



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 13, 2026

Theresa Alvarado  
Addie's Acres, LLC  
11525 Wood Road  
DeWitt, MI 48820

RE: License #: AL190357883  
Investigation #: 2026A0466014  
Addie's Acres, LLC

Dear Ms. Alvarado:

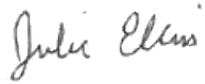
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 335-5985.

Sincerely,

A handwritten signature in cursive script that reads "Julie Elkins".

Julie Elkins, 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**

<b>License #:</b>	AL190357883
<b>Investigation #:</b>	2026A0466014
<b>Complaint Receipt Date:</b>	01/20/2026
<b>Investigation Initiation Date:</b>	01/20/2026
<b>Report Due Date:</b>	03/21/2026
<b>Licensee Name:</b>	Addie's Acres, LLC
<b>Licensee Address:</b>	11633 Wood Road DeWitt, MI 48820
<b>Licensee Telephone #:</b>	(517) 410-1197
<b>Administrator:</b>	Theresa Alvarado
<b>Licensee Designee:</b>	Theresa Alvarado
<b>Name of Facility:</b>	Addie's Acres, LLC
<b>Facility Address:</b>	11633 Wood Road DeWitt, MI 48820
<b>Facility Telephone #:</b>	(517) 410-1197
<b>Original Issuance Date:</b>	07/24/2015
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	01/24/2026
<b>Expiration Date:</b>	01/23/2028
<b>Capacity:</b>	20
<b>Program Type:</b>	AGED ALZHEIMERS

**II. ALLEGATIONS:**

	<b>Violation Established?</b>
The facility failed to follow Resident A's written assessment plan.	No
Medication orders are not being followed for Resident A.	Yes
Residents are not being fed and the direct care workers are contaminating the food.	No
The facility is understaffed.	Yes

**III. METHODOLOGY**

01/20/2026	Special Investigation Intake 2026A0466014.
01/20/2026	Special Investigation Initiated – Letter to assigned licensing consultant Bridget Vermeesch interviewed.
01/21/2026	APS Referral does not apply Resident A is deceased.
01/23/2026	Contact - Telephone call received Relative A1 interviewed.
01/28/2026	Contact - Telephone call made Relative C1 interviewed.
02/05/2026	Inspection Completed On-site.
03/13/2026	APS- referral not required, no suspected abuse/neglect.
03/13/2025	Exit Conference with Theresa Alvarado.

**ALLEGATION: The facility failed to follow Resident A's written assessment plan.**

**INVESTIGATION:**

On 01/20/2026, anonymous Complainant reported direct care workers (DCW)s do not toilet a resident unless they are asked by a relative or visitor of the resident. Complainant reported that residents were being left soiled for long periods of time. Complainant was anonymous therefore no further information or details were able to be gathered.

On 01/23/2026, Relative A1 reported that Resident A was admitted to the facility on 6/1/2025 and she passed away on 1/2/2026 at 95 years. Relative A1 reported that Resident A was left wet and soiled but could not provide dates when this occurred. Relative A1 reported that Resident A did not have any skin breakdown or need any medical treatment because of being left in soiled or wet adult incontinence briefs.

Relative A1 reported that Resident B was also left wet and soiled and she did have skin breakdown.

On 01/28/2026, Relative C1 reported that Resident C, 95 years was not taken to the bathroom by facility staff members and she had to do that herself. Relative C1 reported that Resident B was being left in wet and soiled briefs and had skin breakdown. Relative C1 reported that she has discussed her concerns about Resident B's care with Relative B1. Relative C1 reported that Relative B1 reported that he is happy with the care provided at the facility for Resident B.

On 02/05/2026, I conducted an unannounced investigation and I reviewed written *Assessment Plans for Adult Foster Care (AFC) Residents (assessment plan)* and *AFC Resident Care Agreements (RCA)* for Resident A, Resident B and Resident C. Listed below is what was documented and agreed to for each resident.

