



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 31, 2025

Katelyn Fuerstenberg
Flourish Collection at Oakland Charter Twp
3215 Silverbell Rd.
Oakland Twp, MI 48306

RE: License #: AH630396969
Investigation #: 2026A1027004
Flourish Collection at Oakland Charter Twp

Dear Licensee:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. 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 dates 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 home for the aged authorized representative and a date.

Upon receipt of an acceptable corrective action plan, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result. 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 feel free to contact the local office at 877-458-2757.

Sincerely,

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 #:	AH630396969
Investigation #:	2026A1027004
Complaint Receipt Date:	10/13/2025
Investigation Initiation Date:	10/14/2025
Report Due Date:	12/12/2025
Licensee Name:	Blossom Ridge, LLC
Licensee Address:	3005 University Drive Auburn Hills, MI 48326
Licensee Telephone #:	(248) 340-9400
Administrator:	Michael Hamid
Authorized Representative:	Katelyn Fuerstenberg
Name of Facility:	Flourish Collection at Oakland Charter Twp
Facility Address:	3215 Silverbell Rd. Oakland Twp, MI 48306
Facility Telephone #:	(248) 601-0505
Original Issuance Date:	11/23/2020
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	56
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Food was served cold.	No
The facility was dirty.	No
Resident A was dropped due to lack of staff training.	No
Additional Findings	Yes

Allegations related to staffing were investigated under Special Investigation Report 2025A1035064.

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

10/13/2025	Special Investigation Intake 2026A1027004
10/14/2025	Special Investigation Initiated - Letter Email sent to Michael Hamid and Katelyn Fuerstenberg to request documentation
10/14/2025	Contact - Document Received Email received with requested documentation
10/15/2025	Inspection Completed On-site
10/23/2025	Contact – Document Received Additional allegations were received
10/23/2025	Contact – Document Sent Email sent to Katelyn Fuerstenberg, Michael Hamid and Employee #1 requesting documentation pertaining to Resident A
10/24/2025	Contact – Document Received Requested documentation received by email for Resident A
10/27/2025	Contact – Document Sent

	Email sent requesting additional information and documentation
10/30/2025	Contact Document – Received Email received with requested information and documentation
10/31/2025	Inspection Completed – BCAL Sub. Compliance
11/03/2025	Exit Conference Conducted by email with Katelyn Fuerstenberg, Michael Hamid and Employee #1

ALLEGATION:

Food was served cold.

INVESTIGATION:

On October 13, 2025, the Department received an anonymous allegation which read that residents were being served cold food. Due to the anonymous nature of the complaint, no additional details were available.

On October 15, 2025, I conducted an on-site inspection and interviewed staff.

Employee #1 explained that meals are prepared and temperature-checked in the main kitchen before being transported in a heated hot box to the assisted living and memory care satellite kitchens. She acknowledged that during a recent meeting held with residents, their families, and the local ombudsman, one concern raised was that food could be hotter upon arrival. In response, the facility has been working to maintain food temperature during transport to the various dining areas.

While on-site, I observed the kitchen and the equipment used to transport meals. A food warmer was observed maintaining a temperature of 180°F, and lunch items were being prepared. I also observed the hot box being used to deliver food to the memory care unit.

Review of food menus and temperature logs from October 1 to October 14, 2025, showed that staff were consistently recording food temperatures prior to all three meal services.

APPLICABLE RULE	
R 325.1976	Kitchen and dietary.
	(6) Food and drink used in the home shall be clean and wholesome and shall be manufactured, handled, stored,

	prepared, transported, and served so as to be safe for human consumption.
ANALYSIS:	Based on staff interviews, direct observations, and review of food service documentation, there was insufficient evidence to substantiate the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The facility was dirty.

INVESTIGATION:

On October 13, 2025, the Department received an anonymous allegation which read that the facility was dirty throughout, including inadequate cleaning in both resident areas and dining spaces. Due to the anonymous nature of the allegations, no further details could be obtained.

On October 15, 2025, I conducted an on-site inspection and interviewed staff.

Employee #1 stated that the facility employs a housekeeping manager and three housekeepers, with one staff member specifically assigned to clean all common areas. She reported that no complaints about cleanliness were raised during a recent meeting held with residents and their families. She acknowledged that the facility has white carpeting, which can show stains more easily, but stated that housekeeping staff work daily to spot-clean and that routine carpet cleaning was scheduled to begin the following week.

Employee #2 confirmed this information and added that night shift staff would be completing carpet cleaning in memory care and assisted living next week. She stated that moving forward, carpets would be cleaned on a scheduled basis and resident rooms deep-cleaned quarterly. She explained that one housekeeper is assigned to memory care rooms, another to assisted living rooms, a third to common areas, and one staff person handles laundry. A part-time second-shift staff member is responsible for common areas and laundry, while the midnight shift handles laundry and carpet cleaning. Additionally, a housekeeper is on duty every weekend until 3:00 PM.

