GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 12, 2024

Debra Smith
We Care Management LLC
3973 W. Grand River Rd.
Owosso, MI 48867

RE: License #: AS780307442
Investigation #: 2024A0584024
We Care Management

Dear Ms. Smith:

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) 284-9727.

Sincerely,

Candace Coburn, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS780307442
Investigation #:	2024A0584024
Complaint Receipt Date:	04/10/2024
Investigation Initiation Date:	04/10/2024
Report Due Date:	06/09/2024
Licensee Name:	We Care Management LLC
Licensee Address:	3973 W. Grand River Rd. Owosso, MI 48867
Licensee Telephone #:	(989) 723-9973
Administrator:	Debra Smith
Licensee Designee:	Debra Smith
Name of Facility:	We Care Management
Facility Address:	3973 W. Grand River Rd. Owosso, MI 48867
Facility Telephone #:	(989) 723-9973
Original Issuance Date:	06/03/2010
License Status:	REGULAR
Effective Date:	12/19/2022
Expiration Date:	12/18/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 3/6/2024, the facility did not have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents.	Yes
On the morning of 3/6/2024, Resident A was not administered her 8am medications until 10:47am.	No
Plumbing not in good working order.	No
The laundry room is a fire hazard.	Yes
Not enough food in the facility.	No
Additional Findings	Yes

III. METHODOLOGY

04/10/2024	Special Investigation Intake - 2024A0584024.
04/10/2024	Special Investigation Initiated - Email to complainant.
04/30/2024	Contact -Investigation on site. Interview with Resident B, direct care staff Kathy Wertzbar, Amanda Deverney, and maintenance manager John Smith.
05/08/2024	Contact - Face to Face interview with licensee designee Deb Smith and interview with Resident E.
05/20/2024	Contact - Telephone call made to Heart to Heart Hospice.
6/3/2024	Exit conference with Deb Smith, licensee designee.

ALLEGATIONS:

- **On 3/6/2024, the facility did not have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents.**
- **On the morning of 3/6/2024, Resident A was not administered her 8am medications until 10:47am.**
- **Plumbing not in good working order.**
- **The laundry room is a fire hazard.**

- **Not enough food in the facility.**

INVESTIGATION:

On 4/10/2024, the Bureau of Community and Health Systems received the above allegations. According to the written complaint, the facility did not have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents, as evidenced by Resident A being found soaked in urine on the morning of 3/6/2024, and her 8am medications not given until 10:47am.

The written complaint also indicated that on an unknown date, a facility toilet backed up into a resident's bedroom. According to the written complaint, the laundry room area is a fire hazard, and there is not enough food in the home, as evidenced by staff having to bring food to the home to feed the residents.

On 4/10/2024, I conducted an email interview with the Complainant who indicated Resident A used a Hoyer lift for mobility and passed away on or around 3/10/2024.

On 4/30/2024, I conducted an unannounced investigation at the facility and conducted face-to-face interviews with Resident B, and facility staff members Kathy Wertzbar, Amanda Deverney, and John Smith.

Resident B stated that he is satisfied with the care receives at the facility, that he always has enough food to eat, and has no complaints about the facility.

Both Ms. Wertzbar and Ms. Deverney stated they are scheduled to provide care, supervision, and protection to residents at the facility for periods of time by themselves.

Ms. Wertzbar stated she was unaware of any allegations regarding Resident A's care. According to Ms. Wertzbar, she had no concerns being the only staff member assigned to provide care to Resident A, as well as the other facility residents, at the time of Resident A's residence at the facility. Ms. Wertzbar stated the facility is always well stocked with food and the only time she brought food to the facility was to provide a special treat for the residents. Ms. Wertzbar denied the laundry area was a fire hazard and stated it is a room that houses extra equipment. Ms. Wertzbar stated bedding is also stored in the laundry room temporarily.

