GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2025

Tim Stoll
The Villa
307 N Franks Ave.
Sturgis, MI 49091

RE: License #: AH750236918
Investigation #: 2025A1028075
The Villa

Dear Tim Stoll:

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

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 #:	AH750236918
Investigation #:	2025A1028075
Complaint Receipt Date:	07/23/2025
Investigation Initiation Date:	07/24/2025
Report Due Date:	09/22/2025
Licensee Name:	Thurston Woods Village Inc.
Licensee Address:	307 N. Franks Ave. Sturgis, MI 49091
Licensee Telephone #:	(269) 651-7841
Authorized Representative/Administrator:	Tim Stoll
Name of Facility:	The Villa
Facility Address:	307 N Franks Ave. Sturgis, MI 49091
Facility Telephone #:	(269) 651-7841
Original Issuance Date:	09/23/1999
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	100
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has not been administered medication in accordance with physician orders since May 2025.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/23/2025	Special Investigation Intake 2025A1028075
07/23/2025	Special Investigation Initiated - Face to Face
07/23/2025	APS made referral to Homes for the Aged (HFA)
07/23/2025	Contact - Face to Face Interviewed the facility authorized representative/administrator at the facility.
07/23/2025	Contact - Face to Face Interviewed Employee 1 at the facility.
07/23/2025	Contact - Document Received Received requested documentation from the facility authorized representative/administrator.
08/01/2025	Contact - Document Received Received requested documentation from Employee 2.

This investigation will only address allegations pertaining to potential violations of the rules and regulations for Homes for the Aged (HFA). Please note that HFA facilities are not licensed to provide skilled medical care services.

ALLEGATION:

Resident A has not been administered medication in accordance with physician orders since May 2025.

INVESTIGATION:

On 7/23/2025, the Bureau received the allegations through the online complaint system.

On 7/23/2025, I interviewed the authorized representative/administrator at the facility who reported no knowledge that Resident A has not received medication administration in accordance with physician orders since May 2025. The authorized representative/administrator reported that Resident A's medication orders are changed regularly and that staff verify orders and enter the new orders as soon as the orders are received. The authorized representative/administrator reported the orders are typically communicated via fax and that facility staff also communicate with the physician via telephone as well. Each shift supervisor also verifies any new or changes to medication orders and educates all staff that administer medications of the new orders or changes to medication orders. Due to the almost daily changes to Resident A's medication orders, Resident A's medication orders are monitored closely. The authorized representative/administrator provided me with the requested documentation for my review.

On 7/23/2025, I interviewed Employee 1 at the facility who confirmed that Resident A's medication orders change frequently and that the newest medication order was entered just this morning. Employee 1 reported that to [their] knowledge, Resident A has been administered medication in accordance with the physician orders. Employee 1 also confirmed that medication orders are communicated via fax and that staff will also communicate with the physician and pharmacy via telephone as well. Employee 1 reported that as soon as medication orders are received, the orders are updated immediately in the resident's medication administration record. Employee 1 also confirmed that staff are provided with education daily on new and/or changing physician orders for all residents at the facility; and that due to the frequent changes in Resident A's medication orders, the orders are monitored closely.

On 8/1/2025, I received requested additional documentation from Employee 2 via email.

On 8/13/2025, I reviewed the requested documentation which revealed the following:

- At the time of this report, Resident A is prescribed Warfarin (also known as Coumadin). Resident A was to receive *1 tablet of 6mg of Warfarin on Wednesday and Thursday at 4pm. Resident A was to receive 1 tablet of 5mg of Warfarin Friday through Tuesday at 4pm.*
- The physician prescribed/changed the order for Warfarin on 7/16/2025 and the order was sent to the pharmacy on 7/16/2025. It cannot be determined when the facility received this medication administration order from the pharmacy.
- A lab order was received and completed for Resident A on 7/22/2025.
- The physician order for Warfarin was changed in Resident A's medication administration record on 7/23/2025.

- There is evidence the facility received medication orders from the physician on 5/13/2025, 5/16/2025, 5/21/2025, 5/27/2025, 6/2/2025, 6/6/2025, 6/10/2025, 6/24/2025, 6/30/2025, 7/1/2025, and 7/22/2025 via fax.

