GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2025

Amy Rogers
Hawthorn Landing
600 Golden Drive
Kalamazoo, MI 49001

RE: License #: AH390236775
Investigation #: 2025A1028077
Hawthorn Landing

Dear Amy Rogers:

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 #:	AH390236775
Investigation #:	2025A1028077
Complaint Receipt Date:	07/25/2025
Investigation Initiation Date:	07/28/2025
Report Due Date:	09/24/2025
Licensee Name:	Heritage Community of Kalamazoo
Licensee Address:	2400 Portage St. Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-5345
Administrator:	Amy Rogers
Name of Facility:	Hawthorn Landing
Facility Address:	600 Golden Drive Kalamazoo, MI 49001
Facility Telephone #:	(269) 349-8694
Original Issuance Date:	03/01/1974
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	89
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A incurred a fall on 7/18/2025 contributing to [their] fatality.	Yes
Facility staff neglected Resident A and did not provide care in accordance with the service plan.	No
Additional Findings	Yes

III. METHODOLOGY

07/25/2025	Special Investigation Intake 2025A1028077
07/28/2025	Special Investigation Initiated - Letter
07/28/2025	Contact - Face to Face Interviewed the facility administrator at the facility.
07/28/2025	Contact - Face to Face Interviewed Employee 1 at the facility.
07/28/2025	Contact - Face to Face Interviewed Employee 2 at the facility.
07/28/2025	Contact - Document Received Received requested documentation from Employee 1.

This investigation will only address allegations pertaining to potential violations of the rules and regulations for Homes for the Aged (HFA). Please note that HFAs do not provide skilled medical services.

ALLEGATION:

Resident A incurred a fall on 7/18/2025 contributing to [their] fatality.

INVESTIGATION:

On 7/25/2025, the Bureau received the allegations through the online complaint system.

On 7/28/2025, I interviewed the facility administrator at the facility who reported Resident A resides in the memory care unit and has a camera in [their] room that is monitored by family daily. The administrator reported no knowledge that Resident A incurred a fall but reported Resident A was sent to the hospital due to demonstrating a change in condition.

On 7/28/2025, I interviewed Employee 1 at the facility who reported to [their] knowledge Resident A did not fall but was demonstrating a decline in condition. Resident A's last documented fall was 4/1/2025 and Employee 1 reported if Resident A were to fall, Resident A would not be strong enough to get up from the floor without staff assistance. Employee 1 also reported that the camera in Resident A's room would have either caught the visual, sound, or both of Resident A falling and that due to the regular monitoring by the family, staff would have been alerted by the family if Resident A had fallen. Employee 1 reported the family communicated consistently with facility staff. Employee 1 also reported it was noted that Resident A vocalized that [they] were not feeling well on Thursday, 7/17/2025, so staff provided increased monitoring for Resident A. On 7/18/2025, there was a flood in Resident A's bathroom due to an overflowing toilet. Due to the bathroom flood, staff checked on Resident A and found that Resident A had thrown up in the bathroom and on [their] clothes. Staff cleaned Resident A and helped Resident A change [their] clothes. Staff provided increased monitoring due to this incident as well. Staff notified Resident A's physician and requested a visiting nurse come to the facility to assess Resident A due to the continued demonstrated change in condition. Resident A continued to demonstrate lethargy with the physician recommending that Resident A be sent to the hospital for further evaluation. Resident A was sent to the hospital and later expired. Employee 1 provided me with requested documentation for my review.

On 7/28/2025, I interviewed Employee 2 at the facility who reported Resident A was sent to the hospital on 7/18/2025 on first shift due to demonstrating lethargy and a change in condition. Employee 2 reported to [their] knowledge Resident A did not fall but confirmed that staff cleaned up Resident A and [their] bathroom earlier that morning on 7/18/2025. Employee 2 confirmed that Resident A's bathroom flooded and that Resident A was found with vomit on [their] clothes and in the bathroom. Employee 2 reported Resident A's physician and authorized representative were notified of Resident A's change in condition. Employee 2 also confirmed Resident A expired after admission to the hospital.

On 8/4/2025, I interviewed complainant 1 via telephone with the complainant providing additional information related to this allegation.

On 8/5/2025, I received the requested information and documentation from complainant 1 and complainant 2 via email.

On 8/7/2025, I received additional information and documentation from complainant 2 via email.

On 8/13/2025, I received additional documentation from complainant 2 via email.

On 8/14/2025, I received additional information and documentation from complainant 1 and complainant 2 via email.

