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 #:	AL610260125
Investigation #:	2025A0356046
	Sanctuary at the Oaks #2

Dear Ms. Cuddington:

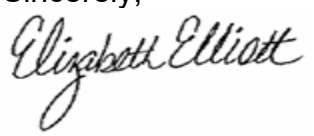
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL610260125
Investigation #:	2025A0356046
Complaint Receipt Date:	06/17/2025
Investigation Initiation Date:	06/17/2025
Report Due Date:	08/16/2025
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 #2
Facility Address:	2nd Floor 1740 Village Drive Muskegon, MI 49442-4282
Facility Telephone #:	(231) 672-2700
Original Issuance Date:	04/21/2005
License Status:	REGULAR
Effective Date:	11/23/2023
Expiration Date:	11/22/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff Alexis Morris was rough with Resident A while providing care.	Yes

III. METHODOLOGY

06/17/2025	Special Investigation Intake 2025A0356046
06/17/2025	APS Referral Complaint referred to LARA from APS.
06/17/2025	Special Investigation Initiated - Telephone Julie Treakle, administrator.
06/17/2025	Contact - Telephone call made Julie Treakle, administer.
07/02/2025	Inspection Completed On-site
07/02/2025	Contact - Face to Face Sharon Cuddington, LD, Julie Treakle, Administrator, Angie Hicks, RN.
07/02/2025	Contact - Document Received Facility docs.
07/02/2025	Contact - Face to Face Resident A.
07/22/2025	Contact - Telephone call made Alexis Morris, Direct Care Worker.
08/06/2025	Contact - Telephone call made Relative #1
08/06/2025	Contact - Document Sent Request for police report. City of Muskegon PD. Did not receive copy of report. Rec'd 08/13/2025.
08/07/2025	Contact - Telephone call made Malissa Black, RN.
08/12/2025	Contact-Telephone call made

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

ALLEGATION: Staff Alexis Morris was rough with Resident A while providing care.

INVESTIGATION: On 06/16/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs-Bureau of Community Health Systems) online complaint from Muskegon County, Department of Health and Human Services (DHHS), Adult Protective Services (APS). The complainant reported Resident A is physically unable to get around without assistance and on 06/10/2025, around 10-11:00p.m., Resident A called for assistance to the bathroom. Direct Care Worker (DCW) Alexis Morris responded to Resident A's call. The complainant reported that Ms. Morris forcefully pulled Resident A from her bed and did not put her in her wheelchair correctly. The complainant reported when they got to the bathroom, Ms. Morris put Resident A on the toilet "Catty Wampus." The complainant reported Resident A was unable to go to the bathroom, so Ms. Morris put Resident A back into her wheelchair, hitting her side on the wheelchair during a rough transfer. When they reached Resident A's bed, Ms. Morris grabbed Resident A's left forearm and flung her onto the bed. The complainant reported Resident A was too afraid to call for help for the rest of the night and soiled herself twice. Relative #1 sees Resident A daily and reported the bruises to staff and said the bruises were new. The complainant reported that Resident A has a handprint bruise on her left forearm, and pinpoint bruises on her rib. Additionally, the nurse said she felt a bump on Resident A's ribs. A complaint was filed with the City of Muskegon Police Department; an investigation is ongoing. Muskegon County DHHS, APS worker Stephanie Kindle is also investigating.

On 06/17/2025, I interviewed Julie Treakle, Administrator via telephone. Ms. Treakle stated on 06/10/2025, it was reported that DCW (direct care worker) Alexis Morris was rough with Resident A while taking her to the bathroom. Ms. Treakle stated Resident A reported the rough care, and she (Ms. Treakle) thought Resident A had a left rib fracture from the incident. Ms. Treakle stated she is not sure if Resident A's ribs were bruised and injured when she was taken out of bed or put into her wheelchair. Ms. Treakle stated that Resident A reported she wet herself twice throughout the night after the incident because Resident A stated, "I didn't want to go through that again." Ms. Treakle stated Ms. Morris was assigned the hall that includes Resident A's room. This occurred on 3rd shift, and Ms. Morris is assigned one side of the facility, and another staff is assigned the opposite side so Ms. Morris was the only staff on that side of the facility caring for Resident A on the evening of 06/10/2025. Ms. Treakle stated Resident A did not want to go to the hospital, but did go on Thursday, 06/12/2025 with Relative #1. Ms. Treakle stated Resident A was evaluated by Merideth Heinlein, nurse practitioner from Trinity Health Geriatrics

when the incident occurred. Ms. Treakle stated there had been nothing in Ms. Morris' work history directly related to patient care, that had been a concern, and that the police had been out to investigate the incident.

