GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 28, 2025

Deborah Pettyplace
The Barton Woods Group, Inc.
9472 Kochville Road
Freeland, MI 48623

RE: License #: AL730317749
Investigation #: 2025A0572040
Barton Woods Assisted Living

Dear Deborah Pettyplace:

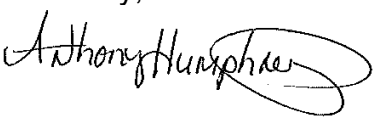
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 643-7960.

Sincerely,



Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL730317749
Investigation #:	2025A0572040
Complaint Receipt Date:	05/29/2025
Investigation Initiation Date:	06/02/2025
Report Due Date:	07/28/2025
Licensee Name:	The Barton Woods Group, Inc.
Licensee Address:	9472 Kochville Road Freeland, MI 48623
Licensee Telephone #:	(989) 695-2014
Administrator:	Deborah Pettyplace
Licensee Designee:	Rebecca Williams
Name of Facility:	Barton Woods Assisted Living
Facility Address:	9472 Kochville Road Freeland, MI 48623
Facility Telephone #:	(989) 695-5380
Original Issuance Date:	10/15/2012
License Status:	REGULAR
Effective Date:	04/15/2025
Expiration Date:	04/14/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A had two medications sitting out.	Yes
Resident A was asleep; the medications were not administered	Yes
Feces were left all over the shower floor and Resident A's recliner was soaked with urine.	No
Resident A's bedroom window was left open when it was 41 degrees outside. Resident A was cold and uncomfortable.	No
Resident A fell and hit Resident A's head, resulting in a skin tear. Staff are supposed to write an incident report, but did not do one.	No

III. METHODOLOGY

05/29/2025	Special Investigation Intake 2025A0572040
05/29/2025	APS Referral APS made referral.
06/02/2025	Special Investigation Initiated - Letter APS
06/02/2025	Contact - Document Sent APS, Jessire Ramos.
06/04/2025	Inspection Completed On-site Administrator, Rebecca Williams; and Resident Care Supervisor, Kelsey Treichel.
06/04/2025	Contact - Face to Face Resident A.
07/18/2025	Contact - Face to Face Resident Care Supervisor, Kelsey Treichel.
07/18/2025	Contact - Telephone call made Staff, Ashiya Washington.
07/18/2025	Contact - Telephone call made Family Member #1.
07/18/2025	Inspection Completed-BCAL Sub. Compliance

07/18/2025	Exit Conference Licensee Designee, Deborah Pettyplace.
07/21/2025	Contact - Face to face Resident Care Supervisor, Kelsey Treichel
07/21/2025	Contact - Face to face Administrator, Rebecca Williams
07/21/2025	Contact – telephone call made Staff, Ashiya Washington
07/22/2025	Contact – telephone call made Staff, Ashiya Washington
07/22/2025	Contact – telephone call made Resident A's Family Member #1

ALLEGATION:

- **Resident A had two medications sitting out.**
- **Resident A was asleep; the medications were not administered.**

INVESTIGATION:

On 05/29/20205, the local licensing office received a complaint for investigation. Adult Protective Services are also investigating the allegations.

On 06/02/2025, APS, Jessire Ramos informed that she investigated the allegations and would not be substantiating.

On 06/04/2025, I made an unannounced onsite at Barton Woods Assisted Living, located in Saginaw County Michigan. Interviewed were Administrator, Rebecca Williams, and Resident Care Supervisor, Kelsey Treichel. I was able to observe Resident A.

On 06/04/2025, I interviewed Administrator, Rebecca Williams regarding the allegation. Rebecca Williams is not aware of any pills being left out, but recalled an incident where Staff, Ashiya Washington was the med passer and went into Resident A's bedroom, saw that Resident A was sleeping and didn't want to wake Resident A, so she didn't administer the medication. Management had Ashiya Williams speak with the family so she could explain to them why she did it, so that the family would not think that it was done maliciously. Ashiya Washington was reprimanded and retrained on med passing. Some families do not want their loved ones awakened for meds, depending on what the medication is and the timeframe, but in this instance, the medication should have been administered.

