GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2025

Steven Tyshka
Waltonwood at Lakeside
14650 Lakeside Circle
Sterling Heights, MI 48313

RE: License #: AH500285320
Investigation #: 2025A0585078
Waltonwood at Lakeside

Dear Mr. Tyshka:

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,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500285320
Investigation #:	2025A0585078
Complaint Receipt Date:	08/18/2025
Investigation Initiation Date:	08/19/2025
Report Due Date:	10/17/2025
Licensee Name:	Waltonwood At Lakeside I, L.L.C.
Licensee Address:	Suite #200 7125 Orchard Lake Rd. West Bloomfield, MI 48325
Licensee Telephone #:	(248) 865-1600
Administrator:	Gina Steigerwald
Authorized Representative:	Steven Tyshka
Name of Facility:	Waltonwood at Lakeside
Facility Address:	14650 Lakeside Circle Sterling Heights, MI 48313
Facility Telephone #:	(586) 532-7601
Original Issuance Date:	07/16/2007
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	90
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility does not have sufficient staff.	No
Resident A missed doses of medication.	Yes
Resident A did not always get scheduled showers.	No
Additional Findings	No

III. METHODOLOGY

08/18/2025	Special Investigation Intake 2025A0585078
08/19/2025	Special Investigation Initiated - Letter A referral was made to Adult Protective Services (APS)
08/19/2025	Inspection Completed On-site Completed with observation, interview and record review.
08/19/2025	Inspection Completed-BCAL Sub. Compliance
09/30/2025	Exit Conference Conducted via email to authorized representative Steven Tyshka and administrator Gina Steigerwald.

ALLEGATION:

The facility does not have sufficient staff.

INVESTIGATION:

On 08/18/2025, the licensing department received a complaint via BCHS online complaint. The complaint alleged, staff don't answer call lights because the staff is always short.

On 08/19/2025, a referral was made to Adult Protective Services (APS). The complaint was assigned to APS worker Debra Johns.

On 08/19/2025, an onsite was completed at the facility. I interviewed the complainant whose statements were consistent with what was written in the complaint. The complaint alleged that the facility staff is short all the time. The complainant stated that it takes 40-45 minutes for staff to answer call light for Resident A. She said that staff would turn the pendant off and say they are coming back but they don't come back.

During the onsite, I interviewed the administrator Gina Steigerwald at the facility. The administrator stated that there are 51 residents at the facility. There are 33 in assisted living (1st floor – 14 and 2nd floor – 19), with 18 in memory care. The staff consists of two caregivers who are able to care for the needs of the residents. She explained that the expected respond time to call lights varies but they try to keep it under four minutes when possible. She said, there is one caregiver and one med tech on the first and second floor. She said there are one med tech and up to three caregivers on the third floor in memory care.

During the onsite, I interviewed Employee #1 whose statements were consistent with the administrator regarding staffing.

I interviewed Employee #2 at the facility and her statements were consistent with the administrator and Employee #1.

During the onsite, I observed staff on floors one, floor two and the memory care unit. The staff was consistent with what was on the schedule and the statements of the administrator, Employee #1 and Employee #2.

A review of Resident A's call light pendant audit for June, July and August reveals the following:

06/01 – 06/30 total pulls: 186 average response time: 8:45
07/01 – 07/31 total pulls: 188 average response time: 9:16
08/01 – 08/19 total pulls: 154 average response time: 9:13

Resident B and Resident C stated there are no issues with staffing answering call lights and their needs are being met.

A review of the staffing schedule showed that staff was consistent to administrator's statement and the staff observed on duty.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) A 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:	The complaint alleged the facility does not have sufficient staff. Based on interviews and observation of staff on duty, and review of call light audits, there is no evidence to support this claim.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A missed doses of medication.

INVESTIGATION:

The complaint alleged, Resident A ran out of her Klonopin and her thyroid medication. The complaint alleged she missed four doses so far. The complaint alleged that this was the second time they have allowed it to run out of her multiple sclerosis medication, and she has also run out of her thyroid medication twice.

