GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 31, 2025

Christina Cotton
LakeHouse Coldwater
150 N. Shore Drive
Coldwater, MI 49036

RE: License #: AH120378302
Investigation #: 2026A1021001
LakeHouse Coldwater

Dear Christina Cotton:

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) 335-5985.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH120378302
Investigation #:	2026A1021001
Complaint Receipt Date:	10/10/2025
Investigation Initiation Date:	10/13/2025
Report Due Date:	12/09/2025
Licensee Name:	Coldwater AL LLC
LicenseeAddress:	150 North Shore Drive Coldwater, MI 49036
Licensee Telephone #:	(646) 844-3600
Administrator:	Dustin Heisler
Authorized Representative:	Christina Cotton
Name of Facility:	LakeHouse Coldwater
Facility Address:	150 N. Shore Drive Coldwater, MI 49036
Facility Telephone #:	(517) 278-6805
Original Issuance Date:	12/14/2016
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	89
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A cannot return to the facility.	No
Residents are treated disrespectfully.	No
Employees are not trained.	No
Medications are administered incorrectly.	Yes
Dirty briefs are left in Resident D's room.	No
Medications are not secured.	No
Additional Findings	Yes

III. METHODOLOGY

10/10/2025	Special Investigation Intake 2026A1021001
10/13/2025	Special Investigation Initiated - On Site
10/17/2025	Contact-Document Received Received additional medication information
10/31/2025	Exit Conference

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Resident A cannot return to the facility.

INVESTIGATION:

On 10/10/2025, the licensing department received an anonymous complaint with allegations Resident A cannot return to the facility. The complainant alleged Resident A was sent to the emergency room for a possible UTI, was sent back to the

facility, exhibited behaviors, and was then sent back to the emergency room. The complainant alleged the facility is refusing to accept Resident A back.

On 10/13/2025, I interviewed facility administrator Dustin Heisler at the facility. The administrator reported that Resident A was sent to the emergency room due to exhibiting behaviors at the facility. The administrator reported that the hospital recommended a short-term rehabilitation stay for Resident A. The administrator reported that the family refused this, and the facility agreed to accept Resident A back to the facility. The administrator reported that when Resident A returned, she was putting herself on the floor, crawling on the floor, and attempting to eat the walls. The administrator reported that these behaviors were too much for the facility and Resident A was sent back to the hospital. The administrator reported that the hospital then sent Resident A to short term rehabilitation. The administrator reported that the facility never refused to accept Resident A back to the facility.

On 10/13/2025, I interviewed staff person 1 (SP1) at the facility. SP1 statements were consistent with those made by the administrator. SP1 also reported when Resident A was sent back to the hospital, the hospital nurse said they had a lengthy conversation with Resident A's family on the benefits of a short term rehabilitation stay and that this would be the best option for Resident A. SP1 reported that Resident A was exhibiting these difficult behaviors in the hospital, but this information was not shared with the facility. SP1 reported that Resident A's family was in the facility a few days ago and reported Resident A has been placed in a short-term rehabilitation.

I reviewed facility notes for Resident A. The notes read,
"9/25/25: Up at 12am confused with time again at 2am and back up to the front desk at 2:55am. She believes she has had company from her sisters and her parents as well and was wondering where they went.
09/25/25: Up again saying she can not sleep at 4:15am seems to be really struggling to sleep at night and she does seem irritated/annoyed that she can not. Is there anything she could get to help her sleep better at night?
10/03: Back in the building, still very confused and seeing things.
10/3: Confused! Crawling on the floor trying to find things, refused PJ's saying she needs to get to the hotel, asking about cabs to get out of her. Very hard time with pills tonight, will need to have them in applesauce. Started two new meds, one of them is an antibiotic to be given 2x a day. Keep a careful eye on, will need frequent checks.
10/10: Grandson was in during supper on 10/09. She is at the Laurels for short term PT/OT stay."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	16) A home that proposes to discharge a resident for any of the reasons listed in subrule (15) of this rule shall take all of the following steps before discharging the resident: (e) The resident shall not be discharged until a subsequent setting that meets the resident's immediate needs is located.
ANALYSIS:	Interviews conducted and review of documentation revealed the facility has not issued a discharge for Resident A nor has refused for Resident A to return to the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are treated disrespectfully.

