GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 29, 2025

Steven Tyshka
Waltonwood at Royal Oak
3450 W. 13 Mile Road
Royal Oak, MI 48073

RE: License #: AH630336552
Investigation #: 2025A1027074
Waltonwood at Royal Oak

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 #:	AH630336552
Investigation #:	2025A1027074
Complaint Receipt Date:	08/05/2025
Investigation Initiation Date:	08/07/2025
Report Due Date:	10/04/2025
Licensee Name:	Waltonwood at Royal Oak, L.L.C.
Licensee Address:	Suite 200 7125 Orchard Lake Road West Bloomfield, MI 48322
Licensee Telephone #:	(248) 865-1606
Administrator:	Taylor Obomsawin
Authorized Representative:	Steven Tyshka
Name of Facility:	Waltonwood at Royal Oak
Facility Address:	3450 W. 13 Mile Road Royal Oak, MI 48073
Facility Telephone #:	(248) 549-6400
Original Issuance Date:	11/28/2012
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	105
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's catheter care was not consistent with his service plan.	Yes
There were errors with Resident A's medications.	Yes
Staff were rude and took Resident A's pendant.	No
Additional Findings	No

Allegations related to Resident A's overall care, including catheter care, were previously investigated under Special Investigation Report (SIR) 2025A0784016, and again specifically regarding catheter care under SIR 2025A1019046.

III. METHODOLOGY

08/05/2025	Special Investigation Intake 2025A1027074
08/07/2025	Special Investigation Initiated - Letter Email sent to Taylor Obomsawin requesting documentation pertaining to Resident A
08/08/2025	Contact - Document Received Requested documentation received by email.
08/14/2025	Contact - Telephone call made Telephone interview conducted with Relative A1
08/14/2025	Contact - Telephone call made Telephone call conducted with the Administrator. Additional documentation requested.
08/15/2025	Contact - Document Received Email received from the administrator with requested documentation for Employees #2 and #3
08/18/2025	Contact - Telephone call received Telephone interview conducted with the administrator
08/19/2025	Contact - Document Sent Email sent to the administrator asking additional questions

08/20/2025	Contact - Document Received Email received from the administrator with requested information
08/20/2025	Contact - Telephone call received Voicemail received from Relative A1
08/21/2025	Contact - Document Sent Follow up with Relative A1 conducted via text
08/22/2025	Contact - Document Received Email received from the Administrator with additional information and documentation
08/25/2025	Contact - Document Sent Email sent to the Administrator for clarification
08/26/2025	Contact - Telephone call received Voicemail received from Relative A1
08/26/2025	Contact - Document Received Email received with requested information and additional documentation
08/28/2025	Contact - Document Received Email received from the Administrator with additional information
09/02/2025	Contact - Document Received Additional information received from Relative A
09/02/2025	Contact - Document Sent Email sent to the administrator requesting additional information and documentation
09/03/2025	Contact - Document Received Email received with requested information and documentation
09/11/2025	Contact – Document Sent Email sent requesting additional documentation
09/11/2025	Contact – Document Received Email received with requested documentation
09/12/2025	Inspection Completed – BCAL Sub. Compliance
09/29/2025	Exit Conference Conducted email with Steven Tyshka and Taylor Obomsawin

ALLEGATION:

Resident A's catheter care was not consistent with his service plan.

INVESTIGATION:

On 8/5/2025, the Department received allegations which read the catheter care for Resident A was unsafe on 6/28/2025, 7/13/2025, 7/19/2025, and 8/2/2025.

Review of Resident A's face sheet revealed he moved into the home on 7/28/2022, and Relative A1 was his primary contact. His most recent service plan, updated 7/31/2025, indicated that Resident A has a suprapubic catheter and required assistance each morning with switching from his nighttime to daytime catheter bag and putting on a pull-up. The plan also read that his nighttime catheter bag should be soaked in a vinegar and water solution, with Relative A1 responsible for rinsing it in the morning and attaching the nighttime bag in the evening. Resident A empties his catheter bag independently throughout the day.

