GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 22, 2026

Laura Whaley
Leisure Living Management of Coopersville
640 West Randall
Coopersville, MI 49404

RE: License #: AL700070219
Investigation #: 2026A0340050
FV Ret Vill Of Coopersville #1

Dear Ms. Whaley:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

If you desire technical assistance in addressing these issues, please 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 (616) 356-0100.

Sincerely,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700070219
Investigation #:	2026A0340050
Complaint Receipt Date:	06/12/2026
Investigation Initiation Date:	06/15/2026
Report Due Date:	08/11/2026
Licensee Name:	Leisure Living Management of Coopersville
Licensee Address:	640 West Randall Coopersville, MI 49404
Licensee Telephone #:	(616) 588-9131
Administrator:	NONE ASSIGNED
Licensee Designee:	Laura Whaley
Name of Facility:	FV Ret Vill Of Coopersville #1
Facility Address:	620 W Randall Street Coopersville, MI 49404
Facility Telephone #:	(616) 997-9253
Original Issuance Date:	11/25/1996
License Status:	REGULAR
Effective Date:	03/27/2026
Expiration Date:	03/26/2028
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was hospitalized after staff delayed seeking emergency medical care.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/12/2026	Special Investigation Intake 2026A0340050
06/15/2026	APS Referral Complaint filed by APS
06/15/2026	Special Investigation Initiated - Telephone Amanda Beecham
06/24/2026	Inspection Completed On-site
06/26/2026	Contact - Telephone call made staff Hailie Burwell
06/26/2026	Contact - Telephone call made Dir. Resident Care Amber Schmidt-LM
06/26/2026	Contact - Telephone call received Staff Hailie Burwell
07/08/2026	Contact – Document Received From Laura Whaley
07/17/2026	Inspection Completed On-Site
07/17/2026	Contact – Phone Call Made Laura Whaley
07/23/2026	Exit Conference Laura Whaley

ALLEGATION: Resident A was hospitalized after staff delayed seeking emergency medical care.

INVESTIGATION: On June 15, 2026, a complaint was filed with the BCHS Online Complaints by Adult Protective Services. It stated that on 6/11/26, Resident A was

found unresponsive by staff Hailie Burwell. The day prior, Resident A had been completely fine and coherent. When Ms. Burwell found Resident A, she was slumped over and unresponsive in a chair. Instead of calling 911, Ms. Burwell tried to give Resident A some orange juice. Hours later, 911 was called by Resident A's daughter and she was transported to Zeeland Hospital where she was admitted. Resident A has not returned to Fountain View.

On June 15, 2026, I contacted staff Amanda Beecham. Ms. Beecham did not know if Resident A had returned home yet so she looked in the computer system and discovered she had been sent to a rehab facility for recovery. Resident A had been diagnosed with a UTI. I requested the Incident Report, Assessment Plan and Health Care Appraisal. She also provided the names and contact information for staff involved.

On June 16, 2026, I received and reviewed the following documents. The Health Care Appraisal (HCA) for Resident A was signed on 5/8/26 by PA Carrie Stankey. The HCA is handwritten and Resident A's diagnosis are illegible. The Assessment Plan for Resident A was signed by former Designee Brian Nitz on 5/14/26. There is nothing notable on her Assessment Plan regarding her care. The Incident Report (IR) dated 6/11/26 was written by staff Hailie Burwell. It stated, "resident was unresponsive and wouldn't take meds. Had a fever, wouldn't swallow any liquids." Under "Actions Taken By Staff" it states, "contacted family, called 911 per family and sent to hospital".

On June 26, 2026, I interviewed Ms. Burwell. After I introduced myself and explained the reason for my call, I asked Ms. Burwell to tell me what had happened with Resident A the day she had gone to the hospital. She stated that around 7 am she began her shift and started rounds. She saw Resident A sitting in her chair in her room. She stated that Resident A usually does not go down to the dining room for breakfast, so Ms. Burwell did not find this unusual. When she returned to Resident A's room around 9 am Ms. Burwell found Resident A "slumped over" and unresponsive. She called for "the med passer" Cathy Lange, to come to Resident A's room. They took her temperature, which was 101, her vitals, and blood sugar. Ms. Burwell stated that Ms. Lange did not stay as she was passing medication for all the residents in Building 1 as well as Building 3 on campus so she left the building. When I asked Ms. Burwell what she did after that she said she put cold washcloths on Resident A to try to keep her cool. I clarified that Resident A was still unresponsive. She said "yes". I asked her why she did not call 911 and she stated she had never called 911 before. I asked Ms. Burwell if she had been told by anyone in management not to call 911 but she said "no". I asked Ms. Burwell if a resident was unresponsive, regardless if she had ever called 911 or not, why at this time she did not call 911. Ms. Burwell stated she called Resident A's husband, but he said he could not come to the home "for a couple hours". This was around 10 am but it was not until 1:30 or 2 pm that her husband arrived. He tried to wake her up, but she would not wake so he called his daughter who told him to immediately call 911, which Ms. Burwell believes he or the daughter did.

On June 26, 2026, I called Director of Resident Care, Amber Schmidt and left a message.

On July 17, 2026, I conducted an unannounced home inspection. I interviewed Ms. Schmidt who stated she cannot access her voicemail, so she was unaware of my need to speak with her. I asked Ms. Schmidt what she knew about the incident involving Resident A. Ms. Schmidt stated she was not working that day, so she only knew what she had heard. I asked Ms. Schmidt who else was working with Ms. Burwell. She stated that it could have been no one if Ms. Lange had to cover med pass at another building. I clarified that Ms. Burwell is not trained in passing medication and she said she is not. Ms. Schmidt stated that Ms. Burwell has worked at Fountain View for approximately two years but has always worked when someone who is med trained is also on the schedule. I clarified with Ms. Schmidt that Ms. Burwell was left to work alone in the building and she is not med trained, that she would need to call someone from another building to pass medication if the need was to arise. Ms. Schmidt stated that was correct. Ms. Schmidt confirmed that staff move between the three buildings regularly.

