STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

April 1, 2026

Steven Tyshka
Waltonwood at Lakeside
14650 Lakeside Circle
Sterling Heights, MI 48313

RE: License #: AH500285320
Investigation #: 2026A1027029
Waltonwood at Lakeside

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, 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 #:	AH500285320
Investigation #:	2026A1027029
Complaint Receipt Date:	03/03/2026
Investigation Initiation Date:	03/06/2026
Report Due Date:	05/02/2026
Licensee Name:	Waltonwood At Lakeside I, L.L.C.
Licensee Address:	Suite #200 7125 Orchard Lake Rd. West Bloomfield, MI 48325
Licensee Telephone #:	(248) 865-1600
Administrator:	Gina Steigerwald
Authorized Representative:	Steven Tyshka
Name of Facility:	Waltonwood at Lakeside
Facility Address:	14650 Lakeside Circle Sterling Heights, MI 48313
Facility Telephone #:	(586) 532-7601
Original Issuance Date:	07/16/2007
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	90
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her prescribed medications.	Yes
Resident A did not receive checks.	Yes
Additional Findings	No

III. METHODOLOGY

03/03/2026	Special Investigation Intake 2026A1027029
03/06/2026	Special Investigation Initiated - On Site
03/06/2026	Contact - Document Sent Email sent to complainant requesting additional information
03/13/2026	Contact - Document Sent Email sent to Emily Long requesting additional documentation
03/13/2026	Contact - Document Received Email received with information
03/16/2026	Inspection Completed-BCAL Sub. Compliance
03/18/2026	Contact – Document Received Email received from complainant with additional information
03/19/2026	Contact – Document Sent Email sent to complainant requesting additional information
03/27/2026	Contact – Document Received Email received from complainant with additional information
03/27/2026	Contact – Document Sent Email sent to home requesting additional information and documentation
03/27/2026	Contact – Document Received Email received with requested information
03/27/2026	Contact – Telephone Call Made Voicemail left with Employee #4

03/27/2026	Contact – Telephone Call Made Voicemail left with Employee #5
03/27/2026	Contact – Telephone Call Received Telephone interview conducted with Employee #4
03/27/2026	Contact – Telephone Call Made Telephone interview conducted with Employee #2
03/27/2026	Contact – Telephone Call Made Telephone interview conducted with Employee #5
03/27/2026	Contact – Telephone Call Made Telephone interview conducted with Employee #6
04/01/2026	Exit Conference Conducted by email with Steven Tyshka and Gina Steigerwald

ALLEGATION:

Resident A did not receive her prescribed medications.

INVESTIGATION:

On March 3, 2026, the Department received a complaint which read that Resident A was discharged from the hospital on February 5, 2026, and returned to Waltonwood. It is alleged that Resident A did not receive her medications on the evening of February 5, 2026, or the morning of February 6, 2026. The report further indicated that Resident A was experiencing difficulty eating and that staff presumed she had refused the medications.

On March 6, 2026, I conducted an on-site inspection at the home and interviewed staff.

Interim Administrator Emily Long reported that Resident A had been hospitalized from January 26, 2026, to February 5, 2026, and again from February 6, 2026, to February 12, 2026. She confirmed that Resident A returned to the facility on February 5, 2026, sometime between 8:00 AM and 4:30 PM; however, she could not confirm the exact time Resident A was sent to the hospital on February 6, 2026. She further reported that Resident A returned to home on February 12, 2026, and began receiving Gentiva Hospice services, following her recent hospitalizations, and that her family had been staying with her around the clock.

Employee #1 reported that she had not received any concerns from Resident A's family regarding medication administration.

Employee #2 reported that Resident A typically took her medications whole with applesauce and was usually responsive, alert, and able to communicate her needs. Employee #2 stated that on February 6, 2026, another medication technician administered Resident A's medications because Employee #2 has an allergy to Resident A's cats. The medication technician reported that Resident A was not responding; therefore, medications could not be administered. Employee #2 stated that staff cannot force a resident to take medications. She also reported that care staff were unable to assist Resident A out of the recliner at that time. Employee #2 stated that these concerns were reported to her supervisor, and Resident A was subsequently sent back to the hospital on February 6, 2026.