- Resident A's assessment plan was completed on 6/1/2025 and signed by Resident A, Relative A1 and licensee designee Theresa Alvarado. The written assessment plan documented that Resident A required assistance with all activities of daily living (ADL)s. Resident A's assessment plan did not document that she used adult incontinence briefs, it stated that she required assistance to "transfer on and off the toilet." Resident A's assessment plan did not document that she required any assistance with toileting reminders nor did it document any frequency of toileting. In the "walking/mobility" section of the document it stated, "In wheelchair for mobility. Short distances for walker but only with someone with her, fall risk." Resident A's assessment plan did not document that she needed to be taken to the bathroom by a DCW.

Resident A's *AFC Resident Care Agreement* dated 6/1/2025 and signed by Resident A, Relative A1 and licensee designee Alvarado documented "the basic fee includes the following service, room and board, 24/7 supervision, medication administration, basic laundry and housekeeping, assistance with showers. Assistance with walking/transfers & incontinent care."

- Resident B's assessment plan was completed on 5/28/2025 and signed by Resident B, Relative B1 and licensee designee Alvarado. The written assessment plan documented that Resident is "fully dependent on assistance" for toileting. Resident B's assessment plan did not document that she uses adult incontinence briefs, that she requires any assistance with toileting reminders or any frequency of toileting. Resident B requires assistance with all activities of daily living. It documented that Resident B does not walk and uses a wheelchair for mobility.

Resident B's *AFC Resident Care Agreement* dated 5/30/2025 and signed by Resident B, Relative B1 and licensee designee Alvarado documented "the basic fee includes the following service, private room and board, 24/7 supervision, medication administration, basic laundry and housekeeping,

assistance with transfers & walking. Family will supply all incontinence supplies for no charge for this service.”

- Resident C’s assessment plan was completed on 10/25/2025 and signed by Resident C and licensee designee Alvarado. The written assessment plan documented that Resident C required assistance with toileting, bathing, personal hygiene and walking. In the “toileting” section of the document it stated, “needs help to and from.” Resident C’s assessment plan did not document that she used adult incontinence briefs, required any assistance with toileting reminders or frequency of toileting. The assessment plan documented that Resident C uses a walker or wheelchair for mobility.

Resident C’s *AFC Resident Care Agreement* dated 6/1/2025 and signed by Resident C, Relative C1 and licensee designee Alvarado documented “the basic fee includes the following service, private room and board, 24/7 supervision, medication administration, basic laundry and housekeeping, assistance with showers. Assistance with transfers/ambulation plus daily wts.”

Resident A is deceased and Resident C was discharged from the facility so neither could be interviewed at the time of the investigation. Resident B reported that she is provided with good care and all her needs are being met.

I interviewed licensee designee Alvarado, DCW Savada Wells and DCW Debbie Marcinkiewicz who all denied that residents are left in wet/soiled briefs. Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz all reported that residents are checked and changed every two hours. Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz all reported that brief changes are not documented as most of the residents are independent and toilet themselves. DCW Wells reported that Resident B does have skin breakdown which is being addressed with her nurse. DCW Wells reported Resident B is in her wheelchair all day as she is not ambulatory. Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz all reported that the written assessment plans for all residents are followed. Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz all acknowledged that Resident A, Resident B and Resident C required more care than most of the other residents and the care they needed was provided.

<b>APPLICABLE RULE</b>	
<b>R 400.685</b>	<b>Resident admission; resident assessment plan; resident care agreement; health care appraisal.</b>
	<b>(2) A licensee shall not accept or care for a resident until a written assessment has been completed. A written assessment plan must include all of the following: (a) The amount of personal care, supervision, and protection required by the resident that is available at the facility.</b>

<b>ANALYSIS:</b>	Based on the documentation of the <i>AFC Resident Care Agreements</i> , for Resident A, Resident B and Resident C, the amount of personal care, supervision, and protection required by the residents is or was provided and available at the facility therefore there is not enough evidence to establish a violation.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: Medication orders are not being followed for Resident A including orders for ensure and hydration packets.**

**INVESTIGATION:**

On 01/20/2026, anonymous Complainant reported that medication orders are not being followed for Resident A including orders for ensure and hydration packets. Complainant reported that the staff got upset twice with a family member when they asked about medications orders for ensure and hydration packet and the staff became hostile. Complainant was anonymous therefore no further information or details were able to be gathered.

