GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 1st, 2023

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

RE: License #: AH190397181
Investigation #: 2023A1021067
The Woodlands Of DeWitt

Dear Clarence 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

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 #:	2023A1021067
Complaint Receipt Date:	06/08/2023
Investigation Initiation Date:	06/09/2023
Report Due Date:	08/08/2023
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?
Resident C not provided medical attention.	Yes
Residents not treated respectfully.	No
Staff Person 5 not trained in medication administration.	Yes
Medications not administered.	Yes
Additional Findings	No

III. METHODOLOGY

06/08/2023	Special Investigation Intake 2023A1021067
06/09/2023	Special Investigation Initiated - Telephone interviewed complainant
06/19/2023	Contact-Telephone call made Interviewed complainant
06/27/2023	Inspection completed on site
06/30/2023	Contact-Document Received Received Resident's Medication Administration Records
08/01/2023	Exit Conference

The complainant alleged the facility has insufficient staffing. Insufficient staffing was investigation in report AH190397181_SIR_2023A1021060.

ALLEGATION:

Resident C not provided medical attention.

INVESTIGATION:

On 06/08/2023, the licensing department received a complaint with allegations residents do not receive medical attention.

On 06/09/2023 and 06/19/2023, I interviewed the complainant by telephone. The complainant alleged Resident C had a urinary tract infection (UTI) and was not provided medical attention and medication for one week.

On 06/27/2023, I interviewed administrator Evonne White at the facility. Ms. White reported Resident C has frequent UTI's and receives medications for the UTI's. Ms. White reported the facility acts timely to ensure Resident C receive medications.

On 06/27/2023, I interviewed staff person 7 (SP7) at the facility. SP7 reported Resident C was not at her cognitive baseline by acting confused and was harsh with the staff. SP7 reported a urine sample was collected on 05/01/2023 and was placed in the Sparrow Lab pick up box. SP7 reported typically in one or two days the facility has the result from the urine sample. SP7 reported she contacted Sparrow Laboratories and they reported they never received the urine sample. SP7 reported another urine sample was collected on 05/04/2023, the results were obtained on 05/09/2023, and antibiotics were started on 05/10/2023. SP7 reported when Resident C has a UTI her behavior changes and staff noticed this change. SP7 reported sometimes the visiting physician will start antibiotics prior to the urine sample results but, in this instance, antibiotics were not started until urine test results were received.

I reviewed chart notes for Resident C. The chart notes read,

"05/01/2023: Resident presenting with increased confusion/behavior changes this isn't resident's baseline. Temp 97.6. Kelli NP notified and order be sent to Sparrow Lab. Urine collected, put in Sparrow box, lab called claim number is 45027.
05/03/2023: Called Sparrow lab to send UA results. Sparrow said they no record of UA being picked up. Kelli notified, will collect another.
05/04/2023: UA collected, put into Sparrow box. Lab notified of pick up. Claim # 45175.
05/10/2023: Received call from Sparrow Medical Group that prescription will be sent to Advanced Specialty for ATB for positive UA.
05/11/2023: Resident starting Cipro for treatment of UTI."

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following:
For Reference:	**Definitions.**

R 325.1901	
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Interviews conducted and review of documentation revealed Resident C exhibited UTI symptoms on 05/01/2023 but antibiotics were not started until 05/11/2023. While the facility could not have anticipated Sparrow Laboratories losing the urine sample, the facility did not reach out to the physician for medications nor arrange medical attention to Resident C.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents not treated respectfully.

INVESTIGATION:

The complainant alleged Resident D, Resident E, and Resident F are left in the same clothes for multiple days.

Ms. White reported all residents' clothes are changed daily and are provided showers. Ms. White reported Resident D, Resident E, and Resident F are in the memory care unit. Ms. White reported Resident D will often refuse showers, but showers are always offered. Ms. White reported Resident E has a catheter that staff are responsible for changing. Ms. White reported Resident F's health has declined but care is still provided to him. Ms. White reported no concerns from family members or staff have been brought to her attention.

On 06/27/2023, I interviewed SP8 at the facility. SP8 reported all residents receive good care at the facility. SP8 reported the residents' clothes are changed daily and basic hygiene is provided. SP8 reported no concerns with care provided to the residents.

