STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

December 9, 2024

Theresa Alvarado
Addie's Acres, LLC
11525 Wood Road
DeWitt, MI 48820

RE: License #: AL190357883
Investigation #: 2025A1029004
Addie's Acres, LLC

Dear Ms. Alvarado:

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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL190357883
Investigation #:	2025A1029004
Complaint Receipt Date:	10/23/2024
Investigation Initiation Date:	10/23/2024
Report Due Date:	12/22/2024
Licensee Name:	Addie's Acres, LLC
Licensee Address:	11633 Wood Road, DeWitt, MI 48820
Licensee Telephone #:	(517) 410-1197
Administrator:	Theresa Alvarado
Licensee Designee:	Theresa Alvarado
Name of Facility:	Addie's Acres, LLC
Facility Address:	11633 Wood Road, DeWitt, MI 48820
Facility Telephone #:	(517) 668-1590
Original Issuance Date:	07/24/2015
License Status:	REGULAR
Effective Date:	01/24/2024
Expiration Date:	01/23/2026
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A had a wound and the dressing was not changed for over 48 hours which caused the wound to grow and was found black and filled with feces.	Yes

III. METHODOLOGY

10/23/2024	Special Investigation Intake 2025A1029004
10/23/2024	Special Investigation Initiated – Telephone to Tom Hilla APS
10/23/2024	Inspection Completed On-site – face to face with direct care staff members Savada Wells, Deborah Marcinkiewicz, Resident A, Relative A1, Relative A2, Tammy Uribe (Hospice social worker, and licensee designee Theresa Alvarado
10/23/2024	APS Referral - Tom Hilla is already investigating the concerns.
10/24/2024	Contact - Telephone call and email exchanged with Tina Griffith VNA and Sara Johnston, RN- VNA
10/29/2024	Contact - Document Sent - Email exchange with Tom Hilla APS
10/29/2024	Contact – Telephone call made to direct care staff member Valerie Britten.
12/03/2024	Contact - Document Sent Email to Tina Griffith
12/03/2024	Contact - Document Sent APS Tom Hilla
12/04/2024	Contact – Telephone call to licensee designee Theresa Alvarado. Left message and call was returned with a message.
12/06/2024	Contact – Telephone call to licensee designee Ms. Alvarado
12/06/2024	Exit conference with licensee designee Ms. Alvarado

ALLEGATION: Resident A had a wound and the dressing was not changed for over 48 hours which caused the wound to grow and become black and filled with feces.

INVESTIGATION:

On October 23, 2024, I received a complaint from the Bureau of Community and Health Systems online complaint system with allegations that Resident A had a wound and the dressing was not changed for over 48 hours which caused the wound to grow and become black and filled with feces. According to the complaint allegations, the dressing was changed on October 17, 2024 by Visiting Nurses Association RN Sara Johnston and when it was checked again by her on October 21, 2024 it was evident the dressing had not been changed since October 17, 2024. Adult Protective Services (APS) specialist, Tom Hilla was also assigned to investigate the concerns.

On October 23, 2024 I completed an unannounced on-site investigation at Addies Acres and interviewed direct care staff member Savada Wells. Ms. Wells stated she was familiar with Resident A and became emotional stating Resident A has been declining since Ms. Wells returned from her vacation. Ms. Wells stated Resident A is 98 years old and has been declining because she barely eats more than a few bites. Ms. Wells stated Resident A's skin is paper thin and she has sores on her bottom. Ms. Wells stated she was on vacation the weekend of October 18-21, 2024 and returned on October 22, 2024. Ms. Wells stated when she returned she was informed Relative A1 and Relative A2 were upset because Resident A's sore was worse. Ms. Wells stated since she was not working, she did not know if Resident A's dressing was changed. Ms. Wells stated typically she uses DuoDerm on Resident A's wound. Ms. Wells stated she does not know if there is an order for wound changes but they have always done this. Ms. Wells stated there are nurses coming to Addie's Acres to evaluate and provide care to Resident A and Dr. Alvarado is now Resident A's primary provider. Ms. Wells stated when the nurse from Visiting Nurse came in to provide care for Resident A she put the dressing on Resident A's wound and then instructed direct care staff members to change it every other day. Ms. Wells stated Resident A has had a wound for around five months now so she has experience changing the wound dressing. Ms. Wells stated when she left for vacation the wound was open on Resident A but she did not recall seeing it black or filled with feces. Ms. Wells stated the sore is on her bottom so it is easy for fecal matter to cover the top of the dressing but it does not go in the wound because of the bandage. Ms. Wells stated Resident A started receiving Hospice services on October 22, 2024 and her family visits her often. Ms. Wells stated before she left for vacation the week prior Resident A was able to ambulate around the building with her walker and was not bed bound.

