GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 30, 2025

Trina Watson
Waterford Oaks Senior Care Inc.
6474 Oak Valley Rd.
Waterford, MI 48237

RE: License #: AL630284310
Investigation #: 2025A0991023
Waterford Oaks Senior Care, Inc.

Dear Ms. Watson:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 (248) 972-9136.

Sincerely,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630284310
Investigation #:	2025A0991023
Complaint Receipt Date:	08/19/2025
Investigation Initiation Date:	08/19/2025
Report Due Date:	10/18/2025
Licensee Name:	Waterford Oaks Senior Care Inc.
Licensee Address:	3385 Pontiac Lake Road Waterford, MI 48328
Licensee Telephone #:	(248) 681-4788
Administrator:	Trina Watson
Licensee Designee:	Trina Watson
Name of Facility:	Waterford Oaks Senior Care, Inc.
Facility Address:	3385 Pontiac Lake Rd. Waterford, MI 48328
Facility Telephone #:	(248) 681-4788
Original Issuance Date:	10/12/2007
License Status:	REGULAR
Effective Date:	05/01/2024
Expiration Date:	04/30/2026
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On 08/16/25, Resident A was found lying in a ditch after leaving the facility unnoticed the night before, despite staff initially claiming all residents were present.	Yes

III. METHODOLOGY

08/19/2025	Special Investigation Intake 2025A0991023
08/19/2025	Special Investigation Initiated - Telephone Call to home manager- Resident resides in East building- Waterford Oaks Senior Care
08/19/2025	APS Referral Referred to Adult Protective Services (APS) Centralized Intake
08/21/2025	Contact - Telephone call made Call to complainant
08/22/2025	Contact - Telephone call made Call to James Booth- first responder
08/22/2025	Contact - Document Received Report from Waterford Fire Department
08/26/2025	Inspection Completed On-site Unannounced onsite inspection
08/26/2025	Contact - Document Received Discharge paperwork, incident report, assessment plan
08/27/2025	Contact - Face to Face Unannounced onsite inspection- follow up to interview Resident A
08/28/2025	Contact - Telephone call made To accused staff, Caresha Reaves- will call back
09/03/2025	Contact - Document Received Staff training verification

09/03/2025	Contact - Document Received APS acknowledgement- assigned to Gene Evans
09/09/2025	Contact - Document Received Staff training verification
09/11/2025	Contact - Telephone call made Left message for direct care worker, Caresha Reaves
09/29/2025	Contact - Document Sent Email to assigned APS worker, Gene Evans
09/29/2025	Exit Conference Via telephone with licensee designee, Trina Watson

ALLEGATION:

On 08/16/25, Resident A was found lying in a ditch after leaving the facility unnoticed the night before, despite staff initially claiming all residents were present.

INVESTIGATION:

On 08/19/25, I received a complaint alleging that on 08/16/25, Resident A was found lying in a ditch after she wandered away from Waterford Oaks Senior Care during the night. The complaint stated that Resident A walked across a five-lane road, walked up a block, and fell in the ditch after losing her footing. She had been lying in the ditch for several hours before being found by a neighbor who was leaving for work. Resident A was damp, her hands were cold, and she was shivering uncontrollably. The complainant noted that they contacted the facility to let them know what happened. Waterford Oaks staff stated it was not one of their residents, as they had accounted for all the residents. Staff called back 20 minutes later to state that they needed information for an incident report, as it was their resident.

I referred these allegations to Adult Protective Services (APS) Centralized Intake on 08/19/25.

