GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 30, 2024

Daniela Popaj
DeWitt ALC, LLC
3520 Davenport Avenue
Saginaw, MI 48602

RE: License #: AH190397181
Investigation #: 2024A1021090
The Woodlands Of DeWitt

Dear Ms. Popaj:

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.

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 #:	2024A1021090
Complaint Receipt Date:	09/25/2024
Investigation Initiation Date:	09/25/2024
Report Due Date:	11/25/2024
Licensee Name:	DeWitt ALC, LLC
Licensee Address:	910 Woodlands Dr DeWitt, MI 48820
Licensee Telephone #:	(989) 327-7922
Administrator:	Evonne White
Authorized Representative:	Daniela Popaj
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:	10/29/2023
Expiration Date:	10/28/2024
Capacity:	45
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident B care not provided in accordance with service plan.	Yes
Resident B ran out of Lumigen eyedrops.	Yes
Resident B has dirty sheets.	No
Resident B does not receive water.	No
Additional Findings	Yes

III. METHODOLOGY

09/25/2024	Special Investigation Intake 2024A1021090
09/25/2024	Special Investigation Initiated - On Site
09/25/2024	Contact-Telephone call made Interviewed SP3
09/25/2024	Contact-Telephone call made Interviewed University of Michigan-Sparrow Home Hospice registered nurse Mandy Marin
09/25/2024	Contact-Telephone call made Interviewed Advanced Specialty Rx pharmacy department Becky Riegel
10/30/2024	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:

Resident B care not provided in accordance with service plan.

INVESTIGATION:

On 09/25/2024, the licensing staff received a complaint with allegations Resident B does not receive personal care. The complainant alleged staff allow Resident B to stay in the same clothes for multiple days. The complainant alleged staff report Resident B refuses showers and that staff are not properly trained on how to provide more assistance to promote Resident B to bath.

On 09/25/2024, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident B often does refuse care, especially by female caregivers. SP1 reported he can typically get Resident B to change clothes and to get cleaned up for the day. SP1 reported Relative B1 will often come and shower Resident B. SP1 reported there are times that Resident B will refuse to change his clothes even with multiple attempts by caregivers. SP1 reported Resident B has the right to refuse to change clothes or showers. SP1 reported caregivers are to offer three times and then document the refusal.

On 09/25/2024, I interviewed SP2 at the facility. SP2 reported Relative B1 will often shower Resident B as he refuses care from the employees. SP2 reported typically she can get Resident B to change his clothes. SP2 reported caregivers are to ask and promote Resident B to complete activities at least three times before a refusal is documented.

On 09/25/2024, I interviewed administrator Evonne White at the facility. Ms. White reported caregivers encouraged Resident B to change clothes and to shower. Ms. White reported caregivers are to offer three times and then document a refusal. Ms. White reported Resident B has been more agitated and refusal assistance from caregivers. Ms. White reported Relative B1 will often come to the facility and provide a shower to Resident B. Ms. White reported Resident B does receive adequate care and employees encourage Resident B to complete said activities.

On 09/25/2024, I interviewed University of Michigan-Sparrow Home Hospice registered nurse Mandy Marin by telephone. Ms. Marin reported the hospice company was providing an aid to assists with showers, however, Resident B kept refusing showers. Ms. Marin reported Resident B does prefer to wear the same clothes, but she has seen Resident B in various clothing items. Ms. Marin reported Resident B does have dry skin due to refusing showers. Ms. Marin reported Resident B has no skin rashes or skin breakdown. Ms. Marin reported no concerns with Resident B not receiving adequate care at the facility.

I reviewed shower sheets for Resident B. The shower sheets revealed the following:

08/21: shower provided
09/08: refused x3
09/09: shower provided
09/12: shower provided
09/15: shower provided
09/17: refused x3; Relative B1 provided shower

09/19: shower provided

I reviewed charting notes for Resident B. The charting notes read,

"09/15: Since resident has gotten up for the day, resident has been very resistant to staff helping him with ADL's. Resident has not been wanting to change clothes for the day."
09/16: Resident allowed care staff to assist him with dressing and changed into clean clothes and a clean brief
09/20: Resident received his shower tonight from the caregiver."
.

