GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 24, 2025

Todd Dockerty
Woodland Terrace at Longmeadow
13 Longmeadow Village Dr.
Niles Township, MI 49120

RE: License #: AH110353051
Investigation #: 2025A1028032
Woodland Terrace at Longmeadow

Dear Todd Dockerty:

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 #:	AH110353051
Investigation #:	2025A1028032
Complaint Receipt Date:	01/23/2025
Investigation Initiation Date:	01/23/2025
Report Due Date:	03/22/2025
Licensee Name:	Dockerty Health Care Services, Inc.
Licensee Address:	8850 Red Arrow Hwy. Bridgman, MI 49106
Licensee Telephone #:	(269) 487-9468
Administrator:	Heather Carinder
Authorized Representative:	Todd Dockerty
Name of Facility:	Woodland Terrace at Longmeadow
Facility Address:	13 Longmeadow Village Dr. Niles Township, MI 49120
Facility Telephone #:	(269) 683-7900
Original Issuance Date:	01/22/2014
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	90
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell resulting in injury.	Yes
Additional Findings	No

III. METHODOLOGY

01/23/2025	Special Investigation Intake 2025A1028032
01/23/2025	Special Investigation Initiated - Letter
01/23/2025	APS Referral APS made referral to HFA.
02/03/2025	Contact - Face to Face Interviewed the administrator at the facility.
02/03/2025	Contact - Face to Face Interviewed Employee 1 at the facility.
02/03/2025	Contact - Document Received Received requested documentation from the administrator.

ALLEGATION:

Resident A fell resulting in injury.

INVESTIGATION:

On 1/23/2025, the Bureau received the allegations through the online complaint system.

On 2/3/2025, I interviewed the facility administrator at the facility who reported that on 1/7/2025, Resident A was observed with a bruise on the right eye during first shift and Resident A's authorized representative and physician were notified. It could not be determined how Resident A received the bruise and there no evidence of a fall at that time. On 1/11/2025, Resident A was observed with complaints of pain of the right hip. Resident A's authorized representative and physician were notified with Resident A's authorized representative requesting to the facility wait to send Resident A to the hospital until [they] arrived at the facility. Resident A's authorized

representative was also notified at that time that Resident A does not have any prescribed pain medications to assist with pain. Resident A's authorized representative arrived at the facility with Resident A being sent to the hospital for evaluation and treatment at 11:40 am. On 1/13/2025, the facility was notified by Resident A's family that Resident A incurred a hip fracture and a urinary tract infection. On 1/17/2025, Resident A returned to the facility on hospice services. On 1/22/2025, Resident A was found by care staff next to the bed lying on [their] right side. On 1/23/2025, Resident A was found on the floor at 7:27 pm in the living area next to [their] recliner. Resident A was assessed for injury with Resident A's authorized representative and hospice team being notified. A chair alarm and bed were ordered by the hospice team due to Resident A's recent fall history. Resident A continues on hospice services and continues to demonstrate confusion and some refusals of care. The administrator provided me with the requested documentation for my review.

On 2/3/2025, I interviewed Employee 1 at the facility whose statement was consistent with the administrator's statement.

On 2/3/2025, I reviewed the requested documentation which revealed the following:

- Resident A requires care staff assistance with bathing, dressing, grooming, personal hygiene, feeding, oral care, and toileting.
- Resident A requires assistance with bed and chair positioning, transferring, and mobility.
- On 1/7/2025 at 11:00 am, while staff were assisting Resident A with toileting, Resident A was observed with a bruise on the right eye. The area was cleaned, and Resident A's authorized representative and physician were notified.
- On 1/11/2025 at 9:45 am, care staff went to Resident A's room to complete morning care with care staff observing that Resident A was in pain when attempting to assist Resident A. Resident A held [their] hip and yelled "Ouch! Ouch!" Staff were able to assist with clothing change and put Resident A back to bed. The medication tech was notified by care staff and attempted to assess Resident A with Resident A continuing to demonstrate pain*. RCC was notified and instructed med tech to do range of motion procedure. Med tech slowly lifted leg [with Resident A] starting to shake, held right hip, and started weeping.*
- On 1/11/2025 at 10:30 am, Resident A continues to show signs of being in a lot of pain. [Resident A's authorized representative] was notified about Resident A being in pain with movement and with touch to right hip. The [authorized representative] wants [facility] to wait until [they] arrive before sending [Resident A] to hospital. Resident A does not have any PRN medications for pain.
- On 1/11/2025, emergency services arrived at the facility at 11:40 am. Emergency services were notified that [Resident A] was able to walk yesterday but was not taking full steps but dragging leg. Resident A was sent to the hospital for evaluation and treatment.

