GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 13, 2025

Sharon Cuddington
Trinity Continuing Care Services
Suite 200
20555 Victor Parkway
Livonia, MI 48152

RE: License #:	AL610261127
Investigation #:	2025A0356044
	Sanctuary at the Oaks #1

Dear Ms. Cuddington:

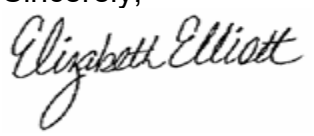
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL610261127
Investigation #:	2025A0356044
Complaint Receipt Date:	06/16/2025
Investigation Initiation Date:	06/17/2025
Report Due Date:	08/15/2025
Licensee Name:	Trinity Continuing Care Services
Licensee Address:	20555 Victor Parkway, Suite 200 Livonia, MI 48152
Licensee Telephone #:	(810) 989-7492
Administrator:	Julie Treakle
Licensee Designee:	Sharon Cuddington
Name of Facility:	Sanctuary at the Oaks #1
Facility Address:	1740 Village Drive, 1st Floor Muskegon, MI 49442-4282
Facility Telephone #:	(231) 672-2700
Original Issuance Date:	04/21/2005
License Status:	REGULAR
Effective Date:	10/26/2023
Expiration Date:	10/25/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff Shelby Enders was rough with Resident A causing injury.	Yes
Additional Finding	Yes

III. METHODOLOGY

06/16/2025	Special Investigation Intake 2025A0356044
06/17/2025	APS Referral CI intake
06/17/2025	Special Investigation Initiated - Telephone Julie Treakle, administer.
07/02/2025	Inspection Completed On-site
07/02/2025	Contact - Face to Face Sharon Cuddington, LD, Julie Treakle, Admin. and Angela Hicks, RN.
07/02/2025	Contact - Document Received Facility and Resident documents reviewed.
07/02/2025	Contact - Face to Face Resident A.
07/22/2025	Contact - Telephone call made DCW's Shelby Enders, Alexis Morris.
07/25/2025	Contact - Telephone call received DCW Shelby Enders.
08/06/2025	Contact - Telephone call made Malissa Black, RN.
08/06/2025	Contact - Telephone call made Relative #1
08/07/2025	Contact - Telephone call made Malissa Black, RN.

08/12/2025	Exit conference-Julie Treakle, Administrator as approved by Licensee Designee, Sharon Cuddington in her absence.

ALLEGATION: Staff Shelby Enders was rough with Resident A causing injury.

INVESTIGATION: On 06/16/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs-Bureau of Community Health Systems) online complaint. The complainant reported that a staff member at the facility pulled a Hoyer lift canvas out from underneath a resident, and that the staff pulled the canvas hard and caused the resident to cry. The complainant reported the resident's arm was bleeding from the staff ripping the canvas from under the resident.

On 06/17/2025, I interviewed Julie Treakle, administrator via telephone. Ms. Treakle stated on 06/01/2025, it was reported that DCW (direct care worker) Shelby Enders pulled a Hoyer canvas out from under Resident A with force causing injury. Ms. Enders was working with DCW Alexis Morris and Ms. Morris was a witness to the incident. Ms. Treakle stated Ms. Morris reported that she was tying a trash bag up in Resident A's room and Ms. Enders was trying to get a Hoyer canvas out from under Resident A. Ms. Enders pulled the canvas out and Resident A sustained a skin tear and bruising down her upper left arm. Ms. Treakle stated medical attention was given to Resident A's arm and she has not suffered any further ill effects.

