GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 10, 2026

Todd Dockerty
The Heritage Assisted Living Community
14420 S. Helmer Road
Battle Creek, MI 49015

RE: License #: AH130403563
Investigation #: 2026A1028022
The Heritage Assisted Living Community

Dear 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 #:	AH130403563
Investigation #:	2026A1028022
Complaint Receipt Date:	01/15/2026
Investigation Initiation Date:	01/20/2026
Report Due Date:	03/14/2026
Licensee Name:	Battle Creek Assisted Living Operator, LLC
Licensee Address:	111 W. Ferry St. #1 Berrien Springs, MI 49103
Licensee Telephone #:	(574) 261-1124
Administrator:	Jamie Guilfoyle
Authorized Representative:	Todd Dockerty
Name of Facility:	The Heritage Assisted Living Community
Facility Address:	14420 S. Helmer Road Battle Creek, MI 49015
Facility Telephone #:	(269) 969-4000
Original Issuance Date:	12/10/2020
License **Status:**	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	78
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility is consistently short staffed for third shift.	No
Staff are not trained to use the Hoyer lift and there is minimal medication technician training.	No
There are medication errors and medications are passed late.	No
Residents cannot adjust their room thermostats and/or the resident room thermostats are not working.	No
Residents were served cold food during the week of 1/11/2026 to 1/17/2026.	No
Additional Findings	Yes

III. METHODOLOGY

01/15/2026	Special Investigation Intake 2026A1028022
01/20/2026	Special Investigation Initiated - Letter
01/20/2026	APS Referral
01/29/2026	Contact - Face to Face Interviewed Employee A at the facility.
01/29/2026	Contact - Face to Face Interviewed Employee B at the facility.
01/29/2026	Contact - Face to Face Interviewed Employee C at the facility.
01/29/2026	Contact - Telephone call made Interviewed the facility administrator by telephone.
01/29/2026	Contact – Face to Face Interviewed Resident A at the facility.
01/29/2026	Contact – Face to Face

	Interviewed Resident A at the facility.
01/29/2026	Contact - Document Received Received requested documentation from Employee A.
02/02/2026	Contact - Document Received Received follow-up email from the facility administrator.
02/02/2026	Contact - Document Sent Sent the facility administrator a request for additional info/documentation via email.
02/02/2026	Contact - Document Received Received some of the requested medication administration info/documentation via email from the facility authorized representative and facility administrator.
02/04/2026	Contact - Document Received Received the rest of the requested documentation from the facility authorized representative.

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

**Please note the memory care unit was also referenced in this complaint allegation pertaining to short staffing on third shift. The memory care unit is a separate license number and will not be included in this special investigation report. However, I did review the working staff schedules for the memory care unit due to the allegations. No concerns were noted during the review, and the memory care unit demonstrated an appropriate number of staff assigned, working, and/or covering to prevent a shift shortage. On 2/4/2026, the facility authorized representative confirmed via email that there are 37 residents in the memory care unit and that staff assigned to the memory care unit are separate from staff assigned to the assisted living unit. Had there been any evidence to support the allegation that the memory care unit was short staffed, a separate special investigation report would have been entered and issued.

ALLEGATION:

The facility is consistently short staffed for third shift.

INVESTIGATION:

On 1/16/2026, the Bureau received the allegations through the online complaint system.

On 1/29/2026, I interviewed Employee A at the facility who reported that while call-ins occur, the facility is never short staffed. If a call-in occurs, there is mandation in place and on-call staff to fill in as well to prevent a short shift. Management will also fill in when a call-in occurs to prevent a shift shortage. There are 3 staff members assigned for the night shift which includes one medication technician and two care staff. The medication technician assists care staff when medications are not being passed and completes supervisor duties as well. Employee A reported that despite call-ins, the facility is never short staffed because of the staffing protocols of mandation and using on-call staff including management, to cover a call-in. Employee A provided me with the requested documentation for my review.

On 1/29/2026, I interviewed the facility administrator via telephone who reported the facility has mandation protocols in place to ensure staffing levels are appropriate even when a call-in occurs. Management and on-call staff are also available to help cover a shift when a call-in occurs. The facility administrator reported [they] are working the night shift tonight (1/29/2026) to prevent a short shift.

On 1/29/2026, I interviewed Employee B at the facility who reported that call-ins do occur, but the facility uses mandation and on-call staff to ensure a shift is covered appropriately. Employee B also confirmed that management will cover a call-in on any shift to ensure there is not a shift shortage.

On 1/29/2026, I interviewed Employee C at the facility whose statement was consistent with Employee A's statement and Employee B's statement.

On 1/29/2026, I completed an inspection of the facility due to this special investigation and observed an appropriate number of staff working and assisting residents.

On 2/4/2026, I received additional requested documentation from the facility authorized representative (AR). The facility AR confirmed there are currently 65 residents residing in the facility.