INVESTIGATION:

The complainant alleged that Resident B apologizes for needing assistance and staff are rude to Resident B. The complainant alleged that Resident C fell and was left unattended for over 45 minutes. The complainant alleged Resident C was left unsupervised with a food tray. The complainant alleged Resident D is not wiped properly.

The administrator reported that Resident B brought these concerns to his attention about a particular staff member. The administrator reported that Resident B reported that the staff member is not abusive or mean but is just curt and does not spend time with Resident B. The administrator reported that he did speak with the staff member on appropriate behavior with residents but at this time, there is lack of evidence that the staff member treats residents disrespectfully. The administrator reported that Resident C eats in her room at times. The administrator reported that Resident C's family found Resident C with a room tray approximately 1 hour after lunch time and was concerned about food safety. The administrator reported that employees were provided with education on picking up room trays in a timely manner. The administrator reported Resident C did slide out of her lift chair. The administrator reported that care staff were putting pillows behind Resident C which resulted in her being pushed forward in her chair. The administrator reported that Resident C was also using her remote for her lift chair to lift the chair up. The administrator reported that pillows are now not placed in the lift chair, and the remote is placed behind

Resident C's back. The administrator reported that the residents receive good care and are treated well at the facility.

On 10/13/2025, I interviewed Resident B at the facility. Resident B reported care staff treat her very well. Resident B reported that when she requires assistance, staff are quick to respond and are very helpful. Resident B reported no concerns with staff at the facility.

On 10/13/2025, I interviewed Resident E at the facility. Resident E reported she is happy to be living at the facility. Resident E reported that care staff treat her well and she has no concerns.

On 10/13/20255, I interviewed Resident D at the facility. Resident D reported that there is a care staff member that is very short with her at the facility. Resident D reported that the care staff member is not abusive or rude, just sems busy all the time. Resident A reported she is treated well at the facility.

On 10/13/2025, I interviewed Resident D's hospice case manager. The case manager reported no concerns with the care Resident D receives at the facility. The case manager reported Resident D has brought no concerns to her attention. The case manager reported Resident D typically does not use Depends and is able to access the bathroom herself.

While at the facility, I observed many interactions between care staff and residents. The interactions were appropriate, and all residents were treated well.

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:	Interviews conducted and observations made revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Employees are not trained.

INVESTIGATION:

The complainant alleged employees are not trained. The complainant alleged that medication technicians do not receive adequate training. The complainant alleged medication technicians shadow staff for four days, and then they can pass medications on their own**.** The complainant alleged the staff are not being taught proper resident care.

The administrator reported that when an employee is hired, they spend time with the various departments. The administrator reported that the employee is then placed with a senior worker for three to five days learning their new role. The administrator reported that the senior worker ensures the employee is properly trained. The administrator reported that the regional nurse ensures the medicaiton technicians are properly trained.

SP1 reported that new employes are trained by a senior worker. SP1 reported the senior worker ensures the employee is trained.

On 10/13/2025, I interviewed SP2 at the facility. SP2 reported medicaiton technicians are placed with a senior worker during the orientation process. SP2 reported they shadowed the worker, then administered the medications while being shadowed. SP2 reported medication technicians are properly trained.

On 10/13/2025, I interviewed SP4 at the facility. SP4 reported that new hires are placed with a senior worker to learn the position. SP4 reported care staff are trained.

I reviewed *Medication Pass Competency* training for staff members at the facility. The documents revealed that the medication technicians are properly trained.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**

ANALYSIS:	Interviews conducted and review of documentation revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medications are administered incorrectly.

INVESTIGATION:

The complainant alleged medications are administered incorrectly. The complainant alleged the staff are giving out the wrong medications and some are forging numbers. The complainant alleged staff are not taking blood pressure or checking sugars before giving out medications.

The administrator reported there have been no medication errors since he started. The administrator reported to his knowledge that blood glucose and blood pressure checks are being completed.

