



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 23, 2025

Jenice Choate
OakBrook Senior Living LLC
16013 Middlebelt Rd
Livonia, MI 48154

RE: License #: AM470418122
Investigation #: 2025A0577059
OakBrook Senior Living

Dear Ms. Choate:

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 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 (517) 335-5985.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM470418122
Investigation #:	2025A0577059
Complaint Receipt Date:	09/02/2025
Investigation Initiation Date:	09/03/2025
Report Due Date:	11/01/2025
Licensee Name:	OakBrook Senior Living LLC
Licensee Address:	16013 Middlebelt Rd Livonia, MI 48154
Licensee Telephone #:	(716) 704-9185
Licensee Designee:	Jenice Choate
Administrator:	Jenice Choate
Name of Facility:	OakBrook Senior Living
Facility Address:	10638 Rushton Road South Lyon, MI 48178
Facility Telephone #:	(716) 704-9185
Original Issuance Date:	05/09/2024
License Status:	REGULAR
Effective Date:	11/09/2024
Expiration Date:	11/08/2026
Capacity:	12
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Rashonda Henry left her shift, leaving residents unattended for many hours.	Yes

III. METHODOLOGY

09/02/2025	Special Investigation Intake 2025A0577059
09/03/2025	Special Investigation Initiated – Letter- Email to Complainant requesting documents and information.
09/03/2025	Contact - Document Received- Via Email from Janice Choate, IR and contact information.
09/09/2025	Contact - Telephone call made- Interview with DCS.
09/09/2025	APS Referral
09/10/2025	Referral - Law Enforcement- Detective Hughes, Green Oak Township Police Department.
09/12/2025	Inspection Completed On-site
09/15/2025	Inspection Completed-BCAL Sub. Compliance
09/15/2025	Exit Conference with licensee designee Jenice Choates.

ALLEGATION: Direct care staff member Rashonda Henry left her shift, leaving residents unattended for many hours.

INVESTIGATION:

On August 19, 2025, direct care staff member (DCS) Rashonda Henry left her shift early leaving the facility with no direct care staff to care for the residents. Residents were left alone for many hours through the nighttime shift.

On September 02, 2025, a complaint was filed alleging direct care staff Rashonda Henry abandoned her shift on August 19, 2025, around 11:00pm, leaving the facility with no direct care staff to provide care for residents. The complaint reported that facility cameras were reviewed and there was no activity observed from 11:00pm until 6:58am when a morning direct care staff was observed arriving for work.

On September 03, 2025, I interviewed licensee designee Jenice Choate who reported she was notified by DCS Angela Boggs, whose role is home manager (HM), that she arrived to work on August 20, 2025, around 7:00am and could not locate DCS Rashonda Henry or any other direct care staff member. Ms. Choate stated DCS Henry was scheduled to work on August 19, 2025, from 7:00pm-7:00am and it is unknown when DCS Henry left the property. Ms. Choate reported facility administration is attempting to review facility camera footage to determine when DCS Henry was last seen in the facility. Ms. Choate reported she attempted to contact DCS Henry multiple times through phone calls and text messages with no response from DCS Henry. Ms. Choate reported DCS Henry's employment was terminated on August 22, 2025.

On September 03, 2025, via email from licensee designee Janice Choate sent a screenshot of a text message from Ms. Choate to DCS Rashonda Henry inquiring about DCS Henry's whereabouts. The screenshot documented the following response from DCS Henry of "I'm calling you back, I am getting the voicemail." Ms. Choate reported she did not receive a call from DCS Henry. Ms. Choate provided a copy of a facility Incident Report documenting that on August 20, 2025, at 8:00am, the incoming call stated that DCS Henry abandoned the overnight shift, and no staff were present when 7:00am staff arrived. The Incident Report documented that Jenice Choate, Michelle Hatfield, Kayla Servello, and Angela Boggs all tried to reach out to DCS Henry via phone and text messaging to confirm her whereabouts, but no response was received. Upon reviewing video footage, DCS Henry was last seen on camera around 10:15pm and no further interaction on camera was observed after this time.

