GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 30, 2024

Debra Smith
We Care Management LLC
3973 W. Grand River Rd.
Owosso, MI 48867

RE: License #: AS780307442
Investigation #: 2024A0584031
We Care Management

Dear Ms. Smith:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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) 284-9727.

Sincerely,

Candace Coburn, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS780307442
Investigation #:	2024A0584031
Complaint Receipt Date:	09/10/2024
Investigation Initiation Date:	09/10/2024
Report Due Date:	11/09/2024
Licensee Name:	We Care Management LLC
Licensee Address:	3973 W. Grand River Rd. Owosso, MI 48867
Licensee Telephone #:	(989) 723-9973
Administrator:	Debra Smith
Licensee Designee:	Debra Smith
Name of Facility:	We Care Management
Facility Address:	3973 W. Grand River Rd. Owosso, MI 48867
Facility Telephone #:	(989) 723-9973
Original Issuance Date:	06/03/2010
License Status:	REGULAR
Effective Date:	12/19/2022
Expiration Date:	12/18/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On an unknown date, Resident A did not his receive prescribed medication.	Yes
The posted menu in the kitchen was three months old.	No
The facility did not address the bedbug infestation in Resident A's bedroom.	No
The toilet was plugged. The sink and sheets were not cleaned every Wednesday.	No
The home has unsafe. The back deck railing and exterior siding was filthy.	No
Resident A's bedroom window would not open.	Yes

III. METHODOLOGY

09/10/2024	Special Investigation Intake - 2024A0584031.
09/10/2024	Special Investigation Initiated – Telephone contact with complainant.
09/18/2024	Unannounced onsite investigation and inspection conducted. Face to Face interviews with direct care staff Kathy Wertzbar, Resident B and C, telephone contact with licensee designee Deb Smith.
09/26/2024	Contact – Text message via telephone with licensee designee Deb Smith.
10/11/2024	Contact – Telephone interview with direct care staff Amanda Deverny and Sky Ember.
10/14/2024	Exit conference – via telephone with Deb Smith.

ALLEGATIONS:

- **On an unknown date, Resident A did not receive prescribed medication.**
- **The posted menu in the kitchen was three months old.**
- **The facility did not address the bedbug infestation in Resident A's bedroom.**

- **The toilet was plugged. The sink and sheets were not cleaned every Wednesday.**

- **The home has unsafe. The back deck railing and exterior siding was filthy.**

- **Resident A's bedroom window would not open.**

INVESTIGATION:

On 9/10/2024, the Bureau of Community and Health Systems received the above allegations. According to the written complaint, Resident A did not receive his prescribed nebulizer medication because the apparatus was not functioning properly, and staff had to be reminded a treatment was not provided.

On 9/18/2024, I conducted an unannounced onsite investigation at the facility.

I observed and inspected the exterior perimeter of the facility, checked railings on the front entry way and the back deck, and observed rails and handrails, which were secure for use. I observed under close inspection, small black spots on the exterior siding located near the front entrance of the facility. I was not able to rub the spots off the exterior siding. Otherwise, I did not observe the rest of the exterior siding to be dirty or filthy. I observed the posted kitchen menu, which was dated September 2024. Resident A's bedroom was vacant at the time of inspection, and I observed the toilet and sink were clean. I flushed the toilet, and the toilet flushed appropriately. I tested Resident A's window with direct care staff Kathy Wertzbar and neither of us were able to open the window.

I conducted a telephone interview with licensee designee Debra Smith, who confirmed bed bugs were discovered on Resident A's jacket on 9/05/2024. Ms. Smith stated that on 9/05/2024, she contacted a pest control company who could treat the facility the morning of 9/06/2024. Ms. Smith stated she notified Resident A's family member's on 9/05/2024, and they moved Resident A to another facility that same evening. Ms. Smith stated the facility was treated for bedbugs on 9/06/2024 and will be reinspected and treated again on 9/21/2024. Ms. Smith stated there were insects that stuck to the siding due to the walkway lights and she had the siding power washed, but the black spots remained after treatment. Ms. Smith denied Resident A's toilet was plugged and his room not cleaned according to schedule, due to having a "cleaning check list" that was initialed by cleaning staff. Ms. Smith stated she will have someone check on the window and make repairs as recommended.

I conducted face-to-face interviews with Residents B and C, and Ms. Wertzbar. Residents B and C both stated they were satisfied with the care received at the facility, voiced no concerns about the condition of the interior or exterior of the home and were not able to confirm the dates on the posted menu. Residents B and C

stated they knew about the bedbug issue and confirmed exterminators recently treated the facility. Both Residents B and C denied having issues with plugged toilets and stated staff clean their room at least once per week.

Ms. Wertzbar stated she was not aware of any issues with Resident A's nebulizer or treatments not being conducted, denied any knowledge of Resident A having a plugged toilet, and had no knowledge of bedbugs on Resident A or in the facility prior to 9/05/2024. Ms. Wertzbar stated the resident rooms were cleaned at minimum once per week. According to Ms. Wertzbar, each resident was assigned one day of the week for bedroom cleaning, and staff documented on a schedule when cleaning was completed. Ms. Wertzbar denied the menu posted in the kitchen was three months old and that the facility railings on the back porch were unsafe.

