



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 11, 2026

Laurie Cook
NorthPointe Woods Assisted Living
700 North Avenue
Battle Creek, MI 49017

RE: License #: AH130236857
Investigation #: 2026A1041005
NorthPointe Woods Assisted Living

Dear Licensee:

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 that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

A handwritten signature in cursive script that reads "Tammie Daniels".

Tammie Daniels, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH130236857
Investigation #:	2026A1041005
Complaint Receipt Date:	04/14/2026
Investigation Initiation Date:	04/15/2026
Report Due Date:	06/14/2026
Licensee Name:	NorthPointe Woods
Licensee Address:	700 North Avenue Battle Creek, MI 49017
Licensee Telephone #:	(616) 964-7625
Administrator/Authorized Representative:	Laurie Cook
Name of Facility:	NorthPointe Woods Assisted Living
Facility Address:	700 North Avenue Battle Creek, MI 49017
Facility Telephone #:	(269) 964-7625
Original Issuance Date:	02/01/2000
License Status:	REGULAR
Effective Date:	08/01/2026
Expiration Date:	07/31/2027
Capacity:	66
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility is short-staffed on night shift.	Yes
Residents are not being checked and changed.	No
Residents are being served raw meat.	No
Medications are pre-set and not administered	No
Additional Findings	Yes

III. METHODOLOGY

04/14/2026	Special Investigation Intake 2026A1041005
04/15/2026	Special Investigation Initiated - On Site
04/23/2026	Contact - Requested documentation received from the Authorized Representative
05/12/2026	Contact - Telephone interview with Employee 1 and the Authorized Representative
05/13/2026	Contact- Requested documentation received from the Authorized Representative
06/11/2026	Exit Conference

ALLEGATION:

The facility is short-staffed on night shift.

INVESTIGATION:

On 04/14/2026, the licensing department received a complaint with allegations the facility is short staffed during the night shift.

On 04/15/2026, I conducted an interview with the complainant. The complainant alleged the facility was regularly short staffed for third shift and has occurred even in the last couple weeks. The complainant alleged that in addition to being short-

staffed, staff from the Home for the Aged must respond to call lights at the attached independent living facility, leaving only one caregiver for all the Home for the Aged facility residents on the night shift.

On 04/15/2026, I interviewed the Authorized Representative (AR), Laurie Cook, and Employee 1 at the facility. Employee 1 reported the facility has three shifts and third shift hours are from 10:00 p.m. to 6:00 a.m. Employee 1 reported the facility has a general assisted living unit and a locked memory care unit, both on the same floor within the building. Employee 1 reported that third shift staffing levels for both units combined were at minimum, two staff members, including one medication technician and one caregiver. Employee 1 reported that medication technicians do not punch out or leave the building for breaks on third shift. Employee 1 reported that medication technicians are responsible for assisting with caregiver tasks as well as passing medications. Employee 1 reported that the current total resident census was 38. The AR reported that there is an independent living facility (ILF) attached to the same building as the Home for the Aged (HFA). The AR reported that HFA staff get notification alerts for pull-cords that have been pulled by residents in the ILF. The AR reported that HFA staff may have to respond to an ILF pull-cord alert on any shift.

On 04/15/2026, I interviewed Employee 2 at the facility. Employee 2 reported working on first and third shifts. Employee 2 reported that staff are mandated to stay over if the facility is short staffed. Employee 2 reported that HFA staff get called to help residents who pull their call light at the ILF. Employee 2 reported that ILF calls happen a couple of times a month on third shift. Employee 2 reported that medication technicians are the ones that must go to the ILF if there is a call because they must complete an incident report.

On 04/15/2026, I interviewed Employee 5 at the facility. Employee 5 reported working on both first and second shifts. Employee 5 reported that HFA staff respond to pull-cord alerts at the ILF for falls; to call emergency services; or for lift assistance. Employee 5 reported that when a staff member leaves to go to the ILF, care to HFA residents may be delayed. Employee 5 reported that HFA staff can get called over to the ILF two or three times a week on first or second shift.

On 04/15/2026, I interviewed Resident A in her room. Resident A reported that at times, it takes staff up to 30 minutes to respond to her call light. Resident A reported needing to use a sit-to-stand device for transfers to the toilet. Resident A reported that staff have left her “hanging” in the sit-to-stand device while waiting on another caregiver to come and help in the early morning hours.

On 04/15/2026, I interviewed Resident B in his room. Resident B reported being dependent on staff to assist with transfers to the toilet, wheelchair, and bed. Resident B reported that most of the time, his call light is answered timely, but it has taken up to one hour for staff to come, and delays were typically in the early morning hours.

