GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 4, 2025

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

RE: License #: AH390394454
Investigation #: 2025A1028064
North Woods Village At Kalamazoo

Dear Lori McLaughlin:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH390394454
Investigation #:	2025A1028064
Complaint Receipt Date:	06/10/2025
Investigation Initiation Date:	06/11/2025
Report Due Date:	08/10/2025
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	61
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was restrained by facility staff due to aggressive behavior which resulted in Resident A incurring bruising.	No
Additional Findings	No

III. METHODOLOGY

06/10/2025	Special Investigation Intake 2025A1028064
06/11/2025	Special Investigation Initiated - Letter
06/11/2025	APS Referral
06/12/2025	Contact - Document Sent Emailed the facility administrator requesting documentation.
06/12/2025	Contact - Document Received Received requested information and documentation from the facility administrator via email.
06/23/2025	Contact - Telephone call made Interviewed the facility administrator by telephone.

This investigation will only address allegations pertaining to potential violations of the rules and regulations for Homes for the Aged (HFA).

ALLEGATION:

Resident A was restrained by facility staff due to aggressive behavior which resulted in Resident A incurring bruising.

INVESTIGATION:

On 6/10/2025, the Bureau received the allegations through the online complaint system.

On 6/12/2025, I requested documentation via email from the facility administrator because no identifiable resident information or dates was provided in the complaint.

On 6/12/2025, I received the requested documentation via email from the facility administrator.

On 6/23/2025, I interviewed the facility administrator by telephone. The facility administrator reported that on 6/2/2025, Resident A attempted to enter Resident B's apartment while Resident B's spouse was visiting. Resident A became very combative when staff intervened to prevent Resident A from entering Resident B's room. Resident A hit and kicked staff and began yelling. Employee 1 grabbed Resident A's wrists to prevent Resident A from hitting anyone else. Employee 1 and Employee 2 then re-directed Resident A and were able to walk with Resident A to another room away from Resident B's apartment to further de-escalate and calm Resident A. It was later observed by Employee 3 when assisting Resident A to bed that there were red marks on Resident A's wrists. Resident A denied any pain at that time. On 6/3/2025, Resident A's authorized representative and physician were notified of the incident and the red marks on the wrists. A psychological evaluation was also discussed with Resident A's authorized representative at this time and Resident A was taken to the hospital by [their] authorized representative for further evaluation. The facility also notified Adult Protective Services on 6/3/2025 of the incident with APS completing an investigation at the facility on 6/5/2025.

The facility administrator also reported Employee 3 notified the shift supervisor immediately on 6/2/2025 after observing red marks on Resident A's wrists during nighttime care. Upon notification, the facility opened an internal investigation into the incident to ensure resident safety and staff skill and competency. The facility administrator reported that due to the observed red marks on Resident A's wrists, Employee 1 received re-education, re-training, and a corrective action on appropriate de-escalation techniques. Also, all facility staff were provided re-education on appropriate de-escalation techniques and procedures to ensure staff skill and competency from 6/10/2025 to 6/11/2025.

On 6/23/2025, I reviewed the requested documentation which revealed the following:

- Resident A attempted to enter Resident B's apartment on 6/2/2025 at 7:30 pm with staff intervening.
- Resident A became physically and verbally aggressive, hitting and kicking staff.
- Employee 1 grabbed Resident A's wrists to prevent Resident A from further hitting staff.
- Employee 1 and Employee 2 redirected Resident A and walked with Resident A to a different room away from Resident B's apartment.
- Employee 3 observed red marks on Resident A's wrists during nighttime care and reported it to management. Resident A reported no pain at that time and had no memory of the incident.
- On 6/3/2025, a facility internal investigation was opened and conducted due to the incident.
- On 6/3/2025, Resident A's authorized representative and physician were notified of the incident and red marks.

- On 6/3/2025, the facility notified APS services, and an APS completed an onsite investigation on 6/5/2025.
- On 6/3/2025, the facility discussed requesting a psychological evaluation with Resident A's authorized representative (AR) with the AR taking Resident A to the hospital for further evaluation.
- Resident A is independent with mobility and transfers.
- Resident A requires reminders, supervision, stand by assist, and/or assistance with showering, dressing, grooming, and hygiene.
- Resident A has current or history of frequent or difficulty remembering and using information; and requires directions and reminding from others.
- Resident A has a current history of disorientation to person, place, time or situation even in familiar surroundings and requires supervision and oversight for safety.
- Resident A resists care.
- Resident A cannot make appropriate decisions for self or makes unsafe decisions and needs supervision. Resident A's judgement is poor.

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: **(a) Assume full legal responsibility for the overall conduct and operation of the home.** **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.** **(c) Assure the availability of emergency medical care required by a resident.** **(d) Appoint a competent administrator who is responsible for operating the home in accordance with the established policies of the home.**

ANALYSIS:	It was alleged Resident A was restrained by facility staff due to aggressive behavior which resulted in Resident A incurring red marks that later developed into bruising. Interviews, investigation, and review of documentation revealed Resident A demonstrated verbally and physically aggressive behavior on 6/2/2025 when staff intervened to prevent Resident A from entering Resident B's apartment. While Resident A incurred red marks on [their] wrists that later developed into bruising, the facility immediately opened an internal investigation and notified Resident A's authorized representative, physician, and APS. The facility also conferenced with Resident A's authorized representative to request a psychological evaluation to further ensure Resident A's health and wellbeing. Employee 1 received re-education, re-training, and a corrective action due to the incident. Also, all staff received re-education and re-training to ensure skill and competency. The facility demonstrated appropriate procedures and protocols along to ensure Resident A and other residents' safety, health, and wellbeing. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend the status of this license remains the same.

Julie Viviano

6/30/2025

Julie Viviano Date
Licensing Staff

Approved By:

Andrea L. Moore

07/31/2025

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