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

"If resident is refusing assistance from care staff, care staff will document any refusals from the resident for assistance. Residents scheduled shower days are Tuesday, Thursday, and Sunday evenings. Residents scheduled linen change is on Tuesday after shower has been completed. If resident refuses assistance from the care staff, care staff will need to document all refusals from the resident for bathing assistance."

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:	Review of Resident B's service plan revealed Resident B was to receive a shower on Tuesday, Thursday, and Sunday. If Resident B refused a shower, it was to be documented. Review of facility documentation revealed no documentation that Resident B refused or was offered a shower on 09/01, 09/03, 09/05, 09/10, 09/22, and 09/24.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B ran out of Lumigen eyedrops.

INVESTIGATION:

The complainant alleged Resident B ran out of Lumigen eye drops.

Ms. White reported the family provided samples of the eye drops to the facility, however, the eye drops were expired and therefore had to be thrown out. Ms. White reported there was an issue with the medication, however, the medication was delivered the same day it had ran out.

On 09/25/2024, I interviewed staff person 3 (SP3) by telephone. SP3 reported she was not made aware that Resident B had ran out of medications. SP3 reported once she was made aware she attempted to have the medication delivered to the facility. SP3 reported she contacted the nurse with Sparrow Hospice on getting a new bottle, but the nurse never returned her telephone call. SP3 reported the facility pharmacy, Advanced Specialty Rx, reported Resident B's insurance only allows for one bottle per month and Resident B had run out prior to the end of the month.

On 09/25/2024, I interviewed Advanced Specialty Rx pharmacy department Becky Riegel by telephone. Ms. Riegel reported the pharmacy was contacted after hours on 09/14/2024, that Resident B required a refill on this medication. Ms. Riegel reported if a request is made after hours and on the weekend, it is processed the following Monday which was 09/16/2024. Ms. Riegel reported the pharmacy was to reach out to the facility to inquire if Resident B did need this medication prior to the cycle fill day, and if so, then the medication would be delivered sooner. Ms. Riegel reported she could not confirm when this communication occurred but that the medication was delivered on 09/18/2024. Ms. Riegel reported no documentation of correspondence with the facility prior to 09/14/2024.

I reviewed Resident B's medication administration records (MAR) for September 2024. The MAR revealed Resident B was prescribed Bimatoprost Sol 0.03% with instruction to administer one eye drop in both eyes at bedtime. The MAR revealed Resident B did not receive this medication on 09/06-09/08 and 09/13-09/17.

I reviewed charting notes for Resident B. The charting notes read,

> *"09/13: Medication cart audit was done and resident did have a bottle of Bimatoprost Sol 0.03% in the cart, but the bottle was expired and had to be taken out of the medication cart.*
> *09/16: Resident Bimatoprost Sol 0.03% were reordered by DRC, and pharmacy will be delivering it on 09/20/24 with the regular cycle fill.*
> *09/18: Tried to call hospice about residents Bimatoprost Sol 0.03% and hospice did not answer call. DRC did call pharmacy, and pharmacy noted that they will be delivering Bimatoprost Sol 0.03%, tonight, 09/18/24."*

I reviewed medication notes for Resident B. The notes read,

> *"09/09: Family provided an extra bottle, which is what was given to the resident.*
> *09/10: Family provided an extra bottle, which is what was given to the resident.*
> *09/11: Family provided an extra bottle, which is what was given to the resident.*
> *09/12: Family provided an extra bottle, which is what was given to the resident."*

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Review of Resident B's documentation revealed Resident B ran out of the Bimatoprost Sol 0.03% on 09/06/2024. However, the pharmacy was not contacted until 09/14/2024 for a refill on the medication. The facility did not ensure the prescribed medication was taken as prescribed by the licensed health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B's sheets are dirty.

INVESTIGATION:

The complainant alleged staff is not checking beds daily per the care plan. The complainant alleged fecal matter has been found on the bedding five times in the last 18 days by Relative B1.

SP1 reported staff are to check Resident B's sheets throughout the day. SP1 reported Resident B has been known to keep dirty depends in his room and has been known to sit on bed and take off depends. SP1 reported Resident B's sheets are changed at least once a week but are often changed more frequently.

