



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 28, 2025

Pamela Reese
700 Eley Street
Otsego, MI 49078

RE: License #: AH030413477
Investigation #: 2025A1010056
Kauhale Otsego

Dear Licensee:

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, 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**

I. IDENTIFYING INFORMATION

License #:	AH030413477
Investigation #:	2025A1010056
Complaint Receipt Date:	06/18/2025
Investigation Initiation Date:	06/20/2025
Report Due Date:	08/18/2025
Licensee Name:	Kauhale Otsego, LLC
Licensee Address:	72 Dorchester Square N Westerville, OH 43081
Licensee Telephone #:	(330) 289-0971
Authorized Representative/ Administrator:	Pamela Reese
Name of Facility:	Kauhale Otsego
Facility Address:	700 Eley Street Otsego, MI 49078
Facility Telephone #:	(269) 694-1621
Original Issuance Date:	05/18/2023
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	56
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's care needs are not met consistent with her service plan.	No
Staff did not administer Resident A's medications as prescribed.	Yes

III. METHODOLOGY

06/18/2025	Special Investigation Intake 2025A1010056
06/20/2025	Special Investigation Initiated - Letter Email sent to assigned Allegan Co APS worker Mike McClellan
06/23/2025	Inspection Completed On-site
06/23/2025	Contact - Document Received Received resident service plan and staff progress notes
07/15/2025	Contact - Document Received Email from Mr. McClellan received
07/21/2025	Contact – Document Received Received Resident A's May and June MARs via email from SP1
07/28/2025	Exit Conference

ALLEGATION:

Resident A's care needs are not met consistent with her service plan.

INVESTIGATION:

On 6/18/25, the Bureau received the complaint from Adult Protective Services (APS). The complaint read, "[Resident A] has on the same clothing and briefs from Friday morning. She has not been changed."

On 6/20/25, I emailed the assigned Allegan County APS worker Michael McClellan. Mr. McClellan initiated his APS investigation.

On 6/23/25, I interviewed Staff Person 1 (SP1) at the facility. SP1 stated Resident A resides in the secured memory care unit in the facility. SP1 denied knowledge regarding Resident A's care needs not being met consistent with her service plan. SP1 stated staff are trained to change a resident's soiled brief or clothing immediately upon discovery. SP1 stated Resident A does not have skin breakdown on her buttocks.

SP1 said Resident A does have a limited amount of clothing, therefore staff must launder hers more frequently. SP1 reported staff likely laundered the clothing Resident A wore in the same day for her to wear the following day. SP1 said Resident A does use the toilet, however she also wears a brief. SP1 explained Resident A's toileting needs are outlined in her service plan.

SP1 provided me with a copy of Resident A's service plan for my review. The *DRESSING* section of the plan read, "Requires occasional assistance with some aspects of dressing (socks, shoes)." The *TOILETING* section of the plan read, "Continent of bowel and bladder. Requires supervision/assistance with major or all parts of the task. Wears proactive garments. BATHROOM ASSISTANCE: The resident requires assistance for toilet use. Needs assistance from 1 staff of care team members for toilet use."

On 6/23/25, I interviewed SP2 at the facility. SP2's statements were consistent with SP1. SP2 reported she knows of instances in which Resident A wore the same clothing as she did the day before, however the clothing was laundered before the clothing was put on Resident A the following day.

On 6/23/25, I interviewed SP3 at the facility. SP3's statements were consistent with SP1 and SP2.

On 6/23/25, I interviewed Relative A1 at the facility. Relative A1 reported there have been instances in which she observed Resident A in the same clothing as the day before when visiting Resident A at the facility. Relative A1 expressed concern regarding staff often being on the patio outside off the dining room in the secured memory care unit. Relative A1 said staff do not supervise or provide care to the residents as a result. Relative A1 reported these concerns were brought to the attention of management staff, however the issues continue.

Relative A1 denied arriving at the facility to find Resident A soiled. Relative A1's statements were consistent with the toileting needs outlined in Resident A's service plan.

On 6/23/25, I interviewed Relative A2 by telephone. Relative A2's statements were consistent with Relative A1.

On 6/23/25, I attempted to interview Resident A at the facility. I was unable to engage Resident A in meaningful conversation. I observed Resident A's clothing was

clean and she was well groomed. I did not detect any foul odors in Resident A's presence, or within her room.

On 7/15/25, I received an email from Mr. McClellan. Mr. McClellan reported he completed his APS investigation with no findings.