A review of Resident A's Medication Administration Records (MARs) for June, July, and August 2025 reflected catheter care consistent with the service plan. The MARs specified that caregivers were responsible for performing catheter-related tasks, while medication technicians were to verify the tasks were completed. Staff initials were documented for all four dates in question—6/28, 7/13, 7/19, and 8/2/2025—indicating catheter care was performed as scheduled.

On 8/12/2025, I conducted an on-site inspection.

> Administrator Taylor Obomsawin reported she was unaware of any concerns regarding Resident A's catheter care on the specified dates. She stated that biweekly telephone meetings with Relative A1 had been held, with the last on 7/11/2025. At that time, both parties agreed that Resident A's care was satisfactory, and they would move to monthly check-ins, with the next meeting scheduled for August 26, 2025.
>
> Employee #1 also reported no issues or concerns related to Resident A's catheter care on the dates in question.
>
> During an interview, Resident A stated he had no current concerns regarding his catheter care. At the time of the observation, he was wearing his leg catheter bag, and his nighttime bag was soaking per the instructions outlined in the service plan.

On 8/14/2025, I conducted a telephone interview with Relative A1, who reported that the catheter bag was not soaked in the prescribed vinegar and water solution on the dates referenced in the allegation. Photographs provided showed the catheter bag

left in the designated trash can without being cleaned, left in the shower, or still containing urine.

On 8/22/2025, email correspondence with the Administrator confirmed that a mandatory meeting and in-service were held on August 20, 2025, for all care associates. The training covered conduct expectations, catheter care procedures, and reporting protocols. Additionally, coaching and training on reporting were conducted with the Supervisor in Charge on August 15 and August 21, 2025. The email included attachments of the in-service sign-in sheets.

On 9/8/2025, additional correspondence from Relative A1 indicated that Resident A's catheter care on 9/7/2025, was not provided in accordance with the service plan.

APPLICABLE RULE	
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:	A review of Resident A's records confirmed that staff were instructed to switch from the nighttime to the daytime catheter bag and to soak the used bag in a vinegar and water solution. Although in-services on catheter care procedures were provided, photographic evidence and additional correspondence from Relative A1 indicated that this care routine was not consistently followed on the dates referenced in the allegation, nor after the in-services were conducted. Consequently, a violation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There were errors with Resident A's medications.

INVESTIGATION:

On 8/5/2025, the Department received an allegation which read that medication errors had occurred, resulting in Resident A nearly choking.

Resident A's service plan, updated on 7/31/2025, indicated he received a regular no-added-salt diet with thin liquids, and that staff are responsible for administering his medications. A review of Resident A's MARs for June, July, and August 2025

showed that his medications were to be given one at a time in applesauce. The MARs were initialed by staff, indicating this procedure was followed.

On 8/12/2025, I conducted an on-site inspection.

> The Administrator reported she was not aware of any incidents involving improper medication administration or any reports of a choking incident involving Resident A.
>
> Employee #1 also denied any concerns regarding medication errors related to Resident A.
>
> During an interview, Resident A stated he had no concerns and confirmed that staff administered his medications as ordered, with no incidents of choking.

On 8/14/2025, I conducted a telephone interview with Relative A1. She reported that in 2023, Resident A was administered medication while lying down, which caused him to nearly choke. More recently, she observed that staff administered all Resident A's medications at once, rather than one at a time. She also stated that on 8/11/2025, at 2:36 AM, Resident A's as-needed Tylenol was not administered in a timely manner. According to Relative A1, she had to call the facility to request that the medication be given.

During a telephone call with the Administrator on the same date, she indicated that Resident A's service plan would be updated to specify that he should be in an upright position when receiving medications. She also confirmed that staff were reminded to administer his medications one at a time. The Administrator stated that staff are expected to respond to residents' call pendants as promptly as possible, ideally within 10 minutes; however, response times may be longer if staff are assisting another resident.