On July 22, 2026, I called staff Cathy Lange and explained who I was and the reason for my call. I asked her to tell me what she had witnessed the day of Resident A's incident. She stated she went to her room to pass medications and found Resident A "unresponsive" and could not wake her up. Ms. Lange attempted to give Resident A her medications but was not successful even after she crushed them and attempted to give the medication in applesauce, even though Resident A would not wake up. Ms. Lange clarified that Resident A looked as if she was sleeping. Ms. Lange then left to pass other medications for other residents. I asked Ms. Lange if she returned to Resident A's room to check on her and she did not. Ms. Lange stated she was also working in another building to cover medication passes. Ms. Lange confirmed that Ms. Burwell is not trained to pass medication. Ms. Lange did know that Resident A was eventually sent to the hospital.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	The allegation was made that Resident A was hospitalized after staff delayed seeking emergency medical care on 6/11/2026. An Incident Report (IR) dated 6/11/26 was written by staff Hailie Burwell and stated "resident was unresponsive and wouldn't take meds. Had a fever, wouldn't swallow any liquids." Under Actions Taken By Staff it states, "contacted family, called 911 per family and sent to hospital".

	Ms. Burwell confirmed Resident A was observed in her chair at approximately 7 am. Around 9 am Resident A was observed unresponsive and slumped over in her chair. Ms. Burwell called Ms. Lange who took Resident A's vitals which revealed she had a temperature of 101. Ms. Burwell attempted to give Resident A orange juice and provided her with cold washcloths. She acknowledged she did not call 911 right away and Resident A remained unresponsive. Ms. Burwell called Resident A's husband who did not arrive until approximately 2 pm. 911 was not called until Resident A's husband called their daughter who is believed to have called 911, approximately five hours after Resident A was first observed to be unresponsive. Ms. Lange confirmed that Resident A was unresponsive and that Ms. Burwell was working by herself in the home and that Ms. Burwell is not trained to pass medication. Resident A was left unresponsive for at least five hours and staff failed to seek emergency medical care during this time. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While conducting this investigation, I was made aware that staff Hailie Burwell was working by herself and not trained in passing medication. Ms. Burwell stated she worked by herself on 6/11/26 and confirmed she is not trained in passing medication. Ms. Schmidt confirmed that Ms. Burwell worked by herself on 6/11/26 and is not trained in passing medication. Ms. Lange confirmed she left Ms. Burwell working by herself and that Ms. Burwell is not trained in passing medication.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Staff Burwell worked by herself and was not trained in passing medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While conducting this investigation, I asked Ms. Burwell if anyone else was working with her during this time. Ms. Burwell stated that Ms. Lange was the “med passer”, but she went to Building 3. The home manager was Brice Parcher, but he was working at Building 2 and she did not have contact with him. So, at the time of the incident, Ms. Burwell was working alone.

I reviewed the Assessment Plans for all 13 residents living in Building 1 and there is a required 2-person assist for Resident B who utilizes a hoyer lift, which would mandate at least two staff working in Building 1 at all times.

I asked Ms. Schmidt about Ms. Burwell working by herself. She stated Ms. Lange was the “med passer” but she also was covering Building 3 so she would have left at some point to cover medications at the other building. Ms. Schmidt attempted to show me the staff work schedule but was unable to show me a comprehensive schedule which made sense. When asked if there was a way to show the Building 1 schedule in an organized manner, Ms. Schmidt stated that was not possible.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.** **(b) 12 residents for small group and family homes.**
ANALYSIS:	Building 1 requires at least 2 people working at all times. This ratio was not maintained when Ms. Burwell was left working alone. The three buildings on campus share staff and Ms. Lange who was identified as the “med passer” had gone to Building 3 to pass medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION: While conducting this investigation, during an unannounced

inspection, I observed four bottles of prescribed Enulose for Resident B, a tube of Triamcinolone cream for Resident C, and a bottle of eyelid cleansing gel sitting on the shelf by the resident books. The medication room door was wide open and accessible to the rest of the home.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	While in the facility I observed four bottles of prescribed Enulose, a tube of Triamcinolone cream, and a bottle of eyelid cleansing gel sitting on the shelf by the resident books. The medication room door was also wide open and accessible to the rest of the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION: The home does not have an assigned Administrator and has not had one since March 16, 2026.

APPLICABLE RULE	
R 400.625	**Administrator**
	Except for family homes, a facility shall have an administrator.
ANALYSIS:	The home does not have an Administrator.
CONCLUSION:	**VIOLATION ESTABLISHED**

On July 23, 2026, I conducted an exit conference with acting Licensee Designee Laura Whaley. I informed her of the allegation and rule violation found, as well as the other additional findings. I requested a Corrective Action Plan from Ms. Whaley

which she understood and agreed to send. I informed her that I am recommending a Provisional license. Ms. Whaley had no other questions at this time.

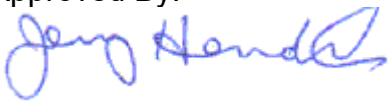
IV. RECOMMENDATION

Due to the above-cited quality of care violations, I recommend, upon receipt of an acceptable corrective action plan, that the license be modified to Provisional status.

July 24, 2026

Rebecca Piccard — Date
Licensing Consultant

Approved By:



July 27, 2026

Jerry Hendrick — Date
Area Manager