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 Infinity Watkins worked 3rd shift on 06/10/2025 and reported that is was a normal night and she knew of nothing out of the ordinary that occurred on that shift. Ms. Treakle stated when she came into the facility on the morning of 06/11/2025, Malissa Black, facility RN came and talked to her (Ms. Treakle) and informed her that she had just talked to Resident A and Resident A reported that the staff during 3rd shift the night before had grabbed her out of bed to go to the toilet, that staff was rough with her and she was sore. Ms. Treakle reported that she interviewed Resident A and Resident A said it had been a rough couple of nights with the same staff. Ms. Treakle stated Resident A reported she had used the call light and waited for a DCW to help her to the bathroom. Resident A reported when the DCW arrived, she grabbed her (Resident A) by the arm and put her half in and half out of her wheelchair, she was leaning hard on the left side of her body in the wheelchair and then staff put her on the toilet but she was unable to go to the bathroom and requested staff assist her back to her bed. Ms. Treakle stated Resident A reported that staff "plopped" her back into her bed and left without adjusting her or making sure she was safely in bed. Ms. Treakle stated on both 06/09/2025 and 06/10/2025, DCW Alexis Morris was assigned to Resident A's hallway for care. Ms. Cuddington stated staff have been reassigned and retrained on resident care and reporting incidents. Ms. Cuddington stated Ms. Morris no longer works at the facility.

On 07/02/2025, I reviewed the Patient Care Process Event report dated 06/12/2025 and written by Malissa Black, facility RN. The report documented the event date as 06/11/2025, and described the following information, *'Resident asked to speak with nurse. Stated last night she rang her pendant to use the bathroom. When she (*staff*) came in, I (*Resident A*) could not get to the edge of the bed. She (*staff*) grabbed my arm and was put in my chair. She then put me half onto the toilet. Once there I told her that I no longer needed to go to the bathroom and wanted to go back to bed. When by the bed she just stood there and then flung me onto the bed. I was not on the bed comfortably. I did not want to call her for any more help because I did not want to go through it again. This happened 2 nights in a row. I have pain in my left side (pointed to left ribs). Observed bruise to left hand in the shape of thumb, palm and 2 fingers. Left ribs sore to touch and lump felt on examination. Notified Meredith Heinlein and recommend taking to Emergency Room for full evaluation. Son to take resident to emergency room on 06/12/2025 due to resident being tired.'*

On 07/02/2025, I interviewed Resident A in her room at the facility. Resident A stated the staff that worked that night "roughly assisted me to the toilet." Resident A stated the staff "set me on the toilet sideways" and then "put me in my wheelchair but I was just hanging there and then threw me in my bed and hurt my side."

Resident A stated staff did not straighten her out in the bed and left her laying there before she even checked if she was in bed and laying the correct way. Resident A stated she was bruised on both sides of her body and her back, that is what the doctors at the hospital told her but there is no break to her ribs, but her ribs are bruised. Resident A did not know the staff's name that was rough with her. Resident A stated "two people with dark uniforms" came to talk to her about this incident and Ms. Treakle, Ms. Cuddington and Ms. Hicks stated the police have interviewed Resident A.

On 07/22/2025, I interviewed Ms. Morris via telephone. Ms. Morris stated she worked 3rd shift on 06/09/2025 and 06/10/2025. Ms. Morris stated she was told Resident A can be forgetful and that she rings the pendant and if it is not answered as soon as possible, she will make up stories. Ms. Morris stated on 06/09/2025, Resident A used the pendant, she was panicky and said she was afraid to go to the bathroom because whoever was on the previous shift, bumped her leg and caused an injury. Ms. Morris stated Resident A bumped her leg on the wheelchair and had an injury to the top right side of her knee and a Band-Aid on her knee. Ms. Morris stated on 06/09/2025, she changed Resident A in her bed and charted it and handed it over to the next staff. Ms. Morris stated Resident A stated she was afraid to use the bathroom and wanted to urinate in bed, but Ms. Morris stated she told Resident A no and changed her in bed. Ms. Morris stated she wrote a report and gave the report to Courtney Riccord, the next staff on duty, and reported it to Ms. Black.

Ms. Morris stated the following night, 06/10/2025, Resident A rung the on-call pendant twice, the first time, she (Ms. Morris) got Resident A up and went to the bathroom without incident. Ms. Morris explained that Resident A can get up on her own with help from a railing on the left side of the bed. She turns, gets into her wheelchair, and sometimes plops down into the wheelchair. Ms. Morris stated she has never had to pull Resident A and never forcefully did anything to her.