The complainant stated there have been four different times that her medication was late. She said the staff told her that they ordered her medication from the pharmacy on Monday, but she didn't get it until Thursday. The complaint stated that she called the pharmacy herself and found that she didn't have a refill. The complaint stated that she believes the facility did not contact her doctor for the refill.

The administrator stated that Resident A is not cooperative with her medication. She stated that Resident A had an issue with her narcotics and had to get a new order from the doctor. She said the order was called in to the pharmacy and it took 2-3 days to fill it.

Upon request, the administrator shared copies of Resident A, Resident B and Resident C's medication administration record (MAR) and service plan.

Employee #1 stated, when the resident gets down to five of her Klonopin medication, they call the pharmacy to reorder.

Employee #2 stated that they always administer Resident A's medication on time. She said Resident A always the staff to come back to bring it. She said they called the pharmacy to reorder the medication but there where an issue. She said the pharmacy did not let them know that they needed a new doctor's order.

Resident A's service plan read, not able to take medication without assistance. Please alert the med-tech for proper medication administration. Resident is able to communicate effectively and make needs known with or without assistive device.

A review of Resident A's MAR show:

Klonopin (Clonazepam) was prescribed one tablet by mouth, 2 times a day. It shows that Klonopin dose at 10:00 a.m. was not given on 8/12, 8/13, 8/14, and the 10:00 p.m. dose was not given on 8/12 and 8/13. The notes indicate it was waiting for delivery on 8/12, 8/13 and 8/14.

Citalopram was prescribed, take one tablet by mouth every day at bedtime. The MAR shows that on 8/3 the medication was not administered. The noted indicates waiting on delivery. The notes indicate it was waiting for delivery on 8/3.

A review of Resident B and Resident C's MAR shows that medication was given as prescribed.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	The complaint alleged Resident A missed doses of medication. A review of the MAR shows Resident A missed doses of medication on several days. Although medication was ordered, the facility did not follow up to ensure that the resident was administered her medication daily as prescribed. Therefore, the facility did not reasonably comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not always get scheduled showers.

INVESTIGATION:

The complaint alleged that Resident A do not get frequent showers. The complaint alleged that Resident A probably missed a total of 20+ showers. The complaint alleged that Resident A went without showers from July 22 to August 1.

The complainant stated that if you miss a shower, then you don't get one until the next shower day. She explained that she never refuses showers. She said that staff said she had a shower when she didn't have one.

The administrator stated that Resident A likes to get her showers when she wants to get them. She stated Resident A wants certain staff to give her showers and if that staff is not there, she will refuse.

Employee #1 stated Resident A's showers take 1-2 hours because she is very specific about what she wants. Employee #1 stated Resident A will refuse the shower if it is not the staff she wants.

Employee #2's statement was consistent with the administrator and Employee #1 regarding Resident A's showers. She stated Resident A sets her own time for showers and she always wants them to come back. She said that they try to accommodate Resident A.

I reviewed shower sheets for Resident A. The shower sheets showed that showers were completed, and any refusals were documented.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	The complaint alleged Resident A do not always get her scheduled showers. There is insufficient evidence to support this claim.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 8/25/2025, an email was received from APS worker Debra Johns who indicated that she completed an onsite and observed Resident A to be safe and stable. She said that it appears that the showers were given to the residents. The APS worker

stated that there was one medication they were waiting on from the pharmacy for Resident A.

The APS worker emailed me on 9/2/2025, that she had spoken to the pharmacy who reported to her that the medication prescription for Klonopin was sent over on 8/14 around 5 pm and delivered the same day to the facility. Per the manager at the pharmacy, this is a controlled substance and there are a lot of steps, and she had no refills.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

09/30/2025

Brender Howard Date
Licensing Staff

Approved By:

09/30/2025

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