GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 29, 2026

Pamela Reese and Todd Dockerty
Kauhale Otsego
700 Eley Street
Otsego, MI 49078

RE: License #: AH030413477
Investigation #: 2026A1028014
Kauhale Otsego

Dear Pamela Reese and Todd Dockerty:

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 #:	AH030413477
Investigation #:	2026A1028014
Complaint Receipt Date:	12/15/2025
Investigation Initiation Date:	12/16/2025
Report Due Date:	02/14/2026
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility did not provide Resident A and [their] authorized representative an appropriate discharge, refusing Resident A admittance back into the facility after returning from the hospital on 12/13/2025.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/15/2025	Special Investigation Intake 2026A1028014
12/16/2025	Special Investigation Initiated - Letter
12/16/2025	APS Referral APS made referral to HFA.
12/18/2025	Contact - Telephone call made Interviewed the facility administrator via telephone.
12/19/2025	Contact - Document Received Received requested documentation from the facility administrator via email.
01/05/2026	Contact - Face to Face Followed up with facility administrator and the facility's new owner while completing the facility survey inspection onsite.

This investigation will only address allegations pertaining to potential violations of the rules and regulations for Homes for the Aged (HFA). Please note this report contains details of sexual behavior and offensive language as documented in the electronic record.

ALLEGATION:

The facility did not provide Resident A and [their] authorized representative an appropriate discharge, refusing Resident A admittance back into the facility after returning from the hospital on 12/13/2025.

INVESTIGATION:

On 12/16/2025, the Bureau received the allegations through the online complaint system from referral from Adult Protective Services (APS).

On 12/18/2025, I interviewed the facility executive director (ED) by telephone who confirmed that Resident A was sent to the hospital on 12/12/2025 due to a behavioral disturbance in which Resident A was found by staff in Resident B's room. Resident A was sitting on the couch with Resident B and Resident A had [their] pants pulled down to [their] ankles with a stuffed animal placed over [their] genitalia area. Staff removed Resident A from the room while distracting Resident B. Staff completed an assessment of both residents, contacted the facility administrator, and contacted both residents' authorized representatives (AR). The facility ED reported [they] immediately reached out to APS for assistance with emergency alternative placement for Resident A, but the alternatives provided did not meet Resident A's clinical or safety needs. The facility ED contacted Resident A's AR to inform [them] that no appropriate alternative placement could be found for Resident A and to recommend transport to the hospital for cognitive evaluation and treatment. Resident A's AR agreed, and emergency services were contacted with Resident A being transferred to the hospital for further cognitive evaluation and treatment. Due to the nature of this incident and to ensure resident and staff safety, local law enforcement were notified of the incident and were present at the facility when Resident A was transported to the hospital. The facility ED reported [they] instructed staff to refuse Resident A's return to the facility because Resident A was being discharged from the facility immediately due to safety concerns. On 12/13/2025, attempts to return Resident A to the facility were refused by the facility. The facility ED reported [they] conferenced with Resident A's AR to recommend the option of 24-hour one-to-one supervision provided by either the family or a third party, but the AR declined. The facility ED also conferenced with APS to "*reiterate that due to the sexual-natured behavior and patterned boundary issues, [Resident A] could not return to the community due to the immediate risk of other residents.*" Resident A's AR was previously seeking an alternative placement, but no alternative placement was secured at the time of this incident or prior to Resident A being sent to the hospital and attempting to return to the facility. The facility ED reported Resident A's medications and medication list were delivered to the hospital, but Resident A was not accepted back at the facility. At the time of this interview, the facility administrator was unsure if Resident A was still at the hospital or not. I requested documentation related to this special investigation from the facility ED.

On 12/19/2025, I received the requested documentation via email from the facility ED.

On 12/22/2025, I reviewed Resident A's service plan which revealed the following:

- Resident A was admitted to the facility on 11/27/2024.
- Resident A requires monitoring during bathing for safety.

- The facility manages all medication administration, meals, laundry, and housekeeping for Resident A.
- Resident A demonstrates *slight confusion, forgetful a portion of the time, easily redirected, cooperative with care.*
- Resident A does not present a threat to self, staff or others.
- The service plan was last updated on 9/12/2025.