SP1's statements were consistent with those made by the administrator.

SP2 reported that she has not observed incorrect medications administered to residents. SP2 reported that she has observed blood pressure and blood glucose checks to be taken. SP2 reported residents receive the correct medications.

On 10/13/2025, I interviewed SP3 at the facility. SP3 reported that at times medication technicians have not documented immediately when a medication is administered. SP3 reported that she had seen medicine left in cups in the medication drawer.

I observed two medication drawers at the facility. I did not see any medicaiton left in cups in the drawers.

I reviewed Resident G's October 2025 medication administration record (MAR). The MAR revealed the following:
Probiotic 10 cap: no staff initials on 10/10 that this medication was administered
Sucralfate Tab 1gm: no staff initials on 10/10 that this medication was administered.

I reviewed Resident H's October 2025 MAR. The MAR revealed the following:
Metformin Tab 500mg: medication not available on 10/01 and 10/02
Nephro Tab Vitamins: medication not available on 10/03-10/05, 10/11, 10/14, 10/15
Atorvastatin Tab 40mg: medication not available on 10/05, 10/15
Carvedilol Tab 12.5mg: medication not available on 10/10, 10/11, and 10/17/2025

I reviewed Resident I's October 2025 MAR. The MAR revealed Resident I's blood pressure was taken as prescribed by the physician. The MAR did reveal the following:
Pravastatin Tab 10mg: only one tablet was available on 10/06
Famotidine Tab 20mg: only one tablet was available on 10/08, medication not available on 10/09, 10/10, 10/11, 10/12
Senna Tab 8.6mg: medication not available on 10/11
Ferosul Tab 325mg: medication not available on 10/13

I reviewed Resident J's October 2025 MAR. The MAR revealed Resident J was to have blood sugar checked before administering medications. While there were some discrepancies in documentation, Resident J's blood glucose was checked as prescribed by the physician.

APPLICABLE RULE	
R 325.1932	**Resident 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.
ANALYSIS:	Review of Resident MAR's revealed many different instances in which the residents did not receive prescribed medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Dirty briefs are left in Resident D's room.

INVESTIGATION:

The complainant alleged dirty briefs are left in Resident D's room.

The administrator reported no knowledge of dirty briefs left in Resident D's room.

I observed Resident D's room at the facility. The room was neat and tidy.

Resident D reported her trash is taken out daily. Resident D reported no concerns with cleanliness at the facility.

While onsite I observed the facility. I observed a housekeeper cleaning various residents' room. I did not observe any cleanliness issues.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Interviews conducted and observations made revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medications are unsecured.

INVESTIGATION:

The complainant alleged a staff member left medications unattended on the medication cart.

The administrator reported no knowledge of medications left out unattended nor any medication errors.

SP1 reported no knowledge of medications left out unattended nor any medication errors.

SP2 reported she has never seen any medications left out unattended on the cart.

I observed multiple medication carts and did not observe any medications left out unattended.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(3) Hazardous and toxic materials shall be stored in a safe manner.
ANALYSIS:	Interviews conducted and observations made revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed the facility *Controlled Medication Shift Change Log*. The log revealed many instances in which the medication technicians did not attest to the number of controlled substances sheets.

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.**
For Reference: R 325.1901	**Definitions.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Review of the substance inventory sheets revealed many spots were left blank for dates and staff initials and on other spots only one staff initialed at shift change. The inconsistent and lack of documentation on the controlled substance inventory sheet revealed staff are not following the facility's procedure to ensure narcotic medication is not used by a person other than the resident for whom the medication is prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED.**

INVESTIGATION:

The administrator reported for new hires, the employee is placed with different department heads and then is placed with a senior worker. The administrator reported there is no documentation of on-the-job training and if the new employee has reached competency.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(7) The home's administrator or its designees are responsible for evaluating employee competencies.
ANALYSIS:	Interviews conducted revealed the facility does not have a program in place for the facility administrator or its designees on evaluating employee competencies.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Kimberly Horst 10/17/2025

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 10/30/2025

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