GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 31, 2023

Todd Dockerty
Dockerty Health Care Services, Inc.
8850 Red Arrow Hwy.
Bridgman, MI 49106

RE: License #: AL110341658
Investigation #: 2023A0579046
Woodland Terrace of Paw Paw Lake

Dear Todd Dockerty:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 9/21/23, you submitted an acceptable written corrective action plan.

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) 356-0183.

Sincerely,

Cassandra Duursma

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL110341658
Investigation #:	2023A0579046
Complaint Receipt Date:	09/08/2023
Investigation Initiation Date:	09/08/2023
Report Due Date:	11/07/2023
Licensee Name:	Dockerty Health Care Services, Inc.
Licensee Address:	8850 Red Arrow Hwy. Bridgman, MI 49106
Licensee Telephone #:	(574) 529-2014
Administrator:	Roni Brown
Licensee Designee:	Todd Dockerty
Name of Facility:	Woodland Terrace of Paw Paw Lake
Facility Address:	6786 Red Arrow Highway Coloma, MI 49038
Facility Telephone #:	(269) 468-5800
Original Issuance Date:	10/30/2014
License Status:	REGULAR
Effective Date:	04/29/2023
Expiration Date:	04/28/2025
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Medications are not given correctly and are left sitting in the home.	Yes

III. METHODOLOGY

09/08/2023	Special Investigation Intake 2023A0579046
09/08/2023	Special Investigation Initiated - Telephone Todd Dockerty, Licensee Designee
09/12/2023	Contact- Telephone call made Relative A
09/21/2023	Contact- Face to Face Resident A, Nicki Rogers (Direct Care Worker/DCW), Tonya Smith (DCW), Tammy Ehner (DCW), and Todd Dockerty (Licensee Designee)
09/21/2023	Exit Conference Todd Dockerty, Licensee Designee
09/21/2023	Corrective Action Plan Received/Approved
09/21/2023	Contact- Telephone call made Relative A

ALLEGATION:

Medications are not given correctly and are left sitting in the home.

INVESTIGATION:

On 9/8/23, I received this referral through the Bureau of Community Health Systems on-line complaint system. The referral alleged Resident A's medications have gone missing and she has not received them on occasion. Medications have been found on the floor and sitting in a cup in the home.

On 9/8/23, I completed a telephone call, that was previously scheduled, with Mr. Dockerty regarding discharging Resident A due to concerns with Relative A's

behavior in the home. It was agreed a 30-day discharge would be appropriate. The allegations were not discussed at this time.

On 9/12/23, I completed a telephone interview with Relative A. The discharge of Resident A was discussed and confirmed to be appropriate by licensing standards. Relative A stated he has had concerns for finding medications on the floor in Resident A's room on occasion and that he found an unattended cup of medications in a common area on 9/5/23. He stated he refills Resident A's medications himself and in September or October 2022, medications were "disappearing with no explanation" and he was having to refill the medications when they should not have needed a refill. He stated around December 2022, Resident A's medications went missing again so he began counting them himself to ensure they were being given correctly and not running out too soon. He stated there were times when Resident A went "weeks at a time" without receiving her medication due to error. He stated he discussed these concerns with Mr. Dockerty and Ms. Ehner, but they were not addressed.

On 9/12/23, I received photographs from Relative A. There was a photograph of a pill in a person's hand, a photograph of the same pill in a medication cup, and another photograph of the medication in the cup next to Resident A's phone. There was also a text message that read the pill was found near Resident A's phone.

I also received five photographs. One photo was of a page dated 12/28/22 that listed Resident A's medications with a number (presumably the number of tablets) next to it. It was signed by Relative A and Direct Care Worker (DCW) Tonya Smith. There was a photo from 1/19/23 with the same information but not signed. There was a photo with the same information dated 2/21/23 and 3/28/23 signed by Relative A and Ms. Smith. There were two photographed pages where Relative A subtracted the information from the previous photos counting the medications given during that period. The number of medications reportedly varied, at times, from what the count would have been if they were given correctly.

I received two photographs of medications in a cup and medications in a cup on a counter in the common area of the home.

On 9/21/23, I completed an unannounced on-site investigation. Interviews were completed with Resident A, DCW Nicki Rogers, DCW Tonya Smith, DCW Tammy Ehner, and Mr. Dockerty. Interviews were completed privately with Resident A and Ms. Rogers.

Resident A denied concerns for her care at this home. She reported DCWs pass her medications and she believes they are given correctly. She denied medications being left in her room or not receiving her medications regularly.

Ms. Rogers stated she has heard that medications were found on the floor in Resident A's room and medication cups have been left unattended in the home. She

stated she has witnessed medications on the floor when she was working and had to dispose of them. She stated DCWs must watch Resident A take her medication, even if it takes time, because she often has medication fall out of her mouth. She stated not all workers will take the time to ensure she swallows her medications so that they do not fall out of her mouth. She stated she believes management has found that it was primarily one person who was leaving medications unattended and not ensuring Resident A swallowed her pills, and she was sent for additional medication training but now she does not pass medication. She stated she has not witnessed any medications on the floor or in unattended cups recently. She stated when she works, she is the person who passes medications, so the medications on the floor and medications cups are not happening on her shift.