Employee #2 further explained that the facility's protocol when a resident verbally refuses medications is to offer the medications up to three times and have another staff member also attempt to administer them. If the resident continues to refuse, the medications are then wasted according to protocol. However, Employee #2 reiterated that on February 6, 2026, Resident A was unable to take her medications, rather than refusing them.

On March 18, 2026, email correspondence from the complainant confirmed Resident A returned to the home on February 5, 2026, around 4:00 PM, and was sent back to the hospital around 10:30 PM on February 6, 2026.

Resident A's face sheet indicated that she moved into the home on June 7, 2022, and that Relative A1 was listed as her primary emergency contact and durable power of attorney (DPOA). The face sheet also indicated that she received Gentiva Hospice services. Resident A's service plan dated February 24, 2026, indicated that she required total assistance with medication administration.

Resident A's February 2026 Medication Administration Record (MAR) was reviewed and was consistent with staff statements regarding the dates of her hospitalizations. On February 5, 2026, the MAR entry for medications scheduled between 7:00 PM and 10:00 PM showed the staff member's initials circled, with documentation at 7:37 PM indicating the medications were refused, except for Refresh and Retaine eye drops, which were initialed as administered at 6:00 PM. On February 6, 2026, the MAR entry for medications scheduled between 7:00 AM and 10:00 AM showed the staff member's initials circled, with documentation at 11:03 AM indicating the medications were refused. Additionally, the MAR indicated that medications scheduled between 7:00 PM and 10:00 PM on February 6, 2026, were initialed by staff as administered.

The home's Medication Administration Policy dated December 2025 was also reviewed. The policy indicated, in part, that residents have the right to refuse medications and should never be forced to take medication. The Medication Refusals/Holds policy dated December 2025 read consistent with statements from Employee #2. It read that if a resident refuses medication for three dosages, the Resident Care Manager will contact the resident's physician and responsible party. The community shall follow and record the instructions given.

A review of Resident A's progress notes indicated that on February 12, 2026, she refused her medications multiple times. The notes for February 2026 lacked evidence that her physician was notified of these refusals. Medications including Eliquis, Megestrol, Metoprolol, and prescribed eye drops were refused for three consecutive doses and subsequently discontinued on February 12, 2026, except for Retaine night eye drops, which were discontinued on February 18, 2026.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	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.** **(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following:** **(b) Complete an individual medication log that contains all of the following information:** **(vi) A record if the resident refuses to accept prescribed medication and notification as required in subdivision (c) of this subrule.** **(c) Contact the appropriate licensed health care professional when the prescribed medication has not been administered in accordance with the label instruction, an order from a health care professional, medication log, or a service plan.**

ANALYSIS:	A review of Resident A's records showed that her medications were not administered on February 5, 2026, and were documented as withheld due to refusal. Medications were also withheld on February 6, 2026, during the 7:00 AM to 10:00 AM dosing period, again documented as refusal. However, an interview with Employee #2 indicated that Resident A was physically unable to take the medications at that time. The Medication Administration Records (MARs) include an option to document "physically unable to take," yet this was not used. Additionally, the facility documented refusal for three medication doses without evidence that the resident's physician and responsible party were notified. Furthermore, certain as-needed (PRN) medications were not administered in accordance with physician orders. For example, Lorazepam, prescribed for anxiety or restlessness, was documented as administered on February 25, 2026, for pain. Morphine, prescribed for shortness of breath or severe pain, was documented as administered on February 26 and February 27, 2026, for restlessness and anxiety. Based on these findings, Resident A's medications were not administered or withheld in accordance with physician orders; therefore, a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive checks.

INVESTIGATION:

On March 3, 2026, the Department received an allegation which read that staff did not enter Resident A's room to conduct checks due to being afraid of her cats.