On 01/23/2026, Relative A1 reported that Resident A was not provided with prescribed hydration packets as well as water. Relative A1 reported that Resident A would have to yell from her room at the end of the hallway to be provided with fluids. Relative A1 reported that Resident A was not provided with ensure nutrition as prescribed.

On 02/05/2026, I conducted an unannounced investigation and I reviewed Resident A's record which contained *Medication Administration Records (MAR)s*. Resident A passed away on 1/2/2026 therefore none of her medications were at the facility so they could not be reviewed or compared to the MAR. Resident A is deceased so she could not be interviewed.

Resident A's December 2025 MAR documented the following:

- "Give 1ultra hydration pkt in 16oz of water q AM to sip all day. Mix D-MANNOSE in this." This was signed for every day except 12/4/2025 by DCW Wells or DCW Jamie Sailer.
- "Ensure after supper." This was not signed as administered on 12/9/2025, 12/22/2025, 12/25/2025, 12/27/2025, 12/28/2025, 12/29/2025, 12/30/2025 and 12/31/2025. The MAR was blank on all the above dates.

DCW Wells reported that she provided Resident A with water and Resident A shook her head and spit the water at her. DCW Wells denied that there was ever a time when Resident A was yelling from her room for something to drink. DCW Wells and DCW Marcinkiewicz reported that Resident A was checked on frequently because of her needs. DCW Wells and DCW Marcinkiewicz reported that every resident is checked on every two hours but Resident A, Resident B and Resident C were all checked on more frequently. DCW Wells reported that at every meal Resident A was provided with

a beverage of choice and she was provided with a glass of water with a hydration packet in it every morning. DCW Wells reported that Resident A did not drink a lot of fluid so her water rarely needed to be refilled.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<p><b>(1 ) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.</b></p> <p><b>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:</b></p> <p><b>(v) Initials of the individual who administered the medication at the time given.</b></p> <p><b>(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.</b></p>
<b>ANALYSIS:</b>	Resident A's December 2025 Medication Administration Record documented that she was prescribed hydration packets and ensure daily. These supplements were not documented via direct care staff initiates as administered as prescribed on Resident A's Medication Administration Record on 12/04/2025, 12/9/2025, 12/22/2025, 12/25/2025, 12/27/2025, 12/28/2025, 12/29/2025, 12/30/2025 and 12/31/2025 therefore a violation has been established.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION: Residents were not being fed at the facility and the direct care workers are contaminating the food.**

**INVESTIGATION:**

On 01/20/2026, anonymous Complainant reported that residents were not being fed at the facility and were losing weight. Complainant reported that residents are not being provided with water and staff members were hostile when asked about it. Complainant was anonymous therefore no further information or details were able to be gathered.

On 1/23/2026, Relative A1 reported that mealtimes are not being followed as residents are fed dinner early. Relative A1 reported that DCWs that are preparing the food are not hygienic because they lick their fingers then touch resident food or they lick a spoon to taste it and put that same utensil back into the pan where all of the food is being prepared. Relative A1 reported that she did not confront this behavior when she observed it. Relative A1 reported that DCW Wells is the DCW that typically works during the day and she cooks lunch.

On 01/28/2026, Relative C1 reported that Resident C could not eat the hard chicken nuggets that were served and she did not like the meals. Relative C1 reported that meals contained small portions of meat. Relative C1 reported that the facility served a lot of hot dogs and did not follow the menu. Relative C1 reported that Resident C would call her, tell her she was hungry and ask her to bring chicken. Relative C1 reported that the facility served canned mixed vegetables. Relative C1 reported that the posted menu looks great, but nothing is made from scratch. Relative C1 reported that DCWs have long nails, do not wear gloves and lick their fingers while preparing meals. Relative C1 reported that she did not confront this behavior as she was afraid of retaliation for Resident C. Relative C1 reported that the posted mealtimes were 8am, 12 noon and 5pm. Relative C1 reported that dinner would be served at 4:45 therefore there was more than 15 hours between dinner and breakfast.

