GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 25, 2023

Julie King
5585 McFall Circle
Montague, MI 49437

RE: License #: AS610399358
Investigation #: 2023A0340031
Watersedge

Dear Ms. King:

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 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,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610399358
Investigation #:	2023A0340031
Complaint Receipt Date:	06/30/2023
Investigation Initiation Date:	07/03/2023
Report Due Date:	08/29/2023
Licensee Name:	Julie King
Licensee Address:	5585 McFall Circle Montague, MI 49437
Licensee Telephone #:	(231) 894-0049
Administrator:	Julie King
Name of Facility:	Watersedge
Facility Address:	8127 Old Channel Trail Montague, MI 49437
Facility Telephone #:	(231) 292-1695
Original Issuance Date:	08/14/2019
License Status:	REGULAR
Effective Date:	02/14/2022
Expiration Date:	02/13/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A is not supervised at doctor appointments or at the store.	No
Resident A was given the wrong medication.	No
Additional Findings	Yes

III. METHODOLOGY

06/30/2023	Special Investigation Intake 2023A0340031
07/03/2023	Special Investigation Initiated - Letter Licensee Julie King
07/17/2023	Inspection Completed On-site
07/17/2023	Inspection Completed-BCAL Sub. Compliance
07/17/2023	Exit Conference
07/24/2023	Corrective Action Plan requested and due on August 4, 2023
07/24/2023	APS Referral Made

ALLEGATION: Resident A is not supervised at doctor appointments or at the store.

INVESTIGATION: On June 30, 2023, a complaint was filed with the BCAL Online Complaints. It stated that when Resident A goes to the doctor or is taken to the store, she is not supervised.

On July 3, 2023, I contacted Licensee Julie King. She told me she knew I would be calling. When I asked her about Resident A, Ms. King stated that there had been some ongoing issues with Resident A's daughter who believes her mom needs a higher level of care or to reside in a nursing home. Resident A does not have a guardian. Ms. King stated, this has not been a problem, but Resident A's daughter does not believe Resident A can do things on her own. Ms. King stated Resident A uses a wheeled walker, but she is very ambulatory and cognitively aware of her life and surroundings.

Ms. King stated that Senior Resources provides case management services for Resident A. They provide transportation for Resident A but staff also bring Resident

A to doctor appointments. Resident A meets with the doctor independently because she does not need anyone to sit in there with her. Ms. King also stated that when the group goes to get groceries together or other shopping, staff is with them, but if Resident A goes to another aisle or area of the store, she is able because she does not require constant or “eyes on” supervision.

On July 17, 2023, I conducted an unannounced home inspection. I reviewed Resident A’s Assessment Plan which was signed by Resident A and Ms. King on September 25, 2022. There is no documented need for increased supervision noted on the assessment plan.

I interviewed Resident A privately in her room. She presented cognitively aware and fully mobile, even without her wheeled walker. I explained the reason for my visit. Resident A verbalized her irritation that anyone would speak out against the Watersedge home. She stated that she receives really good care and has no complaints. I asked Resident A if someone comes with her to her doctor appointments. She stated that someone drives her, but she does not need anyone in the room with her when she meets with her doctor. I asked Resident A to tell me about going shopping. She stated that if everyone in the home wants to go then they all go. When they are there staff get what they need but she is able to get things she wants as well. I asked if she has to stay right by the staff person when she shops and she said “no” and that she is capable of looking around by herself. She returns to staff when she gets what she wants. I asked Resident A if she is ever dropped off and left on her own at a store and she said she is not, staff are always with them.

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:	The allegation was made that Resident A was not being supervised while at doctor appointments or at the store. Licensee Julie King stated Resident A does not require increased supervision. She is not guarded and while she is driven to appointments and the store, she meets with her doctor on her own and is able to shop independently. Resident A’s Assessment Plan does not indicate a need for constant or enhanced supervision.

	Resident A confirmed that she is not alone at appointments but meets privately with her doctor. She goes with others to the store and will go to another aisle to get something, but a staff person is always with them. There is not a preponderance of evidence to find a rule violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A has been given the wrong medication.

INVESTIGATION: On June 30, 2023, a complaint was filed with the BCAL Online Complaints. It stated that when Resident A was given the wrong medication. No date or prescription type was provided.

On July 3, 2023, I contacted Licensee Julie King. I asked if there had been any issues with medication getting passed and Ms. King stated that Resident A had a change to her medication and the pharmacy had a delay getting the medication, but that was quite a while ago. Ms. King did not know of any other issues.

On July 17, 2023, I conducted an unannounced home inspection and met staff Bonnie Stulp. She showed me the Medication Administration Record (MAR). While reviewing the MAR for Resident A, I did not observe any notation of a medication error. Ms.Stulp denied that there were any medication errors and stated she has always given each resident their own medication. I reviewed the Incident Reports for Resident A and did not find any regarding a medication error.

I then interviewed Resident A privately in her room. I asked her about her medications. She said that she knows what she is supposed to get every day. I asked if she remembers a time that she did not receive her medication and she said that she did not. I asked if she remembered a time that she was given medication she was not familiar with and Resident A stated she knows what her pills look like and she does not take something she does not recognize or know what it is.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	The allegation was made that Resident A was given the wrong medication.

	Resident A's MAR did have missing initials on July 14, 2023 however, staff Stulp indicated she forgot to initial the passes that day but that medications were passed. Resident A denied having knowledge of being given the wrong medications or that she failed to receive her medications.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: On July 17, 2023, while conducting the complaint investigation, I witnessed staff Bonnie Stulp open the Medication Administration Record (MAR) and enter her initials on multiple medications. I asked Ms. Stulp what she was doing and she told me that she was marking the medications given for earlier that day. I asked to see the book and saw that they were the medication for today at 8 am that were to be passed in the morning while I was there around 11 am.

I took this opportunity to explain the medication rule to Ms. Stulp and how her initials need to be entered at the time she passes them and it is not appropriate to pass them and then initial the MAR at a later time. While reviewing the MAR I also noticed some check marks in some of the PRN boxes. When I asked what the check marks meant, Ms. Stulp stated it was to indicate that the PRN was not passed. I advised Ms. Stulp that it was not an appropriate mark and she is to only initial the box if the medication is passed for the PRN and if not, then she needs to leave it blank.

I then looked through the MAR and I noticed that on July 14, 2023, it showed that no medications had been passed. I asked Ms. Stulp about the missing initials and she stated that she must have forgotten to fill in her initials. I again discussed with Ms. Stulp proper medication pass protocol. She stated that she was aware of proper protocols but she "just forgot this one time". I emphasized the importance of initialing after each medication pass. I also pointed out that every resident was missing initials in their MAR for July 14th.

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:** **(i) The medication.** **(ii) The dosage.**

	(iii) Label instructions for use. **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	While conducting this investigation I witnessed staff Bonnie Stulp initial the MAR boxes all at once instead of when she actually passed the medication. I also observed, as previously noted, that there were no boxes initialed on July 14, 2023. Ms. Stulp stated she had gotten busy the morning of my visit and regarding July 14, 2023 stated she "forgot".
CONCLUSION:	**VIOLATION ESTABLISHED**

On July 17, 2023, I conducted an exit conference with Licensee Julie King. I explained the allegations to her and my findings as well as the rule violation. She understood the violation and agreed to a corrective action plan.

IV. RECOMMENDATION

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

Rebecca Piccard July 25, 2023

Rebecca Piccard Date
Licensing Consultant

Approved By:

July 25, 2023

Jerry Hendrick Date
Area Manager