I reviewed the staff work schedule from 03/30/2026 through 04/13/2026. During review, the following was revealed:

On 03/31/2026, 04/01/2026, 04/02/2026, 04/07/2026, 04/10/2026, 04/11/2026, 04/12/2026, and 04/13/2026, there was one medication technician and one resident caregiver working on third shift. On 04/05/2026, there were two staff members who split part of third shift but in total hours, there was one medication technician and one resident caregiver working on third shift.

On 05/13/2026, I reviewed the resident census report between the dates of 03/30/2026 and 04/13/2026. There were between 39 and 41 residents residing in the HFA during that period.

On 05/12/2026, I interviewed Employee 1 by telephone. Employee 1 reported that between 03/30/2026 and 04/13/2026, seven residents needed the assistance of two staff members for at least one care need.

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:	The facility identified that the third shift minimum staffing levels are two staff members; noting that HFA staff may have to respond to pull-cord calls at the attached ILF on any shift; and seven HFA residents needed two staff members to assist with at least one care need during the period reviewed. Based on these findings, having two staff members on third shift is not sufficient to meet the needs of residents with the reported acuity level between the general assisted living and memory care units.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Residents are not being checked and changed.

INVESTIGATION:

The complainant alleged that residents were not getting checked or changed for incontinence every two hours. The complainant alleged that this has noticeably occurred with Resident A who was left in the same incontinence brief for several hours as determined by a brief which was dated and timed.

Employee 1 reported that staff complete "Caregiver Assignment Sheets" each day on each shift which includes shift duties and a list of residents who need to be checked every two hours. Employee 1 reported that Resident A is on a toileting schedule but that she can give staff a very hard time when they try to assist her.

Resident A reported that she sits in her reclining chair for all shifts and does not like to be disturbed when sleeping. Resident A reported that she gives staff a hard time with toileting and incontinence checks. Resident A reported that she refuses toileting and incontinence care at times.

On 04/15/2026, I interviewed Relative A1 at the facility. Relative A1 reported that Resident A can refuse care at times. Relative A1 reported that he feels Resident A's care at the facility is good.

On 04/15/2026, I conducted interviews with Employee 2, 3, 4, 5, 6, and 7 at the facility. All had statements which were consistent with Employee 1.

I reviewed Caregiver Assignment Sheets from all three shifts between 04/09/2026 and 04/16/2026. The review revealed there were between 19 and 21 residents who were listed each shift as needing to be checked for incontinence each day and on each shift. The review revealed that Resident A was listed on the assignment sheets each shift. It was noted that caregivers on all shifts initialed and signed each day for the period reviewed indicating that all residents, including Resident A, were either toileted, checked for incontinence, or had their brief changed if needed.

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 with staff reveal there are no concerns that care is not completed every two hours. Interview with Resident A revealed she refuses incontinence care at times. Review of assignment sheets reveal staff are documenting that care is completed every two hours, including with Resident A. There is insufficient evidence to support a violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Residents are being served raw meat.

INVESTIGATION:

The complainant alleged the facility serves raw meat to the residents. The complainant alleged that Resident A received a raw steak at dinner on October 1, 2025.

On 04/15/2026, I interviewed Employee 9 at the facility. Employee 9 reported that Resident A requests steak to be medium rare and she was not aware of an associated complaint. Employee 9 reported that some employees are not accustomed to meat which is cooked to medium-rare temperature and may feel that the steak is too pink. Employee 9 reported being aware of a complaint regarding cooked hamburger patties which appeared pink in color. Employee 9 reported the pink color was due to the patties being placed in a “*bath*” to maintain the temperature during service. Employee 9 reported the bath caused the outside of the patties to turn slightly pink but that it did not affect the internal temperature. Employee 9 reported that all kitchen staff test meat temperatures to determine if meat being served was at the proper temperature. Employee 9 reported that if a resident returns an item due to dissatisfaction, there is always an alternative food choice. Employee 9 reported that if the residents wanted their meat to be re-made, that was also an option. Employee 9 reported that daily food temperature logs are completed by kitchen staff.

On 04/15/2026, I interviewed Employee 10 at the facility. Employee 10 reported that kitchen staff check the temperature of all meats going out of the kitchen. Employee 10 reported the kitchen thermometers were calibrated monthly to determine their accuracy. Employee 10 reported there were no issues with the functionality of the facility’s stove or oven.

I observed Employee 10 as he demonstrated how to check the internal temperature of meat using a kitchen thermometer. Employee 10 was able to report appropriate

cooking temperatures for different meat products according to recommended guidelines used by the facility.

On 04/15/2026, I observed residents eating their afternoon meal in the main dining room. There was no observation of raw meat being served.

I reviewed kitchen food temperature logs from 03/31/2026 through 04/14/2026. The review revealed no concerns.