On 02/05/2026, I conducted an unannounced investigation and I reviewed Resident A and Resident C's written assessment plans. Neither assessment plans documented any special dietary requirements. Resident A's assessment plan documented that she "often needs encouragement to eat." Resident C did not require any assistance with eating.

I reviewed weight records for Resident A who was 95 years which documented that she did lose 17 pounds while she was at the facility between June 2025 and November 2025. Resident A's weight was last documented in November 2025, she weighed 86 pounds and died January 1, 2026.

I reviewed weight records for Resident B who is 82 years and as of January 28, 2026, she weighed 161 pounds. DCW Wells reported that Resident B has lost weight as she was 184 pounds in May 2025 according to the weight documented in her *Health Care Appraisal* on May 23, 2025. DCW Wells reported that Resident B's weight loss is being reported and monitored by a medical professional.

I reviewed weight records for Resident C who is 95 years and she gained three pounds between November 2025 and December 2025.

I was at the facility during mealtime on 02/05/2026 and I observed lunch being served. The residents were fed boneless BBQ chicken with rice, carrots and watermelon. Resident B was eating lunch at the table and she reported that she is fed and provided with good care from the facility.

The posted menu for 02/05/2026 documented "chicken rice casserole, glazed carrots, watermelon." DCW Wells reported that BBQ chicken was an alternative menu item that was offered along with potato salad.

I reviewed menus dated 11/30/2025, 12/7/2025, 12/14/2025 and 12/21/2025 which were the same offerings each week. The menu contained scrambled eggs, pasta, pork chops, sloppy joe, mac and cheese, tuna, chicken salad, meat loaf, BBQ chicken, fish sticks, baked potatoes, or chicken alfredo. Chicken nuggets is listed as

an option for lunch weekly but fish sticks are also offered. Every meal states it is served with beverage of choice and the documented snack is individualized by the plan of care.

Resident A is deceased and Resident C has been discharged from the facility so neither could be interviewed.

I interviewed licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz who all denied that residents are not being fed. Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz all reported that residents are given water, coffee, juice and other beverages throughout the day. Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz all denied that residents are fed dinner too early or that too much time passes between dinner and breakfast. Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz all reported that they are preparing the food in a hygienic way and denied licking fingers and touching food or licking a spoon to taste the food and put that same utensil back into the pan where all of the food is being prepared. Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz all reported that residents can ask for more food if they are still hungry and reported that they can ask for alternative meal if they do not like the food that is being served. Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz denied that the facility serves hard chicken nuggets. Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz all reported that Relative A1 brought food in for Resident A so often Resident A would ask for that food to be prepared for her and that is the food that she would eat. Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz denied that more than 14 hours elapsed between dinner and breakfast and reported that even if dinner was served early all the residents are provided with an evening snack. Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz all reported that the facility provides all residents with three nutritious uncontaminated meals daily.

<b>APPLICABLE RULE</b>	
<b>R 400.663</b>	<b>Nutrition; adoption by reference.</b>
	<b>(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.</b>
<b>ANALYSIS:</b>	Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz all reported that all residents are provided with three nutritious meals and snacks daily and the menus reviewed reflect this as well. Therefore there is not enough evidence to establish a violation.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.665</b>	<b>Food service.</b>
	<b>(3) Food must be protected from contamination while being transported, stored, prepared, and served.</b>
<b>ANALYSIS:</b>	Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz all reported that they are preparing the food in a hygienic way and I did not find any evidence to the contrary. There is not enough evidence to support that food is being contaminated therefore there is not enough evidence to establish a violation.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: The facility is understaffed.**

**INVESTIGATION:**

On 01/20/2026, anonymous Complainant reported that the facility has appeared to be understaffed as staff does not respond to call lights in a timely manner or at all. Complainant was anonymous therefore no further information or details were able to be gathered.

On 1/23/2026, Relative A1 reported that she only saw two DCWs when they had a DCW in training. Relative A1 reported that the census of the facility did not exceed 15 residents. Relative A1 reported that she was not aware of any residents that require the assistance of two direct care workers at the same time.

