GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 7, 2024

Laurie Cook
NorthPointe Woods Assisted Living
700 North Avenue
Battle Creek, MI 49017

RE: License #: AH130236857
Investigation #: 2025A1028001
NorthPointe Woods Assisted Living

Dear Laurie Cook:

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, 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 #:	AH130236857
Investigation #:	2025A1028001
Complaint Receipt Date:	09/30/2024
Investigation Initiation Date:	10/02/2024
Report Due Date:	11/30/2024
Licensee Name:	NorthPointe Woods
Licensee Address:	700 North Avenue Battle Creek, MI 49017
Licensee Telephone #:	(616) 964-7625
Authorized Representative/Administrator:	Laurie Cook
Name of Facility:	NorthPointe Woods Assisted Living
Facility Address:	700 North Avenue Battle Creek, MI 49017
Facility Telephone #:	(269) 964-7625
Original Issuance Date:	02/01/2000
License Status:	REGULAR
Effective Date:	06/24/2024
Expiration Date:	07/31/2024
Capacity:	66
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff member 1 is verbally abusive to Resident A.	No
Resident B is sexually abused by a known visitor to the facility.	No
It was alleged Employee A took Resident C's personal call light because Resident C was pressing it too much and did not return it to Resident C.	No
Employee B pre-sets narcotic medication prior to administering to residents.	Yes
Additional Findings	No

III. METHODOLOGY

09/30/2024	Special Investigation Intake 2025A1028001
10/02/2024	Special Investigation Initiated - Letter
10/02/2024	APS Referral APS made referral to HFA.
10/03/2024	Contact - Face to Face Interviewed facility Admin/Laurie Cook at the facility.
10/03/2024	Contact - Face to Face Interviewed Employee A at the facility.
10/03/2024	Contact - Face to Face Interviewed Employee B at the facility.
10/03/2024	Contact - Document Received Received requested documentation from Employee A.

ALLEGATION:

Staff member 1 is verbally abusive to Resident A.

INVESTIGATION:

On 9/30/24, the Bureau received the allegations through the online complaint system.

On 10/2/2024, Adult Protective Services (APS) made referral to Homes for the Aged (HFA) through Centralized Intake.

On 10/3/2024, I interviewed the facility authorized representative and administrator, Laurie Cook, at the facility who reported knowledge of allegations that staff member 1 was verbally abusive to Resident A. Due to the allegations, Ms. Cook reported the facility conducted an internal investigation and it was determined that staff member 1 is not verbally abusive to Resident A and the allegations were not substantiated. Ms. Cook reported Resident A demonstrates impaired cognition with impaired reality intermittently. Resident A claims staff member 1 is an intruder due to impaired cognition and impaired reality. Ms. Cook reported to prevent further allegations and triggers of impaired reality, staff member 1 was removed from Resident A's care routine schedule. Ms. Cook reported the facility has no concerns about staff member 1's job performance or interactions with residents. Ms. Cook provided the requested documentation for my review.

On 10/3/2024, I interviewed Employee A at the facility whose statement was consistent with Ms. Cook's statement.

On 10/3/2024, I reviewed the requested documentation, and no concerns were noted during the review.

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:	It was alleged staff member 1 was verbally abusive to Resident A. Interviews, onsite investigation, and review of documentation reveal there is no evidence to support the allegations. The facility addressed the allegations appropriately to ensure Resident A's safety and wellbeing. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B is sexually abused by a known visitor to the facility.

INVESTIGATION:

On 10/30/2024, Ms. Cook reported knowledge of the alleged allegations of Resident B being sexually abused by a known facility visitor. Upon notification of the allegations, the facility immediately investigated and conferenced with Resident B's authorized representative, and the police were notified as well. Ms. Cook reported the investigation determined the known visitor is a private family caregiver for Resident B. Resident B's authorized representative was aware of and confirmed the known visitor provides care to Resident B when visiting the facility. Ms. Cook reported the known visitor has provided care and assistance to Resident B and [their] family for years and that Resident B's authorized representative has no concerns about the known visitor's provision of care. Ms. Cook confirmed adult protective services (APS) and the police investigated the allegations as well and the allegations were unsubstantiated. Ms. Cook reported she thinks the facility caregiver who reported the allegations to APS first was unaware of Resident B's caregiver situation but appreciates whoever reported the allegations for looking out for the wellbeing and safety of Resident B. Ms. Cook provided me the requested documentation for my review.

On 10/3/2024, I interviewed Employee A at the facility whose statement was consistent with Ms. Cook's statement.