I reviewed Resident A's room cleaning schedule and medication administration records (MAR) for June, July, and August 2024.

Documentation on the cleaning schedule confirmed that resident bedrooms were cleaned at least once a week.

As indicated by missing initials on the MAR, Resident A did not receive the following medications on the following dates:

- June 29 and 30th 2ML Budesonide 2 x day, PM dose.
- June 29 Albuterol Sulfate 3ML 4 x day, 8PM dose.
- June 27 and 28 Lisinopril 10MG 1 x day, AM dose.
- June 28 Vitamin D3 25 MG 1 x day, AM dose.
- July 5-12PM and 4PM; 9-12PM and 4PM;11 - 4PM; 12 – 4PM; 18 - 8AM and 12PM; 24 - 12PM and 4PM; 27 - 12PM; 29 – 4PM and 8PM Albuterol Sulfate 4 x day 2.5 MG doses.
- July 6, 18, 21, 28, 31 Vitamin C 500 MG 1 x day, AM dose.
- July 18, 29, 31 Aspirin 81MG 1 x Day, AM dose.
- July 10 Atorvastatin 20MG 1 tab daily, PM dose.
- July 18, 23, 29 Budesonide 2ML inhaled 2 x daily, AM dose.
- July 18, 23, 29 Vitamin D3 25MG 1 x day, AM dose.
- July 18, 29, 31 Docusate Sodium 100 MG 1 x day, AM dose.
- July 18, 29, 31 Lisinopril 10 MG 1 x day, AM dose.
- July 18, 29, 31 Zinc 50 MG 1 x day, AM dose.
- August 8 – 8AM,12PM, 4PM;10 – 12PM and 4pm; 17 – 8PM; 21 – 12PM and 4PM Albuterol Sulfate 2.5 MG inhaled 4 x day.
- August 3, 4, 8, 21, 28 Ascorbic Acid 500 MG 1 x day.
- August 8, 21, 28 Aspirin 81 MG 1 x day.
- August 8 – AM dose, 18 – PM dose, 25 – PM dose Budesonide 2ML inhaled 2 x day.
- August 8 – AM dose Vitamin D3 25 MG 1 x day.
- August 8 – AM dose Docusate Sodium 100 MG, 1 x day.

- August 8 – AM dose Lisinopril 10 MG 1 x day.
- August 8 – AM dose Zinc 50 MG 1 x day.

Resident A no longer resided in the facility. There was no way to determine if Resident A had actually not received the above medications or if direct care staff just failed to document the administration of these medications to Resident A.

On 9/26/2024, Ms. Smith texted to my work phone a picture of a copy of the exterminator's invoice documenting the extermination service was completed on 9/06/2024 and informed me, via text message, that the room with the inoperable window would be assessed to be fixed.

On 10/11/2024, I conducted telephone interviews with direct care staff Amanda Deverny and Sky Ember.

Ms. Deverny confirmed they document on a schedule when they sweep, vacuum, change the bedding, pick up resident laundry, and clean the sink and toilet at a minimum, once a week. Ms. Deverny denied seeing or finding bed bugs in the facility until 9/05/2024 and had not seen any bed bugs when changing Resident A's bed sheets. Ms. Deverny confirmed bed bug treatment began on the morning of 9/06/2024. Ms. Deverny stated Resident A's nebulizer treatment was delayed because there were parts that needed replacement in order for it to be used properly. Ms. Deverny stated she had never attempted to open Resident A's bedroom window and denied Resident A's toilet was plugged. Ms. Deverny also denied the back railings were not safe, and did not find the facility's siding filthy, or the posted menu to be three months old.

Ms. Embers statements were consistent with the statements Ms. Deverny provided to me.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**

ANALYSIS:	Based upon my investigation, which consisted of interviews with multiple staff members and a review of Resident A's MARs for June, July, and August 2024, there is evidence to support that the initials of the person who administered Resident A's medication was not entered at the time the medication is given, on multiple occasions, with no explanation given.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	Based on my investigation, which consisted of interviews with multiple staff members, residents, and my visual inspection of the menu posted, there is insufficient evidence of a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	Based on my investigation, which consisted of interviews with multiple staff members and residents, it has been established that the facility discovered a bedbug infestation on 09/05/2024. The facility provided sufficient documentation confirming they hired a professional pest control service to treat the facility immediately after becoming aware of the infestation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on my investigation, which consisted of interviews with multiple staff members, a personal inspection of the back deck and the exterior siding, there is no evidence of health, safety or threats to residents' well-being on the premises.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(7) Bedrooms shall have at least 1 easily openable window.
ANALYSIS:	Based upon my investigation, which consisted of an inspection of Resident A's bedroom and bedroom window, and interviews with direct care staff, it has been established that Resident A's window failed to open.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/14/2024, I conducted an exit conference via telephone with licensee designee Debra Smith to inform her of the findings of this investigation.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no changes in the status of this license.

10/28/2024

Candace Coburn — Date
Licensing Consultant

Approved By:

10/30/2024

Michele Streeter — Date
Area Manager