I reviewed Resident A's documented facility progress notes which revealed the following:

- On 12/21/2024, Resident A *was pacing the hallways and leaving notes on a [sic] resident's bedroom door.*
- On 12/22/2024, Resident A was *banging on walls and leaving nasty notes on another resident's door.*
- On 12/26/2024, the following strikeout is documented in the record:
  ~~*Give 1 tablet orally every 6 hours as needed for agitation -*~~
  ~~*[Resident A] very aggressive towards other resident and staff.*~~
- On 3/23/2025, Resident A was to receive 1 tablet of Lorazepam 0.5mg orally every 6 hours as needed for agitation, but the *PRN was not yet administered [because Resident A] was very agitated and confrontational.*
- On 4/15/2025, Resident A *was being extra rude to staff and can't be redirected.*
- On 4/24/2025, Resident A *is refusing medications until they see a doctor, saying "No meds or food for me until something changes."*
- On 5/10/2025, Resident A is *very agitated stated [they] are not going to take anything until [they] see a doctor.*
- On 6/2/2025, Resident A *refused the medication stating that [they] have not seen [the doctor] in a long time and the medication does not work.*
- On 6/7/2025, Resident A *was getting agitated/anxious*.
- On 6/9/2025, Resident A *chased after staff saying they were the wrong pills refusing to take them and physically hurt staff.*
- On 6/10/2025, Resident A *would not take med, says they make [them] wacked.*
- On 6/25/2025, Resident A *refused medication until they get a new doctor.*
- From 6/26/2025 to 8/10/2025, Resident A continued to refuse medications frequently stating [they] *will not take medications until they see a new doctor.*
- On 8/11/2025, Resident A refused medications and said, "*I [staff] was a control freak and will not take the [medication] for [you] or anyone who associates with [you]."*
- On 8/16/2025, Resident A continues to refuse medication, stating *[they] won't take pills until [they] see [their] doctor in person.*
- From 8/17/2025 to 9/14/2025, Resident A continued to refuse medications and on 9/15/2025, Resident A *refused medications and was severely having behavior and anger issues.*
- From 9/16/2025 to 10/11/2025, Resident A continued to refuse medications and on 10/12/2025, Resident A *was not in a cooperative mood. Family was present earlier and was able to get Resident A to take PRN.*

- From 10/13/2025 to 10/22/2025, Resident A continued to refuse medications and on 10/22/2025, Resident A *refused all medications stating [they] don't need them and that [they're] moving out.*
- On 10/23/2025, Resident A *refused to take medication this morning because [they] wouldn't trust [their] doctor to medicate [their] dog.*
- On 10/27/2025, Resident A *opened window and climbed out in attempt to leave the premises. Staff saw Resident A outside, immediately and went to bring [them] back inside. Resident A was not willing to go back inside facility. [They] were not combative, just refusing. Staff did call director right away. The director arrived within 10 mins of call and observed staff with Resident A in parking lot. Staff members were trying to convince Resident A to return to the inside. When Resident A saw director, [they] walked inside immediately and without resistance. Director stayed to visit with Resident A for a couple of hours. Family was notified and updated on situation. Director has plan of action to move Resident A to a room that faces the courtyard. This will eliminate the window route of eloping.*
- On 11/2/2025, Resident A *WILL NOT take and said I will be sorry for even asking and [they] WILL be getting out today.*
- On 11/3/2025, Resident A is *refusing to take any meds this morning saying it's [their] last day here because staff are horrible and don't know what they're doing.*
- From 11/4/2025 to 11/8/2025, Resident A continued to refuse medications and on 11/9/2025, Resident A refused all medications stating *[they're] leaving today with [their] lawyers and no longer needs medication.*
- From 11/10/2025 to 11/16/2025, Resident A continued to refuse medications, frequently stating staff do not know what they are doing or that [they] do not need or take medications because [they] haven't seen the doctor.
- On 11/17/2025, *staff reported Resident A took cord of lamp and cut off plug and stripped plastic coating to expose copper wiring. Director notified family and director will have weekly sweeps of resident room to ensure safety of self and others. Staff will look for any objects that could serve as other tools that could cause harm or destruction to self, others or property. Resident A's behaviors remain consistent during this time period. Refusal of medications, oppositional, sullen, agitated.*
- From 11/18/2025 to 11/24/2025, Resident A continues to refuse medications and on 11/25/2025, Resident A *refuses to take meds says [their] doctor is a dumb ass and [they] don't' need any meds.*
- From 11/25/2025 to 12/5/2025, Resident A continued to refuse medications.
- On 12/13/2025, Resident A is *not in the facility.*
- On 12/15/2025, Resident A is *discharged from the facility.*

I reviewed the facility documentation entitled 'Chart Addendum' which revealed the following:

- The documentation reads *[Resident A] has a documented history of boundary-seeking behaviors and a recurrent pattern of strongly attaching to specific female residents. This pattern has included frequent proximity-*

seeking, repeated attempts to insert [their self] into interactions with particular residents, and difficulty maintaining appropriate interpersonal boundaries consistent with the cognitive and supervision needs of a memory care environment. These behaviors required ongoing staff awareness and monitoring.

