STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

June 15, 2026

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

RE: License #: AH630399620
Investigation #: 2026A0627022
River Oaks Senior Living

Dear Ms. Wozniak:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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,

Rick Brummette, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH630399620 |
| | |
| **Investigation #:** | 2026A0627022 |
| | |
| **Complaint Receipt Date:** | 12/23/2025 |
| | |
| **Investigation Initiation Date:** | 01/21/2026 |
| | |
| **Report Due Date:** | 02/22/2026 |
| | |
| **LicenseeName:** | Rochester Care Operations, LLC |
| | |
| **LicenseeAddress:** | 144<br>940 Monroe Ave., NW<br>Grand Rapids, MI 49503 |
| | |
| **LicenseeTelephone #:** | Unknown |
| | |
| **Administrator:** | Elizabeth Mahoney |
| | |
| **Authorized Representative/** | Kimberly Wozniak, Authorized Repr. |
| | |
| **Name of Facility:** | River Oaks Senior Living |
| | |
| **Facility Address:** | 500 E University Dr<br>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<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established?** |
|---|---|
| Multiple wounds were not attended too and not reported, the wounds were infected and were not being cared for and the facility did not know where the bruising on her face had come from. | No |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 12/23/2025 | Special Investigation Intake<br>2026A0627022 |
| 01/17/2026 | Contact - Document Received |
| 01/21/2026 | Special Investigation Initiated - On Site |
| 01/21/2026 | Exit Conference |
| 02/12/2026 | Contact - Telephone call made |
| 04/02/2026 | Special Investigation Closed |
| | |

**ALLEGATION:** Multiple wounds were not attended too and not reported, the wounds were infected and were not being cared for and the facility did not know where the bruising on her face had come from.

**INVESTIGATION:** On 12/22/2025, the Bureau of Community and Health Systems received a complaint alleging that Resident A had multiple wounds that were not attended to, not reported, became infected and there was bruising near the resident's left eye.

On 1/16/2026, I received a call from the complainant and the topics discussed were consistent with the allegations made in the original complaint.

On 1/21/2026, I went onsite to investigate the allegations. The facility has 110 bed capacity with a current census of 42. The care of Resident A revolves around wound care at the facility. I interviewed SP1 in person and Elizabeth Mahoney, the Executive Director (ED), via phone. During the conversation it was inquired what the facility's actions are upon becoming aware of a resident who develops a pressure ulcer. The ED replied that if a resident develops a bedsore or a pressure ulcer, the facility's first action is to consult a home care agency to assist in getting it healed and to follow any orders related to its treatment.

Review of Resident A's clinical record noted an admission date of 2/5/2022, and the following relevant notations:

On 7/27/2025 Resident A had an observation note documenting a staff caregiver applied a band aid to a small scrape on her right leg and that there were no other skin issues to report.

On 8/1/2025, Resident A was visited by a Podiatrist for peripheral vascular disease at which time there was no documented observation of any heel pressure ulcers.

On 8/5/2025, Triad cream was ordered to be applied to Resident A's coccyx twice daily.

On 9/22/2025, an observation note documented that heel sores had developed and that the caregiver had Resident A elevate her feet and removed her shoes to relieve pressure.

An interview with the ED on 2/12/2026 via phone noted that the facility referred Resident A to a hospice agency for wound consultation and treatment on 9/23/2025.

A comprehensive evaluation dated 9/25/25 was performed in response to the new observation of pressure ulcers on 9/22/25. The identified care needs resulting from the evaluation included a skin issue requiring intervention, a pressure ulcer, the need for physical assistance of 1 care giver for dressing, hygiene, bathing, toileting, and feeding assistance. Transfers were assessed as needing 2 care givers. The resulting Service Plan dated 9/25/25 noted Resident A needs assistance for pressure ulcers and skin care. The goal for pressure ulcer assistance was for Resident A to remain free of any new pressure ulcers or infections. The interventions directed the caregiver to notify the supervisor of any new skin condition, to use pressure relieving devices daily and for skilled nursing to provide wound care as ordered. Resident A was discharged to the hospital from the facility on 10/25/25.

On 1/17/26 the complainant emailed photographs of Resident A's wounds dated 9/29/25, 10/21/25 and 1/12/26. The photographs dated 9/29/25 both showed grossly evident pressure wound of the right and left heels. The photographs dated 10/21/25 showed one of Resident A's heels still had a serious pressure wound and a

photograph of the coccyx area that indicated the presence of a pressure wound with superficial excoriation.

On 10/7/2025 a caregiver documented in the observation notes that Resident A had a faint green colored mark by the left eye that looked old and reported it to facility wellness staff.

| APPLICABLE RULE | |
|---|---|
| **R 325.1922** | **Admission and retention of residents.** |
| | **(3) At the time of an individual's admission, a home or the home's designee shall complete a written resident admission contract between the resident and/or the resident's authorized representative, if any, and the home. The resident admission contract shall, at a minimum, specify all of the following:**<br>**(a) That the home shall provide room, board, protection, supervision, assistance, and supervised personal care consistent with the resident's service plan.**<br>**(g) The resident's rights and responsibilities, which shall include those rights and responsibilities specified in MCL 333.20201(2) and (3) and MCL 333.20202.** |
| **ANALYSIS:** | There was no evidence that the facility failed to report the development of her wounds upon the discovery in September and take action to get the wounds evaluated and addressed. The facility conducted a care conference which identified care interventions and documented subsequent implementation. The bruise on Resident A's face had an unknown origin but it was reported to Wellness staff upon discovery. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

## IV. RECOMMENDATION

I recommend no changes in the status of the license.

5/20/26

Rick Brummette Date

Licensing Staff

Approved By:

06/15/2026

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