STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

July 1, 2025

Pamela Reese
Kauhale Otsego
700 Eley Street
Otsego, MI 49078

RE: License #: AH030413477
Investigation #: 2025A1028052
Kauhale Otsego

Dear Pamela Reese:

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

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 #:	AH030413477
Investigation #:	2025A1028052
Complaint Receipt Date:	04/22/2025
Investigation Initiation Date:	04/24/2025
Report Due Date:	06/22/2025
Licensee Name:	Kauhale Otsego, LLC
Licensee Address:	72 Dorchester Square N, Westerville, OH 43081
Licensee Telephone #:	(330) 289-0971
Executive Director:	Melissa Zeithammel
Authorized Representative/Administrator:	Pamela Reese
Name of Facility:	Kauhale Otsego
Facility Address:	700 Eley Street, Otsego, MI 49078
Facility Telephone #:	(269) 694-1621
Original Issuance Date:	05/18/2023
License **Status:**	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	56
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility sent Resident A to the hospital on 4/18/2025 and refused to allow Resident A to come back to the facility, citing it was an emergency discharge.	Yes
Additional Findings	No

III. METHODOLOGY

04/22/2025	Special Investigation Intake 2025A1028052
04/24/2025	Special Investigation Initiated - Letter
04/24/2025	APS Referral
04/30/2025	Contact - Face to Face Interviewed the facility executive director at the facility.
04/30/2025	Contact - Document Received Received requested documentation from the facility executive director.

ALLEGATION:

The facility sent Resident A to the hospital on 4/18/2025 and refused to allow Resident A to come back to the facility, citing it was an emergency discharge.

INVESTIGATION:

On 4/22/2025, the Bureau received the allegations anonymously through the online complaint system.

On 4/30/2025, I interviewed the executive director at the facility who reported Resident A moved into the facility on 1/19/2024. Resident A did not demonstrate aggressive behaviors but would have verbal outbursts due to dementia diagnosis and demonstrated confusion. Resident A began demonstrating exit seeking behaviors in March 2025. On 3/3/2025, Resident A eloped from the facility when a visitor entered the facility. The visitor opened the door to enter the facility and Resident A walked out through the front door of the memory care unit. The visitor did

not know Resident A was a resident at the facility and should not have exited the facility. Staff located Resident A in the parking lot. The executive director reported that due to this incident, the visitors' entrance was re-routed to prevent any more elopements from the memory care unit and the code on the door was changed as well. The executive director notified the physician and attempted to notify Resident A's authorized representative but was unable to make contact with [them]. The executive director reported it was increasingly difficult to get ahold of Resident A's authorized representative, that the authorized representative would not answer the phone, did not have voicemail to leave messages, and would not provide an email.

Resident A eloped from the facility again on 3/22/2025 through the window in their apartment. The windows in Resident A's room open forward so they can be cleaned from inside the apartment and to open them, tabs must be pressed simultaneously on each side of the window. Resident A figured out how to open the windows and pushed furniture against the wall the window was located on to crawl through the window. Resident A was found at a gas station nearby and the police brought Resident A back to the facility about an hour later. The executive director reported all tabs were removed from the windows in the memory care unit to prevent further elopement. The executive director confirmed the window stoppers were intact on Resident A's window and all other residents' windows in the memory care unit. The physician was notified of the elopement to request a review of health and medications. The executive director reported [they] contacted the authorized representative and informed [them] that the discharge process would be initiated because Resident A was exceeding the level of care and safety the facility could provide. The executive director asked the authorized representative to move Resident A out of the facility by the end of the day. The authorized representative refused. Due to this, the executive director reported the facility began 30-minute checks for Resident A to prevent elopement and ensure safety but that the facility was continuing with the discharge.

The executive director reported on 4/18/2025 that Resident A escaped out the window again after being assisted by another resident, who cut the window screen and removed the window screws with a metal spoon. Resident A was spotted in the field behind the facility by a staff member on break. The staff member radioed for assistance and facility staff directed Resident A back to the facility. The physician and authorized representative were notified of the incident. The window was repaired, and a tamper proof device was placed on the window, preventing escape, but still allowing good air flow. The executive director reported [they] filed a petition for mental health treatment on 4/18/2025 due to Resident A's escalating exit seeking behaviors. The executive director spoke with the authorized representative at 3:30 pm via the telephone and informed [them] about Resident A's elopement. At 5:00pm, the executive completed the emergency discharge paperwork and called the police and emergency services to transport Resident A to the hospital. The executive director attempted to call the authorized representative to notify [them] of Resident A's transport to the hospital and got no answer and there was no way to leave a voicemail.

