GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 4, 2022

Lori McLaughlin
North Woods Village At Kalamazoo
6203 Stadium Dr
Kalamazoo, MI 49009

RE: License #: AH390394454
Investigation #: 2022A1010061
North Woods Village At Kalamazoo

Dear Ms. McLaughlin:

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 authorized representative 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) 241-1970.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
This report contains vulgar language

I. IDENTIFYING INFORMATION

License #:	AH390394454
Investigation #:	2022A1010061
Complaint Receipt Date:	07/15/2022
Investigation Initiation Date:	07/19/2022
Report Due Date:	09/14/2022
Licensee Name:	MITN, LLC
Licensee Address:	6203 Stadium Dr Kalamazoo, MI 49009
Licensee Telephone #:	(574) 247-1866
Administrator:	Amanda Buhl
Authorized Representative:	Lori McLaughlin
Name of Facility:	North Woods Village At Kalamazoo
Facility Address:	6203 Stadium Dr Kalamazoo, MI 49009
Facility Telephone #:	(269) 397-2200
Original Issuance Date:	03/11/2019
License Status:	REGULAR
Effective Date:	09/11/2021
Expiration Date:	09/10/2022
Capacity:	61
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A and Resident B share a room. On 7/9/22, Resident A was physically aggressive towards Resident B and knocked items over in their room.	No
Additional Findings	Yes

III. METHODOLOGY

07/15/2022	Special Investigation Intake 2022A1010061
07/19/2022	Special Investigation Initiated - Letter Emailed assigned Kalamazoo Co APS worker
07/26/2022	Inspection Completed On-site
07/26/2022	Contact - Document Received Received resident service plans and incident report
08/01/2022	Contact - Document Received Email received from assigned APS worker Jessica Mellen. Ms. Mellen reported she is going to the facility this week.
08/09/2022	Contact Telephone call made Interviewed facility nurse Rochelle Patton by telephone
10/04/2022	Exit Conference

ALLEGATION:

Resident A and Resident B share a room. On 7/9/22, Resident A was physically aggressive towards Resident B and knocked items over in their room.

INVESTIGATION:

On 7/15/22, the Bureau received the allegations from Adult Protective Services (APS). The complaint read, “On July, 9th, [Resident B] shared a space with another roommate. The roommate attached [Resident B]. The staff reported hearing [Resident B] yelling for help and for someone to ‘get off of her.’ [Resident B] was

found on the ground shaken up, tearful and frightened. The roommate had also destroyed [Resident B's] room, knocking over her lamp, television, and bedding. There was a meeting regarding [Resident B's] incident and the director assured they would move the roommate. After two days the roommate had returned to [Resident B's] room."

On 7/26/22, I interviewed administrator Amanda Buhl at the facility. Ms. Buhl reported on 7/10/22, the facility's second shift licensed practical nurse (LPN) Rochelle Patton was in the hall and heard Resident B yelling from her room. Ms. Buhl stated Ms. Patton observed Resident B was on the floor near her chair after an altercation with Resident A occurred. Ms. Buhl said Ms. Patton assessed Resident B for injuries and none were present. Ms. Buhl explained Resident A was removed from the room and spent two nights in a private room across the facility.

Ms. Buhl stated Resident A and Resident B's responsible persons and physicians were notified after the incident. Ms. Buhl reported a meeting with Resident A and Resident B's responsible persons was also held at the facility the day after the incident. Ms. Buhl said Resident A had a medication change after the incident that her responsible person agreed to. Ms. Buhl explained Resident A is unable to afford a private room at the facility, therefore she must continue to have a shared room. Ms. Buhl reported Resident B can afford a private room, however her responsible person would not agree to move Resident B to a new room.

Ms. Buhl reported all the facility's semiprivate rooms are currently occupied. Ms. Buhl stated there will be an opening in one of the facility's semiprivate rooms next month. Ms. Buhl said Resident A will move to the semiprivate room as soon as it becomes available. Ms. Buhl reported there were no incidents of aggression between Resident A and Resident B prior to 7/10/22. Ms. Buhl stated there have been no incidents between Resident A and Resident B since 7/10/22. Ms. Buhl said Resident A's medication change after the incident has been effective.

Ms. Buhl stated Resident A and Resident B both had a history of being combative towards staff during the provision of their care. Ms. Buhl reported Resident A had not been physically aggressive toward another resident until the incident on 7/10/22. Ms. Buhl said Resident B has displayed physical aggression towards other residents in the past, however staff intervened before an altercation could take place.

Ms. Buhl provided me with a copy of Resident A's service plan for my review. The *Psychosocial* section of the plan read, "Resident has current or history of frequent anxiety. Resident has current or history of frequent disruptive, aggressive, or socially inappropriate behavior, either verbally or physically improper. May require professional consultation or staff training. May have behavior management plan in place."