- Behaviors documented include: *persistent proximity-seeking toward specific female residents; difficulty disengaging from targeted residents; interference with care delivery to other residents; writing notes to residents with varying tone; ranging from affectionate to oppositional, removal of items from common areas or medication carts and bringing them into [their] room; refusal of medications and periodic refusal of meals; destruction of both personal and community property, including furnishings, wiring, blinds, fixtures, writing on walls in common areas; repeated phone use resulting in calls to law enforcement, attorneys, and other external parties, leading to removal of phones from the unit; and Resident A has not demonstrated physical violence toward staff or residents.*
- Interventions attempted by facility staff for Resident A included: *increased staff monitoring and redirection; locking of [Resident B's] door to prevent Resident A from entering; transitioning [Resident B's] door to a coded lock; and placement of clear visual signage on the resident's door to discourage entry and reinforce boundary expectations.*
- Despite the interventions, Resident A *continued to gain access to Resident B's room. At times, Resident B allowed entry due to impaired cognition. At other times, Resident A accessed the room by locating keys belonging to other residents. Due to continued concerns, [Resident B's] family requested limitations on [the] use of common areas for [Resident B's] safety.*
- Resident A *manipulated the physical environment, including opening windows and exiting through them. Resident A also assisted another resident in exiting through a window.*
- Resident A *was observed assisting a female resident toward a bathroom doorway. No sexualized behavior or harm was identified. However, the incident prompted further discussion with [Resident A's] family regarding boundary awareness and placement appropriateness. Family was advised that while immediate discharge was not being initiated at that time, it would be appropriate to begin actively pursuing alternative placement. Family subsequently pursued placement options, including community assessments; however, [Resident A] was not accepted.*
- Other plans of action implemented to prevent discharge included: *increased supervision and monitoring; consistent redirection strategies; environmental controls and room access interventions; ongoing communication with family and support of family placement efforts.*
- On December 12, 2025, [Resident A's] *behavior escalated to sexual-natured behavior involving a vulnerable female resident, representing a significant change in risk level.*
- No dates or times were identified or provided in the record for this chart addendum.

I reviewed the communication log between the facility and Resident A's AR which revealed the following:

- The facility communicated regularly with the Resident's AR about Resident A's increasing behaviors, refusal of medications, and incidents at the facility.
- The Resident's AR collaborated with the facility in an effort to find Resident A an alternative placement prior to Resident A's 12/12/2025 behavioral incident.
- No dates or times were identified or provided in the communication record.

I reviewed the discharge letter to the family which revealed the following:

- The discharge letter read that Resident A was issued an emergency discharge on 12/12/2025 by the facility because of Resident A's behavioral incident that *represented a significant escalation and created immediate safety concern. Continued residency posed a risk that could not be mitigated through supervision, redirection, or environmental controls within this setting.*
- *On December 12, 2025, the resident was transferred to the hospital emergency department for further evaluation and determination of appropriate next steps. Due to ongoing safety concerns, the resident cannot return to Woodland Terrace of Otsego.*

On 1/5/2026, I followed up with the facility ED at the facility, and the facility ED confirmed the following:

- The facility ED does not know where Resident A is currently located and is unsure if Resident A is at the hospital or not.
- The discharge letter was mailed priority service to Resident A's AR on 12/15/2025.
- Resident A's AR removed Resident A's things from the facility on 12/20/2025 and did not further communicate with staff or the facility ED.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(15) A home may discharge a resident before the 30-day notice if the home has determined and documented that either, or both, of the following exist: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or due to the inability of the home to assure the safety and well-being of the resident, other residents, visitors, or staff of the home.** **(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:** **(a) The home shall notify the resident, the resident's authorized representative, if any, and the agency**

	responsible for the resident's placement, if any, not less than 24 hours before discharge. The notice shall be verbal and issued in writing. The notice of discharge shall include all of the following information: **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged.** **(iv) The right of the resident to file a complaint with the department.** **(b) The department and adult protective services shall be notified not less than 24 hours before discharge in the event of either of the following:** **(ii) The resident does not have a subsequent placement.** **(c) The notice to the department and adult protective services shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged, if known.** **(d) If the department finds that the resident was improperly discharged, then the resident may return to the first available bed in the home that can meet the resident's needs as identified in the resident's service plan.** **(e) The resident shall not be discharged until a subsequent setting that meets the resident's immediate needs is located.**

ANALYSIS:

It was alleged that the facility refused to admit Resident A back to the facility after Resident A returned from the hospital. Interview with the facility executive director, review of documentation, and onsite investigation revealed the facility did not appropriately provide Resident A or Resident A's authorized representative the less than 30-day discharge ~~in accordance with Homes for Aged (HFA) rules and regulations~~.