On March 6, 2026, I conducted an on-site inspection at the home and interviewed staff.

Interim Administrator Emily Long reported that Resident A had been hospitalized from January 26, 2026, to February 5, 2026, and again from February 6, 2026, to February 12, 2026. She confirmed that Resident A returned to the facility on February 5, 2026, sometime between 8:00 AM and 4:30 PM; however, she could

not confirm the exact time Resident A was sent to the hospital on February 6, 2026.

Employee #1 reported that one staff member was allergic to cats, but other staff covered for that employee when needed. She stated that no staff were afraid of Resident A's cats. Employee #1 stated staff were required to conduct checks every two hours and were expected to enter the resident's apartment to complete those checks. She further reported that Resident A's family had been staying with her since initiation of hospice services and was currently staying in the apartment. Her family asked staff not to enter the room while the resident was sleeping. She also stated there was a camera located in Resident A's bedroom.

Additionally, Employee #1 reported that care staff charted Activities of Daily Living (ADLs) by exception and would document in the system when care was not provided consistent with the resident's service plan.

Employee #2's statements were consistent with those of Employee #1. She confirmed that she was allergic to cats, but other staff provided care for Resident A without concern regarding cats. Employee #2 stated that care staff conducted two-hour checks by entering the resident's room and pressing a button to confirm the check had been completed. Employee #2 reported that care staff were unable to assist Resident A out of the recliner in the morning on February 6, 2026, and that she had declined since her hospitalizations. She further stated that prior to Resident A's recent hospitalizations, Resident A had been ambulatory, participated in meals and activities, and completed her own Activities of Daily Living.

On March 18, 2026, email correspondence from the complainant confirmed Resident A returned to the home on February 5, 2026, around 4:00 PM, and was sent back to the hospital around 10:30 PM on February 6, 2026.

Resident A's face sheet indicated that she moved into the home on June 7, 2022, and that Relative A1 was listed as her primary emergency contact and durable power of attorney (DPOA). The face sheet also indicated that she received Gentiva Hospice services. Her service plan, dated February 24, 2026, read she required a mechanical lift for transfers and utilized a wheelchair. The plan also indicated she required extensive hands-on assistance with bathing and was dependent on staff for grooming and hygiene needs. It further documented that she received Gentiva Hospice services and had video and/or audio surveillance in her apartment.

Review of the call pendant log for all shifts from February 5 through February 6, 2026, showed wellness checks documented on the following dates and times:

- February 5, 2026, at 11:01 PM

- February 6, 2026, at 5:21 AM
- February 6, 2026, at 5:45 PM
- February 6, 2026, at 10:56 PM

On March 27, 2026, the Department received additional allegations from the complainant which read that Resident A was held down to administer medications by three staff members on February 12, 2026, between approximately 11:00 AM and 1:00 PM, and that one staff member was bitten.

Also on March 27, 2026, email correspondence with Employee #3 indicated, in part, that no members of leadership were aware of these allegations. Employee #3 reported that Employees #2, #4, #5, and #6 were working with Resident A during that time frame.

Subsequent telephone interviews with Employees #2, #4, #5, and #6 revealed they denied holding Resident A down and that no staff member reported being bitten by her.

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:	Staff attestations indicated that Resident A had declined since her hospitalizations, and two-hour checks were to be conducted. The complainant confirmed Resident A returned on February 5, 2026, at approximately 4:00 PM and was transferred back to the hospital on February 6, 2026, at approximately 10:30 PM. Resident A’s service plan read she was dependent on staff for care. The call pendant log documented one check on February 5, 2026, at 11:01 PM, and a total of three checks on February 6, 2026. Based on this information, staff did not conduct checks in accordance with their reported practice of two-hour monitoring; therefore, a violation was substantiated for this allegation. Additional allegations that Resident A was held down by staff and that a staff member was bitten could not be substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Jessica Rogers 03/27/2026

Jessica Rogers Date
Licensing Staff

Approved By:

Andrea L. Moore 03/31/2026

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