On 01/28/2026, Relative C1 reported that the facility routinely staffed one DCW per shift and the facility census did not exceed 15 residents. Relative C1 reported that she was not aware of any residents that require the assistance of two direct care workers at the same time.

On 02/05/2026, I conducted an unannounced investigation and I interviewed licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz separately and all reported that the facility has one DCW per shift and denied that the capacity has ever exceeded 15 without adding an additional DCW to the daytime shifts.

Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz all reported that Resident B requires two DCWs to transfer. Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz reported that because Resident B constantly uses a wheelchair before DCW Wells leaves her shift around 2pm, Resident B is placed in bed for the remainder of the day at 2pm since there are two DCWs available to complete that task safely. DCW Wells stated when she comes back in the morning, they get Resident B up before the nighttime shift DCW leaves work. DCW Marcinkiewicz reported that Resident B is checked and changed every two hours in bed as Resident B does not stand. DCW Marcinkiewicz reported that she has never

tried to transfer Resident B by herself as Resident B has never asked to get out of bed when she is working alone.

I reviewed Resident B's written *Assessment Plan for AFC Residents* that was completed on 5/28/2025 and signed by Resident B on 5/27/2025, Resident B's designated representative on 5/24/2025 and licensee designee Alvarado on 5/28/2025. In the "toileting" section of the report it stated, "fully dependent on assistance." In the "physical limitations" section of the report it stated "does not walk, right side limitations." In the "special equipment used" section of the report it stated, "wheelchair." Resident B's record documented that she is 82 years, she was admitted to the facility on 5/30/2025.

I reviewed Resident B's *Resident Care Agreement* which was signed by Resident B on 5/30/2025, Resident B's designated representative on 5/24/2025 and licensee designee Alvarado on 5/31/2025. It was documented that the basic fee included, "room and board, 24/7 supervision, medication administration, basic laundry and housekeeping, assistance with showers. Assistance with transfers and walking. Family will supply all incontinence supplies for no charge for this service."

<b>APPLICABLE RULE</b>	
<b>R 400.633</b>	<b>Staffing requirement.</b>
	<b>(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: (a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.</b>

<p><b>ANALYSIS:</b></p>	<p>Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz all reported that Resident B requires two DCWs to transfer. Licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz reported that because Resident B is a wheelchair user, before DCW Wells leaves her shift around 2pm Resident B is placed in bed for the remainder of the day while there are two direct care workers available to transfer her safely. When DCW Wells comes back in the morning, Resident B is transferred out of bed before the nightshift DCW leaves work. DCW Marcinkiewicz reported that Resident B is checked and changed every two hours in bed from 2pm until the following morning as Resident B does not stand.</p> <p>Although Resident B's <i>Resident Care Agreement</i> documented that the basic fee included, "room and board, 24/7 supervision, medication administration, basic laundry and housekeeping, assistance with showers. Assistance with transfers and walking. Family will supply all incontinence supplies for no charge for this service" between at least the hours of 2pm and the following mornings, Resident B is not being provided the opportunity to be transferred out of bed or assisted with walking due to only one DCW being available rather than when she prefers.</p> <p>A violation has been established as there is not sufficient staff to meet the needs of Resident B during any shift as licensee designee Alvarado, DCW Wells and DCW Marcinkiewicz all reported that she is not able to be transferred with only one direct care worker on duty. Consequently, Resident B remains in bed at least from 2pm until the following morning due to lack of staff available to safely transfer her.</p>
<p><b>CONCLUSION:</b></p>	<p><b>VIOLATION ESTABLISHED</b></p>

On 3/13/2026 an exit conference was conducted with licensee designee Alvarado who understood the violations and agreed to submit a corrective action plan.

**IV. RECOMMENDATION**

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in license status.

*Julie Elkins*

03/13/2026

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Julie Elkins  
Licensing Consultant

Date

Approved By:

*Dawn Timm*

03/13/2026

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Dawn N. Timm  
Area Manager

Date