On October 23, 2024 I interviewed Resident A. Resident A stated she does have a sore on her backside near her buttocks and direct care staff members are treating it and cleaning it for her. Resident A then stated a nurse usually cleans it and that she has had the sore for "quite a while" but was unable to give a time frame. Resident A stated she has a sore because she sits in her red chair too often. Resident A stated she

receives “good care” at Addies Acres. Resident A stated typically direct care staff members Ms. Wells or Ms. Marcinkiewicz will assist her.

During the on-site investigation, Relative A1 and Relative A2 were visiting with Resident A in her room. Relative A1 stated they were both upset the dressing was not changed for approximately three days and she sat with an open wound until RN Sarah Johnston responded from Michigan Community VNA and changed her dressing on October 21, 2024. Relative A2 stated this is the same dressing which was placed on her October 17, 2024 and she was informed RN Johnston gave specific instructions to direct care staff members on how to provide wound care and wrote an order for this to be done on October 14, 2024. Relative A1 stated the wound was “filthy, puffed with feces, and black.” Relative A1 stated Ms. Johnston informed them the dressing was not changed because there was only one bandage out of the box which was given to them and the smell was so bad. Relative A1 and Relative A2 both reported they have been satisfied with the care up until this wound was discovered.

Relative A1 stated Resident A’s primary physician is Dr. Alvarado and the first visit with him was October 10, 2024 and at the visit, Dr. Alvarado did not take the dressing off but he did order visiting nurse, RN Johnston, services. Relative A1 stated she contacted Dr. Alvarado and let him know she needed to have an order to receive Hospice Services due to Resident A’s decline. Relative A1 stated Resident A is currently in pain due to her wound and declining health so she has been receiving Morphine every four hours to make her comfortable. Relative A1 and Relative A2 both stated they are trying to find a Hospice facility to move Resident A due to this incident. Relative A1 stated there was another wound in May 2024 this year but that one did heal. Relative A1 heard about this bed sore the first week of October 2024 and before that time was not told she needed to take Resident A to the physician because of bed sores.

During this discussion Sparrow Hospice social worker, Tammy Uribe arrived and stated she also had concerns about the dressing not being changed. Ms. Uribe stated she will be assisting the family in moving Resident A to a Hospice facility. Ms. Uribe stated they were using a large dressing and bandage on the wound now and crushing Flagyl to help with the odor because it is an antibiotic.

Relative A1 stated she had a text message from RN Johnston describing the wound. I reviewed the text from October 21, 2024 which stated:

“[Resident A] has a Stage 3 pressure ulcer to coccyx with possible infection, foul odor, and bloody drainage. Also showing signs of dehydration with elevated heart rate and lower blood pressure. Eating very minimal, aspiration risk, pocketing medications. Needs comfort medications ASAP, I also let our social worker know the interaction with the MA and they will be following up with the doctor.”

