GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 20, 2025

Laurie Pare
Lake (Bloomfield) TRS LLC
6688 N.Central Expressway Suite 1600
Dallas, TX 75206

RE: License #: AH630409730
Investigation #: 2025A0784070
The Avalon of Bloomfield Township

Dear Laurie Pare:

Attached is the Special Investigation Report for the above-mentioned 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (517) 335-5985.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

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

I. IDENTIFYING INFORMATION

License #:	AH630409730
Investigation #:	2025A0784070
Complaint Receipt Date:	07/16/2025
Investigation Initiation Date:	07/18/2025
Report Due Date:	09/14/2025
Licensee Name:	Lake (Bloomfield) TRS LLC
Licensee Address:	Suite 1600 6688 N.Central Expressway Dallas, TX 75206
Licensee Telephone #:	(214) 754-8623
Administrator/Authorized Representative:	Laurie Pare
Name of Facility:	The Avalon of Bloomfield Township
Facility Address:	100 W Square Lake Rd Bloomfield Twp, MI 48302
Facility Telephone #:	(248) 480-7343
Original Issuance Date:	09/30/2022
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	158
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Mistreatment of Resident A.	Yes
Staff were not trained for transfers.	Yes
Additional Findings	No

III. METHODOLOGY

07/16/2025	Special Investigation Intake 2025A0784070
07/18/2025	Special Investigation Initiated - On Site
07/18/2025	Inspection Completed On-site
07/21/2025	Contact - Document Received Investigative documents/info reviewed via email from administrator Laurie Pare
07/21/2025	Contact - Telephone call made Made with administrator
07/23/2025	Contact - Telephone call made Made with administrator
08/05/2025	Inspection Completed On-site Completed previously for SI#2025A0784074
08/20/2025	Exit – Email Sent to AR/Administrator Laurie Pare

ALLEGATION:

Mistreatment of Resident A

INVESTIGATION:

On 7/16/2025, the department received this online complaint. Due to the anonymous nature of the complaint, additional information could not be obtained.

According to the complaint, staff 1 struck a resident while providing care. The incident was reported to supervision and staff 1 was allowed to continue working at the facility.

On 7/18/2025, I interviewed staff 2 and 3 together at the facility. Staff 2 stated that approximately one month ago, an interaction between staff 1 and Resident A was observed by video that was reported to administration due to concerns that staff 1 had physically hit Resident A. Staff 2 stated Resident A has a camera in her room which was placed by the family. Staff 2 stated staff are aware of the camera. Staff 2 stated staff are not only made aware of the presence of such a camera, but that there is also a sign outside of Resident A's room notifying staff of the camera and that it is recording. Staff 2 stated that the video in question captures an interaction in which staff 1 came into Resident A's room and was attempting to change her brief. Staff 2 stated the video appeared to show Resident A being "somewhat combative" with staff 1 while staff 1 was attempting to change her brief. Staff 1 stated that at one point during the interaction, Resident A reached back and slapped staff 1 and that staff 1 slapped Resident A back on the hand. Staff 2 stated that based on his observation of the video, his recommendation was for staff 1 to be terminated. Staff 2 stated normally these kinds of incidents are investigated by the department head, which in this case he stated would be staff 3. Staff 2 stated staff 3 normally would have also had the responsibility to make the final decision on what kind of action would be taken, if any. Staff 2 stated that in this particular case, administrator Laurie Pare took the lead. Staff 2 stated administrator decided to place staff 1 on a final warning. Staff 2 stated administrator has supervised staff 1 for a long time and felt the situation was a one-time issue. Staff 3 agreed with the statements provided by staff 2. Staff 3 stated he also felt staff 1 should have been terminated based on what he saw on the video. Staff 1 and 2 stated that while staff 1 has been given a final notice verbally, no one has documented this discipline to date. During the interview, staff 2 called administrator by speaker phone. Administrator stated she believed staff 2 had documented the written discipline. Administrator stated she would make sure to have this done as soon as she was back in the office on 7/21/2025.

