GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 13, 2026
Tim Stoll
Thurston Woods Village Inc.
307 N. Franks Ave.
Sturgis, MI 49091

RE: License #: AL120418792
Investigation #: 2026A1030049
The Branches

Dear Mr. Stoll:

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.

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 (616) 356-0100.

Sincerely,

Nile Khabeiry, LMSW

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL120418792
Investigation #:	2026A1030049
Complaint Receipt Date:	08/04/2026
Investigation Initiation Date:	08/05/2026
Report Due Date:	10/03/2026
Licensee Name:	Thurston Woods Village Inc.
Licensee Address:	307 N. Franks Ave. Sturgis, MI 49091
Licensee Telephone #:	(269) 651-7841
Administrator:	Tim Stoll
Licensee Designee:	Tim Stoll
Name of Facility:	The Branches
Facility Address:	99 Vista Dr. Coldwater, MI 49036
Facility Telephone #:	(269) 651-7841
Original Issuance Date:	12/16/2024
License Status:	REGULAR
Effective Date:	06/16/2025
Expiration Date:	06/15/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided with adequate care.	No
Additional Findings	Yes

II. METHODOLOGY

08/04/2026	Special Investigation Intake 2026A1030049
08/05/2026	APS Referral APS referral made
08/05/2026	Special Investigation Initiated - Telephone Interview with referral source
08/05/2026	Contact - Document Received Received and reviewed 3 pictures
08/07/2026	Inspection Completed On-site Interview with Resident A
08/07/2026	Contact - Face to Face Interview with Sarah Vanguilder
08/07/2026	Contact - Telephone call made Interview with Maggie Ward
08/11/2026	Contact - Telephone call made Interview with DPOA
08/12/2026	Exit Conference Exit conference by phone

ALLEGATION:

Resident A was not provided with adequate care.

INVESTIGATION:

On 8/5/26, I interviewed the referral source (RS) by phone. The RS reported she is very concerned about Resident A and the care she is receiving at the facility. The RS reported that Resident A had been living at the facility for about two years and was a hospice patient who had been diagnosed with Dementia. The RS reported she had spoken with the direct care staff members as well as the facility administrator several times with no improvement. The RS reported Resident A's left foot was purple and her right foot was black and believed Resident A's diabetes had not been treated properly. In addition, Resident A's toe nails had not been trimmed and her ears had not been cleaned out despite her asking several times. The RS was also concerned that the staff members at the facility had been trying to get her removed at Resident A's trustee and financial POA due to the complaints she had been making against the facility.

On 8/5/26, I received three photographs from the RS. The first picture was a handwritten note that appeared to be instructions for Resident A to contact her bank to have the current trustee removed and replaced. The note also indicated the name of the RS's supervisor and that Resident A should ask him for a new trustee.

The second and third pictures were of Resident A's feet and I noted that in one picture her left foot was slightly discolored and her right foot was a deep purple/black color. The second picture both her feet were deep purple/black in color.

On 8/7/26, I interviewed Resident A at the facility. Resident A was unsure how long she had lived at the facility but indicated that she liked living at the facility. I noted that Resident A was neat, clean and dressed appropriately. I also observed Resident A's feet and noted they were not discolored and her toenails were trimmed. Resident A denied that she was diabetic or that she had problems with the facility not caring for her feet. Resident A reported that the facility had a person who comes in to trim the resident's toenails. Resident A was unsure if she received hospice care or if she had a primary care doctor. Resident A reported that she received some assistance with personal care and used a wheelchair to ambulate. Resident A reported that she makes her own decisions but had a "bank lady" who managed her monies. Resident A also indicated several times that she had been unhappy with her and that she had only visited twice since she had lived at the facility.