On 08/19/25, I interviewed the home manager, Erica Martin, via telephone. Ms. Martin confirmed that Resident A resides in the East building, Waterford Oaks Senior Care. She stated that Caresha Reaves was the staff member who was on shift on Friday night when Resident A wandered away. Ms. Reaves was let go and is no longer employed at Waterford Oaks Senior Care. Ms. Martin stated that they have cameras in the common areas at the facility. They reviewed the video footage from the night Resident A walked away and observed that Ms. Reaves was sitting near the front entrance of the facility, scrolling on her phone, when Resident A left out of the side door. Ms. Reaves was not

paying attention and did not appear to see or hear Resident A leave the facility. According to the video footage, Resident A left the facility around 1:54am. Police came to the facility to notify staff that Resident A was found around 5:20am. Ms. Martin stated that Resident A did not have a history of wandering or leaving the facility. She was recently hospitalized for a urinary tract infection (UTI), and her mental status changed at that time. She was still experiencing some confusion post-UTI. Ms. Martin stated that staff are supposed to check on the residents every two hours. She stated that the video footage showed that Ms. Reaves did not complete checks every two hours. Ms. Reaves checked on two residents in her assigned hall. Resident A was not one of the individuals who she checked on. Ms. Martin stated that Ms. Reaves had worked at the facility for approximately one year, but she called Resident A by the wrong name when she was reporting what happened. Ms. Martin stated that Resident A was transported to the hospital after she was found in the ditch. She did not have any bruises or broken bones. Resident A is still at the hospital, but it is anticipated that she will return to Waterford Oaks. Resident A is her own person and does not have a guardian.

On 08/21/25, I interviewed the complainant via telephone. The complainant stated that she was leaving for work around 5:00am on Friday, when she saw something in the ditch next to the road. There was a handle sticking up, which was Resident A's walker. Resident A then stuck her head up and looked at the complainant. The complainant stated that they stopped their car and got out to make sure Resident A was okay. She got a blanket to cover Resident A and called 911. Resident A's hands were ice cold and she was shivering. The complainant stated that the weather was in the upper 50s or lower 60s that morning. It appeared as though Resident A had been in the ditch for a while. She was soaking wet and had grass all over her. Resident A stated that she had been calling for help, but nobody heard her. She told the complainant that she lived across the street, but she did not want to live there. Resident A kept asking the complainant who they were. The complainant helped Resident A stand up and had her sit on the seat on her walker. She did not see any visible injuries and Resident A stated that she did not think she was hurt. Resident A was dressed in slacks, a short sleeve sweater, and was wearing shoes. When the paramedics arrived, Resident A told them her name. They loaded Resident A onto a stretcher and transported her to the hospital.

The complainant stated that she called Waterford Oaks to let them know they picked up Resident A in the ditch and that she had been sent off with the paramedics. Staff at the facility stated that they did not have anyone there by Resident A's name. They put the complainant on hold for several minutes and then stated that all of the residents were there and they did not have anyone by that name. The staff person stated that they checked both buildings, as there are two licensed facilities next to each other on the property. The complainant stated that 20-30 minutes later, around 5:40am, someone from Waterford Oaks called back and said that it was one of the residents from their facility. Staff told the complainant that Resident A has "a condition" that causes her to shiver uncontrollably. The complainant stated that Resident A was found about a half block away from the facility, on the opposite side of the road.

On 08/22/25, I interviewed James Booth, a lieutenant/paramedic with the Waterford Township Fire Department. Mr. Booth was one of the first responders on the scene when Resident A was found in the ditch on 08/16/25. Mr. Booth stated that he was dispatched to respond to a call that a passerby saw an individual lying in the ditch with her walker. He stated that they got Resident A onto a stretcher and she was able to answer some questions, but she seemed to have some dementia/confusion. Resident A was dressed and was wearing shoes. The weather was warm, and Resident A did not appear to have any visible injuries. Resident A kept saying that she "wanted to get away from that place." Mr. Booth stated that he went over to Waterford Oaks Senior Care and staff did not know that Resident A was missing. They did not know how Resident A got out. Mr. Booth stated that it is believed that Resident A left the facility around 1:00-1:30am and she was found around 5:00am. Staff thought that Resident A was in bed and were not aware that she had wandered away from the facility.

