GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 14th, 2024

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

RE: License #: AH390394454
Investigation #: 2024A1021069
North Woods Village At Kalamazoo

Dear Lori 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 authorized representative 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) 284-9730.

Sincerely,
Kimberly Horst

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH390394454
Investigation #:	2024A1021069
Complaint Receipt Date:	06/24/2024
Investigation Initiation Date:	06/25/2024
Report Due Date:	08/24/2024
Licensee Name:	MITN, LLC
Licensee Address:	6203 Stadium Dr Kalamazoo, MI 49009
Licensee Telephone #:	(574) 247-1866
Administrator:	Amanda Buhl
Authorized Representative:	Lori McLaughlin
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:	09/11/2023
Expiration Date:	09/10/2024
Capacity:	61
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was found unattended outside.	Yes
Call buttons do not work.	Yes
Emergency medical attention was not sought for Resident A.	No
Resident A's service plan is not followed.	Yes
Medications not administered in appropriate manner.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/24/2024	Special Investigation Intake 2024A1021069
06/25/2024	Special Investigation Initiated - Letter referral sent to Adult Protective Services
07/02/2024	Inspection Completed On-site
07/22/2024	Contact-Telephone call made Interviewed SP1
07/25/2024	Contact-Document Received Received Resident A documents
08/14/2024	Exit Conference

ALLEGATION:

Resident A was found unattended outside.

INVESTIGATION:

On 06/24/2024, the licensing department received an intake with allegations Resident A was found unattended outside the facility. The complainant alleged Resident A was wearing a sweater and it was 85 degrees outside.

On 06/25/2024, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 07/02/2024, I interviewed Relative A1 at the facility. Relative A1 alleged she came to the facility to visit Resident A and found Resident A outside. Relative A1 alleged there were no staff members present, it was very warm outside, and Resident A was wearing a sweater. Relative A1 reported the courtyard doors were unlocked and residents were able to move freely in and out of the facility.

On 07/02/2024, I interviewed administrator Amanda Buhl at the facility. Ms. Buhl reported this event occurred in the summer of 2022. Ms. Buhl reported when this event occurred, Resident A was more ambulatory and cognitively intact. Ms. Buhl reported Resident A was able to go into the courtyard without staff assistance. Ms. Buhl reported Resident A requested to go outside and staff provided this. Ms. Buhl reported the courtyard doors are now locked and have an alarm system. Ms. Buhl reported Resident A's service plan reflects that Resident A can not be left outside unattended.

While onsite I observed the courtyard doors. The courtyard was located near the common area of the facility. The doors were locked, and the courtyard was not accessible without staff assistance.

I reviewed Resident A's service plan. The service plan omitted all information on Resident A's ability to be outside unattended.

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.**
For Reference: R 325.1901	**Definitions.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.

ANALYSIS:	Interviews conducted revealed Resident A is not to be left unattended in the courtyard. However, review of Resident A's service plan revealed this information was omitted from the service plan. By not detailing this in the service plan, the facility is unable to ensure the safety and protection of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Call buttons do not work.

INVESTIGATION:

The complainant alleged Resident A's call button does not work.

Relative A1 reported Resident A has a suite with a shared bathroom. Relative A1 reported when Resident A would require assistance in the bathroom, it would ring as the adjoining room and caregivers would not respond as there is not a resident in that room. Relative A1 reported family have attempted to utilize the emergency cord system while visiting Resident A and no care staff responded.

Ms. Buhl reported the issue with the call light response system has been addressed. Ms. Buhl reported if the caregiver does not log into the internal system, they cannot address the call lights. Ms. Buhl reported she has provided education to staff members on answering call lights.

On 07/22/2024, I interviewed staff person 1 (SP1) by telephone. SP1 reported Resident A does not use the call light system. SP1 reported Resident A is usually located in the common area and within caregiver line of sight. SP1 reported Resident A's room is also near the common area so that caregivers can hear her request for assistance or can see that she requires assistance.

I reviewed Resident A's service plan. The service plan read,

> *"Resident is unable to utilize the emergency response system; may have frequent monitoring."*

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.
For Reference: R 325.1901	**Definitions.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Interviews conducted revealed Resident A is unable to utilize the call button due to cognitive ability. Review of Resident A's service plan reflects this statement and states the need for increased monitoring. However, the service plan does not state the frequency of monitoring to ensure the safety and protection of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Medical attention was not sought for Resident A.

INVESTIGATION:

The complainant alleged Resident A has fallen and staff encouraged Relative A1 not to seek medical attention.

Relative A1 reported Resident A has fallen at the facility. Relative A1 reported staff members have not always contacted emergency medical services and have encouraged medical attention to not be sought.