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:	The interviews with SP1, SP2, and SP3, revealed Resident A's clothing is laundered often because she has a limited amount. SP2 stated there were instances in which Resident A's clothing was laundered after she wore it one day and put on her to wear the following day. On 6/23/25, I observed Resident A wore clean clothing and she was adequately groomed. Resident A was not soiled, and I did not detect any foul odors. There is insufficient evidence to suggest the facility is not in compliance with this rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff did not administer Resident A's medications as prescribed.

INVESTIGATION:

On 6/18/25, the complaint read Resident A "has cellulitis in her legs. Many residents including [Resident A] are missing medications."

On 6/23/25, SP1 denied knowledge regarding Resident A, or any other residents in the facility, "missing" their prescribed medications. SP1 reported Resident A does currently have chronic pain and redness and swelling in her legs. SP1 said this issue is being monitored closely and treated by Resident A's nurse practitioner who is at the facility once a week to evaluate Resident A. SP1 reported Resident A's nurse practitioner is at the facility today and will be meeting with Resident A. SP1 said Resident A's nurse practitioner has prescribed Resident A medications to treat Resident A's pain and the swelling in her legs. SP1 stated that to her knowledge, Resident A's medications are administered as prescribed.

On 6/23/25, SP2's statements were consistent with SP1.

On 6/23/25, Relative A1 reported there have been several incidents in which Resident A did not receive her prescribed medications. Relative A1 said during these incidents Resident A's medication was not present in the medication cart. Relative A1 reported she observed these incidents firsthand.

On 6/23/25, Relative A2's statements were consistent with Relative A1.

On 6/23/25, I observed Resident A's nurse practitioner enter Resident A's room.

On 7/21/25, I received Resident A's May and June's medication administration records (MARs) via email from SP1 for my review. Resident A's May MAR read her prescribed "Ibuprofen Oral Tablet 600 MG (Ibuprofen) Give 1 tablet by mouth in the afternoon for treatment of pain" was not administered on 5/16/25, 5/17/25, and 5/29/25, her prescribed "Lasix Oral Tablet 20 MG (Furosemide) Give 1 tablet by mouth one time a day for treatment of edema" was not administered on 5/17 and 5/31/25, her prescribed "Melatonin Oral Tablet 3 MG (Melatonin) Give 1 tablet by mouth at bedtime for sleep" was not administered on 5/17/25, her prescribed "Diclofenac Sodium External Gel 1% (Diclofenac Sodium Topical) apply to both knees topically two times a day for treatment of arthritis" was not administered at 8:00 pm on 5/17/25 and at 8:00 am on 5/31/25, and her prescribed "traMADol HCl Oral Tablet 100 MG (Tramadol HCl) Give 100 mg by mouth two times a day for treatment of pain" was not administered at 8:00 pm on 5/17/25.

Resident A's June MAR read her prescribed "Ibuprofen Oral Tablet 600 MG (Ibuprofen) Give 1 tablet by mouth in the afternoon for treatment of pain" was not administered on 6/15/25 and 6/17/25, her prescribed "Omeprazole Oral Tablet Delayed Release 20 MG (Omeprazole) Give 1 tablet by mouth one time a day for GERD Omeprazole 20 mg; Give 1 cap PO daily for GERD" was not administered on 6/14/25, her prescribed "Tiger Balm Ultra Strength External Ointment (Menthol-Camphor (Liniments) Apply to knees topically two times a day for treatment of knee pain and stillness" was not administered at 8:00 am on 6/14/25 and 8:00 pm on 6/24/25 and 6/30/25, her prescribed "Clindamycin HCl Oral Capsule 300 MG (Clindamycin HCl) Give 1 capsule by mouth three times a day for treatment of infection for 7 days" was not administered at 12:00 pm on 6/17/25, and her prescribed "traMADol HCl Oral Tablet 50 MG (Tramadol HCl) Give 2 tablet by mouth three times a day for treatment of pain" was not administered at 8:00 am on 6/14/25, 12:00 pm on 6/14/25 and 6/18/25.

APPLICABLE RULE	
R 325.1932	Resident's medications.
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional

	<p>(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following:</p> <p>(b) Complete an individual medication log that contains all of the following information:</p> <p>(v) The initials of the individual who administered the prescribed medication.</p>
ANALYSIS:	The interviews with Relative A1 and Relative A2, along with review of Resident A's May and June 2025 MARs revealed there were incidents in which Resident A did not receive her prescribed medications. The MAR did not document an explanation as to why the medications were not administered. The facility was not in compliance with this rule.
CONCLUSION:	VIOLATION ESTABLISHED

I shared the findings of this report with the facility's authorized representative on 7/28/25.

IV. RECOMMENDATION

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



07/23/2025

Lauren Wohlfert
Licensing Staff

Date

Approved By:



07/28/2025

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

Date