Ms. Morris stated the second time Resident A pulled the on-call pendant on 06/10/2025. Resident A grabbed the railing, used it to lift herself, grabbed the handle on the wheelchair, backed up and sat in the wheelchair on her own. Ms. Morris stated Resident A requires a "standby assist", she did not have to physically assist Resident A and only provided minimal assistance. Ms. Morris stated she wheeled Resident A to the bathroom where Resident A transferred herself to the toilet with minimal assistance and then she went back to bed. Nothing out of the ordinary occurred. Ms. Morris stated the next morning, 06/11/2025, Ms. Treakle and Ms. Black called her stating that Resident A claimed someone black was rough with her. Ms. Morris stated that Resident A's family said her ribs were fractured prior to living in this facility and that this complaint is a retaliation because she (Ms. Morris) reported another incident that occurred in the facility. Ms. Morris added when she took breaks on both nights, 06/09/2025 and 06/10/2025, she left the facility to go to the store. She was working with Infinity Watkins on the same floor and so it is possible that Ms. Watkins provided care to Resident A. Ms. Morris stated Resident A only said it was a black DCW that was rough with her, she did not identify that staff

as Ms. Morris. Ms. Morris stated she did not do anything wrong, she was not rough with Resident A, she did not push, pull or harm her in any way.

On 07/24/2025, I reviewed Resident A's assessment plan for AFC residents. The assessment plan documented Resident's need for staff assistance with toileting and walking/mobility. The assessment plan documented that Resident A required a "1-2 person assist' with toileting and that she 'ambulates with walker x 1 assist.'

On 08/06/2025, I interviewed Relative #1 via telephone. Relative #1 stated he was notified of the incident immediately and spoke to Ms. Treakle. Relative #1 stated Resident A is not able to get to the bathroom without staff assistance and needs staff help with transferring from bed to her wheelchair and back. Relative #1 stated Resident A told him that on 06/09/2025, the staff was not helpful or accommodating to her and on 06/10/2025, that same staff grabbed her by the arm, pulled her off her bed and stuck her in her wheelchair, but sitting crooked. Relative #1 stated Resident A reported staff then put her crooked on the toilet where she sat for a long time. Relative #1 stated when staff came back they "flung her" back into bed. Relative #1 stated he observed what appeared to be finger shaped bruising on Resident A's arm and bruising on the side of her body. Relative #1 stated the police interviewed Resident A, they saw the bruises and suggested to Relative #1 that he take Resident A to the hospital. Relative #1 stated he took Resident A to the emergency room where they determined Resident A had contusions, bruising, but no broken ribs. Relative #1 stated Resident A had broken ribs prior to living in this facility but did not sustain any broken ribs during this incident.

On 08/07/2025, I interviewed Ms. Black via telephone. Ms. Black stated on 06/11/2025, the morning following the evening of the incident, Resident A requested to speak to the nurse. Ms. Black stated Resident A told her the exact same information that was called into the LARA-BCHS online complaint. Ms. Black stated she asked Resident A if she knew the staff's name that was rough with her and Resident A said she did not know the staff's name, but she knew she was black and that is the only identifying information Resident A could provide. Ms. Black stated that Ms. Morris called her (Ms. Black) on the morning of 06/11/2025 and reported that she noticed Resident A was soiled and the other staff on duty would not change Resident A, and that Resident A often refused to be toileted by staff, but Ms. Morris never mentioned anything to Ms. Black about any incident occurring during her shift on 06/10/2025. Ms. Black stated staff are assigned to one of the two hallways in the facility. Ms. Morris was working Resident A's side and Infinity Watkins was on the other side for 3rd shift on 06/10/2025.

On 08/12/2025, I interviewed DCW Infinity Watkins, via telephone. Ms. Watkins stated Resident A always has bruises on her legs, but not on her arms. Ms. Watkins stated Resident A said staff was rough in their care of her but Resident A was not able to say who the staff was, other than the staff was black. Ms. Watkins confirmed she worked 3rd shift on 06/10/2025 and worked on the same floor but on the opposite hallway as Ms. Morris. Ms. Watkins stated she never went to the other hall

or provided any care to Resident A during the 3rd shift on 06/10/2025. Ms. Watkins stated she has never seen Ms. Morris be rough with any residents including Resident A.

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 staff, Alexis Morris, was rough with Resident A while providing assistance with toileting on the evening of 06/10/2025. Based on information gathered through interviews with staff, Resident A and Relative #1, there is a preponderance of evidence to show that on 06/10/2025, during 3rd shift, staff Alexis Morris was rough while providing care to Resident A. Resident A was not treated with dignity and therefore, a violation of this rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

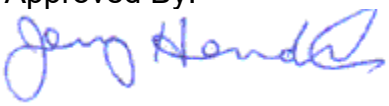
Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Elizabeth Elliott

08/13/2025

Elizabeth Elliott Date
Licensing Consultant

Approved By:



08/13/2025

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Jerry Hendrick Date
Area Manager