GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2025

Kimberly Wozniak
River Oaks Senior Living
500 E University Dr
Rochester, MI 48307

RE: License #: AH630399620
Investigation #: 2025A1019087

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630399620
Investigation #:	2025A1019087
Complaint Receipt Date:	09/08/2025
Investigation Initiation Date:	09/09/2025
Report Due Date:	11/08/2025
Licensee Name:	Rochester Care Operations, LLC
Licensee Address:	940 Monroe Ave., NW, Suite 144 Grand Rapids, MI 49503
Administrator:	Kathleen Walker
Authorized Representative:	Kimberly Wozniak
Name of Facility:	River Oaks Senior Living
Facility Address:	500 E University Dr Rochester, MI 48307
Facility Telephone #:	(248) 601-9000
Original Issuance Date:	01/01/2020
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	117
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A missed his medication.	Yes
Additional Findings	No

III. METHODOLOGY

09/08/2025	Special Investigation Intake 2025A1019087
09/09/2025	Special Investigation Initiated - Letter Emailed licensee requesting information.
09/09/2025	APS Referral
09/16/2025	Inspection Completed On-site
09/18/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A missed his medication.

INVESTIGATION:

On 9/8/25, the department received a complaint alleging that following hospitalization, Resident A's medications were not filled correctly, and he missed several doses. The complaint alleged that the facility did not provide the hospital with the correct pharmacy information, so the medications were not refilled properly which caused the delay. Due to the anonymous nature of the complaint, additional information could not be obtained.

On 9/16/25, I conducted an onsite inspection. I interviewed the former administrator [Employee 1] at the facility. Employee 1 reported that she was not directly involved in the situation with Resident A, but from what she recalled, Resident A was hospitalized with a urinary tract infection and was prescribed an antibiotic upon his discharge. Employee 1 reported that the hospital sent Resident A's prescription to the incorrect pharmacy and not to the facility's contracted pharmacy, so it didn't get delivered to the facility. Employee 1 reported that facility staff were unaware of this issue until Resident A's family brought it to their attention a few days later. Employee 1 reported that Employee 2 had the most knowledge of what occurred, however was

not present during my onsite visit and reported that Employee 3 may also be able to provide additional information.

While onsite, I interviewed Employee 3. Employee 3's account of events was similar to Employee 1. Employee 3 added that Resident A's wife brought a copy of the prescription to the facility which she personally faxed over to Pharmascript. Employee 3 reported that Pharmascript was unable to fill the medication because it had already been filled elsewhere. Employee 3 reported that Resident A's wife was able to obtain the prescription from the outside pharmacy and brought it to the facility for staff to administer. Employee 3 reported that the facility did not have a copy of Resident A's hospital discharge paperwork, so they were initially unaware that he had any new orders.

During follow-up correspondence, the authorized representative (AR) Kimberly Wozniak submitted a timeline of events prepared by Employee 2 that read:

> *Friday, August 29:*
> *[Resident A] returned from the hospital mid-afternoon. A paper prescription for his antibiotic was found unattended on the front desk by med tech during the dinner shift. At the time, no staff were present at the desk. Recognizing the importance of the document, they scanned the prescription to both the wellness director and the pharmacy via the main printer's scan-to-email function.*
>
> *Saturday, August 30:*
> *No communication was received from the pharmacy or facility staff regarding whether the prescription had been processed or if the medication had been delivered.*
>
> *Sunday, August 31:*
> *I was called in due to staffing shortages during the morning shift. While completing the medication pass, I noted that [Resident A's] antibiotic was not present in the medication cart. I documented a reminder to email [name omitted] at the pharmacy requesting an emergency medication send-out, as the pharmacy was closed and the next day was a holiday.*
>
> *While assisting [Employee 3] with repositioning [Resident A] in his bed, [Employee 3] asked for assistance at the wellness desk. Upon arriving, I encountered [Resident A's] daughter, who was visibly upset and raising her voice at [Employee 3]. I respectfully asked her to speak calmly to staff. Despite multiple requests, she continued in a confrontational tone, expressing frustration that the medication had still not arrived and began directing disrespectful comments toward both [Employee 3] and myself.*
>
> *After the interaction, I regrouped with [Employee 3] to clarify the sequence of events. [Employee 3] reported that [Resident A's wife], had returned with [Resident A] and left the prescription on the front desk without notifying staff or*

providing any additional paperwork. I later confirmed that the prescription had been emailed to both myself and the pharmacy.

Note on protocol:
Our standard discharge process involves the hospital e-faxing prescriptions directly to our preferred pharmacy (Pharmascript of Farmington Hills) as well as sending discharge paperwork with EMS who will provide it to staff. If the discharge occurs before 3:00pm, medications typically arrive that evening, if after 3:00pm, delivery occurs the next day. In cases where a hard copy prescription is brought in, staff are expected to scan and send it immediately to both the pharmacy and the wellness director. Additionally, if medication does not arrive as expected, med techs are instructed to notify me and contact the pharmacy directly.

Follow up interaction:
[Resident A's] daughter later returned and informed us that the pharmacy was refusing to fill the prescription because it had already been filled at a CVS pharmacy. I was unaware of this development and reiterated that our facility does not use outside pharmacies without prior coordination. She again became confrontational and accused the facility of mishandling the discharge process.

At this point, I informed her that I would not continue the conversation as she is not the resident's designated Power of Attorney (POA), and any further communication should be directed to his wife [name omitted] to obtain discharge paperwork and information on pharmacy switch.

Approximately an hour later, the daughter returned to the desk, handed me a bag of medications, and stated that she had administered the first dose to [Resident A] herself. She instructed that the remaining doses be administered as scheduled. I assured her that the medication would be properly managed going forward.

The AR also submitted a copy of the paperwork that was provided to EMS by Employee 3. In the thirteen-page packet, I observed on the front page that Pharmascript was listed as the resident's pharmacy and provided the address, email, phone and fax numbers to the Farmington Hills pharmacy location. The AR also confirmed that facility staff did not obtain Resident A's hospital discharge paperwork.

Resident A's antibiotic prescription and medication administration records (MAR) were obtained. The prescription for cefpodoxime written on 8/29/25 instructed "*1 tab PO Q12H for 7 day*". Resident A's MAR read that he is to receive this medication daily at 8:00am and 8:00pm. Staff documented the first those they administered to him as 8:00pm on 8/31/25.

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:	Facility staff failed to follow proper protocol and did not obtain a copy of Resident A's hospital discharge paperwork that contained changes to Resident A's medication. Additionally, facility staff failed to follow up with the pharmacy in a timely manner to coordinate obtaining his newly prescribed medication, resulting in multiple missed doses.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1932	**Resident's 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:	Resident A's medications were not obtained from the pharmacy timely, resulting in multiple missed doses.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon completion of an acceptable correction action plan, I recommend no changes to the status of the license at this time.

09/26/2025

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

09/30/2025

_____

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