On 07/02/2025, I conducted an inspection at the facility and interviewed Ms. Treakle, Sharon Cuddington, Licensee Designee and Angela Hicks, RN (registered nurse). Ms. Treakle stated Ms. Enders called Malissa Black, RN, on 06/01/2025 to report the incident with Resident A. Ms. Treakle stated Ms. Enders stated the Hoyer canvas got caught, causing the skin tear on Resident A's arm. Ms. Treakle stated Ms. Black talked to Ms. Morris who reported that Ms. Enders did not wait for her to help provide the two-person assistance that Resident A required. Ms. Treakle stated Ms. Morris reported she was tying up Resident A's garbage bag while Ms. Enders was pulling the Hoyer canvas out from under Resident A. Ms. Treakle stated Resident A requires 2-person assistance, and the correct procedure was not followed to remove the canvas from under Resident A so Ms. Enders no longer works at this facility. Ms. Cuddington and Ms. Hicks concurred with the information provided by Ms. Treakle.

On 07/02/2025, I reviewed the Patient Care Process Event report dated 06/04/2025, written by Malissa Black, RN. The reported documented the following information, *'After transferring resident to the bed, Anam Cara (another name used by this facility for a direct care worker) was getting the Hoyer pad from underneath the resident. When getting the Hoyer pad from under the resident, the Hoyer pad string got caught under the resident's skin and pulled causing it to tear. Anam Caras cleaned the wound with a warm washcloth and proceeded to put protective ointment and a bandage on the wound. Anam Cara informed the on-call nurse and family of the incident. Assessed resident left upper arm post skin tear, 1.5cmX.01cm covered with clear bandage. Range of motion performed and slight pain in left shoulder, which*

resident stated is her normal pain. Treatment initiated. Review safe handling with colleague.'

On 07/02/2025, I reviewed a skin integrity event dated 06/01/2025, written by Ms. Enders. The report documented the incident that occurred on 06/01/2025 and documented the following information: *'After transferring resident to the bed, Anam Cara was getting the Hoyer pad from underneath the resident. When getting the Hoyer pad from under the resident, the Hoyer pad string got caught under the residents skin and pulled causing it to tear. Anam Caras cleaned the wound with a warm washcloth and proceeded to put protective ointment and a bandage on the wound. Anam Cara informed the on-call and family of the incident. Action set in place for more care tomorrow.'*

On 07/02/2025, I reviewed Resident A's assessment plan for AFC residents. The assessment plan documented Resident A does not require staff assistance for walking/mobility and uses a wheelchair and slide board for transfers. The assessment documented Resident A required a 2 person assist for toileting and bathing.

On 07/02/2025, I interviewed Resident A in her room at the facility. Resident A stated she thought she had a cut on her arm but stated she caused it herself and the staff at the facility were "great". She had no complaints about staff. Resident A then stated she could not recall what happened to her arm.

On 07/22/2025, I interviewed Ms. Morris via telephone. Ms. Morris reported she was working with Ms. Enders and that Resident A required a 2-person assist while using a Hoyer to transfer her. Ms. Morris stated they had changed Resident A and Ms. Enders was getting her clean and while Ms. Enders was doing that, Ms. Morris was changing out Resident A's garbage bag and tying the garbage up. Ms. Morris stated Ms. Enders "snatched" the Hoyer pad from under Resident A, pulling it out from under her "without a care and without being gentle". Ms. Morris stated the canvas caught Resident A's arm and Resident A began to cry and put her head in the pillow. Ms. Morris stated Resident A got a tear on her upper left arm from her shoulder to her elbow and the injury bled. Ms. Morris stated bruising was evident along Resident A's left upper arm. Ms. Morris stated she cleaned up and bandaged it. Ms. Morris stated she instructed Ms. Enders to notify the on-call nurse and inform her what took place, but she was unsure if Ms. Enders reported the incident. Ms. Morris stated she contacted Ms. Treakle and stated Ms. Treakle told her it was none of her concern and that this incident had nothing to do with her.