On 2/5/2026, I reviewed the requested documentation which revealed the following:
Review of the working staff schedules from 11/30/2025 to 2/1/2026:

- There were a minimum of three staff working in the assisted living unit on third shift from 11/30/2025 to 2/1/2026.
- There is evidence of mandation and/or on-call staff coverage to prevent a short shift.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable

	of providing for resident needs consistent with the resident service plans.
ANALYSIS:	It was alleged the facility is consistently short staffed for third shift. Interviews, on-site investigation and review of documentation reveal there is no evidence to support this allegation. The facility demonstrates an appropriate number of staff assigned, working, mandated, or on-call to prevent a short shift. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff are not trained to use the Hoyer lift and there is minimal medication technician training.

INVESTIGATION:

On 1/29/2026, Employee A reported that all care staff are trained to use the Hoyer lift. Staff are trained at orientation, and it is reviewed routinely during staff meetings. Employee A reported that to [their] knowledge, there is 1 resident (each) in the assisted living unit (and in the memory care unit) that requires use of the Hoyer lift and that no issues or incidents have occurred when using the Hoyer lift.

On 1/29/2026, the administrator confirmed all staff are trained on how to use the Hoyer lift safely and correctly at orientation and it is reviewed throughout the year at staff in-service meetings. The administrator also reported there have been no issues or incidents with use of the Hoyer lift.

On 1/29/2026, Employee B's statement and Employee C's statement were consistent with Employee A's statement and the administrator's statement.

On 2/2/2026, I requested documentation via email from the facility administrator.

On 2/4/2026, I received the requested documentation via email from the facility AR.

On 2/4/2026, I reviewed the requested documentation which revealed the following:
Review of communication documentation:

- There is 1 resident that requires use of the Hoyer lift in assisted living.
- There is 1 resident that requires use of the Hoyer lift in memory care.

Review of staff training documentation:

- There is evidence that all caregivers and medication technicians are trained and tested on the use of a Hoyer lift.

- There is no evidence that there have been any accidents or injuries at the facility using the Hoyer lift.

Review of staff medication administration documentation:

- There is evidence that medication technicians receive training at orientation and ongoing training to administer medication correctly.

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: **(b) First aid and/or medication, if any.** **(c) Personal care.** **(g) Medication administration, if applicable.**
ANALYSIS:	It was alleged that staff are not trained to use the Hoyer lift and there is minimal medication technician training. Interviews, onsite investigation, and review of documentation reveal there is no evidence to support this allegation. The facility demonstrates appropriate training in accordance with the Homes for the Aged rules and regulations. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There are medication errors and medications are passed late.

INVESTIGATION:

On 1/29/2026, Employee A reported medication errors may occur, but the errors are documented and tracked through the incident report process. Employee A reported medication errors can occur intermittently, but if they occur, it is investigated and staff are provided with re-education or re-training as necessary.

On 1/29/2026, the facility administrator’s statement and Employee B’s statement was consistent with Employee A’s statement.

On 2/2/2026, I requested documentation via email from the facility administrator.

On 2/4/2026, I received the requested documentation via email from the facility AR.

On 2/2/2026, I received and reviewed the requested documentation which revealed the following:
Review of the medication error reports for January 2026:

- Medication errors occurred on 1/8/2026, 1/12/2026, 1/12/2026, 1/12/2026, and 1/14/2026.
- The medication error that occurred on 2nd shift on 1/8/2026 was due to Resident C leaving the facility and staff did not check the resident back into the facility system when the resident returned to the facility. Since staff did not check the resident back into the facility system upon return, the resident's medications did not show in the medication system to be administered at that time. However, the medications that were missed were PRN medications. Resident D's authorized representative and physician was notified of the missed medications. Resident C did not suffer any adverse reactions from the incident. Staff was provided re-education and re-training on proper resident check-in procedures, communication and medication administration.
- The medication error that occurred on 2nd shift 1/12/2026 for Resident D was due to the staff member using an advanced search filter on the medication administration computer system. The advanced filter did not show that Resident D was due to be administered 0.5 mg of Repaglinide and 1000 mg of Metformin. Resident D did not suffer any adverse reactions from the incident. The physician and Resident D's authorized representative were notified of the medication error. Staff were provided re-education and re-training on medication administration.
- Another medication error occurred on 2nd shift on 2/12/2026 for Resident E due to the advanced search filter being used on the computer system during medication administration. The advanced search filter did not show that Resident E was to receive 0.5-3 mg / 3ml of Albuterol. Resident E did not suffer any adverse reactions from the incident. The physician and Resident E's authorized representative were notified of the medication error. The electronic computer medication administration system IT department was also contacted by facility management to remove the advanced search filter to prevent further issues. Staff were provided re-education and re-training on medication administration.
- Another medication error occurred on 1st shift on 2/12/2026 for Resident F. Staff failed to mark 50 mg of Hydroxyzine in the electronic computer system as being administered for Resident F. The medication technician received re-education, re-training, and a final written corrective action due to the medication administration error.
- On 1/14/2026, a new staff member was training on 2nd shift with a medication technician when it was discovered that Resident G's nighttime medications (5 mg of Amlodipine, 12.5 mg of Carvedilol, and 40 mg of Pravastatin) were administered in error with the morning medications. Staff were provided re-education and re-training on medication administration.