On October 23, 2024, I interviewed direct care staff member Deborah Marcinkiewicz. Ms. Marcinkiewicz stated she does not typically handle physicians orders for the residents because she mainly works second shift. Ms. Marcinkiewicz stated Resident A has had bed sores for “quite a while due to age and not eating.” Ms. Marcinkiewicz

stated she also stays in her chair a lot and does not want to move around as much although she sometimes comes to the dining area for meals. After several attempts to get Ms. Marcinkiewicz to clarify how long the sores have been there, she said Resident A has had bed sores for about six months. Ms. Marcinkiewicz stated the family and Resident A's physician were both notified of the sores. Ms. Marcinkiewicz stated licensee designee Theresa Alvarado is the one who works primarily third shift and handles all the paperwork and medical orders. Ms. Marcinkiewicz stated when a resident has a wound they are trained to keep it covered but Resident A is always lying on the dressing in her bed. Ms. Marcinkiewicz stated Resident A's dressing is changed when she is washed which varies. Ms. Marcinkiewicz stated if there was stool on the bandage then it would always be changed. Ms. Marcinkiewicz stated she tried to keep it clean but stated direct care staff were not automatically checking the wound each day. Ms. Marcinkiewicz stated the dressing was not changed over the weekend because she thought RN Johnston was going to come back and change the dressing. Ms. Marcinkiewicz stated RN Johnston did not come during the weekend to change the dressing. Ms. Marcinkiewicz continued stating "we try to keep it clean" but could not state how often she checked the dressing or if it was checked throughout the weekend noted in the allegation. Ms. Marcinkiewicz stated she did not notice an odor coming from the wound but Resident A "has had a smell for a long time." Ms. Marcinkiewicz also denied making a phone call to Michigan Community Visiting Nurses Association or Ms. Alvarado to find out if she should change the dressing or if any other steps should be taken.

On October 23, 2024, I interviewed licensee designee Teresa Alvarado. Ms. Alvarado stated she has been in business with her AFC for many years and has never had a special investigation. Ms. Alvarado stated she cannot perform tasks they do not have an order for and that is why no one changed the wound over the weekend. Ms. Alvarado stated Resident A's family is upset with her because of this and want to move Resident A.

During the on-site investigation, I reviewed Resident A's resident record which included the following documentation:

1. Resident A's *Assessment Plan for AFC Residents* which includes documentation Resident A needs assisting for bathing, toileting, grooming, dressing, and personal hygiene.
2. Resident A's *Resident Care Agreement* which stated the fee includes 24/7 supervision, medication administration, basic laundry, housekeeping, assistance with shower, ambulation, and transfers.
3. Resident A's Health Care Appraisal from August 2023 did not include documentation of any bed sores or any abnormalities on her skin however there was a note on the bottom of her medication list which stated "Potassium ER 20 mg daily for supplement and Doxycycline 100 mg 2 times daily for leg wound (August 30, 2023).
4. Sparrow Discharge Summary from September 4, 2023 when she was admitted to the hospital for DX: Wound infection, sepsis, cellulitis of right leg.

5. Sparrow Patient Support Services Comprehensive Assessment dated from September 8, 2023 stating an appointment was made at a wound clinic and wound care directions were documented for all parties for care. Resident A was returned to Addie's Acres after this hospitalization and the assessment noted regular wound care and dressing change on her right posterior calf having a wound that worsened to the point of having bloody drainage and maggots in the wound.
6. Order dated October 22, 2024 to use Flagyl on the wound with a dressing change, Morphine Sulfate every four hours, and acetaminophen.
7. According to the direct care staff members *Master Staffing Schedule* for the weekend of October 18-20, 2024, Ms. Britten worked first shift, Ms. Marcinkiewicz worked second shift, and Yvette King worked third shift.