A review of Resident A's call pendant usage from 7/13/2025 to 8/12/2025, showed consistent daily use, with a total of 189 activations and average to-room elapsed time was 7 minutes 45 seconds. On 8/11/2025, the log showed that Resident A pressed his call pendant at 2:18 AM, which was answered within two minutes. He pressed it again at 2:26 AM, with a response time of 16 minutes. A review of Resident A's August 2025 MAR for 8/11/2025 showed that Tylenol was not administered.

However, review of Employee #4's statement dated 8/23/2025, read in part she had pulled his medication to be administered on 8/11/2025 prior to receiving a telephone call from Relative A1.

On 9/2/2025, additional information was received from Relative A1, who reported that she was given permission by the Administrator to administer Resident A's PRN

Tylenol at 12:50 AM, as no medication technician had been available to do so for the prior two hours.

On 9/11/2025, email correspondence with the administrator included staff schedules for 9/1/2025 and 9/2/2025. The schedule for the overnight shift on 9/1/2025 (10:00 PM to 6:30 AM), indicated that a medication technician was brought in to cover for the originally scheduled staff member, who did not report for their shift.

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:	Relative A1's account, combined with the absence of MAR documentation, indicates that medication administration procedures were not consistently followed. Specifically, PRN Tylenol medication was not always administered in a timely manner nor properly documented. Given the lack of documentation for the administration of PRN Tylenol and the inconsistencies in adhering to prescribed procedures, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff were rude and took Resident A's pendant.

INVESTIGATION:

On 8/5/2025, the Department received allegations which read that staff were "rude and hostile" toward Resident A and that his call pendant was taken as a form of punishment.

Resident A's service plan, updated 7/31/2025, noted that he did not require assistance in using the community response system.

On 8/12/2025, I conducted an on-site inspection.

The Administrator reported she had not been informed of the incident by either Resident A or Relative A1 and stated that she would have investigated had she

been made aware. She noted that Resident A experiences increased confusion during nighttime hours but typically uses his pendant appropriately to request assistance.

Employee #1 also stated that no concerns regarding this incident had been brought to their attention.

Resident A was unable to recall the exact date of the incident but believed it occurred the previous week. He stated that around 2:00 AM, while lying in bed, he used his call pendant several times to request Tylenol. According to Resident A, a staff member responded and asked him to remove the pendant from his wrist so it could be repaired. He claimed the pendant was returned by the staff member, who threw it at him and told him to “find it” before walking away. Resident A said he felt frantic but eventually located the pendant. He reported the incident to Relative A1 the following morning. He added that he had not experienced similar treatment before or since and could not recall which staff member was involved.

At the time of inspection, Resident A was observed wearing his pendant on his wrist.

In a follow-up interview, the Administrator explained that pendants with low batteries may alarm continuously and not reset until the battery is replaced. She speculated that this may have occurred that night but emphasized that she would have preferred to know which staff member was involved so the situation could be addressed.

On 8/14/2025, I conducted a telephone interview with Relative A1, who reported that Resident A called her in distress at 4:09 AM on 8/4/2025. According to Relative A1, Resident A had requested staff assistance with his blankets. He stated that a staff member took his call pendant, later returned it, and threw it onto his bed, telling him to “find it.” Resident A reportedly struggled to locate the pendant in his blankets, eventually finding it 5–8 minutes later. He told Relative A1 he had thought to himself, “I’m going to make it.”

A review of Resident A’s call pendant usage from 8/4/2025, log showed pendant activations at 3:25 AM, 3:27 AM, 3:50 AM, and 4:20 AM. The log did not specify who responded at 3:25 AM; however, showed Employee #2 responded at 3:27 AM and 3:50 AM, while Employee #3 responded at 4:20 AM.

On 8/15/2025, email correspondence with the Administrator confirmed that Employee #2 was hired on 3/10/2025, and Employee #3 on 6/2/2025. Workforce Background Checks confirmed both employees were eligible for employment.

