



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 27, 2022

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

RE: License #: AH190397181
Investigation #: 2023A1010014
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 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) 241-1970.

Sincerely,

A handwritten signature in blue ink that reads "Lauren Wohlfert".

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH190397181
Investigation #:	2023A1010014
Complaint Receipt Date:	12/06/2022
Investigation Initiation Date:	12/09/2022
Report Due Date:	02/05/2023
Licensee Name:	DeWitt ALC, LLC
Licensee Address:	910 Woodlands Dr DeWitt, MI 48820
Licensee Telephone #:	(989) 327-7922
Administrator:	Cheri Cordell
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:	10/29/2022
Expiration Date:	10/28/2023
Capacity:	45
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There are not enough staff to ensure resident care needs are met consistent with their service plans.	No
Staff are not trained to administer resident medications.	No
Residents are not being bathed.	No
Resident C's bed is too small for her.	No
Additional Finding	Yes

III. METHODOLOGY

12/06/2022	Special Investigation Intake 2023A1010014
12/09/2022	Special Investigation Initiated - Letter Emailed administrator and requested the staff schedule from the last two weeks
12/12/2022	Contact - Document Received Received staff schedule
12/15/2022	Inspection Completed On-site
12/15/2022	Contact - Document Received Received resident service plan, staff training documents, and resident bathing schedule
12/27/2022	Exit Conference

ALLEGATION:

There are not enough staff to ensure resident care needs are met consistent with their service plans.

INVESTIGATION:

On 12/6/22, the Bureau received the allegations from Adult Protective Services (APS). This complaint was not assigned for APS investigation. The complaint read,

“The facility is frequently understaffed, where only 1 employee is responsible to care for 50 residents. Employees sleep on the job.”

On 12/9/22, I requested a copy of the staff schedule for the previous two weeks from administrator Cheri Cordell.

On 12/12/22, I received a copy of the staff schedule for 11/26/22 through 12/9/22 via email from Ms. Cordell.

On 12/15/22, I interviewed Ms. Cordell at the facility. Ms. Cordell reported some staff work 12 hours shifts and some choose to work eight-hour shifts based on their personal preference. Ms. Cordell said two staff persons are scheduled in the facility’s general assisted living area and two staff persons are scheduled in the secured memory care area on first, second, and third shifts. Ms. Cordell explained one of the two staff persons scheduled in each area is a medication technician (med tech). Ms. Cordell stated there are 28 residents in the general assisted living area and 32 residents in the secured memory care unit.

Ms. Cordell stated there is one resident in the secured memory care unit who requires the assistance from two staff persons to transfer. Ms. Cordell reported there are enough staff scheduled on each shift to ensure resident care needs are met consistent with their service plans. Ms. Cordell said staff volunteer to pick up shift vacancies and are offered various incentives to do so. Ms. Cordell denied knowledge regarding there being only one care staff person to care for all the residents during a shift.

I observed the staff schedule for 11/26/22 through 12/9/22 that Ms. Cordell previously provided me was consistent with her statements. Ms. Cordell reported there was one alleged incident in which a staff person slept during their shift. Ms. Cordell said this alleged incident was several months ago and the staff person no longer worked at the facility.

On 12/15/22, I interviewed Staff Person 1 (SP1) at the facility. SP1’s statements were consistent with Ms. Cordell and the staff schedule. SP1 reported the residents in the general assisted living area are independent and do not require a lot of assistance with their activities of daily living (ADLs). SP1 stated as a result, she often “floats” between the general assisted living area and the secured memory care unit to assist staff scheduled there if needed. SP1 said residents in the general assisted living area only need cueing from staff to complete their ADLs. SP1 reported staff communicate using two-way radios during their shifts.

On 12/15/22, I interviewed SP2 at the facility. SP2’s statements were consistent with Ms. Cordell and SP1. SP2 reported the facility is admitting more residents, therefore additional staff will be needed to accommodate the additional residents being admitted in the secured memory care unit.

On 12/15/22, I interviewed Resident A at the facility. Resident A reported he can complete his ADLs independently. Resident A stated there are enough staff at the facility to assist him as needed.

On 12/15/22, I interviewed Resident B at the facility. Resident B's statements were consistent with Resident A. Resident B reported he has pushed his pendant to summon staff for assistance before. Resident B said staff responded promptly and he had no concerns regarding staff at the facility.

APPLICABLE RULE	
R 325.1931	Employees; general provisions.
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	The interviews with staff, Resident A, Resident B, along with review of the staff schedule, revealed there are enough staff scheduled to meet resident care needs consistent with their service plans. There is insufficient evidence to suggest there was a recent incident regarding staff sleeping during their shift.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff are not trained to administer resident medications.

INVESTIGATION:

On 12/6/22, the complaint read staff “do not have the proper training to administer medication to the residents.”

On 12/15/22, Ms. Cordell reported med techs are trained to administer resident medications upon hire at the facility. Ms. Cordell stated med techs shadow experienced staff for two days, then the experienced staff shadow the trainee for two days. Ms. Cordell said the med tech being trained and the experienced staff person go through a training checklist during this process. Ms. Cordell reported the facility's wellness director then signs off on the checklist after evaluating the trainee and the list.