The executive director confirmed Resident A went to the hospital on 4/18/2025 and that the facility did not accept Resident A back to the facility because [they] had completed the emergency discharge paperwork. The executive director reported they reached out to the local Ombudsman office for assistance with the situation as well and was provided some guidance from [them], but did not involve Adult Protective Services (APS). The executive director did not reach out to the department for assistance either. The executive director provided me with requested documentation for my review.

On 4/30/2025, I reviewed the requested documentation which revealed the following:

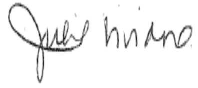
- Resident A has a diagnosis of Alzheimer's disease, moderate unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and other co-morbidities.
- Resident A is deaf in the right ear and requires assistance or supervision with bathing and medication administration.
- Resident A is an active exit seeker.
- Resident A exited the facility on 3/3/2025, 3/22/2025, and 4/18/2025.
- Evidence demonstrates that the facility executive director attempted to communicate with Resident A’s authorized representative on 3/3/2025 and 4/18/2025 to notify [them] about Resident A's exit seeking behavior and discharge of Resident A from the facility, but there was no answer from the authorized representative.
- Evidence demonstrates that the executive director communicated with the authorized representative on 4/4/2025 when [they] visited the facility to see Resident A. The executive director communicated to the authorized representative that the physician wanted to speak with [them] about Resident A’s medications, health, and behaviors and that the physician had been unable to reach [them]. The executive director expressed concerns to the authorized representative about being unable to reach [them] pertaining to Resident A and requested that the authorized representative answer [their] phone when the facility calls. The authorized representative was dismissive of the request.
- Evidence demonstrates that the executive director communicated with the authorized representative 3/22/2025 about Resident A’s elopement and informed the authorized representative that an immediate discharge needed to occur. The facility requested the authorized representative move Resident A out of the facility by the end of the day and the authorized representative refused. Due to this, the executive director reported the facility began 30-minute checks for Resident A.
- Evidence that staff completed 30-minute checks for Resident A from 3/22/2025 to 3/23/2025.
- Evidence that a discharge letter was written on 4/18/2025.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(16) A home that proposes to discharge a resident for any of the reasons listed in subrule (15) of this rule shall take all of the following steps before discharging the resident: **(a) The home shall notify the resident, the resident's authorized representative, if any, and the agency responsible for the resident's placement, if any, not less than 24 hours before discharge. The notice shall be verbal and issued in writing. The notice of discharge shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged.** **(iv) The right of the resident to file a complaint with the department.** **(b) The department and adult protective services shall be notified not less than 24 hours before discharge in the event of either of the following:** **(i) A resident does not have an authorized representative or an agency responsible for the resident's placement.** **(ii) The resident does not have a subsequent placement.** **(c) The notice to the department and adult protective services shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged, if known.** **(d) If the department finds that the resident was improperly discharged, then the resident may return to the first available bed in the home that can meet the resident's needs as identified in the resident's service plan.** **(e) The resident shall not be discharged until a subsequent setting that meets the resident's immediate needs is located.**

ANALYSIS:	It was alleged the facility sent Resident A to the hospital on 4/18/2025 and refused to allow Resident A to return to the facility, citing it was an emergency discharge. Interview, onsite investigation, and review of documentation reveal that while the facility had valid reasons to discharge Resident A from the facility due to Resident A's exit seeking behaviors, the facility did not follow discharge rules. The facility discharge procedures and letter were missing the following: • The facility did not notify the resident and the resident's authorized representative with a verbal and written notice of discharge despite having written a discharge letter. • All of the alternatives to discharge that the home attempted were not listed in the discharge. The facility had provided 30-minute checks after the second discharge and removed the tabs from the window to prevent elopement. These attempts were not listed in the discharge letter. • The location to which the resident will be discharged was not listed in the discharge letter. • The right of the resident to file a complaint with the department was not provided in the discharge letter. • The department and adult protective services were not notified of the emergency discharge or that the resident did not have a subsequent placement. • The facility refused to accept Resident A back to the facility and discharged Resident A even though [they] did not have a subsequent setting in place prior to discharge from the facility. The facility made alternative attempts prior to discharge to prevent Resident A's exit seeking behaviors and ensure safety and made multiple attempts to communicate with Resident A's authorized representative about Resident A's behaviors and health. The facility also communicated with the physician about Resident A and filed a petition for mental health treatment on 4/18/2025 to address Resident A's escalating behaviors. Despite the facility's actions, the facility did not follow Homes for the Aged discharge rules and therefore is in violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remains the same.



5/5/2025

Julie Viviano
Licensing Staff

Date

Approved By:

06/30/2025

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

Date