



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

January 27, 2026

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

RE: License #: AH030413477  
Investigation #: 2026A1028021  
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,

A handwritten signature in cursive script that reads "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**

<b>License #:</b>	AH030413477
<b>Investigation #:</b>	2026A1028021
<b>Complaint Receipt Date:</b>	01/12/2026
<b>Investigation Initiation Date:</b>	01/13/2026
<b>Report Due Date:</b>	03/11/2026
<b>Licensee Name:</b>	Kauhale Otsego, LLC
<b>Licensee Address:</b>	72 Dorchester Square N Westerville, OH 43081
<b>Licensee Telephone #:</b>	(330) 289-0971
<b>Authorized Representative/Administrator:</b>	Pamela Reese and Todd Dockerty
<b>Name of Facility:</b>	Kauhale Otsego
<b>Facility Address:</b>	700 Eley Street Otsego, MI 49078
<b>Facility Telephone #:</b>	(269) 694-1621
<b>Original Issuance Date:</b>	05/18/2023
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	08/01/2025
<b>Expiration Date:</b>	07/31/2026
<b>Capacity:</b>	56
<b>Program Type:</b>	AGED ALZHEIMERS

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Multiple medication errors have occurred with Resident A's medication administration.	Yes
Additional Findings	Yes

## III. METHODOLOGY

01/12/2026	Special Investigation Intake 2026A1028021
01/13/2026	Special Investigation Initiated - Letter
01/13/2026	APS Referral
01/13/2026	Contact – Document Sent Emailed the facility executive director requesting documentation related to this special investigation.
01/14/2026	Contact - Document Received Received the requested documentation and information from the facility executive director.
01/21/2026	Contact – Document Sent Requested additional information from the facility executive director via email.
01/21/2026	Contact – Document Received Received the requested documentation and information from the facility executive director via email.

This special investigation will only address potential violations of Homes for the Aged (HFA) rules and regulations. This special investigation will not address the allegation that staff are not qualified to provide residents with care and that staff may neglect residents resulting in injury. Staff qualifications and training were verified during the recent onsite survey inspection on 1/5/2026. There was no evidence found during the survey inspection that residents were neglected by staff or that residents had injuries due to staff neglect.

## **ALLEGATION:**

**Multiple medication errors have occurred with Resident A's medication administration.**

## **INVESTIGATION:**

On 1/12/2026, the Bureau received the allegations through the online complaint system.

On 1/13/2026, I emailed the facility executive director (ED) to request information and documentation related to the special investigation allegations.

On 1/13/2026, I received communication from the facility ED that read that the [ED] *spoke with [Resident A's family] in [January 2026] about a medication that has not been filled since October 2025. The [family member] set up auto fill with the pharmacy one year ago and the prescriptions are automatically filled with the [family member] picking the medications up and delivering them to the facility. The ED reported [they] informed the [family member] that [they] are unsure why the medication had not been filled since it was on automatic refill, but that the medication was currently in the cart. The ED reported the family has full control of Resident A's medication and since the refills are on automatic refill, [the facility] does not call-in any of the medications. The ED also reported that the [family member] handles all refills and either the [family member] or the pharmacy contacts [Resident A's] physician when a new prescription is required.*

On 1/14/2026, I received the requested documentation from the facility ED via email, in which the ED confirmed that *the family has maintained control of the medication refill and pickup process. The [facility] does not initiate refills for medication, and medications are brought in by the family once filled. Facility review of the medication administration record (MAR) shows [Resident A] has been receiving the medication as documented, with no observed or reported adverse physical effects noted [during this period.] The facility ED reported that [the facility's] medication error response protocol is to follow the "3 R's": re-educate, retrain, and reset. The reset component includes temporary removal from medication administration as indicated, along with follow-up monitoring.*

On 1/15/2026, I reviewed the requested documentation which revealed the following:  
Review of the November 2025 MAR:

- Resident A's medication was administered in accordance with the physician orders from 11/1/2025 to 11/30/2025.
- No errors, missing medication, or issues were noted in the review of the November 2025 MAR.

Review of the December 2025 MAR:

- On 12/24/2025, the MAR is blank for Resident A's medication of 1 tablet of Sacubitril-Valsartan 24-26 mg to be administered by mouth one time per day. There are no additional notes or information provided on the MAR as to why the entry is blank.
- On 12/25/2025, the MAR is blank for Resident A's medication of 1 tablet of Metoprolol Tartrate 25 mg to be administered by mouth two times per day. There are no additional notes or information provided on the MAR as to why the entry is blank.
- On 12/25/2025, the MAR is blank for Resident A's second daily check of diabetes management using the glucometer with lancet(s) twice daily. There are no additional notes or information provided on the MAR as to why the entry is blank.

Review of the January 2026 MAR:

- Resident A's medications were administered in accordance with the physician orders from 1/1/2026 to 1/14/2026.
- No errors, missing medication, or issues were noted in the review of the January 2026 MAR.

On 1/21/2026, I emailed the facility ED requesting additional follow up information and documentation.

On 1/21/2026, the facility ED provided the requested information and documentation to me via email. I subsequently reviewed the requested information and documentation which revealed the following:

Review of Resident A's service plan:

- Staff administers all medication.

<b>APPLICABLE RULE</b>	
<b>R 325.1932</b>	<b>Resident medications.</b>
	<b>(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.</b>

<b>ANALYSIS:</b>	It was alleged that multiple medication errors have occurred with Resident A's medication administration. Interviews and review of documentation reveal that there are blank entries on Resident A's medication administration record on 12/24/2025 and 12/25/2025. Due to the blank entries, it cannot be determined if Resident A received medication in accordance with prescribed physician orders or if Resident A's diabetes management check occurred in accordance with prescribed physician orders. Therefore, the facility is in violation.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

On 1/14/2026, the facility ED reported via email that *[Resident A's] family has maintained control of the medication refill and pickup process for an extended period of time. The community does not initiate refills for this medication; medications are brought in by the family once filled.*

On 1/22/2026, review of Resident A's service plan reads *staff administers all medications (only uses oral medications.)*

On 1/22/2026, the facility ED reported via email that *the [family member] has indicated that refills are managed through pharmacy auto-refill notifications, which [they] receive directly from the pharmacy and pick up as needed. While there is no formal written agreement on file, we have received consistent verbal communication from the [family member] confirming that the family manages the refill and pickup process. [Resident A] has also stated [they are] picking up the meds at times when leaving with [the family] for the day. The resident remains highly independent with minimal changes in condition since admission and no recent medication changes noted.*

<b>APPLICABLE RULE</b>	
<b>R 325.1932</b>	<b>Resident medications.</b>
	<b>(1) A service plan must identify prescribed medication to be self-administered or managed by the home.</b>
<b>Definitions</b>	<b>R 325.1901(14) - Definitions. (14) "Medication management" means assistance with the administration of a resident's medication as prescribed by a licensed health care professional.</b>

<b>ANALYSIS:</b>	Interviews and reviews of Resident A's service plan, documentation, and communication reveal that the facility administers all of Resident A's medications, but Resident A's family has been managing the refilling, pickup, and delivery of Resident A's medications. This practice directly conflicts with the Homes for the Aged (HFA) medication rule(s) and regulation(s) because Resident A is not identified as being independent with medication administration within [their] service plan. Also, the facility cannot have partial supervisory responsibilities with Resident A's medication administration. Due to the facility not managing the entire medication administration process as identified in Resident A's service plan, the facility is in violation.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remains the same.

*Julie Viviano*

1/22/2026

Julie Viviano  
Licensing Staff

Date

Approved By:

*Andrea L. Moore*

01/26/2026

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

Date