I received and reviewed a Patient Care Record report from the Waterford Regional Fire Department. The report notes that they were dispatched at 4:56am and found Resident A presenting with signs of confusion and disorientation. The report notes the following:

> Waterford Fire dispatched to an intersection for an elderly female laying in a ditch. Engine 3 and Rescue 3 responded lights and siren on dark, dry roads. Engine 3 and Rescue 3 arrived on scene without incident. Upon Rescue 3 arrival patient was sitting upright on her walker. Patient was located in a roadside drainage ditch wearing a wet jacket. Patient was in the care of bystanders. Patient had hallucinations. Patient stated that the nursing home staff drugged her. She stated that they rearranged her stuff and painted over her mother's paintings. Patient stated that for these reasons she decided to leave the nursing home. Patient stated that she left the nursing home at approximately 01:30 and was found by a passerby around 04:50. Bystander stated that they found the patient on the ground and had moved her to her walker. Patient was awake and confused with a GCS (Glasgow Coma Scale) rating of 15. Patient was alert to time and place, but confused to events. Patient denied any injuries. Patient denied any chest pain or shortness of breath. Patient denied any nausea or vomiting. Patient's skin was pink, warm, and dry. Patient's pupils were equal, round, and reactive tonight. Patient had no noted deformity to head. Patient had a midline trachea with no noted JVD (jugular vein distention). Patient had no noted deformity to chest. Patient had a soft, non-tender abdomen. Patient stable, non-tender pelvis. Patient had no noted deformity to upper or lower extremities with adequate pulse, motor, or sensory functions. Patient was given supportive care throughout transport. Patient was moved to the stretcher using a stand and pivot technique. Patient was secured to the stretcher using all straps and both handrails. Patient was moved to the ambulance and loaded without incident. Patient was safely transported non emergent to Trinity Oakland Hospital. Patient was transferred into the care of an RN (registered nurse) in ED (emergency department) hall bed 7 with report.

On 08/26/25, I conducted an unannounced onsite inspection at Waterford Oaks Senior Care. I interviewed the home manager, Erica Martin. Ms. Martin stated that Resident A moved into the facility around May 2025. She never had a history of wandering or attempting to leave the facility. On 08/15/25, direct care workers, Caresha Reaves and Jalen Lile, were working the midnight shift from 11:00pm-7:00am. The two staff on shift split duties and are each responsible for one of the halls in the building. Caresha Reaves was assigned to the hall where Resident A resides. Jalen Lile was using the bathroom in the hall he was assigned to around the time Resident A wandered away from the facility. Ms. Reaves was sitting in the front room. She was scrolling on her phone or an iPad. Ms. Martin stated that she might have had earbuds or headphones on, but she did not appear to be sleeping. Ms. Reaves contacted Ms. Martin around 5:00am to state that Resident A left the building. Ms. Reaves told Ms. Martin that the door chimes were not working; however, Ms. Martin stated that she observed the door alarms were all functioning when she came to the facility early that morning. Ms. Martin stated that there are sensors on the door, which make an audible noise when someone goes near the door.

During the onsite inspection, I reviewed the video footage from the cameras that are located in the hallways and common areas of the facility. There is video footage that has a time stamp of 1:53am on 08/16/25, which shows Resident A going out the door that is in the side hallway. I also reviewed video footage from the camera near the front room that has a time stamp of 1:53am on 08/16/25, which shows a female staff person sitting in a chair near the front door. She appears to be scrolling on her phone or an electronic device. She continues to look at the device for more than five minutes, and she does not get up or look around. There is no indication that she heard the door alarm or was aware that Resident A left the building at this time. The home manager, Erica Martin, and assistant manager, Tiffany Jones, identified the staff person in the video as Caresha Reaves. They stated that they reviewed all of the camera footage for that night, and Ms. Reaves was sitting in the chair on her phone for more than three hours. They stated that the video shows that Ms. Reaves checked on two residents around 1:30am, but she did not check on Resident A. Staff are expected to check on the residents at least every two hours. The assistant manager, Tiffany Jones, stated that since this incident occurred, they have been doing random checks and pop-ins during the midnight shift, as well as practicing elopement drills to see how long it takes for staff to respond to when they stand by the doors.

During the onsite inspection, I observed that the door alarms in the facility were working properly. The assistant manager, Tiffany Jones, walked near the door located in the side hallway from which Resident A left the building. I was able to clearly hear the door alarm chime from the chair in the front room where Caresha Reaves was observed to be sitting.