On 8/14/2025, I reviewed the facility requested documentation which revealed the following:

- Resident A was admitted to the facility on 7/1/2024 and resided in the memory care unit.
- Resident A requires assistance and setup with bathing and dressing.
- Resident A is independent with transfers, toileting, and eating.
- The facility manages Resident A's medication administration, laundry, and mobility.
- On 7/17/2025 at 9:00pm, staff found Resident A's bathroom flooded. Staff cleaned and disinfected the bathroom.
- On 7/18/2025 at 4:30am, staff found that Resident A had thrown up in the bathroom and there was vomit on Resident A's clothes. Staff cleaned the bathroom and changed Resident A's clothes. Staff to monitor Resident A.
- On 7/18/2025 at 12:30pm, staff spoke with Resident A's physician and reported Resident A's demonstrated condition to the physician. Staff requested a nurse visit to further assess Resident A.
- On 7/18/2025 at lunchtime, staff went to get Resident A for lunch and observed that Resident A was weak, drooling, and unable to communicate. Staff contacted the physician with the physician returning the phone call at 12:17 pm. to send Resident A to the hospital. Emergency services arrived at 12:40pm and departed with Resident A at 12:52pm.

I reviewed the information and the documentation that the complainant provided, and it revealed the following:

- On 7/17/2025:
    - At 9:53pm, staff member 1 enters Resident A's room and discovers that the bathroom has flooded, and feces is observed on the floor of the bathroom and carpet in the living area. Resident A is seated in [their] recliner with [their] forehead hand resting in [their] left hand.
    - From 10:20pm to 10:50pm, staff member 1 cleans Resident A, who is seated in [their] recliner that is located in front of the room camera. Staff then instruct Resident A to go to the bathroom to wash their hands, while staff member 1 cleans Resident A's recliner.
    - From 10:50pm to 10:54pm, staff member 1 cleans Resident A's recliner. Resident A is out of view of the camera and in the bathroom at this time. Resident A can be heard vocalizing something to staff member 1, but it cannot be determined what Resident A said due to

the volume on the television in the room. Staff member 1 can be heard assuring Resident A that “it was just an accident.”

- From 10:54pm to 11:07pm, Resident A transfers to sit in the cleaned recliner and says something to staff member 1 that cannot be heard. Staff member 1 responds, “Don’t worry about it, Ok?” Staff member 1 places clean socks on Resident A’s feet and covers Resident A up with a blanket. Resident A is observed resting the left side of [their] face in [their] hand while the staff member 1 retrieves the walker from the bathroom, placing it in the living room near the recliner. Staff member 1 then continues to finish cleaning the room.
- At 11:07pm, the staff member 1 exits the room.
- From 11:33pm to 11:36pm, staff member 1 assists Resident A from the bathroom to the recliner. Resident A can be heard saying something to staff member 1, but it is undistinguishable, with staff member 1 again reassuring Resident A that, “it’s Ok, it’s Ok. No, worries. I will help you.” Staff member 1 then selects and presents different clothing items to Resident A and asks Resident A if [they] need any help with changing clothes.
- At 11:36 pm, staff member 2 enters Resident A’s room, leaving the main door to Resident A’s room open to the hallway; and then proceeds into the bathroom.
- From 11:36pm to 11:39pm, staff member 2 assists Resident A in changing clothes. The main apartment door is observed to still be open to the hallway during this time. Staff member 2 assists Resident A to a seated position in the recliner and then exits the room.
- On 7/18/2025 From 4:15am to 4:23am, staff member 1 enters Resident A’s room with Resident A observed seated in the recliner. Staff member 1 asks Resident A if [they] “pooped again” and then enters the bathroom to assess it. Staff member 1 then exits the bathroom and begins assisting Resident A with clean up, while Resident A is still seated in the recliner. Resident A can be heard saying something to staff member 1, but it is undistinguishable. Staff member 1 can be heard saying Resident A has vomit on [their] clothes. Staff member 1 cleans Resident A and spot cleans the room before exiting.
- From 4:53am to 4:57am, Resident A appears to throw up in [their] hand while attempting to ambulate with the walker to the bathroom.
- At 5:12am, staff member 3 is viewed in the bathroom doorway asking Resident A, “you don’t feel well?”
- From 5:20am to 6:18am, Resident A enters and exits the bathroom independently and transfers to the recliner. Resident A appears to not feel well at this time and there are no staff present.
- From 6:18am to 6:20am, staff member 1 is observed walking by Resident A’s room and stops to inquire what Resident A is doing as Resident A demonstrates difficulty transferring to the recliner. Staff

member 1 enters the room and assists Resident A to the recliner and then exits the room.

