GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 3, 2023

Virginia Ingle
Drews Place Of Coldwater Inc..
300 E. Washington St.
Coldwater, MI 49036

RE: License #: AL120074548
Investigation #: 2023A1032008
Drews Place Of Coldwater

Dear Mrs. Ingle:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503
(616)-240-3850

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL120074548
Investigation #:	2023A1032008
Complaint Receipt Date:	10/13/2022
Investigation Initiation Date:	11/09/2022
Report Due Date:	11/12/2022
Licensee Name:	Drews Place Of Coldwater Inc..
Licensee Address:	300 E. Washington St. Coldwater, MI 49036
Licensee Telephone #:	(517) 398-5333
Licensee Designee:	Virginia Ingle
Name of Facility:	Drews Place Of Coldwater
Facility Address:	289 E Perkins Street Coldwater, MI 49036
Facility Telephone #:	(517) 278-9400
Original Issuance Date:	03/17/1997
License Status:	REGULAR
Effective Date:	08/14/2022
Expiration Date:	08/13/2024
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Employees treated Resident A in an undignified manner, amusing themselves at the resident's expense.	No
Additional Findings	No

III. METHODOLOGY

10/13/2022	Special Investigation Intake 2023A1032008
11/09/2022	Special Investigation Initiated - Face to Face
11/10/2022	Contact - Telephone call received Voicemail from complainant verifying the accuracy of the complaint information.
11/15/2022	Contact - Document Received Training report received for Employee #1
12/15/2022	Exit Conference With Licensee Virginia Ingle
12/15/2022	Contact - Telephone call received Interview with Lauren Anzell, Gentiva Hospice nurse

ALLEGATION:

Employees treated Resident A in an undignified manner, amusing themselves at the resident's expense.

INVESTIGATION:

On 11/9/22, I interviewed Nurse Manager Stacy Morgan at the home. Ms. Morgan explained that Resident A received hospice care and was near the end of life at the time. Ms. Morgan stated that Resident A had issues aspirating on food and from what was gathered, when feeding her, employees would try to keep her alert from choking on meals. She reported that the employees in question appeared to have a good rapport with Resident A and would often laugh and joke with her. She stated that on the day in question, from what she gathered from talking with the employees involved separately, the employees fed Resident A in order to provide medication,

and that this incident occurred prior to relatives visiting. Ms. Morgan stated that she surmised that when the relatives entered, they may have misinterpreted what was happening, and that they may have been angry, given Resident A's condition. Ms. Morgan stated that Employee # 1 and Employee #2 were on shift but that Employee #3 was not scheduled to work.

I interviewed Employee #1 at the home. Employee #1 stated that on the day in question, she was attempting to keep Resident A alert to feed and provide medication to prevent Resident A from choking. She reported that there were two other employees in the room with her. Employee #1 stated that Resident A winked at her and she laughed and joked with Resident A about the wink. Employee #1 stated that the winking was an indication that Resident A was alert, so that she could receive the medication and not choke on it or the food. She stated that relatives came to visit at that time and from the look on a relative's face, she deduced that the relative was not happy about the interaction. Employee #1 stated that she tried to explain the interaction but that the relative remained displeased, so she and the other employees exited the room.

I interviewed Employee #2 at the home. Employee #2 stated that while administering food and medication, Resident A winked at Employee #1 and they were laughing and joking about the wink. Employee #2 stated that relatives came to visit and that it appeared that one of the relatives did not look pleased with the interaction. Employee #2 stated that the third employee, Employee #3, appeared to grow uncomfortable and left the room. She stated that Employee #1 tried to explain the context of the interaction but this did not assuage the relatives, so then she and Employee #1 also left the room to accommodate the visit.

The home was Covid positive, so I was unable to speak with other residents. I did observe Ms. Morgan interact with a resident in a wheelchair in the parking lot, and the interaction appeared positive, with Ms. Morgan appearing to speak to the resident in a dignified manner.

On 11/10/22, I received a voicemail from the complainant confirming the information for accuracy.

On 11/15/22, Ms. Morgan provided training transcripts for Employee #1. The documents reflect that Employee #1 had the required training to execute her job duties.

On 12/15/22, I interviewed Gentiva Hospice nurse Lauren Anzell. Ms. Anzell denied being present for the incident referenced but stated that as far as she was aware, the employees in question, and the home in particular, usually provided good care to the residents. She stated that she had interacted with Resident A, and that yet another family member had expressed satisfaction with the quality of care provided.

APPLICABLE RULE	
R 400.15305	**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:	I interviewed Nurse Manager Stacy Morgan, Employee #1 and Employee #2. They denied being unprofessional or treating Resident A in a disrespectful manner. I observed Ms. Morgan interacting with another resident, and it appeared positive and in keeping with the applicable licensing rule above. I received collateral information from Gentiva Hospice nurse, Lauren Anzell, who affirmed that based on other interactions that she observed, Resident A received good care. Employee #1's training transcripts reflect that she is competent in those requirements. Therefore, there was insufficient evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 12/15/22, I conducted an exit conference with licensee designee, Virginia Engle. I shared my findings and she agreed with the conclusions reached.

IV. RECOMMENDATION

I recommend no change to the status of this license.

12/27/22

Dwight Forde Date
Licensing Consultant

Approved By:

1/3/22

Russell B. Misiak Date
Area Manager