~~Also, while~~ Resident A demonstrated behavioral outbursts from December 2024 to December 2025, facility documentation does not support the reason for the less than 30-day discharge or an emergency discharge.

- The most updated service plan reads: [Resident A] demonstrates *slight confusion, forgetful a portion of the time, easily redirected, cooperative with care and does not present a threat to self, staff or others.*
- The 'Chart Addendum' documentation reads: *Resident A has not demonstrated physical violence toward staff or residents.* It also documents an incident where Resident A *was observed assisting a female resident toward a bathroom doorway.* However, the documentation reads: *No sexualized behavior or harm was identified* during this incident. While the 'Chart Addendum' lists Resident A's behaviors, no associated dates or time frames are listed in the documentation to establish a pattern of behaviors or to determine if specific behaviors were recurring or a one-time incident.
- Interventions were listed in the documentation but there is no evidence in the electronic record completed by facility care staff that the interventions were utilized when Resident A was demonstrating behaviors. Due to this it cannot be determined whether staff consistently provided Resident A with *increased supervision and monitoring, consistent redirection strategies, or environmental controls and room access interventions* as listed in the 'Chart Addendum'.
- The communication log between the facility and Resident A's AR does not list dates or time frames of the communication. It cannot be determined how often the communication occurred to find Resident A an alternative placement prior to Resident A's 12/12/2025 behavioral incident.
- Review of the discharge letter reads: *Resident A was transferred to the hospital for further evaluation and determination of appropriate next steps. Due to ongoing*

	safety concerns, the resident cannot return to [the facility.] However, no appropriate 'next steps' were provided in the letter, and Resident A was refused admission upon return to the facility. Also, the letter is dated 12/12/2025, but when interviewing the facility ED at the facility on 1/5/2026, [they] reported the discharge letter was not mailed to Resident A's AR until 12/15/2025, after Resident A was refused admittance back to the facility. It also cannot be determined whether Resident A was provided with the verbal or written notice of the discharge letter in accordance with HFA rules and regulations. • Assistance from APS was requested by the facility ED to secure Resident A an alternative placement, but the HFA department was never notified of Resident A's immediate discharge from the facility on 12/12/2025 or that an alternative placement had not been secured for Resident A. ~~Also, HFA rule and regulation R 325.1922 pertaining to discharge processes specify that a resident transported to a hospital or that is admitted to a hospital is not discharged from the facility and are entitled to return to the facility upon discharge from the hospital. If the facility determines it cannot meet the resident's care needs at hospital discharge, an immediate discharge in compliance with R 325.1922 (16) may be initiated but it is recommended that the facility communicate with the hospital discharge planner prior to the resident's release from the hospital. There is no evidence to support communication between the facility and hospital discharge planner was completed to ensure Resident A's return to the facility until a more appropriate alternative placement could be secured.~~ ~~In the event of an emergency discharge, the resident and [their] AR and/or responsible agency must select placement before the resident is discharged. This decision cannot be made by the facility on behalf of the resident. If a subsequent placement following proper discharge has not been secured, then the home may follow the legal eviction process.~~ Therefore, due to the refusal of Resident A's admittance back to the facility and the improper discharge, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

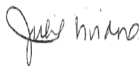
ADDITIONAL FINDINGS:

On 12/22/2025, review of the documentation record shows that Resident A demonstrated behaviors from December 2024 to December 2025. However, the 'Behavior' section in the service plan reads: [Resident A] demonstrates *slight confusion, forgetful a portion of the time, easily redirected,* and is *cooperative with care.* The service plan and the record documentation of Resident A's behaviors conflict. The service plan was last updated on 9/12/2025 but no changes were made to the service plan to detail behaviors and care interventions to address the behaviors.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Review of the service plan along with record documentation revealed Resident A's service plan was not updated to reflect any facility or care staff interventions to address, prevent, or reduce Resident A's documented behaviors towards staff, other residents, and/or [their self]. The service plan was not updated to appropriately meet Resident A's needs due to the demonstrated behaviors. 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 remains the same.



1/7/2026

Julie Viviano
Licensing Staff

Date

Approved By:

01/29/2026

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