Ms. Deverney stated she worked the morning of 3/6/2024 and recalled discovering Resident A's urine bag was empty. Ms. Deverney confirmed Resident A was soaked in urine. However, this was not because the facility was short-staffed but because her catheter was not functioning properly. According to Ms. Deverney, she contacted Heart to Heart Hospice as a result. Ms. Deverney stated she did not recall the exact time medications were given to Resident A on the morning of 3/6/2024. Subsequently, she was unbale to confirm or denied the allegation Resident A's medications were administered late that morning. Ms. Deverney stated that it was difficult to be the only staff member working at the facility, as Resident A required the use of a Hoyer lift to get in and out of her bed. According to Ms. Deverney, it was a challenge for one facility staff

member to transition Resident A using the Hoyer lift by themselves. Ms. Deverney stated it was also difficult to reposition Resident A in bed when needed without the assistance of another facility staff member. Ms. Deverney denied the facility did not have enough food and that the facility's laundry room was a fire hazard.

Neither Ms. Wertzbar nor Ms. Deverney had any information regarding allegations of inadequate plumbing in the facility,

Mr. Smith, who is responsible for maintenance of the facility, stated the only incident he recalled regarding issues with plumbing in the facility, was an incident on 01/22/2024, when he received a call from the overnight staff around 3am. According to Mr. Smith, the toilet in Resident E's bedroom was not flushing, and water had backed up to the rim. Mr. Smith stated he believed the septic was most likely clogged and informed staff to turn off the water at the base and to not run any water until he could get there to identify the problem. Mr. Smith stated that when he arrived at the facility that morning, he removed the septic tank lid, saw it was full of water and subsequently called the septic company to pump it out. Mr. Smith provided me with an invoice from the septic company, which confirmed his statements.

I attempted to conduct face-to-face interviews with Residents C and D. However, they were unable or unwilling to be interviewed. Both Residents C and D appeared to be well groomed and in good health.

I inspected the facility's physical plant. The home was clean and had no evidence of pests or foul odors. I observed the laundry room where there were extra beds and other stored resident items. I tested sinks and toilets, which drained properly. I observed the facility had adequate fresh and frozen food to provide a well-balanced diet to four residents for several days.

On 5/8/2024, I conducted a second unannounced investigation at the facility, and interviewed Resident E, and licensee designee Deb Smith.

Resident E stated he is satisfied with the care provided in the facility and has enough food to eat. Resident E confirmed Mr. Smith's statements regarding the toilet in his bedroom.

Ms. Smith stated she shops for food for the facility once a week and is available to pick up food when necessary. Ms. Smith stated that the laundry area is located in a bedroom size room and is in a constant state of organization due to residents bringing their own items, plus storing equipment they do not use. Ms. Smith stated she will continue to monitor and maintain the room to make sure it remains orderly. Ms. Smith confirmed Mr. Smith's statements regarding the toilet in his bedroom.

I requested to review the facility's *Program Statement*, which indicated the licensee provides personal care, supervision, and protection to the physically handicapped, developmentally disabled, mentally ill, and aged populations.

I requested and reviewed the facility's current *Resident Register*, which indicated that on 5/8/2024, the census was four residents. Until March 10, 2024, five residents resided at the facility, including Resident A.

I requested and reviewed a copy of the facility's direct care staff schedules from January 1, 2024, to present. According to documentation on the schedules reviewed, one staff member was assigned to work each morning, afternoon, and overnight shift at the facility.

I requested and reviewed five resident *Assessment Plan for AFC Residents (assessment plans), Weight records, and Medication Logs, as well as the facility's Menus.*

According to documentation on the assessment plans reviewed:

- One resident need assistance with mobility.
- One resident (Resident A) required two person assistance or transfer assistance with the use of a mechanical lift.
- No residents require routine positioning and turning.
- No residents require toileting assistance due to chronic incontinence.
- No residents require assistance from direct care staff members during mealtimes.
- Four residents require medications be administered to them by facility staff members.
- No residents have aggressive behaviors.
- No residents are at risk for elopement.
- No residents require enhanced supervision.
- No residents have increased anxiety and/or confusion.