On 08/26/25, I attempted to interview Resident A. Resident A was resting in her bed. She stated that she was tired and did not want to talk. She asked that I come back later. I conducted a follow-up onsite inspection on 08/27/25 and interviewed Resident A.

Resident A stated that she left the facility at 1:30am. She stated that she did not see anyone following her, so she kept going. She went out the door at the end of the hallway where her bedroom is located. She heard the alarm go off on the door, but she did not see any staff coming to stop her. She could not recall who was working at the time. She stated that the staff was dancing in one of the rooms. Resident A stated that she went across the street, but there was a ditch, and she fell in it. She was rolling around for a bit and crying for help, but nobody came to help her. She could not stand or get up. It was cold outside. Resident A stated that she was wearing shoes, and she was dressed in clothes, not pajamas. She stated that she was outside for close to four hours. Resident A stated that eventually EMS came and took her to the hospital. She stated that she did not have any broken bones. She was in the hospital for several days, but she was not sure why they kept her there. Resident A stated that it is “okay” living at Waterford Oaks Senior Care. Her family told her that it is the best place for her to live. She stated that nobody explained anything to her when she moved in. Sometimes staff take a long time to respond, and they do not always pay attention to the call light. Sometimes it takes up to 30 minutes for staff to come help her.

I received and reviewed a copy of an incident report completed by direct care worker, Caresha Reaves, on 08/16/25 at 5:00am. The incident report notes that around 5:00am, the fire department arrived notifying staff that Resident A was outdoors. The door alarm did not go off. Resident A was in her room earlier throughout the night. She was sent to St. Johns Hospital. Resident A’s family and management were contacted. The incident report notes that the corrective measures taken to prevent recurrence include conducting more wellness checks on residents and notifying management about the door issue.

I received and reviewed a copy of an incident investigation report for Resident A’s unauthorized exit and injury on 08/16/25 at 1:54am, which states the results of an internal investigation conducted by the Waterford Oaks Senior Care managers. The report summarizes the incident and notes that staff, Caresha Reaves, claimed that the door chime was not functioning. The report notes that management inspected the facility’s door alert system immediately following the incident and confirmed that all exit door alarms were fully operational. The report notes that a review of the surveillance camera footage shows Resident A exiting the building via the side hall door at approximately 1:54am. At the time of exit, Caresha Reaves was seated in a chair near the front door in a darkened room. Although the footage was not clear enough to confirm, she appeared to be using a mobile device and may have had earbuds in her ears. Jalen Lile was in the restroom located in the opposite hall. The report states that Caresha Reaves falsified her incident report, claiming that the door alarms were not working. The investigation confirmed that the statement was false. Required two-hour wellness checks were not completed properly during the shift. Staff failed to respond to the functioning door chime, which is clearly audible from where Caresha was seated. All staff are trained at the start of employment to complete two-hour wellness and incontinence checks and to remain attentive to door alarms as a critical safety precaution. The conclusion of the report states that this incident was preventable and occurred due to staff neglect, failure to complete required wellness checks, inattention

to the door alarm, and false reporting of events. As a result of these findings, Caresha Reaves's employment was terminated for neglect of duties, falsification of documentation, and failure to ensure resident safety as required by facility policies and training.

I received and reviewed an employee warning notice dated 08/18/25, which indicates it is a termination notice for direct care worker, Caresha Reaves. The notice states:

> On 6/16/25 at approximately 5:15am, EMS professionals had to inform staff that one of their residents had eloped from the facility. The resident had been outside for an estimated four hours before being located by emergency responders and was immediately transported to the hospital.
>
> During your scheduled shift, it was observed that you were in a dark room using an electronic device. While doing so, you failed to hear and respond to the door alarm when it was activated.
>
> This is a serious safety violation. Not being alert and attentive to your surroundings while on duty placed residents at significant risk. Such inattention is considered neglect and could have resulted in a fatal outcome had the situation escalated.
>
> During review of the shift, it was determined that you did not complete any required wellness checks on this resident at the designated times of 11:00pm, 1:00am, 3:00am, and 5:00am. Additionally, documentation shows that you only checked on two other residents at approximately 12:45am, despite being responsible for the care and supervision of approximately eight other residents.
>
> This failure to perform required wellness checks and to provide adequate supervision constitutes neglect and a serious violation of both facility policy and state regulations regarding resident safety.

