GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 3, 2026

Tim Stoll
Thurston Woods Village Inc.
307 N. Franks Ave.
Sturgis, MI 49091

RE: License #: AL120418792
Investigation #: 2026A1030027
The Branches

Dear Ms. Omo:

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.

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,

Nile Khabeiry, LMSW

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL120418792
Investigation #:	2026A1030027
Complaint Receipt Date:	03/18/2026
Investigation Initiation Date:	03/28/2026
Report Due Date:	05/17/2026
Licensee Name:	Thurston Woods Village Inc.
Licensee Address:	307 N. Franks Ave. Sturgis, MI 49091
Licensee Telephone #:	(269) 651-7841
Administrator:	Theo Omo
Licensee Designee:	Tim Stoll
Name of Facility:	The Branches
Facility Address:	99 Vista Dr. Coldwater, MI 49036
Facility Telephone #:	(269) 651-7841
Original Issuance Date:	12/16/2024
License Status:	REGULAR
Effective Date:	06/16/2025
Expiration Date:	06/15/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility is not administering medications to the residents.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/18/2026	Special Investigation Intake 2026A1030027
03/18/2026	APS Referral APS referral made
03/28/2026	Special Investigation Initiated - Telephone Interview with Sarah Vanguilder
03/30/2026	Inspection Completed On-site
03/30/2026	Contact - Face to Face Interview with Caryn Rosfeld
03/30/2026	Contact - Face to Face Interview with Resident F
03/30/2026	Contact - Face to Face Interview with Resident C
04/02/2026	Exit Conference Exit conference by phone

ALLEGATION:

The facility is not administering medications to the residents.

INVESTIGATION:

On 3/18/26, I interviewed facility supervisor, Sarah Vanguilder by phone. Ms. Vanguilder reported the facility currently has seven residents and there is one staff member providing care to the seven residents. Ms. Vanguilder denied the staff members ever neglected to pass medication to the residents.

On 3/30/26, I interviewed direct care staff member (DCSM) Caryn Rosfeld who reported she works for a staffing agency that the facility contracts with to fill shifts at the facility. Ms. Rosfeld reported she has been working at the facility since November 2025. Ms. Rosfeld reported the facility is understaffed and thinks there are three staff that work for the agency and the rest work for the staffing agency, Quinable. Ms. Rosfeld was unsure if the allegations about the staff not passing medications appropriately was accurate. I reviewed the electronic Medication Administration Record (MAR) for Residents A, B, C, D, and E and found that there were blank entries on 3/22/26. Ms. Rosfeld reported she is unsure who was working on 3/22/26 and is unsure if the medication was passed but not documented on the MAR or if the medications were not passed at all.

On 3/30/26, I interviewed Resident F at the facility. Resident F reported she has lived at the facility for two months and believes she receives good care. Resident F reported she is administered her medication everyday and is a retired nurse, so she is aware of her prescriptions.

On 3/30/26, I interviewed Resident C at the facility. Resident C reported she has lived at the facility for 6 months. Resident C reported she receives good care from the staff members. Resident C reported being passed her medications daily and has not missed any medications.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	It was alleged that facility was not administering medications to the residents. Based on interviews and review or the MAR this violation will be established. After reviewing the MAR for five residents there were blank entries for all medications on 3/22/26 making it impossible to determine if the medications were administered to the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I conducted an on-site inspection at the facility on 3/20/26. Upon entering the facility, I noted there was one staff member working barefoot. I also noted that the medication room was open, the medication cart was unlocked, and a medication cup was on the medication cart with one pill in the cup. Ms. Rosfeld was informed that the medications needed to be secured and had her place the loos medication on the top of the medication cart inside a drawer and lock the cart. The medication was identified as Divalproex and belonged to Resident A.

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:	During an unannounced on-site inspection I noted the medication room was open, the medication cart was unlocked and there was one tablet belonging to Resident A in a clear cup sitting on top of the medication cart.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/2/26, I shared the findings of the investigation with licensee designee, Tim Stoll by phone. Mr. Stoll acknowledged the findings and agreed to submit a corrective action plan.

IV. RECOMMENDATION

Contingent upon the submission and acceptance of a corrective action plan, I recommend no change to the current license status.

Nile Khabeiry, LMSW 4/3/26

Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak 4/3/26

Russell B. Misiak Date
Area Manager