Ms. Buhl provided me with a copy of Resident B's service plan for my review. The *Orientation and Behaviors* section of the plan read Resident B is "Resistive (at

times).” Ms. Buhl stated the entire facility is secured and serves residents who have memory loss. Ms. Buhl reported as a result, Resident A and Resident B were unable to recall the incident and have not exhibited aggression or fear towards one another since the incident on 7/10/22.

Ms. Buhl provided me with a copy of the incident report regarding the altercation. The report is dated 7/10/22. I observed the written report was consistent with Ms. Buhl’s statements.

On 7/26/22, I interviewed care staff person Kelsey Roselip at the facility. Ms. Roselip reported she was not present on 7/10/22 when the incident occurred. Ms. Roselip’s statements regarding Resident A and Resident B’s behavior before and after the incident on 7/10/22 were consistent with Ms. Buhl.

Ms. Roselip reported the door to Resident A and Resident B’s is always kept open so staff can see inside. Ms. Roselip stated staff have been checking on Resident A and Resident B more frequently than the required two hours because of the incident on 7/10/22. Ms. Roselip said Resident A has a history of being out of the room she shares with Resident B during the day. Ms. Roselip explained Resident A prefers to walk around the halls during the day, rather than stay in her room. Ms. Roselip reported Resident B often sits in her chair during the day in the room she shares with Resident A. Ms. Roselip stated there is a divider present in Resident A and Resident B’s room to separate their areas. Ms. Roselip reported the divider can easily be moved by staff.

On 7/26/22, I attempted to interview Resident A at the facility. I was unable to engage Resident A in meaningful conversation. I observed Resident A walking around the hallways.

On 7/26/22, I attempted to interview Resident B at the facility. I was unable to engage Resident B in meaningful conversation. I observed Resident B sitting in her chair on her side of the room she shares with Resident A. I observed the divider staff use to separate Resident A’s area of the room from Resident B’s area of the room.

On 8/9/22, I interviewed facility nurse Rochelle Patton by telephone. Ms. Patton reported she responded to Resident A and Resident B’s room on 7/10/22 after she heard Resident B yelling for help. Ms. Patton reported she entered the room on Resident A’s side as there are doors to enter Resident A and Resident B’s sides of the shared room. Ms. Patton stated as she opened the door on Resident A’s side, Resident A was standing by it and exited the room.

Ms. Patton said she observed a picture that was on one of the walls on Resident A’s side of the room was on the floor. Ms. Patton reported when she walked over to Resident B’s side of the room, she observed Resident B on the floor near her recliner chair. Ms. Patton stated Resident B’s Television was still plugged in, but it was on the floor. Ms. Patton explained two lamps were “pushed over” and the

bedding on Resident B's bed was on the floor. Ms. Patton stated Resident B told her, "that bitch attacked me."
Ms. Patton stated she assessed Resident A and Resident B for injuries and neither had any. Ms. Patton reported after she assessed Resident B, she talked to Resident B in the hallways. Ms. Patton said Resident A told her she hit Resident B because she "wanted to be free." Ms. Patton explained she separated Resident A and Resident B and had Resident A sleep in another room across the facility for the night. Ms. Patton stated she did not know when Resident A returned to the room she shared with Resident B.

Ms. Patton reported she worked at the facility on a as needed basis, therefore she did not know what measures were taken to protect Resident A and Resident B after the incident on 7/10/22.

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.**
ANALYSIS:	The interviews with staff revealed Resident A and Resident B were separated after a physical altercation between them occurred on 7/10/22. Ms. Buhl reported Resident A will be moved to another semiprivate room as soon as it becomes available. Ms. Buhl stated Resident B's responsible person would not agree to move Resident B to another private room. There have been no incidents between Resident A and Resident B since 7/10/22.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 7/26/22, I reviewed Resident A and Resident B's service plans. I observed the plans did not specify Resident A and Resident B's behaviors and how staff were to intervene when they displayed such behavior. The service plans lacked detail regarding Resident A and Resident B's specific behaviors and what interventions are to be used.

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:	Review of Resident A and Resident B's service plans revealed they lacked details regarding Resident A and Resident B's behaviors that required intervention from staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with administrator Amanda Buhl by telephone on 10/4/22. A telephone message was left for licensee authorized representative Lori McLaughlin regarding this report on 10/4/2022. Ms. Buhl and I discussed the need to update Resident A and Resident B's service plans to address their behavioral needs and how staff are to intervene.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

8/10/22

Lauren Wohlfert Date
Licensing Staff

Approved By:

09/26/2022

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