On 06/04/2025, I interviewed Resident Care Supervisor, Kelsey Treichel regarding the allegation. Kelsey Treichel is not aware of any medications being left out, but informed that Staff, Ashiya Washington did not want to wake Resident A because when Resident A does not get enough sleep, Resident A's behaviors get worse due to dementia. Resident A will get up and walk off, open other residents' doors, etc. Ashiya Washington was spoken to and written up as a result and had to explain to the family why Resident A's medication was not passed. Ashiya Washington received additional medication administration training.

On 06/04/2025, as I entered the facility, I observed a med cart in the hallway where staff keep the medications locked. I observed Resident A sitting on recliner, holding a baby doll. Resident A appeared to be neat and clean in appearance with an appropriate amount of care and supervision. While in Resident A's bedroom, I did not notice any medications laying around.

On 07/18/2025, I contacted Staff, Ashiya Washington regarding the allegation. Ashiya Washington informed me that she does not know anything about medications being left out in the open, but she indicated that she was written up once regarding medications as it relates to Resident A. Ashiya Washington explained that she went into Resident A's bedroom to administer medications, but Resident A was asleep and she did not want to wake Resident A. She was not aware that she was supposed to come back and give meds, so she was written up for it. She received additional med passing training after the incident.

On 07/18/2025, I contacted Resident A's Family Member #1 regarding the allegation. Family Member #1 has a camera in Resident A's bedroom and informed that she observed a staff member walk in Resident A's bedroom, saw that Resident A was asleep on the recliner and then left without giving Resident A her medications.

On 07/21/2025, I asked Resident Care Supervisor, Kelsey Treichel if the meds that Staff, Ashiya Washington didn't pass to Resident A, if they were left in the room to be administered later or were they disposed of. Kelsey Treichel informed that she was told that they were disposed of, and that would be her guess because they weren't in the room when they went in there.

On 07/21/2025, I asked Administrator, Rebecca Williams what did Staff, Ashiya Washington do with the medications that were not administered to Resident A. Rebecca Williams informed that she believed that staff disposed of the medication.

On 07/21/2025, I reviewed a video of Staff, Ashiya Washington entering Resident A's bedroom with a medication cup in hand. Ashiya Washington appears to see that Resident A was asleep on the recliner and then walked into the bathroom. Ashiya Washington then walks out of the bathroom and then out of Resident A's bedroom without administering the medication.

On 07/21/2025, I reviewed Resident A's Medication Administration Record. It indicates that four of Resident A's medications were not passed during the 3rd shift. Melatonin 1mg, Omeprazole 20mg, Quetiapine 25mg and Venlafaxine 150mg. I did not see any other issues regarding medications.

On 07/22/2025, contact was made with Ashiya Washington again. She informed that the medications that she did not administer due to Resident A being asleep, she disposed of them and let management know that she did not pass the medication. Ashiya Washington does not know anything about medications being left out as the medications are always locked up in the med carts in the hallway and medication rooms. All direct care staff workers and supervisors have access to the medication. The cooks and the families do not have access.

On 07/23/2025, I contacted Resident A's Family Member #1 regarding the medications being left out in the open. Family Member #1 informed that this occurred more than once. This particular time it occurred on 05/10/2025 and the medication was found after taking Resident A back to Resident A's bedroom after the Mother's Day Brunch that the facility held for the residents. This occurred the day before staff failed to administer Resident A's meds because Resident A was asleep. One of the pills was for hormones and the other was for irregular heartbeat. There were only two pills in the medication cup so the other pills from that morning must have been administered. Family Member #1 informed Resident Care Supervisor, Kelsey Treichel and she said they had a busy morning and they will provide additional training. Family Member #1 gave the two pills to a staff person that was working that day and they locked the medication in the med cart. Family Member #1 does not know who that staff was and does not know if they were the med passers that day due to there being extra staff working because of the Mother's Day Brunch.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the interviews with Management, Staff and Family Member #1, there is enough evidence to issue a citation. Staff informed that she did not administer the medication and management informed that staff was written up for it and received additional training.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**

	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on the interviews with Management, Staff and Family Member #1, there is enough evidence to issue a citation. Management and staff denied knowing about any medications being left out in the open. Family Member #1 informed that the medication was found in a med cup in Resident A's bedroom. This has occurred more than once.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
Feces was left all over the shower floor and Resident A's recliner was soaked with urine.