I reviewed the additional requested documentation that I received via email which revealed the following:

- The May 2025 medication administration record (MAR) reads Resident A was to be administered *1 tablet of 4mg of Warfarin on Sunday, Monday, Wednesday, Thursday, and Friday at 4pm*. It cannot be determined when this order was received because there is no date referenced in the MAR.
- From 5/1/2025 to 5/15/2025, Resident A was prescribed *1 tablet of 4mg of Warfarin on Sunday, Monday, Wednesday, Thursday, and Friday to be taken at 4pm*. It cannot be determined if Resident A received medication in accordance with the physician orders because the Monday, 5/5/2025, Thursday, 5/8/2025 and Friday, 5/16/2025 entries are blank on the MAR.
- From 5/18/2025 to 5/31/2025, there was an *order change.*
- From 5/16/2025 to 5/31/2025:
    - Resident A was to be administered *1 tablet of 6mg of Warfarin on Fridays and Saturdays at 4pm.*
    - Resident A was to be administered *1 tablet of 5mg of Warfarin on Wednesday at 4pm.*
    - Resident A was to be administered *1 tablet of 4mg of Warfarin on Thursdays at 4pm.*
- The June 2025 MAR reads that there was a medication administration order change on 6/6/2025 and Resident A was to receive *1 tablet of 6mg of Warfarin daily at 4pm.*
- On 6/19/2025, the physician order on the MAR reads that Resident A was to receive *1 tablet of 5mg of Warfarin daily at 4pm.*
- On 6/24/2025, it was written by facility staff in the MAR notes section "*Warfarin – wrong dosage."* It cannot be determined what dosage was administered due to the limited documentation in the MAR.
- On 7/23/2025, the physician order on the MAR reads that Resident A was to *receive 1 tablet of 6mg of Warfarin on Wednesday and Thursday at 4pm.* Resident A was to receive *1 tablet of 5mg of Warfarin Friday through Tuesday at 4pm.*

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.

ANALYSIS:	It was alleged that Resident A has not received medications in accordance with the prescribed physician orders since May 2025. Interviews, onsite investigation, and review of documentation revealed the following: • Resident A's medication order for Warfarin changed multiple times from May 2025 to July 2025. • Resident A's medication changes are noted by facility staff from May 2025 to July 2025 in the medication administration record (MAR). • However, the MAR contains multiple discrepancies that include missing entries, blank entries, missing dates, and missing medication notation related to the blank and/or missing entries etc. Due to the discrepancies throughout the May 2025 to July 2025 MARs, it cannot be determined if Resident A received medication administration in accordance with physician orders. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

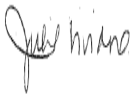
On 8/13/2025, during the review of Resident A's medication administration records, it was noted that from May 2025 to July 2025 there are missing administration entries for the following:

- Administration of Acetaminophen, Aspirin, Atorvastatin, Famotidine, Ferrous Sulfate, Gavilax Powder, Ipratropium 0.03% nasal spray, Ketoconazole, Lidocaine 4% patch, Lisinopril, Melatonin, Reguloid Powder, Tamsulosin, vitamin B-12, and Warfarin.
- Blood pressure checks.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(i) The name of the prescribed medication.** **(ii) The prescribed required dosage and the dosage that was administered.** **(iii) Label instructions for use of the prescribed medication or any intervening order.** **(iv) The time when the prescribed medication is to be administered and when the medication was administered.** **(v) The initials of the individual who administered the prescribed medication.** **(vi) A record if the resident refuses to accept prescribed medication and notification as required in subdivision (c) of this subrule.** **(vii) A record of the reason for administration of a prescribed medication that is on an as-needed basis.**
ANALYSIS:	Review of Resident A's medication administration records (MAR) from May 2025 to July 2025 revealed there are multiple missing entries for multiple medications and blood pressure checks. It cannot be determined if Resident A received medications or blood pressure checks in accordance with physician orders. Due to the incomplete MAR and because facility staff did not complete Resident A's MAR in accordance with the rules and regulations, 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 remains the same.



8/13/2025

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Julie Viviano Date

Licensing Staff

Approved By:

09/29/2025

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