On October 24, 2024, I interviewed Tina Griffith, RN from Visiting Nurses Association. RN Griffith stated Resident A was admitted to nursing services on October 14, 2024 and there were three appointments with her at Addies Acres. RN Griffith stated there are notes from RN Johnston which confirmed direct care staff members were told to change the dressing throughout the weekend however they did not and there was a moderate amount of fecal matter in the dressing and a stage 3 wound discovered on October 21, 2024. RN Griffith stated the wound was a stage 2 wound when she started services on October 14, 2024 so the lack of care caused a decline. RN Griffith stated according to RN Johnston's case notes on October 14, 2024 she instructed a caregiver on turning and repositioning every two hours, cleaning the wound, and wound care. RN Griffith stated she did not know which caregiver she spoke to but knew they were educated on what to do with Resident A's wound. RN Griffith sent the following case notes from RN Johnston for review. The first was a screenshot of their "Start of Care Narrative" from October 14, 2024:

"She has problems with repositioning herself and her reclining chair which is why she has ongoing issues with coccyx pressure ulcers. The doctor ordered a pressure relieving mattress topper and she has a chair cushion as well as a wedge I did show the staff how to use the wedge and how to put it under one side of her every two hours to help relieve pressure on her buttock area. They have been putting Calmoseptine cream and Duoderms on her pressure sores and stated they have not improved much. ***She had several open areas upon looking and I did explain to them that we will be trying a different type of dressing to see if it will help. I did explain how to do the new dressing and how to apply it if it gets soiled it needs to be changed.*** *They verbally understood."*

The next note was from the visit on October 21, 2024 when the wound was found:

"Patient received in home. Daughters called last night and stated she has taken a turn for the worse and they feel she needs to be on hospice immediately over the weekend she stopped eating was having increased pain and agitation and is pocketing her medications I did call Dr. Alvarado's office again today along with the family they stated they did not have any openings today or time to write in in order to start Hospice and it

would have to be done tomorrow. I explained to them she may not be able to wait that long and will need to go to the hospital to get pain management under control. They said OK. Family was able to get a zoom appointment scheduled for tomorrow morning and also has called Hospice House at Saint Lawrence who is possibly able to accept her. She [Resident A] did wake up during the visit and was able to answer her questions she stated that the pain in her coccyx and back area has gotten much worse and the medication was not controlling the pain anymore. She stated that swallowing has become difficult and she no longer wants to eat she did need a small amount of oatmeal yesterday but that was it. Staff stated they could no longer take her regular medications she has been refusing them. They are crushing her tramadol and putting it in applesauce currently so that she can have some pain medication. ***I did roll her over to check her dressing wound and staff did not change this at all since last Thursday it did have moderate amounts of fecal matter under the dressing and a foul odor. I did explain to the daughter and the doctor as well as she possibly has an infection the wound did increase in size as well and is now potentially a stage 3. I did place a new dressing on the wound and educated the staff they need to be changing the stressing if it becomes soiled they cannot leave it. They verbally understood.*** *I also educated them on aspiration risk at this point and how to use the pink mouth swabs instead of forcing water. They understood this as well. I did reposition the patient in bed and she was comfortable at the end of the visit her daughters are continuing to follow up with the doctor as well as Hospice House to see what the next steps are they were thankful for our services and will let us know what the outcome is if we see her again or not."*

On October 29, 2024, I received an email from APS specialist, Mr. Hilla with an APS Death Report attached. According to Mr. Hilla, Resident A move to Eaton County Community Hospice on October 24, 2024 and passed away on October 27, 2024. Mr. Hilla stated he would be substantiating the concerns for neglect and closing the APS case.

On October 29, 2024, I interviewed direct care staff member Valarie Britten. Ms. Britten stated she was aware Resident A had a wound near her coccyx. Ms. Britten stated she knew that a RN came in and changed the dressing at the start of the weekend and the same RN told her "not mess with it unless it fell off." Ms. Britten stated she could not remember the RN's name or what company she was with. Ms. Britten stated before then she was not completing any wound care for Resident A because she was on third shift and Ms. Wells and Ms. Marcinkiewicz were working 1st and 2nd before Ms. Wells went on vacation so she was filling in a shift for Ms. Wells. Ms. Britten stated Resident A was checked during that time to assess her wound. Ms. Britten stated she checked Resident A every two hours and some residents she had to change every two hours however she stated "yes and no" when asked if Resident A was changed every two hours during the weekend. Ms. Britten stated if Resident A would page her then she would change her because Resident A was able to inform her when she needed to be changed. Ms. Britten stated the only time she saw her wound was when the nurse showed her how bad it looked but she did not remember what day she saw it. Ms. Britten stated she did see there was dried blood on the bandage but when she wiped it