On September 09, 2025, I interviewed DCS/HM Angel Boggs who reported that she reported to work around 7:00am on August 20, 2025, at the same time as DCS Kayla Servello. Ms. Boggs reported DCS Henry was scheduled to work from 7:00pm-7:00am, starting on August 19, 2025, and Ms. Boggs stated she can confirm DCS Henry arrived for her shift at 7:00pm because Oakbrook Senior Living provided DCS Henry with an Uber to get to work. Ms. Boggs reported when she arrived to work on August 20, 2025, it was quiet so she walked through the facility looking for DCS Henry to get the medication cart keys and start the narcotic count, but DCS Henry could not be located. Ms. Boggs reported direct care staff use an application on their phones that provides GEO location of direct care staff members. Ms. Boggs stated this application showed DCS Henry clocking in at 7:00pm and was still clocked in at 7:00am even though DCS Henry could not be located. Ms. Boggs reported she searched the inside of the facility and the outside property without locating DCS Henry. Ms. Boggs reported she attempted to contact DCS Henry via telephone with no success. Ms. Boggs reported she contacted licensee designee Jenice Choate to report DCS Henry could not be located on the property. Ms. Boggs reported she did not receive any correspondence from DCS Henry requesting to leave her shift or any missed calls from DCS Henry explaining what occurred.

On September 09, 2025, I interviewed DCS Rashonda Henry who reported she arrived to work around 6:00pm to start her shift at 7:00pm. DCS Henry reported she was the

only direct care staff scheduled from 7:00pm-7:00am on August 19, 2025. DCS Henry reported there were eight residents currently admitted to the facility, and none required assistance from two direct care staff with personal care, transferring or mobility. DCS Henry reported she administered resident medications around 8:00pm, got the residents changed into nighttime clothing, toileted and ready for bed between 8:00pm-10:00pm. DCS Henry reported it was around 10:00pm that she was able to look at her phone and had a message that her mom was in a car accident. DCS Henry stated, "I freaked out, I called Angel, and she did not answer the phone." DCS Henry reported she did not leave a message for DCS/HM Angel Boggs, nor did she attempt to contact any other managers or direct care staff to relieve her from her shift. DCS Henry reported she left the facility sometime after 10:00pm. DCS Henry reported she left the residents unsupervised, with no direct care staff at the facility, from approximately 10:15pm to 7:00am when first shift arrived.

On September 10, 2025, I contacted Detective Matthew Hughes with Green Oak Township Police Department and filed a formal complaint.

On September 12, 2025, I completed an unannounced onsite investigation where I reviewed and received a copy of the *Resident Register* which confirmed that on August 19, 2025, there were eight residents living at the facility. I also reviewed the *Assessment Plan for AFC Residents and Health Care Appraisals* for each resident which confirmed no residents required assistance from two direct cares staff with personal care, mobility, or transfers. Per the *Assessment Plans for AFC Residents* all eight residents require assistance from direct care staff to take medications and varying degrees of assistance with personal care needs. All eight resident *Health Care Appraisals* documented Alzheimer's as a diagnosis with a cognitive decline.

APPLICABLE RULE	
R 400.14305	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:	On August 19, 2025, direct care staff member Rashonda Henry left her shift around 10:15pm, due to a family emergency, but did not find another direct care staff to cover for her. This action left all eight residents, whose <i>Health Care Appraisals</i> documented Alzheimer's disease as a diagnosis with cognitive decline, alone in the facility for approximately eight hours. Consequently, the protection, personal care and safety needs of all eight residents were not attended to at all times.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14206	Staffing requirements.
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	On August 19, 2025, the ratio of direct care staff to residents was not adequate from 10:15pm-7:00am, to carry out the responsibilities due to direct care staff Rashonda Henry abandoning her shift and leaving the eight residents in care unattended.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14206	Staffing requirements.
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	On August 19, 2025, from 10:15pm to 7:00am there was not sufficient direct care staff on duty to provide supervision, personal care, and protection due to direct care staff direct care staff Rashonda Henry abandoning her shift and leaving the eight residents unsupervised.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend the continuation of the current license status.

Bridget Vermeesch

09/22/2025

Bridget Vermeesch
Licensing Consultant

Date

Approved By:

Dawn Timm

09/23/2025

Dawn N. Timm
Area Manager

Date