Resident A reported that she ordered her steaks to be medium rare. Resident A reported that if the steak is cooked beyond medium rare, she will not eat it. Resident A reported that she is fed well at the facility. Relative A1 reported that Resident A has always requested steak to be medium rare and denied being aware of any issues with the meals at the facility.

Resident B reported that he has not received raw meat during meals at the facility. Resident B reported that if there was an issue with any meal, the kitchen had an alternative meal option available.

Employee 7 reported that Resident A had received a raw steak in the past. Employee 7 reported that when the steak was returned to the kitchen, there was an alternative, however, Employee 7 did not feel the alternative was appropriate.

Employee 2; Employee 3; Employee 4; Employee 5; and Employee 6 reported no issues with raw meat being served to the residents.

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:	Interviews with Employee 9 and 10 revealed kitchen staff monitor all meats for proper cooking temperature according to guidelines used by the facility. Employees 9 and 10 reported that residents can have food re-cooked to their satisfaction and there is an alternative food option. Interviews with Resident A and Relative A1 revealed that Resident A wants her steak to be medium-rare. Interviews with Employees 2-6 reveal no concerns about the facility kitchen serving raw meat to residents. Review of the kitchen temperature logs for two weeks reveal no temperature issue with meat leaving the kitchen. Although Employee 7 reported an incident with Resident A's steak

	appearing raw, there is a lack of evidence to establish a persistent issue with the kitchen serving raw meat.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Medications are pre-set and not administered

INVESTIGATION:

The complainant alleged that staff pre-set medications. The complainant alleged that Resident A did not get medications which were pre-set and left in the medication cart. The complainant alleged that Resident A's narcotic medication was signed out from the narcotic book but was not in the pre-set medication cup. The complainant alleged that Resident A did not receive her medications that day. The complainant did not recall the date on which the allegation occurred.

On 04/15/2026, I observed the facility's three medication carts with Employee 4. There were no medications observed to be pre-set found within any of the facility's three medication carts. Employee 4 reported that she was not aware of any staff who pre-set medications and was not aware of any issues with residents not receiving narcotic medications.

Employee 1 reported that there was one instance in which an anonymous complaint was made regarding medications being pre-set. Employee 1 reported that Employee 8 was mentioned in the anonymous complaint. Employee 1 reported that the practice of medications being pre-set had never been personally witnessed by Employee 1. Employee 1 reported that due to the seriousness of the complaint, Employee 1 took immediate action and re-educated Employee 8 on the facility's medication administration guidelines. Employee 1 reported that in addition, Employee 8 was given a written violation with an action plan for improvement. Employee 1 reported that she is not aware of any complaints that residents were not receiving prescribed narcotics.

Resident A reported that she can be forgetful but currently could not recall a time when she did not receive her medication including her narcotic.

Employees 2, 5, and 7's statements regarding medication pre-setting or narcotic medication issues were consistent with Employee 4.

I reviewed the written violation signed by Employee 8 for pre-setting medications and noted it to be as described by Employee 1.

APPLICABLE RULE	
R 325.1932	Resident's medications.
	(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed healthcare professional.
ANALYSIS:	<p>Interview revealed that Resident A could not recall an instance of not receiving medications including narcotics. Interviews with employees reveal no current issue with pre-setting medication and no issue with residents receiving their narcotic medications. Interview with Employee 1 revealed an instance when she was informed anonymously about Employee 8 pre-setting medications but was not aware of any issues with residents not receiving narcotic medications.</p> <p>There were no observations of pre-set medications during the onsite investigation. There is a lack of evidence to support a violation.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During the medication cart observations with Employee 4, review of the narcotic medication inventory logs on all three medication carts revealed that staff did not consistently document completion of the narcotic count at shift change. Employee 4 reported that two medication technicians are supposed to sign the narcotic medication count log each day at shift change to acknowledge the medication counts were correct.

Review of the entries for the month of April 2026 revealed the A hall cart narcotic medication log was missing at least one of two staff signatures for eight shift changes; the D hall cart log was missing at least one of two staff signatures for four shift changes; and the B/C hall cart log was missing one staff signature for two shift changes.

Review of facility policy titled "*Policy & Procedure: Controlled Substance (Narcotic) Count*" revealed the following:

“Counts must be documented in the Controlled Substance Count Log Book... Documentation must include... Signatures/initials of both staff completing the count...”

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:	Observation of the narcotic medication inventory logs revealed that staff did not consistently document completion of the narcotic count at shift change. Review of facility policy revealed the two staff members completing the narcotic counts must sign/initial in the narcotic count log.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Tammie Daniels

05/26/2026

Tammie Daniels
Licensing Staff

Date

Approved By:

Andrea Moore

06/11/2026

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

Date