On 06/27/2023, I interviewed SP9 at the facility. SP9 reported residents receive good care at the facility. SP9 reported the residents are treated with respect and are happy to be at the facility. SP9 reported there were concerns with Resident E's

catheter, but staff were provided more education on catheter care and there are no longer any concerns. SP9 reported family members will bring concerns to the staff and no concerns from their family members have been brought to her attention.

On 06/27/2023, I observed Resident D, E, and F at the facility. All residents appeared to be clean as their skin was clean, hair was washed, and they had clean clothes on.

On 06/27/2023, I interviewed Resident F at the facility. Resident F reported he was having a good day and felt great.

I reviewed Resident E's service plan. The service plan read,

> *"Resident needs to have catheter care which includes peri care each shift and emptying my catheter twice daily and prn. Resident is on heart to heart hospice. Hospice will change my catheter monthly and prn. Please do not get alarmed due to the blood in my catheter or if I have low or no output. I get frequent UTI's and I am choosing not to treat them anymore."*

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Interviews conducted and observations made revealed lack of evidence to support the allegation residents are treated disrespectfully.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff Person 5 not trained in medication administration.

INVESTIGATION:

The complainant alleged that SP5 is not trained in medication administration but is responsible for administering medications.

On 06/27/2023, I interviewed SP6 at the facility. SP6 reported the medication technician training consists of three days. SP6 reported the first day the trainee is observing, the second and third day they are administering under the supervision of the training technician. SP6 reported herself or another member of the management

team signs off on the paperwork but that they do not evaluate the new medication technician for any skills or competencies.

I reviewed SP5's medication technician training paperwork. The paperwork revealed SP5 trained three days on medication administration and was signed off to administer medications by a member of the management team without any evaluation of staff knowledge and competencies.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(7) The home's administrator or its designees are responsible for evaluating employee competencies
ANALYSIS:	Review of SP5's medication technician training revealed the facility administrator or designees did not evaluate SP5's competencies in medication administration.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Medications not administered.

INVESTIGATION:

The complainant alleged that residents do not receive medications. The complainant alleged medications are found unsecured in the medication cart. The complainant alleged there are differing amounts of medications found in the medication blister packs.

On site I observed the two medication carts located in the memory care unit. I did not observe any unsecured medications. The blister packs for the medications were administered in various ways and there did not appear to be an organized order for the medication technicians to administer the medications. I observed the narcotic count sheets for the medication carts. The narcotic count sheets revealed staff were counting narcotic medications at the start and end of each shift. The count sheets revealed the same number of medications on the count sheets as found in the blister packs.

SP8 reported she was trained to administer medications from the blister packs starting at the top and going down. SP8 reported the mediation technicians administer the medications from the blister packs in differing ways and therefore it can be difficult to quickly count how many pills are left in the blister packs. SP8 reported she has never observed unsecured medications in the medication carts.

SP8 reported medication technicians are to count narcotic medications at the start and end of each shift. SP8 reported residents receive their medications.

I pulled the medication variance report. Ms. White reported the facility does not review this report but will do so moving forward.

I reviewed five June 2023 resident medication administration records (MAR). The MAR revealed the following instances where staff did not initial when a medication was administered:

Resident G:
Acetaminophen 325mg tablet 6/11, 6/13
Ear Drops 6/1, 6/3, 6/4
Enoxaparin Injection 6/20
Hydrocap Tab 325mg 6/27

Resident H:
Tamsulosin Cap .4mg: 6/15, 6/16, 6/20

Resident I:
Divalproex Tab 250mg: 6/14
Oxybutynin Tab 5mg 6/14

Resident J:
Acetamin Tab 500mg: 06/20
Lidocaine Patch: 06/20
Quetiapine Tab 50mg: 06/19, 06/20
Trazodone Tab 50mg: 06/20

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self administer shall comply with all of the following: **(v) The initials of the individual who administered the prescribed medication.**
ANALYSIS:	Review of multiple resident MAR's revealed staff are not initialing when medications are provided and therefore it is difficult to determine if the resident received the medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/07/2023

Kimberly Horst Date
Licensing Staff

Approved By:

07/31/2023

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