GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 4, 2023

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

RE: License #: AH190397181
Investigation #: 2023A1028069
The Woodlands Of DeWitt

Dear Clarence 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,
Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH190397181 |
| | |
| **Investigation #:** | 2023A1028069 |
| | |
| **Complaint Receipt Date:** | 07/18/2023 |
| | |
| **Investigation Initiation Date:** | 07/18/2023 |
| | |
| **Report Due Date:** | 09/17/2023 |
| | |
| **Licensee Name:** | DeWitt ALC, LLC |
| | |
| **Licensee Address:** | 910 Woodlands Dr<br>DeWitt, MI 48820 |
| | |
| **Licensee Telephone #:** | (989) 327-7922 |
| | |
| **Administrator:** | Evonne White |
| | |
| **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<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A was given morphine without a prescription. | Yes |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 07/18/2023 | Special Investigation Intake<br>2023A1028069 |
| 07/18/2023 | Special Investigation Initiated - Letter |
| 07/18/2023 | APS Referral<br>No APS referral due to resident being deceased. |
| 08/03/2023 | Contact - Face to Face<br>Interviewed Admin/Evonne White at the facility. |
| 08/03/2023 | Contact - Face to Face<br>Interviewed Employee A at the facility. |
| 08/03/2023 | Contact - Face to Face<br>Interviewed Employee B at the facility. |
| 08/03/2023 | Contact - Telephone call made<br>Interviewed hospice staff by telephone. |
| 08/03/2023 | Contact - Document Received<br>Received Resident A's record from Admin/Evonne White. |

**ALLEGATION:**

**Resident A was given morphine without a prescription.**

**INVESTIGATION:**

On 7/18/2023 the Bureau received the allegations anonymously through the online complaint system.

On 7/18/2023, no APS referral was made due to resident being deceased.

On 8/3/2023, I interviewed the facility administrator, Evonne White, at the facility who reported Resident A has resided at the facility since December 2021. Resident A began to demonstrate a recent history of urinary tract infections which contributed to a recent decline in health. Resident A began receiving hospice services with morphine being prescribed by the attending physician. A low dose was prescribed as needed with Resident A refusing administration intermittently. Ms. White reported the family wanted the prescribed morphine to be increased to every hour, but hospice and facility staff conferenced with the family about the parameters of the prescription and that it would be administered as provided. Ms. White reported the family would tell staff that “they knew when [Resident A] was in pain and would request staff give it to [Resident A].” Ms. White reported facility staff were educated on the signs and symptoms of pain and to follow the physician orders despite what family was requesting. Ms. White reported Resident A was not on morphine for very long before passing and the dose was very low to begin with. Ms. White also reported hospice reviewed the physician orders a few times to ensure Resident A was receiving appropriate comfort care and to address Resident A’s family requests concerning morphine administration. Ms. White provided me Resident A’s record for my review.

On 8/3/2023, I interviewed Employee A who reported Resident A’s family would request from staff that morphine be administered every hour despite Resident A not demonstrating signs or symptoms of pain. Employee A reported Resident A was receiving hospice services with the facility and hospice conferencing with Resident A’s family to ensure appropriate comfort care but to also educate the family on the parameters of the physician orders. Employee A reported the family continued to tell staff Resident A was in pain, requesting morphine every hour for pain, despite Resident A not demonstrating any signs or symptoms of pain. Resident A would also refuse medication intermittently as well. Employee A reported to [their] knowledge staff followed physician orders for all medication administration.

On 8/3/2023, I interviewed Employee B at the facility whose statements were consistent with Ms. White’s statements and Employee A’s statements. Employee B confirmed the family continually requested staff administer morphine hourly “because they could tell when [Resident A] was in pain and we [staff] couldn’t.” Employee B reported [they] administered morphine in accordance with the prescribed physician order and demonstrated knowledge of the prescription parameters.

On 8/3/2023, I interviewed hospice staff 1 by telephone who confirmed Resident A’s family required conferencing with both hospice and the facility staff present due to initially requesting morphine be given to Resident A every hour. Hospice staff 1 reported [they] explained to the family it cannot be given outside of the prescription parameters and staff have to follow physician orders. Hospice staff 1 reported the physician order was reviewed to ensure appropriate comfort care and to address the

family's concerns. To hospice staff 1's knowledge, facility staff administered morphine in accordance with the physician order.

On 8/8/2023, I reviewed Resident A's physician orders and medication administration record (MAR) from June 2023 to July 2023. The review revealed the following:

- Hospice physician order - Resident A was prescribed 5mg of morphine concentrate 100mg/5ml (20mg/ml) oral solution for pain/shortness of breath to be given every 4 hours/ PRN. Start date 6/15/2023. Discharge date 6/20/2023.
- Hospice physician order - Resident A was prescribed 5mg of morphine concentrate 100mg/5ml (20mg/ml) oral solution for pain/dyspnea to be given hourly/PRN. Start date 6/20/2023.
- Hospice physician order entered on 7/7/2023 for morphine 5mg scheduled Q4 hours. Pharmacy notified.
- Hospice physician order entered on 7/8/2023 for clarification order. Morphine 20mg/ml. Give 10mg Q 4 ATC and give 5mg PO Q Hour as needed for increase pain. Faxed to pharmacy and facility. Morphine concentrate 10mg/0.5 ml oral syringe (For Oral Use Only) every 4 hours. Start date 7/8/2023.