- At 6:35am, staff member 2 enters the room to administer Resident A medications.
- At 7:48am, staff member 4 enters the room and calls Resident A's name once. Resident A is sleeping in the recliner. Staff member 4 exits the room.
- At 7:53am, Resident A attempts to get up from the recliner.
- From 7:55am to 7:58am, Resident A is sitting on the edge of the recliner seat with staff member 5 entering room and observing that Resident A had vomited. Staff member 5 is heard saying [they] will go get Resident A a towel and exits the room. Staff member 5 returns with a towel, offers water, and tells a staff member passing by that Resident A is sick and will not be eating breakfast. Staff member 5 can be heard saying to another staff member, "We might need to call it out." Staff member 5 retrieves a cup of ginger ale and provides it to Resident A. Staff member 5 exits the room leaving Resident A in an improper position in the recliner.
- At 8:32am, Resident A is observed dozing in the recliner as the maintenance person enters the bathroom to assess the prior flood.
- At 8:37am, Resident A is observed either coughing or gagging once while seated in the recliner.
- From 8:37am to 8:57am, staff member 6 and staff member 7 enter the room to assist Resident A with going to the bathroom, cleaning up, and changing clothes. Resident A's clothes are observed to be soiled. Staff member 6 attempts to assist Resident A back to the recliner but completes an improper transfer with Resident A almost falling off the recliner. Staff member 6 then improperly positions Resident A in the recliner. Staff member 6 can be seen struggling with the recliner to get the recliner and footrest into position.
- From 10:59am to 11:08am, Resident A is seen seated in the recliner with the recliner pointing towards the main door of the room that exits to the hallway. Staff member 8 enters the room to try and assist Resident A. Staff member 8 observes that Resident A is unable to answer [their] questions and is demonstrating lethargy. Staff member 8 attempts to engage Resident A but is unsuccessful.
- At 12:42pm, emergency services arrive to assess Resident A.

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. **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	It was alleged that Resident A incurred a fall on 7/18/2025 contributing to [their] fatality. Interviews, onsite investigation, and review of documentation reveal that there is no evidence to support that Resident A actually incurred a fall on 7/17/2025 or 7/18/2025 that could have contributed to [their] fatality. However, interviews and documentation revealed the following: • Resident A first began to demonstrate a change in condition and health on 7/17/2025 at 9:53pm. • Multiple facility staff members entered Resident A's room to assist Resident A with care due to Resident A's demonstrated decline in condition and health from 7/17/2025 at 9:53pm until 7/18/2025 at 12:42pm when emergency services arrived to evaluate Resident A. While facility staff provided Resident A assistance during [their] demonstrated change in condition, almost 15 hours passed from the start of Resident A's demonstrated decline in condition on 7/17/2025 at 9:53pm to when emergency services arrived to transport Resident A to the hospital on 8/18/2025 at 12:42pm. Emergency medical care was not sought in a timely manner as Resident A continued to demonstrate and vocalize a significant change in condition. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility staff neglected Resident A and did not provide care in accordance with the service plan.

INVESTIGATION:

On 7/28/2025, the facility administrator reported that care staff provided Resident A care in accordance with the service plan. The facility administrator reported all staff are trained and required to provide residents care in accordance with the service plans.

On 7/28/2025, Employee 1 reported staff provided Resident A care in accordance with the service plan. Employee 1 reported that Resident A might intermittently refuse care such as showers but not often. Redirection would be provided, and Resident A would often comply. Also, another staff member would approach Resident A to encourage a shower and during reapproach, Resident A would be more agreeable to have a shower or participate in other care. Employee 1 reported Resident A preferred certain staff over other staff, so the facility would try to schedule the preferred staff with Resident A to prevent the refusal of showers and any other care routines and to prevent any behaviors. Resident A received showers twice per week and if a refusal occurred, an alternative shower would be offered the next day. Employee 1 confirmed that a hearing aid battery became lodged in Resident A's ear. Staff informed the family and physician once staff suspected something was lodged in Resident A's ear when Resident A refused to allow staff to assist [them] with the hearing aids. Resident A was taken to the physician, and the hearing aid battery was located deep in the ear canal and removed on 7/1/2025. Employee 1 reported Resident A is followed closely by the physician through the local senior program and that the facility regularly coordinates with them to ensure Resident A's care, health, and wellbeing. Employee 2 provided me with the requested documentation for my review.