Review of Employee #2's new associate compliance training checklist (caregiver), completed on 3/18/2025, indicated training was conducted over a 17-day period. The record noted she completed hands-on training alongside other staff. A Care Nurse Aide Skill Performance Checklist Summary documented that Employee #2 satisfactorily demonstrated competencies in personal care skills, infection prevention, vital sign measurements, elimination, hydration and nutrition, mobility, and basic treatments.

Employee #2 also completed Relias training in April 2025, which included modules on: Alzheimer's Disease and Dementia, The Journey of Dementia, The Art of Caregiving, Essentials of Resident Rights, and Abuse, Neglect, and Exploitation.

Employee #3's training documentation reflected similar initial onboarding. She completed her new associate compliance training checklist (caregiver) and the Care Nurse Aide Skill Performance Checklist Summary on 6/7/2025. Additionally, she completed her Medication Technician floor orientation on the same date.

Employee #3's Relias training log showed completion of only one module—Abuse, Neglect, and Exploitation—on 7/15/2025. The log lacked documentation on the additional training modules completed by Employee #2.

During a telephone interview on 8/18/2025, the Administrator reported she planned to coordinate a phone meeting with Relative A1 per the relative's request. She also stated that she had received written statements from Employees #2 and #3, which would be sent via email.

In a follow-up email dated 8/20/2025, the Administrator stated she had reviewed the home's camera footage. She did not observe Employee #3 in the hallway during the relevant time frame of the incident but did see Employee #2 entering apartments in that area. The email further noted that the facility was conducting an internal investigation, had held meetings with staff regarding all discussed concerns from the prior week, and would provide updates as the investigation progressed.

On 8/22/2025, an email from the Administrator read that Employee #4 had been removed from the schedule effective 8/19/2025, pending an investigation and an in-person interview. The email also included statements from Employees #2 and #3.

> Employee #2 reported that she responded to Resident A's call pendant multiple times throughout the night and observed that he appeared more on edge and confused than usual. Employee #2 stated that Employee #4 had asked to borrow her magnet. As a result, when she went to respond to Resident A's call pendant, she did not have it in her possession. She explained that she used Resident A's own pendant to deactivate the call.

According to Employee #2, Resident A became upset and stated that he was going to call the police. She attempted to explain her actions, clarifying that she only canceled the call to respond and then immediately returned the pendant. Resident A reportedly told her that staff members like to take his pendant when he needs it. Employee #2 added Employee #4 worked with Resident A earlier that day and thought she was taking his pendant.

On 8/26/2025, an email from the Administrator stated that performance concerns had been identified regarding Employees #2 and #4, and that action was being taken in accordance with the facility's progressive performance management policy. The email also included a written statement from Employee #4, dated 8/23/2025, in which she stated that on 8/3/2025 and 8/4/2025, she had no knowledge of Resident A's call pendant being removed from his person.

On 9/3/2025, email correspondence with the Administrator provided Employee #4 date of hire 5/27/2025, and she was eligible for employment. Review of Employee #4's training revealed she completed Care Nurse Aide Skill Performance Checklist Summary by satisfactorily demonstrating competencies in personal care skills, infection prevention, vital sign measurements, elimination, hydration and nutrition, mobility, and basic treatments. She completed her Medication Technician floor orientation, as well as a checklist. Additionally, her Relias training included but was not limited to Abuse, Neglect, and Exploitation, Dementia Care: Effects of Medications, Dementia Care: Managing Medications, and assisted living medication training exam.

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:	Although the incident described by Resident A appears to have occurred, there was insufficient evidence to confirm that staff intentionally removed his pendant as a form of punishment. Disciplinary action was taken against Employees #2 and #4 following an internal investigation related to performance concerns; however, it was not confirmed that these actions were directly related to this specific incident. Based on the available information, the allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

09/15/2025

Jessica Rogers — Date
Licensing Staff

Approved By:

09/29/2025

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