Employee #2 described the housekeeping schedule, stating that each resident's room is assigned a specific cleaning day. Weekly, housekeepers perform a full

cleaning of each room including bathrooms, surfaces, mopping, vacuuming, and bedding changes while staff perform daily surface cleaning in residents' rooms.

During the inspection, I toured the assisted living and memory care areas, including dining rooms, common spaces, and 15 resident rooms. All observed areas appeared clean. Although the white carpet in hallways showed occasional staining, it was generally well-maintained.

Review of the housekeeping and laundry schedules was consistent with staff reports.

APPLICABLE RULE	
R 325.1979	General maintenance and storage.
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Based on staff interviews, review of schedules, and direct observations, there was insufficient evidence to substantiate the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A was dropped due to lack of staff training.

INVESTIGATION:

On October 23, 2025, the Department received additional allegations which read Resident A was dropped for the third time on October 4, 2025, most recently by an untrained employee who did not know how to properly use the lift equipment. The allegations that the same untrained staff were assigned to care for Resident A despite assurances from Employee #3, that only experienced staff would be assigned to her care.

On 10/24/2025, email correspondence from Employee #1 read Employees #4 and #5 worked on October 4, 2025. Additionally, they have since completed education, with documentation on file, with these two individuals, as well as other team members, around body mechanics and proper use of assistive devices including sit-to-stand, hooyer, gait belts, etc. The email included Resident A's face sheet, service plan and incident report.

On October 30, 2025, additional email correspondence with Employee #1 clarified that Resident A utilized a sit-to-stand lift for transfers and that there were no additional incident reports around the timeframe of October 4, 2025.

A review of Resident A's face sheet indicated that she moved into the facility on April 3, 2023, and that Relative A1 was listed as her power of attorney and first emergency contact. The service plan, updated August 29, 2025, read that Resident A required assistance of one staff member for transfers in and out of bed, chair, and toilet, and that staff were to remain present throughout the duration of each activity. Staff were instructed to utilize a gait belt during transfers. The service plan also noted that Resident A was generally independent in communication but occasionally experienced moments of confusion, and staff were advised to allow her adequate time to respond to questions.

The incident report dated October 4, 2025, at 4:30 p.m., authored by Employee #4, read that Resident A's foot slipped off the Hoyer lift during transfer. The report indicated that Resident A was removed from the lift, emergency medical services were contacted, and no injuries were observed. The report listed environmental factors as contributing elements, specifically furniture and rugs/carpet, and documented that Relative A1 was notified and Employee #5 served as a witness.

A review of Employees #4 and #5's training records indicated that both had completed a Caregiver Competency Checklist on September 18, 2025, which included demonstrated competency in transfers using a Hoyer lift, sit-to-stand lift, gait belt, Raizer chair, transfer aids, slide board, and both one-person and two-person assists.

APPLICABLE RULE	
R 325.1931	Employees; general provisions.
	<p>(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following:</p> <ul style="list-style-type: none"> (a) Reporting requirements and documentation. (b) First aid and/or medication, if any. (c) Personal care. (d) Resident rights and responsibilities. (e) Safety and fire prevention. (f) Containment of infectious disease and standard precautions. (g) Medication administration, if applicable.

ANALYSIS:	Review of Employees #4 and #5's training records confirmed that both staff had received training on the proper use of the sit-to-stand lift prior to the incident on October 4, 2025. The incident report indicated that environmental factors may have contributed to the event. Additionally, the facility had no other reported incidents with the sit to stand during the relevant timeframe. Based on the information obtained, this allegation was not substantiated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

On October 30, 2025, additional email correspondence with Employee #1 clarified that Resident A utilized a sit-to-stand lift for transfers. However, review of Resident A's service plan, updated August 29, 2025, indicated that Resident A required the assistance of one staff member for transfers in and out of bed, chair, and toilet, with staff required to remain present for the duration of each activity. The service plan further directed that staff were to utilize a gait belt during all transfers.

APPLICABLE RULE	
R 325.1922	Admission and retention of residents.
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Staff statements indicated that Resident A required the use of a sit-to-stand lift for transfers. However, review of Resident A's service plan showed it identified her as a one-person transfer utilizing a gait belt. The service plan had not been updated to reflect Resident A's current care needs. Based on this information, a violation was substantiated.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

I recommend the status of this license remain unchanged.

Jessica Rogers

10/31/2025

Jessica Rogers
Licensing Staff

Date

Approved By:

Andrea Moore

10/31/2025

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

Date