GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 19, 2023

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

RE: License #: AH190397181
Investigation #: 2023A1021061
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 #:	2023A1021061
Complaint Receipt Date:	05/17/2023
Investigation Initiation Date:	05/17/2023
Report Due Date:	07/16/2023
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 does not allow Resident B to speak with Relative B1.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/17/2023	Special Investigation Intake 2023A1021061
05/17/2023	Special Investigation Initiated - Letter referral sent to APS
05/17/2023	Inspection Completed On-site
05/18/2023	Contact-Documents Received Received Resident B documents
	Exit Conference

ALLEGATION:

Facility does not allow Resident B to speak with Relative B1.

INVESTIGATION:

On 05/16/2023, the licensing department received a complaint with allegations the facility does not allow Relative B1 to visit Resident B at the facility.

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

On 05/17/2023, I interviewed administrator Evonne White at the facility. Ms. White reported Resident B resides in the memory care unit at the facility. Ms. White reported Resident B can make his needs and wants known. Ms. White reported Resident B has an enacted durable power of attorney (DPOA) which is Relative B2 for financial and Relative B3 for medical. Ms. White reported Relative B2 and Relative B3 have requested for the facility not allow any visitation between Relative B1 and Resident B. Ms. White reported there has been family dynamics between the relatives. Ms. White reported Relative B1 would take Resident A out of the facility for outings. Ms. White reported the physician did write a statement saying that visitors

need to leave by 9:00pm as Resident A needs his sleep but there has not been any physician statement to limit visitation by Relative B1. Ms. White reported Resident B has not been told that Relative B1 cannot visit. Ms. White reported Resident B has requested to speak with Relative B1 by telephone and this request was granted.

I reviewed facility correspondence sent to Relative B1. The correspondence read,

> *"It has been brought to our attention that (Resident B) POA's (Relative B2) and (Relative B3) have requested you to no longer visit with (Resident B) at the Woodlands. Going forward we are going to abide by their wishes and ask that you abide by them as well. Regretfully we will no longer be able to allow you access to the building."*

I reviewed the one statement letter on decision making capacity. The statement read,

> *"Regarding decision making capacity, he can express his values and preferences, but he struggles to keep track of complex information to weight risks and benefits over time due to poor encoding and significant memory impairment. Thus, it is my clinical opinion (Resident B) also lacks the capacity to make medical decisions for himself and it SHOULD BE ACTIVATED."*

I reviewed the service plan for Resident B. There was no mention in the service plan to limit communication.

I reviewed physician statement limiting visits past 9:00pm. The letter read,

> *"(Resident B) has a history of Alzheimer's dementia. Due to his diagnosis, it is very important for him to have a regular sleep pattern. I recommend for him to have no visitors past 9 pm each evening so he can get to sleep at a reasonable hour."*

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
For Reference: MCL 333.20201	**(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff.**

	Patients or residents shall be treated in accordance with the policy.
For Reference: MCL 333.20201	**(2) (k) A patient or resident is entitled to associate and have private communications and consultations with his or her physician or a physician's assistant to whom the physician has delegated the performance of medical care services, attorney, or any other person of his or her choice and to send and receive personal mail unopened on the same day it is received at the health facility or agency, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services. A patient's or resident's civil and religious liberties, including the right to independent personal decisions and the right to knowledge of available choices, shall not be infringed and the health facility or agency shall encourage and assist in the fullest possible exercise of these rights. A patient or resident may meet with, and participate in, the activities of social, religious, and community groups at his or her discretion, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant.**
ANALYSIS:	Interviews conducted and documents reviewed revealed the facility is limiting Relative B1 from visiting Resident B at the facility. The attending physician has not documented in the record that these visits are medically contraindicated. Resident B has a right to associate with any person of his choice and this right has not been ensured as this law requires.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

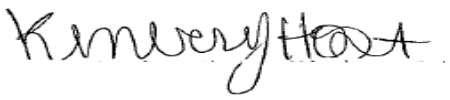
I reviewed the DPOA paperwork for Resident B. The DPOA paperwork appointed Relative B2 as the DPOA for Resident B for financial and Relative B3 for medical. There was only one physician statement stating that Resident B is unable to make medical and financial decisions.

Review of Resident A's admission agreement revealed the admission agreement was signed by Relative B2 and was not signed by Resident B.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(1) A home shall have a written resident admission contract, program statement, admission and discharge policy, and a resident's service plan for each resident.
ANALYSIS:	Review of Resident B's paperwork revealed the DPOA was not active, as two physicians did not state Resident B lacked decision making capacity. The facility had Relative B2 sign the admission agreement and not Resident B. Therefore, the admission agreement is not valid as it was not appropriately signed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



05/19/2023

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Kimberly Horst Date
Licensing Staff

Approved By:

05/19/2023

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