SP2 reported at a minimum Resident B's sheets are changed on shower days. SP2 reported staff are checking the sheets for any fecal matter.

Ms. Marin reported she has not observed Resident B to have dirty sheets on his bed.

Ms. White reported Resident B will sit on his bed and attempt to take off a dirty depend. Ms. White reported care staff are changing sheets, as needed.

I observed Resident B's bed. The bed was made, and the sheets appeared clean with no fecal matter on the bed.

Resident B's chart notes read,

> *"09/23: Resident has no dirty briefs anywhere in his room including his bed. his sheets are clean and his trash has been taken out.*
> *09/20: Upon arrival, resident's sheets were soiled, he was wearing two briefs again, one was soiled and the other was partially soiled. Resident was also wearing soiled pants.*
> *09/19: Resident's bed was made, and his linens were clean."*

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

> *"Care staff will assist resident with linen change as needed on scheduled shower days. Care staff will check residents bed linens daily. If residents bed linens are dirty/soiled, care staff will take off the bed linens, and go place them in the washer, and then the dryer. Once the bed linens have been washed, staff will put the clean bed linens back on the residents bed."*

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(1) Bedding shall be washable, in good condition, and clean, and shall be changed at least weekly or more often as required.
ANALYSIS:	Interviews conducted, observations made, and review of documentation revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B does not receive water.

INVESTIGATION:

The complainant alleged Resident B does not drink water out of Styrofoam cups and prefers to drink water out of a water bottle with liquid IV. The complainant alleged staff members are not providing this type of water to Resident B.

SP1 reported he provided IV hydration water in the blue water bottle to Resident B this morning. SP1 reported when he reports to his shift, there is evidence of water provided to Resident B in his personal water bottle.

SP2 reported Resident B does receive water that is flavored with Liquid IV. SP2 reported no concerns with Resident B not receiving water.

Ms. White reported the facility has educated staff on Resident B's water preferences. Ms. White reported there is signage on Resident B's door not to provide water in a Styrofoam cup.

Ms. Marin reported she observed Resident B at the facility today. Ms. Marin reported Resident B's legs appeared to be swollen due to increase in hydration. Ms. Marin reported caregivers reported Resident B's briefs are full. Ms. Marin reported Resident B was admitted on hospice due to dehydration but there have not been any recent concerns about dehydration.

I observed Resident B in his room. There were various blue water bottles and liquid IV in Resident B's room. Resident B observed to have a water bottle that was ½ filled in his hand.

Resident B's chart notes read,

> *"09/23: No Styrofoam cups are in his room his bottle was filled with fresh water and liquid iv and he was encouraged to drink it throughout the day.*
> *09/23: Liquid IV & water bottle filled.*
> *09/22: His water bottle was filled & packet of liquid IV.*
> *09/21: Got him set up with fresh water for his Liquid IV.*
> *09/20: His bottle is filled with water and liquid iv.*
> *09/19: resident does have fresh water in water bottles, and does have liquid IV.*
> *09/19: He has fresh water in his bottle with liquid iv.*

Resident B's care plan read,

> *"Resident needs to be drinking two big cups of water throughout each shift. Resident does have a blue hydration cup that he likes to use. When giving resident water, make sure that Liquid IV had been placed in the cup with water. Make sure that resident drinks all of the water. Resident is very prone to dehydration. Two glasses of water during day shift, and one glass of water during night shift."*

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.

ANALYSIS:	Interviews conducted, observations made, and review of documentation revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

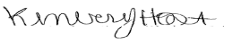
INVESTIGATION:

SP3 reported she contacted hospice regarding the lack of eye drops. SP3 reported she is not certain if the physician was contacted.

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: **(c) Contact the appropriate licensed health care professional when the prescribed medication has not been administered in accordance with the label instruction, an order from a health care professional, medication log, or a service plan.**
ANALYSIS:	Review of facility documentation revealed Resident B's physician was not contacted regarding the multiple missed doses of the Bimatoprost 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.



09/26/2024

_____

Kimberly Horst Date
Licensing Staff

Approved By:

10/30/2024

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