GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 8th, 2021

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

RE: License #:	AH190397181
Investigation #:	2021A1021038
	The Woodlands Of DeWitt

Dear Mr. 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, 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 #:	2021A1021038
Complaint Receipt Date:	07/19/2021
Investigation Initiation Date:	07/19/2021
Report Due Date:	09/18/2021
Licensee Name:	DeWitt ALC, LLC
Licensee Address:	910 Woodlands Dr DeWitt, MI 48820
Licensee Telephone #:	(989) 327-7922
Administrator:	Kathleen Leslie
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:	10/29/2020
Expiration Date:	10/28/2021
Capacity:	45
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Visiting rights of residents are denied.	No
Caregiver violated resident privacy.	No
Resident C was administered the incorrect medication.	No
Medication is not counted for.	No
Additional Findings	Yes

III. METHODOLOGY

07/19/2021	Special Investigation Intake 2021A1021038
07/19/2021	Special Investigation Initiated - Letter referral sent to APS centralized intake
07/19/2021	APS Referral Allegations sent to centralized intake at Adult Protective Services
07/20/2021	Inspection Completed On-site
07/20/2021	Contact-Telephone call made Interviewed medication technician Daneka Thurmond
07/21/2021	Contact-Document Received Received SP4 training record
07/21/2021	Contact-Telephone call made Interviewed medication technician Melissa Wadley
07/29/2021	Exit Conference Exit conference with authorized representative

The complainant alleged the facility has inadequate staff. This complaint was investigated under special investigation 2021A1021037. 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:

Visiting rights of residents are denied.

INVESTIGATION:

On 7/19/21, the licensing department received an anonymous complaint with allegation residents are denied visitors. The complainant alleged an ex-employee wished to visit a resident and was denied the request by management.

Due to the anonymous complaint, I was able to contact the complainant for additional information.

On 7/19/21, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 7/20/21, I interviewed administrator Kathleen Leslie at the facility. Ms. Leslie reported staff person 2 (SP2) walked off the job and then requested to visit a resident. Ms. Leslie reported when SP2 walked off the job she was very violent by throwing the work cell phone, screaming, and throwing other objects. Ms. Leslie reported other caregivers were scared for how SP2 acted. Ms. Leslie reported the following day she requested to visit an assisted living resident. Ms. Leslie reported if an employee is terminated, then they must request for management to be present when the visit occurs. Ms. Leslie reported due to how SP2 acted when she left employment, the facility was concern for the resident safety. Ms. Leslie reported management went to the resident and offered to take her out of the facility to visit SP2 outside the facility. Ms. Leslie reported the resident declined wanting to do this and was fine not seeing SP2. Ms. Leslie reported this visitation policy is in the facility policy and procedure.

I reviewed letter completed by Ms. Leslie. The letter read,

> *"On Monday June 14, 2021, approximately one week following this incident, (SP2) walked in at approximately 6am was altered to an alleged discrepancy, and at approximately 610am, called her manager and quit over the phone, using vulgar language and screaming through the halls. (SP2) then abandoned her post, residents, and position, gathered her belongings and walked out the door."*

I reviewed the facility policies and procedures. The policy read,

> *"Due to HIPPA and the confidential nature of our work, when employees resign and/or are terminated, relationships with the residents end and visitation to the facility will not be permitted."*

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference: MCL 333.20201	**2) (k) A patient or resident is entitled to associate and have private communications and consultations with his or her physician or a physician's assistant to whom the physician has delegated the performance of medical care services, attorney, or any other person of his or her choice and to send and receive personal mail unopened on the same day it is received at the health facility or agency, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services. A patient's or resident's civil and religious liberties, including the right to independent personal decisions and the right to knowledge of available choices, shall not be infringed and the health facility or agency shall encourage and assist in the fullest possible exercise of these rights. A patient or resident may meet with, and participate in, the activities of social, religious, and community groups at his or her discretion, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant.**
ANALYSIS:	SP2 was terminated from the facility and then requested to visit a resident. The facility offered to have SP2 visit with the resident outside the facility. The resident's rights were not violated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Caregiver violated resident privacy.

INVESTIGATION:
The complainant alleged a medication technician violated resident's privacy by having a video telephone call during shift change. The complainant did not include a name of the resident, name of the medication technician, or date the event occurred.

Ms. Leslie reported she is responsible for caregiver discipline. Ms. Leslie reported these allegations have not been brought to her attention. Ms. Leslie reported the facility has a strict no cell phone policy while working on the floor. Ms. Leslie reported if a caregiver needs to take a telephone call, they are to excuse themselves from the floor. Ms. Leslie denied allegations that resident privacy was violated.

On 7/20/21, I interviewed medication technician Daneka Thurmond by telephone. Ms. Thurmond reported she a rumor that a video call occurred while someone was working but she does not believe it to be true.

