GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 25, 2025

Michael Dyki
Flourish Collection at Oakland Charter Twp
3215 Silverbell Rd.
Oakland Twp, MI 48306

RE: License #: AH630396969
Investigation #: 2025A1027067
Flourish Collection at Oakland Charter Twp

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 authorized representative 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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630396969
Investigation #:	2025A1027067
Complaint Receipt Date:	07/03/2025
Investigation Initiation Date:	07/07/2025
Report Due Date:	09/03/2025
Licensee Name:	Blossom Ridge, LLC
Licensee Address:	3005 University Drive Auburn Hills, MI 48326
Licensee Telephone #:	(248) 340-9400
Authorized Representative/ Administrator:	Michael Dyki
Name of Facility:	Flourish Collection at Oakland Charter Twp
Facility Address:	3215 Silverbell Rd. Oakland Twp, MI 48306
Facility Telephone #:	(248) 601-0505
Original Issuance Date:	11/23/2020
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	56
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents were neglected.	No
Residents requested pain medications that were not administered.	Yes
The nightshift lacked a medication technician on duty.	Yes
Additional Findings	No

Allegations pertaining to staff lacking training were investigated in Special Investigation Report (SIR) 2025A1035045. The home was understaffed was investigated in SIR 2025A1035045 and 2025A1035064.

III. METHODOLOGY

07/03/2025	Special Investigation Intake 2025A1027067
07/07/2025	Special Investigation Initiated - Letter Email sent to Mike Dyki requesting documentation
07/11/2025	Contact - Document Received Email received with requested documentation
07/21/2025	Inspection Completed On-site
07/21/2025	Inspection Completed-BCAL Sub. Compliance
07/25/2025	Exit Conference Conducted by email with Mike Dyki

ALLEGATION:

Residents were neglected.

INVESTIGATION:

On 7/7/2025, the Department received anonymous allegations claiming that residents were being neglected, including being left in soiled briefs, wet clothing and bedding, not being checked every two hours, and staff not following medical orders. Due to the anonymous nature of the complaint, no further details could be obtained.

On 7/11/2025, a review of the resident census showed a total of 53 residents: 38 in assisted living and 15 in memory care.

On 7/21/2025, I conducted an on-site inspection and interviewed staff.

Employee #1 explained that any concerns reported by residents or families regarding care were addressed promptly. She acknowledged there had been occasional instances when a resident participating in an activity for too long was found to have a soiled brief, but stated it was changed immediately.

She reported that all residents carry call pendants that alert staff phones and the computers on medication carts. Staff were assigned to designated areas and use walkie-talkies to coordinate care and respond to calls for assistance. At the time of the inspection, no call pendants were active.

Employee #1 confirmed that each resident's service plan was individualized, with most residents receiving checks every two hours. However, some families had requested that brief changes occur every four hours. She noted that there were no residents with coccyx wounds at the time, but three residents had wounds on their lower extremities, for which home care services were providing treatment.

She added that residents receive showers twice weekly on a set schedule, unless otherwise specified, and that hospice agencies also assist with showers when applicable.

Employee #1 stated that most residents use the facility's visiting physician, and a nurse practitioner visits weekly. She reported no concerns regarding adherence to physician orders. Additionally, while activities of daily living were not yet documented electronically, the facility was in the process of implementing the Point Click Care Companion system, which will require staff to record all resident care activities.

During the inspection, I interviewed Resident A, who reported satisfaction with her care and expressed no concerns. In the memory care unit, I observed 11 residents in the common area with staff present and engaged with their care. All residents appeared well-groomed and dressed in clean clothing. In the assisted living area, residents were observed in their rooms and in the activity room, participating in exercises with the activity director. These residents also appeared clean and well-groomed. Additionally, the facility was free of any noticeable urine odors.

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.**
ANALYSIS:	Staff interviews and direct observations indicated that the facility maintained an organized and responsive care program that ensured residents were safe, attended to, and appropriately supported. There was insufficient evidence to support the allegation of resident neglect. Therefore, the allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents requested pain medications that were not administered.

INVESTIGATION:

On 7/7/2025, the Department received an anonymous allegation which read that residents had requested pain medications which were not administered. Due to the anonymous nature of the complaint, no additional information could be obtained.

On 7/21/2025, I conducted an on-site inspection and interviewed staff.

Employee #1 described a situation involving Resident B, who had recently moved into the home. Relative B1 reportedly insisted that Resident B receive certain pain medications, although these medications had not been prescribed. Employee #1 explained that Relative B1 appeared to believe the home could administer any pain medications regardless of physician orders. She stated that she informed Relative B1 that only medications ordered by a licensed healthcare provider could be administered. Employee #1 also noted that Resident B was receiving hospice services, and her medications were adjusted accordingly. Resident B passed away less than a week after admission.

A review of Resident B's face sheet confirmed she moved into the home on 6/24/2025 and discharged (due to death) on 6/29/2025. Review of her June 2025

Medication Administration Records (MARs) showed she had an order for Morphine Sulfate every six hours beginning on 6/26/2025, at midnight. The 1:00 AM doses from 6/26/2025 through 6/29/2025 lacked staff initials, in which it could not be confirmed if the doses were administered or not. Resident B also had an as-needed order for Morphine Sulfate every two hours, with four doses documented as administered. Additionally, Lorazepam was ordered every four hours as needed, with two doses recorded.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(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.
ANALYSIS:	Review of Resident B's June 2025 MARs showed she received her prescribed as-needed medications; however, there were instances where medications were not administered according to physician orders. Based on the information obtained, a violation was substantiated regarding the administration of medications as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The nightshift lacked a medication technician on duty.

INVESTIGATION:

On 7/7/2025, the Department received anonymous allegations stating that no medication technician was present during the night shift. Due to the anonymous nature of the complaint, no additional details were available.

On 7/21/2025, I conducted an on-site inspection and interviewed staff.

Employee #1 stated that residents typically did not require medications during the night shift; however, in most instances a medication technician was scheduled. Employee #1 reviewed the night shift schedule (11:00 PM to 7:30 AM) for the period of July 1–21, 2025, and identified which staff were trained as medication

technicians, along with their assigned shifts. It was confirmed that no medication technician was on duty on the nights of July 6, July 12, and July 20, 2025.

Employee #1 indicated the home was in the process of training all staff in medication administration, as well as hiring more staff.

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:	A review of the night shift staffing schedule confirmed that, on the identified dates, there was no medication technician available should a resident have required medication. As a result, the facility was unable to adequately meet all resident needs. Therefore, a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/23/2025

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Jessica Rogers Date
Licensing Staff

Approved By:

07/25/2025

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