GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 19, 2022

Lori McLaughlin
North Woods Village At Kalamazoo
6203 Stadium Dr
Kalamazoo, MI 49009

RE: License #: AH390394454
Investigation #: 2022A1028071
North Woods Village At Kalamazoo

Dear Ms. McLaughlin:

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
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH390394454
Investigation #:	2022A1028071
Complaint Receipt Date:	08/04/2022
Investigation Initiation Date:	08/04/2022
Report Due Date:	10/03/2022
Licensee Name:	MITN, LLC
Licensee Address:	6203 Stadium Dr Kalamazoo, MI 49009
Licensee Telephone #:	(574) 247-1866
Administrator:	Lori McLaughlin
Authorized Representative:	Amanda Buhl
Name of Facility:	North Woods Village At Kalamazoo
Facility Address:	6203 Stadium Dr Kalamazoo, MI 49009
Facility Telephone #:	(269) 397-2200
Original Issuance Date:	03/11/2019
License **Status:**	REGULAR
Effective Date:	09/11/2021
Expiration Date:	09/10/2022
Capacity:	61
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff locked Resident A out of [their] room due to an altercation with Resident B.	Yes
Resident A put industrial cleaner in [their] mouth.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/04/2022	Special Investigation Intake 2022A1028071
08/04/2022	Special Investigation Initiated - Letter
08/04/2022	APS Referral APS referral emailed to Centralized Intake.
08/24/2022	Inspection Completed On-site Inspection completed onsite due to investigation.
08/24/2022	Contact - Face to Face Interviewed Administrator, Amanda Buhl, at the facility.
08/29/2022	Contact - Document Received Received Resident A and Resident B's service plans.
08/30/2022	Contact – Telephone Call Received Interviewed Employee A by telephone.
10/19/2022	Exit – Voicemail left for Admin/Amanda Buhl. Report sent to AR/Lori McLaughlin and Admin/Amanda Buhl.

ALLEGATION:

Staff locked Resident A out of [their] room due to an altercation with Resident B.

INVESTIGATION:

On 8/4/2022, the investigation was opened by the department due to the receipt of two facility incident reports.

On 8/4/2022, an APS referral was made to Centralized Intake.

On 8/23/2022, I interviewed the facility administrator, Amanda Buhl, at the facility. Ms. Buhl reported Resident A and Resident B reside in memory care and demonstrate confusion. On 8/1/2022, Resident B wandered into Resident A's room uninvited which resulted in Resident A becoming upset and dragging Resident B by [their] feet from the room. Staff immediately intervened and it was noted Resident A had no injuries, but Resident B incurred rug burn to the right shoulder. Resident B did not complain of any pain and was immediately treated for the rug burn. Resident A's and Resident B's authorized representatives, physicians, and the licensing department were notified immediately. Ms. Buhl reported the incident report sent to the department is incorrect and should have been revised to state that staff are not locking Resident A's room. Instead, the facility is using a removable visual door stop aid to deter Resident B from wandering into Resident A's room. Resident A and Resident B are also being monitored and kept separate to prevent any further incidents. I requested a copy of Resident A's and Resident B's service plan from Ms. Buhl for my review.

On 8/23/2022, I completed an observation of Resident A and Resident B. Both residents were clean, well-groomed and content. They were observed in separate areas. The removable visual door stop aid was observed on Resident A's room door.

On 8/29/2022, I received Resident A's and Resident B's service plans from Ms. Buhl. Review of Resident A's service plan revealed the following:

- Resident A is frequently disoriented and requires frequent supervision and oversight.
- Is unable to communicate or receive information and has continuous difficulty following instructions.
- Has history of frequent anxiety, depression and/or mood disorder.
- Has history of frequent disruptive, aggressive, or socially inappropriate behavior.
- Resists care.
- Demonstrates significant history of wandering.
- Does not require assistance with dressing, grooming, bathing, and toileting.
- The facility manages Resident A's medications.

Review of Resident B's service plan revealed the following:

- Resident B has a history of wandering.
- May resist care intermittently.
- Requires frequent verbal reminders and may need physical assistance.
- Requires assistance with dressing, grooming, bathing, and toileting.
- The facility manages Resident B's medications.

On 8/30/2022, I interviewed Employee A by telephone. Employee A's statements about the incident between Resident A and Resident B are consistent with Ms. Buhl's statement. Employee A reported a removable stop was placed on Resident A's door to prevent other residents from the room and a reoccurrence and Resident A was never locked out their room by any staff.

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:	Interviews and review of documentation reveal an altercation occurred between Resident A and Resident B resulting in Resident B incurring rug burn to the right shoulder. Review of service plans reveal Resident A demonstrates significant difficulty with communication, following instructions and is frequently disoriented, requiring frequent supervision and oversight. Resident B has a history of wandering and requires frequent verbal reminders. The alteration between Resident A and Resident B demonstrates the facility did not follow either resident's service plan in accordance with their required levels of staff supervision. The facility did not provide appropriate supervision to deter Resident B from entering Resident A's room resulting in the subsequent escalation of Resident A dragging Resident B out of the room by the ankles with injury to Resident B. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A put industrial cleaner in [their] mouth.

INVESTIGATION:

On 8/23/2022, Ms. Buhl reported on 7/31/2022, a staff member left an industrial cleaner out and Resident A placed the cleaner in [their] mouth. Staff intervened immediately to remove the cleaner. Ms. Buhl reported Resident A did not swallow the cleaner, but poison control was contacted immediately as a precaution and Resident A was sent to the hospital for evaluation. Resident A's physician, authorized representative, and the licensing department were notified about the incident immediately as well. Resident A was assessed by the physician at the hospital and did not incur any injury from the incident. Ms. Buhl reported the staff member was counseled and educated individually on proper chemical handling and an in-service was provided for all staff as well.

On 8/23/2022, I completed an on-site inspection of the facility due to this incident which revealed multiple industrial cleaners in unsecured kitchenette cabinets.

On 8/30/2022, Employee A reported staff were provided education about proper chemical handling due to the incident of Resident A placing industrial cleaner in [their] mouth. Employee A reported staff are trained to secure all industrial chemicals in locked cabinets.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(3) Hazardous and toxic materials shall be stored in a safe manner.
ANALYSIS:	Inspection of the facility revealed industrial cleaners unsecured in three separate kitchenette cabinets. This presents a significant risk of another occurrence of ingestion and harm by Resident A or other residents in the home with impaired cognition and function. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

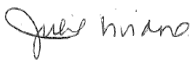
ADDITIONAL FINDINGS:

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.

ANALYSIS:	Review of Resident A's service plan reveals Resident A is frequently disoriented and requires frequent supervision and oversight, has impaired communication, and has continuous difficulty following instructions. Resident A has a history of frequent disruptive, aggressive, or socially inappropriate behavior and can resist care. However, Resident A does not require assistance with dressing, grooming, bathing, and toileting. Resident A is also a considered a high fall risk. Resident A's service plan does not demonstrate appropriate care or supervision based on Resident A's documented level of cognition. At minimum, Resident A's service plan should reflect supervision from staff for safety while completing dressing, grooming, bathing, and toileting due to being high fall risk. The service plan should also reflect the use of the removable visual door stop aid that was implemented to deter other residents from wandering into Resident A's room to prevent escalation. The facility does not demonstrate evidence of an updated service plan reflective of Resident A's current care needs and safety. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an approved correction action plan, I recommend the status of this license remain unchanged.



8/30/2022

_____

Julie Viviano Date
Licensing Staff

Approved By:

10/05/2022

_____

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