GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 5, 2025

Steven Tyshka
Waltonwood at Carriage Park II
2000 Canton Center Rd
Canton, MI 48187

RE: License #: AH820336526
Waltonwood at Carriage Park II
2000 Canton Center Rd
Canton, MI 48187

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

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
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AH820336526
Licensee Name:	Waltonwood at Carriage Park II, L.L.C.
Licensee Address:	#200 7125 Orchard Lake Rd West Bloomfield, MI 48322
Licensee Telephone #:	(248) 865-1012
Authorized Representative:	Steven Tyshka
Administrator:	Tabitha Sheriff
Name of Facility:	Waltonwood at Carriage Park II
Facility Address:	2000 Canton Center Rd Canton, MI 48187
Facility Telephone #:	(734) 844-3060
Original Issuance Date:	10/18/2012
Capacity:	61
Program Type:	AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 10/30/2025

Date of Bureau of Fire Services Inspection if applicable: 10/24/2025

Inspection Type: ☐ Interview and Observation ☒ Worksheet ☐ Combination

Date of Exit Conference: 11/05/2025

No. of staff interviewed and/or observed 12
No. of residents interviewed and/or observed 25
No. of others interviewed 0 Role N/A

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.

- Medication(s) and medication records(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☐ No ☒ If no, explain. No resident funds held in trust.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.

- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  Bureau of Fire Services reviews fire drills. Disaster plan reviewed.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.

- Incident report follow-up? Yes ☐ IR date/s: N/A ☒
- Corrective action plan compliance verified? Yes ☒ CAP date/s and rule/s: CAP dated 7/28/2023 to Licensing Study Report dated 7/14/2023; R 325.1921(1)(b), R 325.1932(2), R 325.1964(9), R 325.1976(13)
- Number of excluded employees followed up? Zero, as verified in the workforce background check account on date of survey. N/A ☐

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:

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.

Review of Resident A's service plan dated June 5, 2025, revealed that it did not include documentation of a halo bedside assist device used for transfers. This omission was inconsistent with the home's bed mobility device procedure guide dated April 2024, which reads that all devices must be documented in the resident's service plan prior to use in the community.

VIOLATION ESTABLISHED.

R 325.1931 Employees; general provisions.

(3) The home shall designate 1 person on each shift to be supervisor of resident care during that shift. The supervisor of resident care shall be fully dressed, awake, and on the premises when on duty.

Review of the staff schedule for the period of October 19 - 25, 2025, showed that three shifts were scheduled; however, the schedule did not specify the shift supervisor for each shift.

VIOLATION ESTABLISHED.

R 325.1931 Employees; general provisions.

(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:

(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.

A review of employee files revealed a lack of training consistent with these regulatory requirements. Employees #2, and #7 lacked verification of any completed training, including Relias training, as it pertains to this rule. In addition, Employees #1, #2, and #7, who serve as caregivers, had no record of personal care training. Furthermore, Employees #4 and #5, who serve as medication technicians, did not have verification of medication administration training. Employee #3's file lacked documentation of training on resident rights and responsibilities. Employee files reviewed, except Employee #3, were missing documentation of training related to reporting requirements.

VIOLATION ESTABLISHED.

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.

Review of the narcotic count log revealed that it was left incomplete on multiple shifts for the following dates: October 24, 25, and 28, 2025.

Additionally, review of Resident A's October 2025 medication administration record (MAR) showed that he was prescribed Myrbetriq on an as-needed (PRN) basis for bladder issues; however, staff documented its administration on October 24, 2025, for pain. Review of Resident B's October 2025 MAR indicated she was prescribed Haloperidol on an as-needed (PRN) basis for agitation, yet staff documented its administration for pain on October 2, 10, 19, and 21, 2025.

REPEAT VIOLATION ESTABLISHED.

[For reference, see licensing study report (LSR) dated 7/14/2023, CAP dated 7/28/2023]

IV. RECOMMENDATION

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

11/05/2025

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Date

Licensing Consultant