Ms. Buhl reported when a resident experiences a medical emergency, the caregivers are to take vials and access for injuries. Ms. Buhl reported the caregiver is then to call the physician and the family. Ms. Buhl reported the family makes the recommendation if the resident is to be sent out. Ms. Buhl reported if a resident is on hospice, the facility also contacts the hospice company.

I reviewed incident reports for Resident A's recent falls. The narrative of the incident report read,

"04/06: Resident was sitting in her recliner when she fell forward out of it and onto the ground. She was rugburn on her forehead and was C/O neck and L wrist pain. Called Careline on call and they ordered a stat x-ray for her neck and wrist. Daughter was called and notified and decided to have her sent to Brogess.
"06/11: Staff noted resident sitting on bottom in front of recliner in room. Slippers on walker beside resident. Denied pain, no new injuries called hospice. DON and (Relative A1) notified."

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: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	Interviews conducted and review of documentation revealed Resident A has fallen at the facility. Following each fall, the physician and/or Hospice company was notified. There is lack of evidence to support the allegation medical attention was not sought for Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's service plan not followed.

INVESTIGATION:

The complainant alleged Resident A's walker is not provided to her. The complainant alleged Resident A has frequent urinary tract infection (UTI's) due to not being offered water.

Relative A1 reported Resident A ambulates with her walker and must use the walker to ambulate. Relative A1 reported Resident A has lost most of her vision. Relative A1 reported Resident A has been diagnosed with dehydration and needs to have water offered and available to her. Relative A1 reported family provides flavored water to Resident A. Relative A1 reported family has observed Resident A to have full water cups in her room and caregivers only providing water to Resident A and not offering the water.

Ms. Buhl reported caregivers pass water to residents at each shift change. Ms. Buhl reported caregivers also provide water to residents in the common area and at every meal service. Ms. Buhl reported Resident A is offered adequate water. Ms. Buhl

reported Resident A can ambulate without her walker but does ambulate better with her walker.

On 07/01/2024, I interviewed staff person 1 (SP1) at the facility. SP1 reported the facility offers water to all residents in their room and in the common area. SP1 reported Resident A prefers flavored water and caregivers provide this.

I observed Resident A at the breakfast meal service. Resident A has a severe visual impairment and required silverware and drinks to be placed in her hand. I observed caregivers explaining to Resident A what was on the plate due to Resident A's inability to see.

I reviewed Resident A's service plan. The service plan read,

"Resident has severe visual impairment. Needs assistance with ADL's. Resident requires hands on assistance and has an assistive device for mobility/ambulation. Walker to be utilized for long distances."

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Interviews conducted and observations made revealed Resident A has a serve visual impairment which requires staff assistance with simple tasks and Resident A is to be provided flavored water. Review of Resident A's service plan revealed this information was omitted from the service plan. There was lack of detail pertaining to the specific care Resident A requires.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Medication not always provided.

INVESTIGATION:

The complainant alleged Resident A's medication is not always provided. The complainant alleged Resident A is to be sedated prior to bedtime routine.

Relative A1 reported if Resident A is having a difficult time taking medications, the medication technician will hand her the cup to administer the medications. Relative

A1 reported once a cup was provided with extra Melatonin. Relative A1 reported Resident A was not administered the medication. Relative A1 reported Resident A is on Seroquel and Melatonin medication at nighttime. Relative A1 reported medication technicians were administering these medications at dinnertime and not at bedtime which was causing Resident A to be very fatigued during the nighttime routine.

Ms. Buhl reported Resident A's medications are ordered for "HS" which means between 7:00-10:00pm. Ms. Buhl reported medication technicians can administer the medication one hour prior and one hour after the timeframe of 7:00-10:00pm. Ms. Buhl reported Relative A1 requested for the medications to be given at 7:00pm and Resident A in bed at 7:30pm.

I reviewed mediation orders for Resident A. The orders read,

> *"CVS Melatonin Gummies chewable tablet 10mg. Give 1 gummy at bedtime. Quetiapine Tab 25mg take one tablet by mouth at bedtime."*

I reviewed Resident A's medication administration record (MAR) for June 30-July 29. The MAR revealed on 07/21/2024, Resident A was administered CVS Melatonin Gummy at 5:42pm.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	While Relative A1 requested for the medications to be administered at a specific time, the orders do not reflect this request. However, review of Resident A's MAR revealed Resident A was administered CVS Melatonin Gummy at 5:42pm which is outside the time window of administration time.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's MAR revealed Resident A was prescribed Quetiapine 25mg.

APPLICABLE RULE	
R 325.1932	**Resident Medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the individual who administered the prescribed medication.**
ANALYSIS:	Review of Resident A's MAR revealed the medication technician did not initial the log that this medication was administered on 07/02/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kimberly Horst 07/31/2024

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 08/14/2024

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