The notice indicates that due to the seriousness of the incident and the breach of resident safety, Caresha Reaves's employment with the facility is terminated effective immediately. The notice indicates that Caresha Reaves refused to sign the document.

I reviewed an orientation checklist dated 06/18/25 and signed by Caresha Reaves, which indicates that she completed personal care, supervision, and protection training. The orientation checklist includes a checked box under the heading "safety" which notes, "Location of residents every 2 hours, Hospice residents can be more often if necessary." Ms. Reaves also signed an acknowledgement on 08/15/24 regarding the ratio of direct care staff to residents, which notes, "Headphones or ear buds are strictly prohibited on company property. Headsets for cell phones are also prohibited. An employee must be always alert including during a break for Resident emergencies." She signed an acknowledgement regarding no sleeping on shift on 05/15/25, which notes "All employees are expected to remain alert and attentive during their scheduled shifts."

Ms. Reaves also signed a document dated 05/15/25 regarding shift responsibilities, which notes, “Greet every person that walks into our building, offer assistance and request that they sign in. To ensure that this happens you must be familiar with the door chime sounds and remain alert to them. *This is for everyone’s safety we need to be able to account for all residents under our care and know who is in our facilities at any given time.”

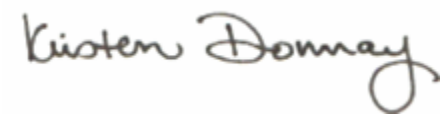
On 09/29/25, I conducted an exit conference via telephone with the licensee designee, Trina Watson. Ms. Watson stated that she would be contesting the issuance of a provisional license, as she did not feel that she should be held responsible for the actions of the staff, Caresha Reaves. Ms. Watson stated that they conducted a background check on Ms. Reaves, she was fully trained, and she was aware of her job expectations. She stated that she could not control the fact that Ms. Reaves ignored her training and did not fulfill her job duties while on shift, which put a resident at risk. Ms. Watson stated that Ms. Reaves was terminated as a result of her actions. Ms. Watson stated that Resident A was moved to the other building due to her frequent UTIs and wandering behavior.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: (a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that direct care worker, Caresha Reaves, was not suitable to meet the needs of each resident. On 08/16/25, Ms. Reaves was observed in video footage to be sitting in a dark room, scrolling on a mobile device for several hours. She did not complete bed checks every two hours as required. Ms. Reaves was inattentive and neglected the needs of the residents. She did not respond to the door alarm when Resident A wandered away from the facility during the middle of the night on 08/16/25. Ms. Reaves was unaware that a resident was missing from the facility when notified by the first responder and neighbor who located Resident A lying in a ditch. Ms. Reaves told management that the door alarms at the facility were not working, which they found to be a false statement upon inspection of the alarms.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15305	**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:	Based on the information gathered through my investigation, there is sufficient information to conclude that direct care worker, Caresha Reaves, did not attend to the safety and protection of Resident A at all times. On 08/16/25, Resident A walked out of the side door of the facility at 1:53am. She crossed a five lane road and fell into a ditch, where she was lying for three hours calling for help before being found by a passerby. At this time, Ms. Reaves was observed in video footage to be sitting in a dark room, scrolling on a mobile device for several hours. She did not respond to the door alarm when Resident A wandered away from the facility and did not complete required bed checks throughout her shift. Ms. Reaves was unaware that Resident A had been missing from the facility for over three hours when notified by the first responder and neighbor who located Resident A lying in a ditch.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

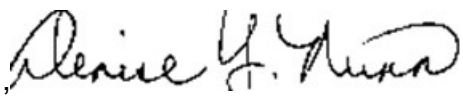
Contingent upon the receipt of an acceptable corrective action plan, I recommend the issuance of a six-month provisional license.



09/29/2025

Kristen Donnay Date
Licensing Consultant

Approved By:



10/08/2025

Denise Y. Nunn Date
Area Manager