginaw, MI 48602

RE: License #: AH190397181
Investigation #: 2023A1021060
The Woodlands Of DeWitt

Dear Mr. Rivette:

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 authorized representative 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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH190397181
Investigation #:	2023A1021060
Complaint Receipt Date:	05/16/2023
Investigation Initiation Date:	05/16/2023
Report Due Date:	07/15/2023
Licensee Name:	DeWitt ALC, LLC
Licensee Address:	910 Woodlands Dr DeWitt, MI 48820
Licensee Telephone #:	(989) 327-7922
Administrator:	Evonne White
Authorized Representative:	Clarence Rivette
Name of Facility:	The Woodlands Of DeWitt
Facility Address:	910 Woodlands Dr DeWitt, MI 48820
Facility Telephone #:	(517) 624-2831
Original Issuance Date:	04/29/2020
License Status:	REGULAR
Effective Date:	10/29/2022
Expiration Date:	10/28/2023
Capacity:	45
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility has insufficient staff.	Yes
Additional Findings	No

III. METHODOLOGY

05/16/2023	Special Investigation Intake 2023A1021060
05/16/2023	Special Investigation Initiated - Letter referral sent to APS
05/17/2023	Inspection Completed On-site
05/26/2023	Contact-Documents Received Received service plans
	Exit Conference

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Facility has insufficient staff.

INVESTIGATION:

On 05/16/2023, the licensing department received an anonymous complaint with allegations the facility has insufficient staff. The complainant alleged residents wait a long time for staff assistance.

On 05/16/2023, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 05/17/2023, I interviewed administrator Evonne White at the facility. Ms. White reported the facility has 19 residents in memory care and 13 residents in assisted living. Ms. White reported the facility has two shifts: 6:00am-6:30pm and 6:30pm-

6:00am. Ms. White reported on first shift the facility likes to have five people with two employees in assisted living, two employees in memory care, and a float worker. Ms. White reported on second shift the facility likes to have four employees with two employees in each unit. Ms. White reported the facility has agency staff workers to assist with staff shortages, but the facility has decreased amount of agency staff workers. Ms. White reported when the schedule is developed there are open shifts, and the facility will ask employees to pick up an extra shift. Ms. White reported if a shift is not picked up then management will work the floor. Ms. White reported this occurs approximately once every few weeks. Ms. White reported the facility has no mandation policy. Ms. White reported if there is an unexpected staff shortage, management will ask employees to stay over or come in earlier. Ms. White reported in assisted living there are two residents on oxygen, one resident that requires increased assistance in the bathroom, and one resident that is a one person assist with care. Ms. White reported in memory care there are two or three residents that are a two person assist transfer, one resident on oxygen, one resident with behaviors, one resident with a catheter, 14 residents that require assistance with dressing and bathing, and two residents that are on two-hour checks. Ms. White reported staffing has improved.

On 05/17/2023, I interviewed staff person 1 (SP1) at the facility. SP1 reported the facility recently opened another memory care unit, the 300 hallway which has increased resident needs. SP1 reported it is typical to have four employees working on day shift with two employees in assisted living and two employees in memory care. SP1 reported there are two hallways of memory care residents and typically the two employees provide care to one hallway which results in the other memory care unit hallway being left unattended. SP1 reported if a resident requires assistance in memory care it can be difficult to recognize the need for resident assistance due to caregivers providing care to the other residents. SP1 reported resident care needs are met but there is lack of supervision due to the staffing ratios.

On 05/17/2023, I interviewed SP2 at the facility. SP2 reported staffing could be better at the facility. SP2 reported typically there are only two care staff assigned to the two hallways for memory care. SP2 reported at times one hallway of memory care residents are left unattended because the workers are in the other hallway providing care. SP2 reported in the memory care unit there are at least two residents that are a two person assist transfer.

While onsite I reviewed the physical layout of the facility. The memory care unit is comprised of two hallways where are separated by a large dining room. The two hallways are approximately five minute walk from one to the other. The assisted living unit is down another corridor which is also not visible from the memory care unit hallways.

I reviewed the staff schedule for 05/01/2023-05/14/2023. The schedule revealed on average there were two caregivers and two medication technicians scheduled for all shifts. There were only five floor workers scheduled to work on three shifts. In

addition, on 05/02/2023 on first shift there were three employees, on 05/05/2023 after 1:00pm there were only three employees, on 05/05/2023 after 2:00am there were only three employees, 05/09/2023 there were only three employees on second shift.

I reviewed Resident B, Resident C, and Resident D service plans. The residents reside in the memory care unit.

Resident B service plan read,

> *"Resident needs extensive x2 assist with gait belt to get into and out of her scooter. Staff to always use gait belt and x2 caregivers for all transfers at all times. 2 person assist with bathing."*

Resident C service plan read,

> *"Resident is an extensive x2 care staff with all transfers using a gait belt at all times."*

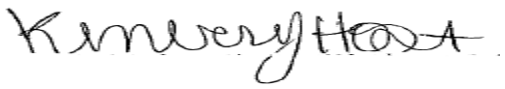
Resident D service plan read,

> *"Resident is a 2x care staff for getting up from recliner, or bed."*

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Interviews with staff, review of physical layout of the memory care wings, consideration of care needs as identified in their plans of care, along with schedule review, revealed a staffing protocol that seems incapable of ensuring care needs of the memory care residents are met. The facility has a cognitively impaired resident population that is subjected to potential harm due to the lack of available staff to ensure there is adequate staff to meet the needs of the residents as detailed in their service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



05/26/2023

Kimberly Horst Date
Licensing Staff

Approved By:

05/26/2023

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