INVESTIGATION:
On 06/04/2025, I interviewed Administrator, Rebecca Williams regarding the allegation. Rebecca Williams indicated that Resident A has severe dementia, which is why they have to conduct regular checks on Resident A. When staff checked on Resident A, the sofa was saturated with urine, so staff changed Resident A. Resident A has constant accidents, so they have to constantly check Resident A. Resident A will have accidents throughout the facility (hallways, dining area, bedroom, public spaces) so staff have to always clean up behind Resident A. The family felt bad about this, so they purchased all kinds of carpet cleaning supplies, but they told the family that it wasn't necessary as it was part of the job.
On 06/04/2025, I interviewed Resident Care Supervisor, Kelsey Treichel regarding the allegation. Kelsey Treichel informed that Resident A had constant accidents. Staff can toilet Resident A and within an hour, Resident A would be soaked. Kelsey Treichel stated, "Because of (Resident A's) dementia, (Resident A) would go into the common area, pull down pants and just go." The family did not want staff to wake Resident A up in the middle of the night anymore due to Resident A's behaviors if not given enough sleep, so the family purchased washable briefs. Staff would check the briefs to see if they were still on because Resident A will constantly pull them off.

On 07/18/2025, I contacted Staff, Ashiya Washington regarding the allegation. Ashiya Washington does not recall a time when Resident A's shower floor was filled

with feces but remembered a time when Resident A smelled of urine, so she gave Resident A an unscheduled shower. She is not aware of Resident A's recliner being soaked with urine.

On 07/18/2025, I contacted Resident A's Family Member #1 regarding the allegation. Resident A's recliner was saturated with urine and the shower floor was filled with feces. Family Member #1 cleaned the recliner and maintenance steamed cleaned the shower floor and shower chair. When asked if Family Member #1 had any pictures of the sofa being saturated with urine, Family Member #1 informed that they did not have any pictures and it would have been hard to see because the recliner is tan in color. Family Member #1 knew it was saturated because when hand pressed onto the recliner, they could feel it. Family Member #1 purchased blue barrier pads and white/pink reusable pads. Resident A was not found covered in urine or feces.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on the interviews with Management, Staff and Family Member #1, there is not enough evidence to issue a citation. Due to dementia, Resident A constantly urinated or had bowel movements in several places throughout the home. Staff constantly had to do checks on Resident A and make sure that Resident A's briefs were still on. Staff informed that Resident A smelled of urine, so she gave Resident A an unscheduled shower. None of the staff were aware that Resident A's recliner was saturated with urine. When Family Member #1 reported that recliner was saturated and shower floor and bench were covered with feces, Family Member #1 cleaned the recliner, while maintenance cleaned the shower.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Resident A's bedroom window was left open when it was 41 degrees outside. Resident A was cold and uncomfortable.

INVESTIGATION:
On 06/04/2025, I interviewed Administrator, Rebecca Williams regarding the allegation. Rebecca Williams informed that most of the residents like it hot in their rooms. It was very hot in Resident A's bedroom and Resident A was also hot, so

they cracked the window. Resident A was so hot that Staff put Resident A on top of the blanket. Resident A is normally covered under the blanket. This was explained to the family. Resident A was not freezing. Resident A may have been crying, but it wasn't due to being uncomfortable or cold. Resident A has dementia and is always crying.

On 06/04/2025, I interviewed Resident Care Supervisor, Kelsey Treichel regarding the allegation. Kelsey Treichel spoke with staff about this, and she was told that there is sometimes an odor in the room due to Resident A having so many accidents, so they would crack open the window to let the odor dissipate. The family has three cameras in the room, so they have nothing to hide because it's all on camera. Resident A was not freezing and staff said that Resident A wanted to sleep on top of the blanket. This was explained to the family, and they appeared to be receptive.

On 07/18/2025, I contacted Staff, Ashiya Washington regarding the allegation. Ashiya Washington is not aware of Resident A's bedroom being too cold. Resident A is usually cold anyways and will have a blanket on. The residents' rooms are usually hot.

On 07/18/2025, I contacted Resident A's Family Member #1 regarding the allegation. Family Member #1 informed that one night, the window was left open, and it was 56 degrees outside. Resident A only had a thin sheet and was cold. The window did not get closed until 5am the next morning.