off Resident A on during the morning on October 18, 2024 and she complained that it hurt so she stopped doing it. Ms. Britten stated she also worked the next two days and did see the bandage however she never observed the wound to be black or filled with feces because she did not take the bandage off. Ms. Britten stated she was never informed by a RN to change it every two hours. Ms. Britten stated Ms. Wells and Ms. Marcinkiewicz were changing the dressing during the day shift. Ms. Britten stated she was taught how to provide wound care by Ms. Alvarado and Ms. Wells. Ms. Britten stated when she changed a wound, Ms. Alvarado had her send a picture to her to see if it was done right and to see if it was infected or not. Ms. Britten stated during that weekend, Ms. Alvarado was never called or texted to tell her there was dried blood on it or asked what to do since cleaning the wound was hurting her. Ms. Britten stated she did not see a RN there during the weekend to complete wound care. Ms. Britten stated she did not call Ms. Alvarado to let her know the nurses had not been there to change the dressing but she was busy and “it slipped her mind.” Ms. Britten stated she did not know how long the bed sores were on Resident A or when this started.

On December 6, 2024 I interviewed licensee designee Ms. Alvarado and completed the exit conference. Ms. Alvarado stated she did not know Resident A needed the dressing changed because they did not leave an order. Ms. Alvarado stated if they did leave an order, direct care staff members would have informed her and she would have entered it in the system and the plan of care document would have been updated. Ms. Alvarado stated she was informed direct care staff members were directed not to touch it unless it fell off. Ms. Alvarado stated she did not know Resident A had a wound at this time. Ms. Alvarado stated she does not know if the dressing was changed but stated it likely would not have made a difference because Resident A was dying, was not getting nutrition and would not let them turn and reposition her so there would always be pressure on the wound. Ms. Alvarado stated she was not able to locate a folder with instructions from the visiting nurses. Ms. Alvarado stated she was upset because the RN verbally informed one of the direct care staff members what to do but she does not believe she demonstrated it and it was not put in writing for all the direct care staff members to follow. Ms. Alvarado stated had she known the wound needed changed, she could have taught direct care staff member how to do it. Ms. Alvarado stated direct care staff members were under the impression they were not supposed to change it. Ms. Alvarado stated the last time she looked at the wound, she did not think it was infected but it had awful drainage which did smell and there was redness which looked like inflammation.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and**

	recommendations shall be recorded in the resident's record.
ANALYSIS:	Resident A is 98 years old and has been susceptible to wounds for the last year. Resident A has had other wounds during her time at Addie's Acres so direct care staff members were knowledgeable about wound care. Based on interviews with Ms. Wells, Ms. Marcinkiewicz, and Ms. Britten, and licensee designee Ms. Alvarado Resident A's wound was not cared for between October 17, 2024 -October 21, 2024. Ms. Alvarado stated wound care was not done because she did not have an order to change the dressing; however, Ms. Wells stated direct care staff had been tending to Resident A's wounds recently. Although there was not a written order regarding these changes, there are case notes from RN Johnston from October 14, 2024 confirming she did explain the process of changing the dressing to one direct care staff members and again on October 21, 2024, however, the direct care staff members did not do this. Ms. Marcinkiewicz stated they tried to keep the area clean and dry however she admitted that she did not change the dressing or check it throughout the weekend of October 17- October 21, 2024. Ms. Britten stated she tried to wipe dried blood from the area but it was sore for Resident A and she wanted her to stop however, she did not proceed further or contact Ms. Alvarado or RN Johnston for instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of a corrective action plan, I recommend no change in the license status.

Jennifer Browning ___________12/06/2024__________________

Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 12/10/2024

____

Dawn N. Timm Date
Area Manager