On 07/25/2025, I interviewed Ms. Enders via telephone. Ms. Enders stated Resident A had a bowel movement in her brief while in bed. Ms. Enders stated she and Ms. Morris used the Hoyer lift so they could clean Resident A up and both she and Ms. Morris used the lift. Ms. Enders stated they had to get the Hoyer sling out from under Resident A while she was in bed and Resident A is heavy so to get the Hoyer sling out from under her, Ms. Enders had to pull the sling harder. Ms. Enders stated she

did not pull on the sling aggressively and she rolled Resident A to one side attempting to get the sling to come out easier. Ms. Enders stated the sling got stuck on Resident A's arm and it caused a skin tear. Ms. Enders stated Resident A cried a little bit. Ms. Enders stated Ms. Morris was assisting her and stated, "I was not doing this by myself," that Ms. Morris was in the room the entire time, she was not dealing with or tying up the garbage bag as she reported. Ms. Enders stated she did not "snatch" the Hoyer sling and pull it aggressively from under Resident A. Ms. Enders stated she pulled it out exactly the way she was trained to do it, and she knows how to use a Hoyer lift and uses it all the time. Ms. Enders stated Resident A's skin is very loose because she has lost a lot of weight and that is how that part of her upper arm was caught and injured by the sling. Ms. Enders stated skin tears happen with the population they care for and that she would never intentionally harm a resident. Ms. Enders stated after the incident occurred, she called Ms. Black, the facility nurse, for medical guidance, Resident A's family and completed a voice report.

On 08/07/2025, I interviewed Ms. Black via telephone. Ms. Black stated she was not present when the injury to Resident A's arm occurred, but she saw the injury. Ms. Black stated there was a skin tear on Resident A's left arm approximately 2-3cm in size, and she had bruising from her shoulder to her elbow. Ms. Black stated staff cleaned and covered the skin tear and the following morning, the facility nurse practitioner looked at the skin tear and suggested putting Tegaderm, clear cover on Resident A's arm, which was done. Ms. Black stated that Ms. Enders called her and reported the skin tear on Resident A's arm was caused by the pad of the Hoyer lift while transferring Resident A. Ms. Black stated that Ms. Enders never stated excessive force was used and that this type of tear could occur without using force. Ms. Black stated the wound was cleaned and bandaged. Ms. Black stated no one reported that only one person was using the Hoyer at the time of the incident and stated using a Hoyer lift requires two staff. Ms. Black confirmed the information in the Patient Care Process Event Report.

On 08/12/2025, I conducted an exit conference with Ms. Treakle via telephone as approved by Sharon Cuddington, Licensee Designee in her extended absence. Ms. Treakle stated she understood and agreed with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	The complainant reported that a staff at the facility pulled hard on a Hoyer lift canvas out from underneath a resident which caused the resident to cry and sustain an injury to her arm.

	While staff may not have maliciously pulled the Hoyer lift sling out from under Resident A or meant to harm Resident A, Resident A did suffer a skin tear and bruising on her left upper arm from her shoulder to her elbow. Based on investigative findings, there is a preponderance of evidence to show that on 06/01/2025, Resident A's protection and safety were not attended to by staff Shelby Ender's at the facility and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

INVESTIGATION: On 07/02/2025, I reviewed Resident A's assessment plan for AFC residents. The assessment plan is dated 08/05/2024 and documented Resident A uses a wheelchair and slide board for transfers. The assessment does not document the use of a Hoyer lift for Resident A.

On 08/11/2025, I interviewed Ms. Treakle and Ms. Hicks via telephone and Ms. Hicks stated the assessment plan is being updated and Resident A began using a Hoyer lift on 10/16/2024.

On 08/12/2025, I conducted an exit conference with Ms. Treakle via telephone as approved by Sharon Cuddington, Licensee Designee in her extended absence. Ms. Treakle stated she understood and agreed with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	The assessment plan was not updated on 10/16/2024 when the use of a Hoyer lift was added to Resident A's care. There is no documentation of the use of a Hoyer lift on the assessment plan and therefore, a violation of this applicable rule is established.

CONCLUSION:	**VIOLATION ESTABLISHED**

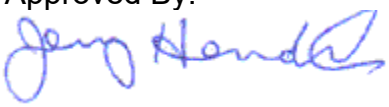
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

08/12/2025

Elizabeth Elliott — Date
Licensing Consultant

Approved By:



08/13/2025

Jerry Hendrick — Date
Area Manager