GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 27, 2023

Janice Wilds
12409 Red Bud Trail, N.
Buchanan, MI 49107

RE: License #: AM110064771
Investigation #: 2023A0579026
Wilds River Rest

Dear Janice Wilds,

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 (616) 356-0183.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM110064771
Investigation #:	2023A0579026
Complaint Receipt Date:	03/10/2023
Investigation Initiation Date:	03/10/2023
Report Due Date:	05/09/2023
Licensee Name:	Janice Wilds
Licensee Address:	12409 Red Bud Trail, N. Buchanan, MI 49107
Licensee Telephone #:	(269) 695-6074
Administrator:	Janice Wilds
Licensee Designee:	Janice Wilds
Name of Facility:	Wilds River Rest
Facility Address:	12409 Red Bud Tr N Buchanan, MI 49107
Facility Telephone #:	(269) 695-6074
Original Issuance Date:	04/28/1995
License Status:	REGULAR
Effective Date:	09/11/2021
Expiration Date:	09/10/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not treated with dignity or provided necessary care.	No
Resident A did not receive his medication correctly.	Yes

III. METHODOLOGY

03/10/2023	Special Investigation Intake 2023A0579026
03/10/2023	APS Referral
03/10/2023	Special Investigation Initiated - Letter Complainant
03/16/2023	Contact- Face to face Janice Wilds, License Designee
04/27/2023	Exit Conference Janice Wilds, License Designee

ALLEGATION:

Resident A was not treated with dignity or provided necessary care.

INVESTIGATION:

On 3/10/23, I entered this referral into the Bureau Information Tracking System after receiving an e-mail which alleged Resident A is unhappy at this home and is afraid of Licensee Designee, Janice Wilds, because she is “harsh” with him. It was reported on Resident A’s first night at the home, he asked what he needed to do in this home if he needed help at night. Ms. Wilds stated she is the only person there and she would not be getting out of bed at night. Resident A has been contacting his family in the middle of the night stating he is afraid of Ms. Wilds and does not want to be at this home.

On 3/10/23, I exchanged emails with the complainant who confirmed the allegations and reported APS worker, John Wheeler, is investigating the allegations as well.

On 3/10/23, I exchanged emails with Mr. Wheeler who stated Resident A has recently been diagnosed with the beginning stages of dementia and this was his first out of home placement at the recommendation of a physician. Mr. Wheeler reported after his interview with Resident A, he believes Resident A is confused and not sleeping well, noting Resident A just began a new medication for sleep. He stated Resident A does not want to be at this home and keeps calling his family and telling them “half-truths” which leads Resident A’s family to assume Ms. Wilds is not doing her job. He stated Ms. Wilds did tell him that she told Resident A’s family that she would not be getting up to attend to Resident A in the middle of the night. He stated efforts are being made to move Resident A to a new placement.

On 3/16/23, I completed an unannounced on-site investigation at the home. An interview was completed with Ms. Wilds. She reported Resident A had moved from the home on 3/15/23 and was not available for interviewing.

Ms. Wilds reported she had her son assess Resident A for placement from Lakeland Hospital in February 2023 and it was believed Resident A would be suitable for this home. She stated Lakeland did not mention Resident A was awake most of the night. She stated she never told anyone that she would not assist Resident A if he requested assistance when he was awake at night, but she did tell Resident A’s relatives and Mr. Wheeler that she is the only direct care worker at this home and she lives in the home, so she is not awake overnight. She stated she checks on residents every few hours overnight, but she cannot stay awake with Resident A overnight. She stated if Resident A needed something, they can use their cell phones or the home phone to call her phone. She stated Resident A’s family was getting upset because he would call them throughout the night because he was awake. She stated he would not alert or call her for assistance, rather he just wanted to speak to his family. She denied feeling that Resident A was unsafe in the home at night while she was asleep and reported he remained in his room and would talk on the telephone. She stated her primary concern was that his being awake and speaking on the phone bothered his roommate and his family.