I reviewed video footage of the interaction with Resident A and staff 1 from 5/30/2025. The footage was five minutes in length. Approximately 34 seconds into the video, staff 1 can be seen entering Resident A's room. The lights in Resident A's room are out with the exception of the light in her bathroom which is enough light to provide a clear view of the interaction. When staff 1 enters the room, she does not announce herself and walks into the bathroom and changes the trash bag in the bathroom. Staff 1 then sets aside the trash bag while approaching Resident A's bed and pulls the covers off of Resident A, who appears to be asleep. Staff 1 did not attempt to announce herself to Resident A, who appears to be woken as staff 1 starts to remove Resident A's brief. As Resident A wakes up, she asks staff 1 "what are you doing" to which staff 1 states "I'm bout to change you". Staff 1 goes on to tell Resident A "You can stop hitting me, you can stop swinging, it's time to change your brief [Resident A] because you are wet, and I'm not stoppin". At this point, staff 1 puts on plastic gloves and begins to start taking Resident A's brief off telling her to

lie on her back. When Resident A doesn't move, staff 1, standing to the left side of Resident A, begins to take her left leg and move it toward her. Resident A is telling staff 1 to stop and moves her left hand toward staff 1 to which staff 1 tells her to stop hitting and fighting her. To this point, Resident A has not hit staff 1. Resident A appears to continue indicating, from her body language and verbally stating "ouch", that she does not want staff 1 to continue while staff 1 continues with the process. At approximately 3 min and 6 sec into the video, as staff 1 is taking Resident A's brief off and Resident A continues to say "ouch" several times, Resident A reaches up with her left hand and swings at staff 1's right shoulder making what appears to be light contact with staff 1's right shoulder. Staff 1 responds to this by slapping back at Resident A, hitting her on her left hand and loudly saying Resident A's name in what appears to be frustration. Staff 1 then abruptly pulls Resident A's left leg toward herself, appearing to try to position her to get her new brief on. Resident A reaches up toward staff 1 again at this time with her left hand at which time staff 1 pushes Resident A's hand away telling her to "stop it". Staff 1 then grabs Resident A's left wrist with her right hand holding Resident A down. Resident A appeared to be in pain, based on her body language, as she also verbalized pain saying "ouch" several times and stating, "it hurts so bad". Staff 1 continues to pull Resident A's brief on to her while Resident A tells her to "get out" and says "ouch" several more times". Resident A tells staff 1 she is hurting her to which staff 1 denies hurting her and tells Resident A she is the one being hurt by Resident A. Staff 1 continues to pull Resident A's new brief on by pulling her legs up and holding them. During this time Resident A says "ow, it hurts so bad" several times. Once staff 1 gets Resident A's brief on, she picks up the old brief, which was still under Resident A, throws it in the trash bag she retrieved from the bathroom, pulls Resident A's covers on to her and walks out without saying a word.

On 7/21/2025, I interviewed administrator by telephone. Administrator stated she did not "take the lead" regarding the allegations against staff 1. Administrator stated she was working closely with staff 3 on the process since he was still new to the community at that time. Administrator stated she did feel she should have followed up to ensure everything was done. Administrator stated she did have the final say regarding a written final warning for staff 1. Administrator stated she had supervised staff 1 in a previous facility and since she has been with this facility and never had this kind of issue with her. Administrator stated the camera in Resident A's room has always been there, since she has been a resident, and that no other similar allegations have been made against staff 1. Administrator stated staff 1 has consistently been a good employee for her. Administrator stated Resident A also did not present with any injuries from the interaction. Administrator stated that due to staff 1's good employment history and the lack of any injuries, she felt a final written notice was warranted rather than termination. Administrator stated staff 1 has now been given a documented formal discipline notifying her of that. Administrator stated the incident happened on 5/30/2025 and that staff 1 has been allowed to work with Resident A after initially being put on leave while the situation was being investigated.

On 8/05/2025, I conducted an onsite visit to the facility for an unrelated investigation. While onsite, I observed a sign outside of Resident A's room which read "Camera in use".