On 8/7/26, I interviewed facility director Sarah Vanguilder at the facility. Ms. Vanguilder reported that Resident A had lived at the facility since 4/19/24. Ms. Vanguilder reported that Resident A received hospice care through Heartland Hospice and provided the name of her nurse who sees her twice per week. Ms. Vanguilder reported that Resident A is not a diabetic and indicated that she had issues with her circulation, which is why

her feet looked discolored in the photographs I received. Ms. Vanguilder reported that Resident A is very active and did not keep her feet elevated during the day, which affects the color. Ms. Vanguilder reported that a woman named Deb comes into the facility a couple of times per month to trim the resident's toenails. Ms. Vanguilder reported that there had been some complaints about Resident A's care but denied that the staff had not been providing appropriate care. Ms. Vanguilder reported that she had been aware of a note that encouraged Resident A to change her trustee but denied that she or any of the staff wrote the note. I reviewed Resident A's file and noted that her Assessment Plan for AFC Residents and her Resident Care Agreement were overdue and had not been updated since she moved into the facility in 2024, however did not list diabetes as one of her medical conditions. Ms. Vanguilder was made aware of the administrative rule that these two forms needed to be updated annually.

On 8/7/26, I interviewed Resident A's hospice nurse, Maggie Ward by phone. Ms. Ward confirmed that she had been working with Resident A for one year. Ms. Ward reported that Resident A is a cardiac patient and had other vascular issues. Ms. Ward reported that Resident A was not diabetic. Ms. Ward reported that Resident A received bathing assistance once per week and she cleaned Resident A's ear yesterday. Ms. Ward reported that Resident A had Dementia and suffered from memory loss which was common for the diagnosis. Ms. Ward reported that she believed that Resident A was being well cared for by the staff members and expressed no concerns about the facility. Ms. Ward reviewed the photographs I received and indicated that she was the one who wrote the note to Resident A regarding obtaining a new trustee based on her request as she was not satisfied with the current trustee. Ms. Ward also indicated that she had only observed Resident A's feet during the morning/afternoon and that "it's not uncommon for swelling to worsen throughout the day and the discoloration is at or near her baseline."

On 8/12/26, I interviewed Resident A's DPOA (Paige Kline) by phone. The DPOA reported she was a friend of Resident A and visited with her regularly. The DPOA reported that Resident A "seemed happy" at the facility although would prefer to live in her own home. The DPOA reported that she believed that the facility provided good care to Resident A. The DPOA reported that she had some concerns about Resident A's feet a while ago and brought those concerns up with Resident A's hospice nurse and was assured that everything was ok. The DPOA reported that she checked Resident A feet every time she visited and noted they are looking much better now.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum

	to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	It was alleged that Resident A was not provided with adequate care. Based on interviews and review of documentation, this violation will not be established. According to the referral source the facility had not been attending to Resident A's diabetic symptoms as her feet were discolored and her toenails were untrimmed and had not cleaned her ears. After reviewing Resident A's AFC file and interviewing Resident A's nurse it was determined that Resident A had cardiac and circulatory issues and the discoloration noted in her feet were a result of Resident A not elevating her feet and were at or near her baseline.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

While reviewing Resident A's AFC file it was noted that her Assessment Plan for AFC Residents had not been updated since her admission in 2024.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	During the investigation it was discovered that Resident A's Assessment Plan for AFC Residents (AP) had not been updated since her admission in 2024. The facility manager acknowledged that the AP was overdue and would ensure a current AP was completed with the appropriate signatures.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While reviewing Resident A's AFC file it was noted that her Resident Care Agreement had not been updated since her admission in 2024.

APPLICABLE RULE	
R 400.685	**Resident admission; resident care agreement.**
	(9) A licensee shall review the written resident care agreement with the resident, resident's designated representative, or responsible agency at least annually or more often if necessary. Any changes to the resident care agreement must be re-signed by all applicable parties. If the annual review results in no changes to the resident care agreement the resident care agreement does not need to be re-signed but the licensee shall document that all applicable parties were contacted and agreed that no changes were necessary.
ANALYSIS:	During the investigation it was discovered that Resident A's Resident Care Agreement (RCA) had not been updated since her admission in 2024. The facility manager acknowledged that the RCA was overdue and would ensure a current RCA was completed with the appropriate signatures.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/12/26, I shared the findings of the investigation with licensee, Tim Stoll by phone. Mr. Stoll acknowledged the findings and agreed to submit a corrective action plan.

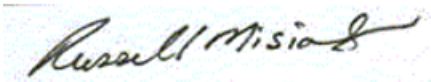
III. RECOMMENDATION

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

8/14/26

Nile Khabeiry Date
Licensing Consultant

Approved By:



8/17/26

Russell B. Misiak Date
Area Manager