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 there are medication errors and medications are passed late. Interviews, onsite investigation, and review of documentation reveal medication errors occurred in January 2026. However, the facility took immediate action to address the medication errors by notifying the physician(s) about the medication errors, notifying the affected residents' authorized representative(s), communicating with the IT department of electronic medication administration record to correct the computer system issue, and by providing staff re-education and re-training. Also, one staff member was provided with a final corrective action as well. Due to the facility taking immediate and appropriate action to address the medication errors in a timely manner and to prevent recurrence, no violation found is found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents cannot adjust their room thermostats and/or the resident room thermostats are not working.

INVESTIGATION:

On 1/29/2026, Employee A reported the thermostats in resident rooms are working and that to [their] knowledge there has not been any issues with residents not being able to adjust their room thermometers or that room thermostats were not working. There have also been no complaints from residents, residents' families, or staff about resident room temperatures or thermostats not working correctly.

On 1/29/2026, the facility administrator's statement and Employee B's statement were consistent with Employee A's statement.

On 1/29/2026, Employee C reported one resident room recently required their room thermostat to be repaired, but it was repaired within an hour or so the same day it was noted to not be working correctly. Employee C reported all the resident room thermostats are being upgraded to digital thermostats and about half of the

thermostats have already been upgraded in the facility. Employee C reported that the facility common areas have a temperature of 74 degrees and that resident room temperatures vary based on the resident's preferences. Employee C confirmed that all residents have access to be able to adjust their room temperature to their preference.

On 1/29/2026, I interviewed Resident A at the facility who reported the temperature was comfortable in their room and that they could adjust it if they preferred. Resident A reported no concerns about their room's temperature.

On 1/29/2026, I interviewed Resident B at the facility who reported their room temperature was comfortable and that they did not know how to adjust the thermostat but would ask staff to help if they needed assistance to adjust it. Resident B reported no concerns about their room's temperature.

On 1/29/2026, I completed an inspection of the facility and found no concerns with the facility temperature or residents' room temperatures. The facility's overall temperature was 74 degrees. Resident A's room temperature was 76 degrees. Resident B's room temperature was 77 degrees. Also, the resident room thermostats were easily accessible for the residents to adjust to [their] preference.

APPLICABLE RULE	
R 325.1973	**Heating.**
	(1) A home shall provide a safe heating system that is designed and maintained to provide a temperature of at least 72 degrees Fahrenheit measured at a level of 3 feet above the floor in rooms used by residents.
ANALYSIS:	It was alleged that residents cannot adjust their room thermostats and/or the resident room thermostats are not working. Interviews and onsite investigation reveal there is no evidence to support this allegation. No violation found.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents were served cold food during the week of 1/11/2026 to 1/17/2026.

INVESTIGATION:

On 1/29/2026, Employee A, Employee B, Employee C, and the administrator reported no knowledge of or complaints about residents being served cold food the week of 1/11/2026 to 1/17/2026.

On 1/29/2026, Resident A's statement and Resident B's statement were consistent with each other's. Neither resident reported any concerns about the food and denied being served cold food.

On 2/4/2026, I received the requested documentation via email from the facility AR.

On 2/5/2026, I reviewed the requested documentation which revealed the following:
Review of January 2026 menu:

- The menu shows both cold and hot food items being available for consumption and/or served to residents in the facility.

Review of January 2026 food temperature log:

- Temperatures of the food served to residents were within the parameters for safe human consumption.

APPLICABLE RULE	
R 325.1976	**Kitchen and dietary.**
	(6) Food and drink used in the home shall be clean and wholesome and shall be manufactured, handled, stored, prepared, transported, and served so as to be safe for human consumption.
ANALYSIS:	It was alleged that residents were served cold food during the week of 1/11/2026 to 1/17/2026. Interviews, onsite investigation and review of documentation reveal there is no evidence to support this allegation. The facility prepared and served food items safely to residents in January 2026, including the week of 1/11/2026 to 1/17/2026. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

On 1/29/2026, when arriving at the facility it was discovered that the facility had a different administrator than what was listed with the department.

On 2/4/2026, the facility AR confirmed the current administrator has been working in that position at the facility since April 2025.

On 2/5/2026, I confirmed with the assigned HFA surveyor that the facility had not notified [them] about the change of administrator in April 2025 or any time after.

APPLICABLE RULE	
R 325.1913	**Licenses and permits; general provisions.**
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.
ANALYSIS:	It was discovered during this special investigation that a different appointee was serving in the role of administrator for the facility and had been in that role since April 2025. The facility did not provide the department notice that the appointment of administrator had changed in April 2025. 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.

Julie Viviano

2/5/2026

_____

Julie Viviano Date
Licensing Staff

Approved By:

Andrea L. Moore

02/09/2026

_____

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