Review of June 2023 MAR revealed the following:

- Morphine SUL SOL 100/5ml Mouth/Throat. Take 0.25 ML (5mg) by mouth every 4 hours as needed for pain and shortness of breath. Start date 6/17/2023. Discharge date 6/20/2023. Resident A was administered medication 6/20/2023 with entry marked *4X.*
- Morphine SUL SOL 100/5ml Mouth/Throat. Give 0.25 ML by mouth or sublingually every hour as needed for pain and shortness of breath. Start date 6/20/2023. Discharge date 6/28/2023. Resident A was administered medication 6/20/2023 with entry marked *6X,* 6/21/2023 with entry marked *13X,* 6/22/2023 with entry marked *16X*, 6/23/2023 with entry marked 22*X,* 6/24/2023 with entry marked *16X,* 6/25/2023 with entry marked 2X, 6/26/2023 with entry marked *AE,* 6/27/2023 with entry marked *4X,* and 6/28/2023 with entry *DOZ.*
- Morphine SUL SOL 100/5ml Mouth/Throat. Give 0.25 ML by mouth or sublingually every hour as needed for pain and shortness of breath. Start date 6/28/2023. Discharge date 7/6/2023. Resident A was administered medication 6/29/2023 with entry marked *BL.*
- On 6/24/2023, it was documented in the MAR notes Resident A was administered Morphine SUL SOL 100/5ML due to *"wife said to give it to him even tho he's not in pain".*
- Quantities of morphine administered to Resident A and documented in MAR notes vary from 0.25, 1.00, and 2.50 from 6/20/2023 to 6/29/2023.
- June 2023 MAR notes reveal intermittent refusal of medication by Resident A.

Review of July 2023 MAR revealed the following:

- Morphine SUL SOL 100/5ml Mouth/Throat. Give 0.25 ML by mouth every 4 hours. Start date 7/7/2023. Discharge date 7/8/2023 at 2:00pm. Resident A was administered morphine 7/8/2023 at 4:00pm, 8:00pm, 12:00am, 4:00am, 8:00am, and 12:00pm with staff appropriately entering initials in the MAR.
- Morphine Sulfate (Concentrate) 20mg/ml Soln. Give 5mg or 0.25 ml by mouth every 4 hours scheduled. Resident can also get 5mg 0.25ml every hour as needed. Start date 7/7/2023 at 2:50pm. Discharge date 7/8/2023 at 2:00pm. Resident A was administered morphine on 7/7/2023 at 4:00pm and 8:00pm; and on 7/8/2023 at 12:00am, 4:00am, 8:00am, and 12:00pm.
- Morphine Sul Sol 100mg/5ml Mouth/Throat. Give 0.25mls (5mg) by mouth every 4 hours. Start date 7/7/2023. Discharge date 7/10/2023 at 7:00pm. Resident A was administered morphine on 7/8/2023 at 4:00pm and 8:00pm. Resident A was administered morphine on 7/9/2023 at 12:00am, 4:00am, 8:00am,12:00pm, 4:00pm and 8:00pm. Resident A was administered morphine on 7/10/2023 at 12:00am, 4:00am, 8:00am,12:00pm, and 4:00pm.
- Quantities of morphine administered to Resident A and documented in MAR /notes vary from 0.25 to 1.00 from 7/3/2023 to 7/10/2023.
- July 2023 MAR notes reveal intermittent refusal of medication by Resident A.

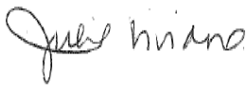
Review of Resident A's service plan revealed Resident A required assistance for all care, ambulation, and medication administration.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1932** | **Resident medications.** |
| | **(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.** |

| | |
|---|---|
| **ANALYSIS:** | It was alleged Resident A was given morphine by facility staff without a prescription. Interviews, onsite investigation, and review of documentation reveal Resident A had a physician ordered prescription for morphine beginning on 6/20/2023 with a discharge date of 7/10/2023.<br><br>However, further review of the medication administration record for June 2023 to July 2023 revealed the following:<br>• Resident A did not miss any administration of morphine, but there are varying physician orders and conflicting administration of doses within the administration records. The doses documented vary from 0.25 to 1.00 to 2.50 from 6/20/2023 to 7/10/2023. These doses do not correlate with physician orders.<br>• Resident A was administered morphine outside of physician orders on 6/24/2023 at 5:17pm due to "*"wife said to give it to him even tho he's not in pain".*<br>• From 6/21/2023 to 6/25/2023 and again on 6/27/2023 the record is incorrectly documented with varying numbers where initials of the facility staff member administering the medication should be documented.<br><br>Due to the variances in the documentation of the MARs, it cannot be determined which physician order was being followed by staff and if the correct dosage was provided to Resident A during medication administration. Therefore, the facility is in violation. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remain the same.



8/8/2023

Julie Viviano — Date
Licensing Staff

Approved By:

01/02/2024

_____

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