I reviewed a document titled *Acknowledgement of Electronic Monitoring*, provided by administrator. The document is signed by staff 1 and dated 8/11/2024. The document read, in part, "I [staff 1], acknowledge that I understand that, at times, the community may use video/surveillance recording devices on the premises. I also understand that such recordings may be used for the purpose of investigation or for other business purposes".

I reviewed a document titled *BEHAVIORAL CHANGE NOTICE FINAL*, provided by administrator. The document was signed by staff 1 and administrator in acknowledgement with a printed signature date of 7/21/2025 from both individuals. Under a section titled *Description of Occurrence*, the document read "Employee was witnessed on camera while giving care to [Resident A], there was an incident of physical contact". Under a section titled *Expectation*, the document read "it is expected that all staff members treat residents with dignity and respect, it is also expected that staff when in a difficult situation, ask for help from a peer or supervisor". This is a last chance, final notice". Under a section titled *Employee's Plan for Behavioral Change*, the document read, in part, "Employee will ask for help when in a difficult situation".

I reviewed a written letter, provided by administrator, signed by staff 1. The letter read "I understand what I did was wrong but it wasn't meant that way I was just trying to protect us both and still take [care] of her that's all and trying to get her to stop hitting me".

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents**
	(2) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician, by a physician's assistant with whom the physician has a practice agreement, or by an advanced practice registered nurse, for

	a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician, physician's assistant, or advanced practice registered nurse who authorized the restraint. In case of a chemical restraint, the physician, or the advanced practice registered nurse who authorized the restraint, shall be consulted within 24 hours after the commencement of the chemical restraint.
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.**
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:	The complaint alleged that a resident was struck by a staff member while care was being provided. Interviews with staff 2, 3 and administrator revealed that an altercation had occurred when staff 1 attempted to provide care to Resident A on 5/30/2025 which was observed on camera, known to staff. Staff 2 reported that the video showed Resident A being "somewhat combative" and that staff 1 slapped Resident A after Resident A first slapped her. Review of the video footage revealed this incident did occur with Resident A hitting staff 1 on her shoulder and staff 1 slapping Resident A back on her hand. Review of the entire interaction revealed staff 1 not only approached Resident A abruptly, starting to pull her brief off while she was sleeping with no formal announcement or transition, but staff 1 was insistent, and forceful, in continuing to take Resident A's brief off and put her new one on while Resident A was clearly uncomfortable as evidenced by her body language and consistent verbalization that she wanted staff 1 to stop and that she was in pain. At no time did staff 1 discontinue the process to re-approach or honor Resident A's wishes while pulling her brief off and putting a new one on in a manner that was not dignified. While administration took some disciplinary action by placing staff 1 on a final notice reportedly for the physical contact with Resident A, staff 1 was ultimately allowed to continue working with Resident A. Additionally, while the care itself provided during the entire interaction appeared to lack dignity and respect for Resident A, there was no indication, within interviews or documented disciplinary action, of the necessity for any additional training that a situation such as this would necessitate for staff 1. Based on the findings, the facility is not in compliance with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff were not trained for transfers

INVESTIGATION:

According to the complaint, the facility has residents who require transfers, including with a Hoyer lift, and staff are not trained to provide these transfers.

When interviewed, staff 2 stated care staff are provided transfer training through a computer program called *Relias*. Staff 2 the facility also hires a company called *Powerback* that does transfer seminars which provide more visual hands-on training

for staff as well. Staff 2 stated all care staff who provide transfers are supposed to have these trainings before working with Residents that require transfers. Staff 2 stated Residents B, C and D all required a two-person assist and that a Hoyer lift is used also. Staff 2 stated these residents are all located on the second floor of the facility. Upon review of the facilities staff roster, this writer randomly selected staff 4, 5 and 6 from the roster and requested documented transfer training for those staff. Staff 2 admitted those staff had not completed the proper training and was unable to provide any documentation. Staff 2 also admitted these staff have worked shifts on the second floor with Residents B, C and D.

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:	According to the complaint, staff working with residents that require transfers were not trained properly trained on how to provide transfers prior to working with those residents. Based on the findings, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Aaron L Clum 8/18/2025

Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 08/20/2025

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