Ms. Cordell provided me with a copy of SP3's medication administration training documents for my review. SP3's *Woodlands of DeWitt Training Record* document read SP3 completed “Med Pass Training” on 7/5/22. This was initialed by SP3 and

the staff person who trained her. SP3 completed the facility's *MEDICATION ADMINISTRATION AND DOCUMENTATION WRITTEN TEST* and the *INTRODUCTION TO MEDICATIONS WRITTEN TEST* on 7/5/22. These documents were signed by her trainer on 7/7/22. SP3's *MEDICATION ADMINISTRATION AND DOCUMENTATION PERFORMANCE TEST* read she was observed administering resident medications on 7/6/22, 7/7/22, and 7/8/22. This document was also signed by her trainer.

On 12/15/22, SP1 reported she is not a med tech.

On 12/15/22, SP2's statements were consistent with Ms. Cordell.

APPLICABLE RULE	
R 325.1931	Employees; general provisions.
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: (g) Medication administration, if applicable.
ANALYSIS:	The interviews with staff, along with review of SP3's training documents revealed med tech receive medication administration training upon hire to the facility. There is insufficient evidence to suggest staff are not properly trained to administer resident medications.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Residents are not being bathed.

INVESTIGATION:

On 12/6/22, the complaint read residents "are going without showering/bathing for several days."

On 12/15/22, Ms. Cordell it is the facility's policy and procedure to offer residents the opportunity to bathe twice a week at a minimum. Ms. Cordell denied knowledge regarding residents not being provided with this opportunity. Ms. Cordell reported if a resident refuses to bathe, staff are trained to redirect or re-approach the resident later. Ms. Cordell said staff utilize a resident bathing schedule.

Ms. Cordell provided me with a copy of the resident “shower schedule” for each resident hall for my review. I observed the schedule was consistent with Ms. Cordell’s statements. I observed some residents were scheduled to bathe three times a week.

On 12/15/22, SP1’s statements were consistent with Ms. Cordell and the “shower schedule.” SP1 denied knowledge regarding residents refusing to bathe or shower during their scheduled time.

On 12/15/22, SP2’s statements were consistent with Ms. Cordell, SP1, and the resident “shower schedule.”

On 12/15/22, Resident A reported he bathes independently as often as he wants during the week. I observed Resident A was well groomed and was wearing clean clothing.

On 12/15/22, Resident B’s statements were consistent with Resident A. I observed Resident B was well groomed and was wearing clean clothing.

On 12/15/22, I observed several residents in the facility. I observed the residents were well groomed and were wearing clean clothing. I did not detect any foul odors within the facility.

APPLICABLE RULE	
R 325.1933	Personal care of residents.
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	The interviews with staff, along with review of the resident “shower schedule” and my observation of multiple residents revealed they are provided the opportunity to bathe at least twice a week. I observed residents were well groomed and wore clean clothing. There were no foul odors detected within the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident C’s bed is too small for her.

INVESTIGATION:

On 12/6/22, the complaint read, "There is one resident identified as [Resident C] who sleeps in a bed too small for her."

On 12/15/22, Ms. Cordell reported Resident C has a hospital bed. Ms. Cordell denied knowledge regarding Resident C's hospital bed being too small for her.

On 12/15/22 SP1's statements were consistent with Ms. Cordell. SP1 reported Resident C has not complaint about her bed being too small or uncomfortable for her.

On 12/15/22, SP2's statements were consistent with Ms. Cordell and SP1.

On 12/15/22, I interviewed Resident C at the facility. Resident C reported her bed was comfortable and she denied any concerns regarding it. I observed Resident C's hospital bed. The bed had side rails with a mesh covering over them.

APPLICABLE RULE	
R 325.1934	Furniture.
	(1) A home shall provide an individual bed at least 36 inches wide, with comfortable springs in good condition and a clean protected mattress not less than 5 inches thick, or 4 inches thick if synthetic construction.
ANALYSIS:	On 12/15/22, I observed Resident C has a hospital bed in her room. Resident C denied concerns regarding the hospital bed. Resident C reported it was comfortable.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION:

On 12/15/22, I observed Resident C's service plan. The plan did not address Resident C's hospital bed or whether she had a physician order for it. The plan also did not address the bed rails that were attached to the hospital bed. I observed the bed rails had a mesh covering over them. Resident C's service plan did not have instruction for staff to check the bed rails for tightness or gaps.

R 325.1921	Governing bodies, administrators, and supervisors.
	<p>(1) The owner, operator, and governing body of a home shall do all of the following:</p> <p>(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.</p>
ANALYSIS:	Review of Resident C's service plan revealed the use of her hospital bed was not outlined. The plan did not address whether the bed was physician ordered. There were also no instructions for staff to regularly check Resident C's bed rails for tightness or gaps. This is not consistent with an organized program of protection.
CONCLUSION:	VIOLATION ESTABLISHED

I shared the findings of this report with Ms. Cordell by telephone on 12/27/22. I left a voicemail for licensee authorized representative Clarence Rivette regarding this report on 12/27/22.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Lauren Wohlfert

12/20/2022

Lauren Wohlfert
Licensing Staff

Date

Approved By:

Andrea Moore

12/21/2022

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

Date