According to documentation on the *Medication Logs* for Resident A from January 2024 to March 10, 2024, there were no documented incidents of missed or delayed medication administration.

According to documentation on the *Weight Records* for five residents from January 2024 to May 8, 2024, there were no indications or concerns of excessive weight loss.

I requested a copy of the facility's practice fire drill records from January to present. According to documentation on the records reviewed, staffing ratios were in place to evacuate the home safely during the practice drills on all shifts.

I requested a copy of all *AFC Division-Incident/Accident Reports* (IRs) from January 1. 2024 to present and there was no evidence of increased falls or accidents.

I requested a copy of the facility menus from January to May 8, 2024.
According to the documentation of the menus reviewed, each meal had a variety of foods served to the residents.

On 5/20/2024, I conducted a telephone interview with Danielle Smith, Heart to Heart Hospice nurse, who cared for Resident A at the facility. Ms. Smith did not have any concerns about the care provided to Resident A by the facility. However, she did state that it took two people to assist Resident A with mobility. Subsequently, she was often asked to help staff get Resident A in and out of bed, and reposition her when she became bound to her bed. It is unclear who or how Resident A was transitioned in and out of bed and repositioned in bed when Danielle Smith was not at the facility to assist.

APPLICABLE RULE	
R 400.14206 [15206]	**Staffing requirements**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based upon my investigation, which consisted of interviews with multiple facility staff members and residents, as well as a review of relevant facility documents pertinent to the allegations regarding the care of Resident A, it has been established Resident A required the assistance of two facility staff members to transition in and out of bed with the use of a Hoyer lift, as well as to reposition while in bed. There is enough evidence to substantiate the allegation the facility did not have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of Resident A, as the facility only schedules one facility staff member to work on the facility's morning, afternoon, and overnight shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon my investigation, which consisted of interviews with facility staff members and hospice staff, as well as a review of relevant facility documents pertinent to the allegations regarding Resident A, there is not enough evidence to substantiate the allegation that on 3/6/2024, Resident A's medications were not administered pursuant to label instructions.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(6) All plumbing fixtures and water and waste pipes shall be properly installed and maintained in good working condition. Each water heater shall be equipped with a thermostatic temperature control and a pressure relief valve, both of which shall be in good working condition.
ANALYSIS:	Based upon my investigation, which consisted of interviews with facility staff members and Resident E, two unannounced onsite inspections, as well as a review of relevant facility documents, there is no evidence the facility's plumbing is not in good working condition.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based upon my investigation, which consisted of interviews with facility staff members and two unannounced onsite inspections, it has been established the facility's laundry area is located in a bedroom size room and is in a constant state of organization due to residents bringing in their own items, plus storing extra bedding, linen, and equipment they do not use. While licensee designee Deb Smith stated she will continue to monitor and maintain the area to make sure it remains orderly, items that are capable of catching fire and burning are not to be store near heat-producing equipment, such as a dryer.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	Based upon my investigation which consisted of interviews with residents and facility staff members, two unannounced onsite inspections, as well as a review of relevant facility documents, there is no evidence the facility did not have enough food.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

During my second unannounced investigation at the facility on 5/8/2024, I discovered Resident A and C's file did not contain a completed assessment plan. I also discovered Residents B and D did not have updated written healthcare appraisals on file in the facility.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home. **(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written healthcare appraisal that is completed within the 90 day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually.**
ANALYSIS:	Based upon a review of relevant facility documents, it has been established Resident A did not have an assessment plan on file in the facility. It has also been established that Residents B and D did not have updated written healthcare appraisals on file in the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/3/2024, I conducted an exit conference with licensee designee Deb Smith and shared with her the findings of this investigation.

On 6/11/2024, I conducted an exit conference with licensee designee Deb Smith via phone text and informed her of the findings of this investigation.

IV. RECOMMENDATION

Upon receiving an acceptable corrective action plan, I recommend no changes in the status of this license.

6/3/2024

Candace Coburn — Date
Licensing Consultant

Approved By:

6/12/2024

Michele Streeter — Date
Area Manager