On 7/21/21, I interviewed medication technician Melissa Wadley by telephone. Ms. Wadley reported no knowledge of a medication technician completing a video telephone call during shift change.

APPLICABLE RULE	
MCL 333.20201	**Policy describing Rights and Responsibilities of residents.**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference:	**(2) (d) A patient or resident is entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity and individuality**

ANALYSIS:	There is lack of evidence to support the allegation that resident's privacy was violated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident C was administered the incorrect medication.

INVESTIGATION:

The complainant alleged the facility has many medication errors. The complainant did not include resident names or dates of medication errors.

Ms. Leslie reported there was one medication error in June 2021. Ms. Leslie reported SP3 administered the incorrect medications to Resident D. Ms. Leslie reported the physician and the family was immediately notified. Ms. Leslie reported the physician instructed staff to monitor Resident D for change in condition. Ms. Leslie reported Resident D did not have any adverse reactions to the medication error. Ms. Leslie reported SP3 went through additional medication training after the incident. Ms. Leslie reported there have been no other medication errors.

On 7/21/21, I interviewed SP3 by telephone. SP3 reported she administered the incorrect medication to Resident D. SP3 reported Resident D had the same name as another resident and she mixed up the medication. SP3 reported following the incident, she was provided additional education and training.

I reviewed the training record for SP3. The record revealed SP3 was trained and supervised in medication administration.

I reviewed chart documentation for Resident D. The chart notes read,

> "*6/24: A medication error took place this evening. Resident will be monitored throughout the night for alertness. Vitals will be taken for the next three hours. 6/24: Spoke with Dr. Nicole Barrett at Dr. Schaars office and informed her of medication error. She instructed not to give Benzodiazepines or Narcotics for the reminder of the evening. Spoke with Dr. Holzhei and informed him of medication error. Dr. Holzhei instructed to return to regular medication regimen tomorrow. Monitor vitals hourly for 4 hours. Daughter was also notified."*

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(g) Upon discovery, contact the resident's licensed health care professional if a medication error occurs. A medication error occurs when a medication has not been given as prescribed.**
ANALYSIS:	Resident D was administered the incorrect medication on 6/25. Following the incident, Resident D's family and physician was notified. In addition, SP3 received additional training and education.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medication is not counted

INVESTIGATION:

The complainant alleged the facility does not complete a count of narcotic medication. The complainant alleged there are cups of medication in the medication carts.

Ms. Leslie reported the facility policy is to have the ongoing and off going medication technician count and record in the narcotic count book. Ms. Leslie reported if there is an issue with the count, it will be addressed immediately. Ms. Leslie reported the facility recently changed the policy on administering PRN narcotic medications to decrease likelihood of a medication count or medication error. Ms. Leslie reported the policy is now to have the medication technician administer the medication from the blister packet in order, not on the date the medication is administered. Ms. Leslie reported there is no cups of medication in the medication cart. Ms. Leslie reported pre-setting of medications is against the facility policy. Ms. Leslie denied all allegations of medication cart issues.

On 7/20/21, I interviewed medication technician Alexis Ledesma at the facility. Ms. Ledesma reported medication technicians do not pre-arranged medications and there is not medication left in cups in the medication cart. Ms. Ledesma reported the medication technicians are responsible for counting and signing the narcotic book.

Ms. Ledesma reported if the count is off, the medication technicians will count again and ensure the count is correct.

On 7/20/21, I interviewed Alyssa Petersen at the facility. Ms. Petersen reported each medication technician is responsible for counting and signing the narcotic book. Ms. Petersen denied allegations that narcotic counts are not being completed. Ms. Petersen reported there is no pre-arranging of medications and medications are not left in cups in the medication carts.

I reviewed the memory care and assisted living medication cart. There were no medications left in cups in the cart. I reviewed the narcotic count book for each medication cart. There were no errors in the narcotic count book. I completed a narcotic count with Ms. Ledesma and the narcotic count was correct for each medication cart.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
ANALYSIS:	Interviews with employees and review of the medication carts revealed lack of evidence to support the allegation the facility is not counting medications.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident D was administered the incorrect medication on 6/25.

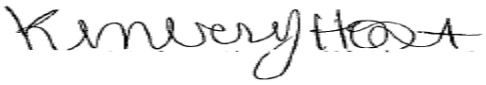
APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.

ANALYSIS:	The facility did not complete and submit an incident report to the licensing department for Resident D's medication error.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/29/21, I conducted an exit conference with authorized representative Clarence Rivette by telephone. Mr. Rivette was not in agreement with the findings in this report and stated the resident was not at risk of harm due to the medication error.

IV. RECOMMENDATION

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



7/29/21

Kimberly Horst Date
Licensing Staff

Approved By:

7/29/21

Russell B. Misiak Date
Area Manager