On 10/3/2024, I reviewed the requested documentation, and no concerns were noted during the review.

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:	It was alleged Resident B was being sexually abused by a known visitor to the facility. Interviews, onsite investigation, and review of documentation reveal there is no evidence to support the allegations. The facility addressed the allegations immediately and appropriately to ensure Resident A's safety and wellbeing. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

It was alleged Employee A took Resident C's personal call light because Resident C was pressing it too much and did not return it to Resident C.

INVESTIGATION:

On 10/3/2024, Ms. Cook reported Employee A did not take Resident C's personal call light because Resident C was pressing it too much. Ms. Cook reported the call light was not working correctly, and Employee A attempted to fix it. Employee A offered to replace the call light, but Resident C refused and did not want the personal call light back. Ms. Cook reported Resident C resides with [their] spouse at the facility and that there are wall call lights throughout the apartment to utilize. Resident C's spouse reported [they] will press the other call lights if needed. The personal call light was offered to Resident C multiple times, but Resident C reported [they] do not want it because [they] can use the call lights in the room, or [their] spouse can press [their] personal call light if needed.

On 10/3/2024, Employee A reported Resident C brought [them] the call light and reported it was not working. Employee A attempted to fix it but it needed to be replaced instead. Employee A reported they attempted to provide a new call light to Resident C but Resident C declined. Employee A reported [they] approached Resident C multiple times about the new personal call light, but Resident C continues to decline to accept the new personal call light. Employee A confirmed Resident C lives with [their] spouse at the facility and that there are wall call lights throughout the apartment. Employee A also confirmed Resident C's spouse was agreeable to pull the call light if needed. Employee A reported Resident C and [their] spouse are [their] own persons. Resident C continues to refuse to accept the personal call light despite staff encouraging [them] to use it. Employee A provided me the requested documentation for my review.

On 10/3/2024, I reviewed the requested documentation which revealed no concerns.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(1) Personal care and services that are provided to a resident by the home shall be designed to encourage residents to function physically and intellectually with independence at the highest practical level.
ANALYSIS:	It was alleged Employee A took Resident C's call light because Resident C was pressing it too much and did not return it to Resident C. Interviews, onsite investigation, and review of documentation reveal that Resident C brought the call light to Employee A to fix. Employee A was unable to fix it and attempted to replace the call light, but Resident C and [their] spouse declined the new personal call light. Employee A attempted multiple times to replace the personal call light, but Resident C continues to decline. There are several wall call lights in Resident C's apartment that Resident C can utilize, and the facility continues to encourage Resident C to use those call lights. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Employee B pre-sets narcotic medication prior to administering to residents.

INVESTIGATION:

On 10/3/2024, Ms. Cook reported knowledge of allegations that Employee B pre-set medications and that it was investigated by facility management. Ms. Cook reported it was confirmed that Employee B pre-set medications but was unable to provide a date it occurred. Ms. Cook reported Employee B was counseled about the pre-setting of the medications immediately and that to her knowledge it has not occurred again.

On 10/30/2024, Employee A reported it was reported to management that Employee B pre-set medications recently and that Employee B was provided re-education on medication administration. Employee A was unable to provide the date it occurred and when asked for documentation that Employee B received re-education on medication administration, it could not be provided because a medication

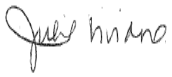
administration error report and documentation of re-education were not completed by the facility.

On 10/3/2024, I interviewed Employee B at the facility who confirmed [they] were provided re-education on medication administration but could not confirm the date of the medication administration error or the date of re-education but confirmed it occurred. Employee B reported [they] did not pre-set medications, that [they] had the medication on top of the med cart in the cup and was with medication while [they] watched and waited for the resident to complete ambulation to the dining room so the medication could be administered to the resident then. Employee B reported, "I think whoever reported it saw this and thought I was pre-setting medications, which I wasn't. I do not pre-set medications."

APPLICABLE RULE	
R 325.1932	**Resident's 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:	It was alleged Employee B pre-sets narcotic medication prior to administering to residents. Interviews and onsite investigation determined Employee B pre-set medication on an unknown date and that Employee B received re-education on medication administration. However, when a medication administration error report or documentation was requested from the facility, it could not be provided because the facility did not complete any report or documentation. Due to the facility not completing a medication administration error report or documentation pertaining to Employee B's re-education, it cannot be determined the date the medication administration error occurred, what medication was pre-set and who it was prescribed for, or that appropriate medication administration re-education for Employee B occurred or when it occurred. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



10/10/2024

Julie Viviano Date
Licensing Staff

Approved By:

10/14/2024

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