GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2024

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

RE: License #: AL120074548
Investigation #: 2024A1032043
Drews Place Of Coldwater

Dear Virginia 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
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL120074548
Investigation #:	2024A1032043
Complaint Receipt Date:	08/07/2024
Investigation Initiation Date:	08/09/2024
Report Due Date:	10/06/2024
Licensee Name:	Drews Place Of Coldwater Inc..
Licensee Address:	300 E. Washington St. Coldwater, MI 49036
Licensee Telephone #:	(517) 398-5333
Administrator:	Stacy Morgan
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:	08/14/2024
Expiration Date:	08/13/2026
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive adequate care in the home.	No
Additional Findings	No

III. METHODOLOGY

08/07/2024	Special Investigation Intake 2024A1032043
08/09/2024	Special Investigation Initiated - On Site
08/09/2024	Contact - Document Received Assessment Plan and Incident Report
09/18/2024	Contact - Document Sent Request for hospice care notes from Oaklawn Hospice
09/24/2024	Contact - Document Received I reviewed Oaklawn Hospice notes
09/30/2024	Exit Conference

ALLEGATION:

Resident A did not receive adequate care in the home.

INVESTIGATION:

On 8/9/24, I interviewed Nurse Manager Jacob Langston in the facility. Mr. Langston denied placing Resident A on water restrictions, stating that Resident A was admitted to the facility with a two litre restriction. He advised that this was put in

place by the hospital, since Resident A had a condition called hyponatremia. This is a condition where a person has low sodium, causing chronic dehydration, but that drinking too much water exacerbates the problem.

Mr. Langston advised that employees receive hoyer lift training as part of their orientation. He reported that there would have been no issues with staff using the hoyer lift with Resident A, but Resident A's family requested that the hoyer be discontinued. I examined two separate AFC Resident Assessment Plans and only the former plan included use of a hoyer lift. Mr. Langston recalled also that Resident A had a boot on her foot, which would have necessitated that use of the wheelchair boot. He made this statement to dispute the claim that the footpads were not attached.

Mr. Langston advised that Resident A did exhibit some aggressive behaviors while in the home but the staff followed the recommendations to address Resident A's dementia.

Mr. Langston stated that as far as he was aware, there have been no reports of employees pre-sorting medications and placing them in cups, simultaneously eating food. I did observe the meal service during the inspection, and the medication cart was locked, with an employee standing nearby.

Mr. Langston detailed a protocol of checking on and turning Resident A every two hours. He advised that Resident A also received care from Oaklawn Hospice.

I interviewed Resident B in the facility. Resident B stated that she receives good care in the facility.

On 9/24/24, I reviewed Oaklawn Hospice social work case notes regarding Resident A's care in the home. The notes initially indicated some communication issues with the facility regarding sundowning protocol. There were two instances where the facility was reminded to contact hospice when Resident A's aggressive behavior increased. Thereafter, I noted a trend where the behaviors decreased, especially in the presence of medication. There was a note referencing a dispute between a family member and the home over dispensing medication, and hospice appeared to have convinced the relative to allow the medication to be provided. I noted compliance with a two-person pivot order, as opposed to use of a hoyer lift. Resident A also did not appear to have multiple instances of being left in wet clothing due to incontinence. The noted reflect compliance with Resident A being turned. There was a recommendation to increase turning, after a stage 1 pressure sore developed. Resident A also stopped drinking fluids on 5/16/24, a week before she passed. It appears that this was self-directed as opposed to the home refusing to provide water.

On 9/30/24, licensee designee Virginia Ingle reported that she had a discussion with Resident A's family regarding medication, and had also conducted a review of the

incident referenced in the complaint. Ms. Ingle clarified that their review looked into whether the residents' needs were being met, and that it was determined that all medications had been passed prior to the employee eating food.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.** **(b) Special diets.** **(c) Susceptibility to hyperthermia and hypothermia and related limitations for physical activity, as appropriate.** **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	I reviewed Resident A's assessment plans, interviewed the nurse manager and another resident, observed meal time and read independent case notes from hospice care. Collectively, these conversations and documents reflect substantial compliance with rules. Based on the information, there is insufficient evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 9/30/24, I conducted an exit conference with licensee designee Virginia Ingle by telephone. I shared my findings and Ms. Ingle agreed with the conclusions reached.

IV. RECOMMENDATION

I recommend no change to the status of this license.

9/30/24

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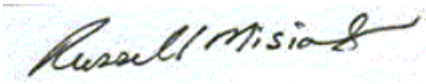
Dwight Forde Date
Licensing Consultant

Approved By:



10/1/24

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Russell B. Misiak Date
Area Manager