Ms. Wilds denied being harsh with Resident A. She stated she would verbally prompt Resident A for tasks of daily living, which he typically refused, but she was not harsh. She stated, if anything, other residents were becoming harsh with Resident A because he had developed an odor from refusing to shower and another resident told him that he “stinks.” She stated Resident A did not seem to be concerned by the other residents’ comments as he continued to refuse bathing and hygiene tasks.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Mr. Wheeler stated after his interview with Resident A, he feels Resident A does not want to be at this home and keeps calling his family and telling them “half-truths.” He confirmed Ms. Wilds admitted to telling Resident A’s family she would not get up at night to attend to Resident A. Ms. Wilds stated she was not aware that Resident A was awake through the night prior to him coming to this home and she is the only direct care worker in the home, so she cannot stay awake overnight. She denied stating she would not attend to Resident A, rather she explained that she would not be awake through the night and Resident A could call her phone for assistance. She stated Resident A preferred to speak to his family at night since he was awake and did not alert her for assistance. Ms. Wilds denied that Resident A was unsafe awake in his room overnight, noting her only concern was his behavior was bothering others. Ms. Wilds denied being harsh with Resident A and reported she verbally prompted Resident A for activities of daily living, but he typically refused. Resident A moved to a new placement and was not available for interviewing at the home. Based on the interviews completed, there is insufficient evidence to support that Resident A was not treated with dignity and his personal needs, including protection and safety, were not attended to at all times.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A did not receive his medication correctly.

INVESTIGATION:

On 3/10/23, I reviewed this referral which alleged Ms. Wilds stated she does not dispense medication. On Resident A’s second day at the home, Ms. Wilds left Resident A’s insulin out of the refrigerator. Ms. Wilds was asked to put signs up regarding oxygen being used in the home and Ms. Wilds refused.

On 3/16/23, Ms. Wilds denied stating she does not pass medication. She stated she passed Resident A’s medication, and he received his medication correctly, aside from an error where she had to request Resident A’s Atorvastatin multiple times

because it was not received correctly by his pharmacy. She stated Resident A's insulin was kept in a small refrigerator and she denied ever leaving Resident A's medication out. She stated she did not receive signs to place in the home regarding Resident A's oxygen and no one requested her to place signs in the home, so she did not refuse to place signs in the home. She reported Resident A moved from the home on 3/15/23 and his medications were no longer present in the home aside from his extra oxygen tanks.

I reviewed Resident A's *Medication Administration Record (MAR)* and Resident A's medication list from Lakeland Hospital. Resident A's medication listed from the hospital included: Torsemide, Albuterol Sulfate, Apixaban, Atorvastatin, Breo Ellipta, Hydrocodone-acetaminophen, Insulin Glargine, Jardiance, Levothyroxine, Liraglutide, Losartan, Metformin, Potassium Chloride, Spironolactone, Cerefolin, Trazadone, and Terazosin. Resident A's MAR was handwritten by Ms. Wilds and listed: Albuterol Sulfate, Apixaban, Atorvastatin, Hydrocodone-acetaminophen, Jardiance, Levothyroxine, Losartan, Metformin, Potassium Chloride, Breo Ellipta, Terazosin, Insulin Glargine, Liraglutide, Cerefolin, and Trazadone. Torsemide, was not listed on Resident A's handwritten MAR. Although the following medications were handwritten in the margins of the MAR, there was no written confirmation Resident A received Breo Ellipta, Terazosin, Insulin Glargine, Liraglutide, Cerefolin, and Trazadone daily, their names were solely written on the MAR.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A's MAR and medication list from Lakeland Hospital were reviewed. Torsemide, was not listed on Resident A's handwritten MAR in the home, although it was listed on his medication list. Resident A's Breo Ellipta, Terazosin, Insulin Glargine, Liraglutide, Cerefolin, and Trazadone medications were noted on the margins of his MAR but there was no written confirmation that it was administered by staff as prescribed. Based on the interview completed and documentation reviewed, there is sufficient evidence to support Resident A's MAR was not completed correctly and lacked the initials of the person who would have administered the medication so it could not be confirmed Resident A had received his medication correctly.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/27/23, I completed an exit conference with Ms. Wilds who did not dispute my

findings or recommendations.

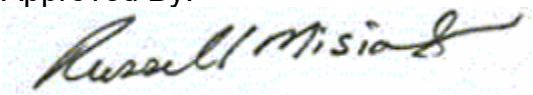
IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remains the same.

4/24/23

Cassandra Duursma — Date
Licensing Consultant

Approved By:



4/25/23

Russell B. Misiak — Date
Area Manager