On 7/28/2025, Employee 2's statement was consistent with the facility administrator's statement and Employee 1's statement.

On 8/21/2025, I reviewed the requested documentation which revealed the following:

- There is evidence Resident A received showers in accordance with the service plan.
- There is no evidence Resident A refused showers, but there is evidence Resident A required redirection from staff during care routines.
- There is evidence that Resident A demonstrated confusion with behaviors and increased agitation from 1/5/2025 until 7/18/2025.
- There is evidence that the facility regularly communicated with Resident A's family, the physician, and the local senior care program.
- On 6/29/2025 at 1:30pm, Resident A's hearing aid battery was replaced by staff per family's request.
- On 6/29/2025 at 2:15pm, the family requested a nurse from the local senior program to go to the facility to assess Resident A's left ear due to a developing scab inside of the ear.
- On 6/29/2025 at 2:45pm, facility staff and visiting family discovered Resident A had a hearing aid battery stuck inside the left ear. The battery was pushed too deep into the canal to retrieve. The facility contacted the local senior program physician to place an urgent request for a nurse to visit the facility to assess Resident A. The facility continued to monitor Resident A.
- On 6/29/2025 at 3:00pm, the local senior program notified the facility that Resident A would be picked up at the facility to go to the physician to address the lodged hearing aid battery and that the local senior program would be in contact with the facility later to confirm the time and transportation.

- On 7/1/2025 at 2:45pm, Resident A was taken to the physician, and the lodged hearing aid battery was removed.

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:	It was alleged that facility staff neglected Resident A and did not provide care in accordance with the service plan. Interviews, onsite investigation, and review of documentation reveal there is no evidence to support this allegation. The facility demonstrated care consistent with the service plan. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

On 8/14/2025, review of the documentation revealed the following:

- On 7/17/2025 at 11:36 pm, staff member 2 entered Resident A’s room and left the main door to Resident A’s room open to the hallway which provided an unobstructed view into Resident A’s room. Staff member 2 then proceeds into the bathroom.
- From 11:36pm to 11:39pm, staff member 2 is observed assisting Resident A change into clean clothes. The main apartment door is observed to still be open to the hallway with an unobstructed view into Resident A’s room while Resident A is being assisted to change clothes. After the changing of clothes is completed, staff member 2 assists Resident A to a seated position in the recliner and then exits the room.

APPLICABLE RULE	
MCL 333.20201(2)	**Policy describing rights and responsibilities of patients or residents; adoption; posting; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.** **Sec. 20201.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(d) A patient or resident is entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity and individuality.**
ANALYSIS:	Staff member 2 assisted Resident A with changing into clean clothes on 7/17/2025, however, this was completed with Resident A's door open to the hallway which provided an unobstructed view into Resident A's room. Staff member 2 did not ensure Resident A was provided with dignity, respect, or privacy during the provision of this care task since staff member 2 left the room door open, which made the care task visible to anyone in the hallway. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

On 8/21/2025, review of documentation revealed the following:

- On 1/12/2025 at 8:45pm, *[Resident A] pretends to swallow all of the [their] pills, spits them out, and puts certain ones in [their] pocket. Please be aware.*
- On 6/30/2025 at 10:45am, *family informed staff that while visiting Resident A last night, the medication technician (MT) passed Resident A [their] medications and then left the room. After the MT left, [Resident A] took the pills out of [their] mouth and shoved them in the crevice of the chair, not actually taking the medication. Please ensure that [Resident A] is swallowing all medications completely when passing.*
- On 7/14/2025 at 8:45am, *[Resident A] was witnessed trying to fake taking all [their] pills and then pocket the few [they] didn't take. [Resident A] took all*

morning pills, however, 5 pills were found in [their] pocket presumably from previous medication passes that [Resident A] was able to pocket the pills without being noticed. Recommended that [Resident A] is watched during passes to make sure [they] are consuming all pills marked as passed.

APPLICABLE RULE	
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: **(a) Be trained in the proper handling and administration of the prescribed medication.**
ANALYSIS:	Review of documentation revealed that medication technician staff did not ensure Resident A swallowed all medication administered on 1/12/2025, 6/30/2025, and 7/14/2025 despite communication being placed in the record that Resident A demonstrated a history of pocketing, hiding, or spitting medication out. The facility did not provide Resident A safe medication administration in accordance with the physician orders or the service plan and did not ensure Resident A's safety due to staff mishandling Resident A's medication during administration. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Viviano

8/21/2025

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Julie Viviano Date
Licensing Staff

Approved By:

09/29/2025

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