- On 1/13/2025 at 3:00 pm, family notified the facility that Resident A has a hip fracture and urinary tract infection.
- On 1/17/2025 at 5:15 pm, Resident A returned to facility with hospice services in place. Staff assigned to complete hourly checks and repositioning every two hours.
- On 1/23/2025 at 7:27 pm, Resident A was observed by care staff in the living room beside the recliner on [their] hands and knees. Resident A was assisted back to the into the wheelchair. Resident A's authorized representative and hospice team were notified. Facility care staff instructed to continue with hospice plan of care.
- On 1/24/2025, Resident A's hospice team was contacted by facility care staff to request physician's order for bed and chair alarms for fall preventative measures.

On 2/3/2025, after reviewing the documentation, I followed-up with the administrator while at the facility, inquiring about the documentation for 1/11/2025 at 9:45 am, in which the RCC was notified [about Resident A's hip pain] and then instructed the attending med tech to do range of motion procedure, despite Resident A's complaints of pain with movement and touch of the right hip. The documentation read that the *med tech slowly lifted leg [with Resident A] starting to shake, held right hip, and started weeping.* The facility administrator reported that staff are instructed to do range of motion but questions the documentation because the facility does not have RCC (resident care coordinators) and does not believe that the med tech would complete range of motion when Resident A is experiencing and demonstrating pain because it could have exacerbated the potential injury and pain. The administrator reported the med tech that completed the documentation is currently out on medical leave, but Employee 1 would have knowledge of the instructions the med tech was given. The administrator reported staff are trained by supervisors in range of motion techniques, but there is not a documented staff training program for range of motion training techniques.

On 2/3/2025, I followed-up with Employee 1 who confirmed facility staff can be instructed to complete range of motion with residents. When questioned who trains staff to complete range of motion procedures, Employee 1 reported supervisors or facility staff train and instruct staff to complete range of motion procedures. Employee 1 reported [they] question the documentation as well because the facility does not have RCC's and that [they] did not instruct the med tech to complete range of motion on Resident A because it would only have increased Resident A's pain and potentially caused further injury. Employee 1 confirmed that there is not a documented training program for range of motion training techniques.

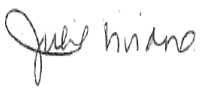
APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**

ANALYSIS:	It was alleged Resident A fell resulting in injury. Interviews, onsite investigation, and review of documentation reveal the following: • On 1/7/2025 at 11:00 am, Resident A was observed with a bruise on the right eye, but it could not be determined how Resident A incurred the bruise. Resident A's authorized representative and physician were notified. • On 1/11/2025 at 9:45 am, care staff went to Resident A's room to complete morning care with Resident A being observed pain with movement and touch to the right hip. *RCC was notified and instructed med tech to do range of motion procedure. Med tech slowly lifted leg [with Resident A] starting to shake, held right hip, and started weeping.* Resident A's authorized representative and physician were notified with Resident A being sent to the hospital for evaluation and treatment. • On 1/13/2025 at 3:00 pm, the facility was notified that Resident A had a hip fracture and urinary tract infection. • On 1/17/2025 at 5:15 pm, Resident A returned to facility with hospice services in place. • On 1/23/2025 at 7:27 pm, Resident A incurred a fall. Resident A's authorized representative and physician were notified. • On 1/24/2025, facility care staff requested physician's order from the hospice team for bed and chair alarms for fall preventative measures. • On 2/3/2025, when questioned about the documentation on 1/11/2025 at 9:45 am, in which the *RCC was notified and instructed med tech to do range of motion procedure* on Resident A, the administrator and Employee 1 reported it appears to be an error in documentation, as the facility does not have RCC (resident care coordinator) and Employee 1 did not instruct the med tech to complete range of motion procedure because it could have potentially exacerbated Resident A's injury. There is a discrepancy between interviews and documentation concerning the range of motion procedure being performed on Resident A on 1/11/2025, despite Resident A's complaints and noted observations of pain with movement and touch to the right

	hip. The facility administrator and Employee 1 reported if range of motion had been performed on Resident A as recorded in the documentation, it would have potentially exacerbated Resident A's pain and potential injury. On 1/13/2025, Resident A was diagnosed a hip fracture and urinary tract infection. Due to the discrepancy between interviews and documentation, it can be determined the facility did not maintain an organized program to ensure Resident A's protection, assistance, or supervised personal care after Resident A was observed by facility care staff vocalizing and demonstrating pain to the right hip with movement and touch. 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 remains the same.



2/6/2025

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Julie Viviano Date
Licensing Staff

Approved By:

02/20/2025

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