Ms. Smith stated Relative A did come to her and Ms. Ehner regarding concerns for Resident A's medications. She stated Relative A became very agitated regarding Resident A's medications claiming she was not receiving them correctly and he was having to refill them too quickly. She stated they attempted to explain that some medications Resident A receives three times a day and since he refills individual bottles, they are received at different times which leads to regularly having to refill prescriptions, but not necessarily the same medication repeatedly. She stated she believes when Relative A was assisting Resident A with her medication at home, she was not taking it as prescribed, and medication was lasting longer. She stated Relative A began to request Resident A's numerous bottles of pills be counted at his request. She stated she agreed that he could count the medications, but that she did not have time to count each pill in each bottle at his request. She stated she did sign documents confirming Relative A counted Resident A's medications but she did not count them with Relative A so she cannot confirm the medications were counted correctly. She denied concern that Resident A was not receiving her medication correctly and stated there was never a time when Resident A went "weeks at a time" without receiving medication.

Ms. Smith reported there were three incidents where Relative A reported he found medication in the home. She stated he reported he found an Aleve tablet in Resident A's room, but Resident A is not prescribed Aleve, and it is not a standing order that is kept in the home, so she is not certain how he reportedly found that tablet in her room. She stated another occasion, Relative A reported Relative A2 found medication in a cup in Resident A's room, and another time, he reported he found medication in a cup in the common area of the home. She stated all Relative A's concerns regarding medication were taken seriously and investigated. She stated it was determined the same DCW was passing medications when the incident with the medication in Resident A's room and the medication in the common area occurred, so the DCW had to complete medication training again. She stated that DCW returned after her second medication training, and it was determined she would no longer be passing medications moving forward.

Ms. Ehner confirmed that Relative A became very agitated regarding Resident A's medications and requested that DCWs count them on his demand. She stated

Resident A has numerous bottles of pills that refill at varying times so counting them is extremely challenging and given the other tasks DCWs must perform, there is no time to count them at Relative A's request. She stated she believes Relative A counted Resident A's medications for a while until Mr. Dockerty began counting them himself. She stated Relative A refills Resident A's medications so if they were not in the home appropriately, it was because he did not refill them as needed. She denied that Resident A had gone "weeks at a time" without her medications.

Ms. Ehner confirmed there were three incidents regarding Resident A's medication that Relative A reported, including when he found an unknown Aleve tablet in Resident A's room, he found medications in a cup in Resident A's room, and he found unattended medications in a cup in the common area of the home. She confirmed it was found there was the same DCW working when medications were found and that DCW went for additional training but when she returned, it was decided she would not pass medications moving forward.

Mr. Dockerty confirmed the reports of Ms. Smith and Ms. Ehner. He stated Resident A brought her own belongings when she moved in so he believes the Aleve tablet may have been in her belongings previously because it is not something that is kept in the home, and it is unknown how it would have been found in Resident A's room. He confirmed the medication found in Resident A's room and in the common area were linked to the same DCW who was sent for training, but it was determined after additional training and passing medication again after that training, that she would not pass medications moving forward. He stated Relative A requested DCWs count each pill in Resident A's pill bottles when he requested, but it was not possible so Relative A began counting the medications himself. Mr. Dockerty stated he then began counting the medications once a month starting in June 2023 and since that time, he has never found the medication to be off like Relative A reported it was when he was counting it. He stated he believes the discrepancies in the counts may have been in error because Resident A can have up to 150 tablets of one medication and it is challenging to count. He denied that Resident A was given her medication incorrectly, aside from that one DCW may not have stayed to supervise Resident A's swallowing of the medication like she should have. He denied that Resident A went weeks at a time without medication and reported Relative A refilled the medication himself.

I reviewed Resident A's medications while at the home. All her prescription bottles were present according to her current Medication Administration Record. Due to the number of medication bottles and individual pills, and to avoid contamination, individual pills were not counted.

On 9/21/23, I completed a telephone call with Relative A. He reported Resident A is moving. He reported he does not believe Mr. Dockerty is being honest and that the DCW who was making the medication errors did stop passing medication but passed them again and he believes she continues to pass them.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Relative A, Ms. Smith, Ms. Ehner, and Mr. Dockerty acknowledge there were three incidents when it was reported medication was found, unattended, in the home. Relative A submitted photographs of medications found in the home. It was reported one DCW was found to be working when these incidents occurred, and she was sent for additional training, returned, and it was determined she would not pass medication anymore. Based on the interviews completed and documentation observed, there is sufficient evidence that prescription medications were not appropriately kept in their pharmacy supplied container, locked cabinet, and given as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/21/23, I completed an exit conference with Mr. Dockerty who acknowledged the rule violation and reported corrective measures were already taken. He agreed to type a Corrective Action Plan and submit it to me.

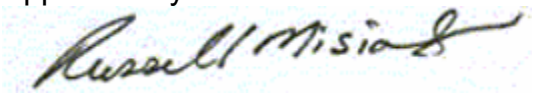
IV. RECOMMENDATION

An acceptable plan of corrective action has been received and it is recommended the status of the license remain the same.

Cassandra Duursma 10/13/23

Cassandra Duursma Date
Licensing Consultant

Approved By:



10/31/23

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Russell B. Misiak Date
Area Manager