On 07/21/2025, I reviewed a video that shows staff assisting Resident A with changing. Resident A was covered with a blanket. Resident A appeared to be agitated that staff was assisting with changing. I was not able to determine if Resident A was cold and uncomfortable.

APPLICABLE RULE	
R 400.15406	**Room temperature.**
	All resident-occupied rooms of a home shall be heated at a temperature range between 68 and 72 degrees Fahrenheit during non-sleeping hours. Precautions shall be taken to prevent prolonged resident exposure to stale, noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations from the requirements of this rule shall be based upon a resident's health care appraisal and shall be addressed in the resident's written assessment plan. The resident care agreement shall address the resident's preferences for variations from the temperatures and requirements specified in this rule.

ANALYSIS:	Based on the interviews with Management, Staff and Family Member #1, there is not enough evidence to issue a citation. Staff recalls the window being cracked open due to it being hot and to allow for an odor to dissipate. The rooms are normally hot. Resident A was sitting on top of blanket. Resident A was crying, but management indicates that it is due to dementia and not being cold. Family Member #1 informed that they believe that Resident A was cold and uncomfortable.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Resident A fell and hit Resident A's head, resulting in a skin tear. Staff are supposed to write an incident report, but did not do one.

INVESTIGATION:
On 06/04/2025, I interviewed Administrator, Rebecca Williams regarding the allegation. Rebecca Williams informed that Resident A did have a fall, but an Incident Report was written. They did an assessment, vitals were taken, and they called Hospice. Hospice came out the next day.

On 06/04/2025, I interviewed Resident Care Supervisor, Kelsey Treichel regarding the allegation. Resident A fell and an Incident Report was written. The family initially did not want a hospital bed but changed their mind after the fall. Resident A was checked and bandaged. Hospice was out the next day because they are there Monday through Friday. Kelsey Treichel showed me their copy of the Incident Report.

On 06/04/2025, I reviewed the Incident Report, dated for 05/15/2025 at 1:15am. Resident A fell out of bed and had a skin tear on left arm. Treatment was given. Skin tear was cleaned. Staff are to make sure that Resident A is positioned in bed better and not laying on the edge. They are possibly going to order a hospital bed with family's approval.

On 07/18/2025, I contacted Staff, Ashiya Washington regarding the allegation. Ashiya Washington informed she worked the day Resident A fell and an Incident Report was written. This fall occurred before Resident A received a hospital bed with a rail, and bed alarm. It takes three staff to assist Resident A up because Resident A is very aggressive. Staff checked vitals, eyes and did a skin assessment. Hospice was also contacted.

On 07/18/2025, I contacted Resident A's Family Member #1 regarding the allegation. Family Member #1 informed that they do not blame staff for any of the falls. Resident A had several falls due to Resident A's dementia and believes that

Resident A may have had vertigo as well. They declined to have Resident A prescribed a seatbelt with wheelchair because Resident A wanted to be able to move about. Staff did everything that they were supposed to do regarding the falls.

APPLICABLE RULE	
R 400.15311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(a) Unexpected or unnatural death of a resident.** **(b) Unexpected and preventable inpatient hospital admission.** **(c) Physical hostility or self-inflicted harm or harm to others resulting in injury that requires outside medical attention or law enforcement involvement.** **(d) Natural disaster or fire that results in evacuation of residents or discontinuation of services greater than 24 hours.** **(e) Elopement from the home if the resident's whereabouts is unknown.**
ANALYSIS:	Based on the interviews with Management, Staff and Family Member #1, there is not enough evidence to issue a citation. Staff indicated that a fall occurred and an Incident Report was written. Family Member #1 indicated that the staff did everything that they were supposed to do. An Incident Report was presented to me.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 07/18/2025, an exit conference was held with Licensee Designee, Deborah Pettyplace regarding the special investigation. She was informed of the findings in the case.

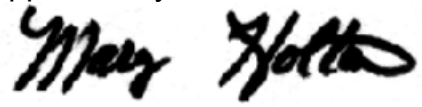
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that no changes be made to the licensing status of this large adult foster care group home (Capacity 7-20).

07/28/2025

Anthony Humphrey — Date
Licensing Consultant

Approved By:



07/28/2025

Mary E. Holton — Date
Area Manager