GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 22, 2026

Sharon Cuddington
Trinity Continuing Care Services
Suite 200
20555 Victor Parkway
Livonia, MI 48152

RE: License #: AL610261127
Investigation #: 2026A0579036
Sanctuary at the Oaks #1

Dear Ms. Cuddington:

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 responsible party and a date.

If you desire technical assistance in addressing these issues, please 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 (616) 356-0100.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W., Unit 13
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL610261127
Investigation #:	2026A0579036
Complaint Receipt Date:	05/06/2026
Investigation Initiation Date:	05/07/2026
Report Due Date:	06/05/2026
Licensee Name:	Trinity Continuing Care Services
Licensee Address:	Suite 200, 20555 Victor Parkway, Livonia, MI 48152
Licensee Telephone #:	(810) 989-7492
Administrator:	DaleTron Thompson
Licensee Designee:	Sharon Cuddington
Name of Facility:	Sanctuary at the Oaks #1
Facility Address:	1st Floor, 1740 Village Drive, Muskegon, MI 49442-4282
Facility Telephone #:	(231) 672-2700
Original Issuance Date:	04/21/2005
License Status:	REGULAR
Effective Date:	10/26/2025
Expiration Date:	10/25/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED/ ALZHEIMERS/ AGED

II. ALLEGATION(S)

	Violation Established?
Direct care workers are not suitable to pass medication.	No
Resident A's behaviors are not always managed by direct care workers.	Yes
Direct care workers do not respect resident privacy.	No

III. METHODOLOGY

05/06/2026	Special Investigation Intake 2026A0579036
05/07/2026	Special Investigation Initiated - Letter Second Complainant
05/07/2026	APS Referral
05/07/2026	Contact- Document sent DaleTron Thompson, Acting Administrator
05/07/2026	Contact- Telephone call made Relative B
05/13/2026	Contact – Face to Face Resident A DaleTron Thompson, Acting Administrator Aryana Gregory, Direct Care Worker Miranda Cockrell, Direct Care Worker
06/18/2026	Exit Conference Sharon Cuddington, Licensee Designee

ALLEGATION: Direct care workers are not suitable to pass medication.

INVESTIGATION: On 5/6/26, I received this referral alleging that direct care workers (DCWs) come to work smelling strongly of marijuana. It was alleged that management was aware and allowed these DCWs to pass medications. It was alleged management does not assist with ongoing problems involving narcotic counts. It also alleged that DCWs had not been trained on handling resident fentanyl patches. The complainant was anonymous, so follow-up questions were not possible. On 5/6/26, a second referral was received indicating Relative B had concerns regarding Resident B's care.

On 5/7/26, I completed a telephone interview with Relative B, who reported that DCWs arrive at the facility smelling of marijuana and are still permitted to pass medications.

On 5/13/26, I conducted an unannounced on-site investigation. Interviews were completed with DCWs Aryana Gregory and Miranda Cockrell, and acting administrator DaleTron Thompson.

Ms. Thompson reported she has never observed or received reports of DCWs arriving at the home smelling of marijuana. She stated she believes DCWs, residents, visitors, or relatives would have reported this to her if it were occurring. She stated DCWs would not be permitted to remain on-site or pass medications if they appeared under the influence.

Ms. Thompson explained that a former resident who received hospice care had been prescribed fentanyl transdermal which was managed by hospice. She stated the patches frequently detached in the resident's clothing or bedding, requiring DCWs to monitor their placement closely. She stated on one occasion, a patch was lost and believed to have gone through the laundry. Due to these issues, she discouraged further use of fentanyl patches in the facility and it was discontinued prior to the resident's death. She stated no fentanyl is currently administered in the facility.

Ms. Thompson stated she has re-educated DCWs on proper narcotic counting. She denied any concern of medication diversion by DCWs, noting that errors stem from incorrect counting, such as failing to notice when a pill was punched from the center of a package instead of a consistent line or when new deliveries were not properly added to the electronic medication administration record (E-MAR). She reported that when discrepancies occur, she or nursing staff recount the medications and the count always matches what is physically present. She noted their E-MAR requires two separate staff logins for narcotic counts at shift changes so there are factors in place to catch misuse promptly and even when she audits, she cannot sign-off on the count herself.

Ms. Thompson reported that DCW medication training includes a medication class, shadowing trained staff, completing three supervised medication passes, and being cleared by nursing staff. She stated nursing staff were previously on-call 24 hours a day, seven days a week and although nursing coverage has decreased, Team Leads are available on all shifts, and Ms. Thompson, a licensed nurse, remains available on-call for emergency questions regarding medications.

Ms. Cockrell stated she is part of the nursing team responsible for monitoring medications. She denied concerns about narcotic diversion. She confirmed that issues have involved counting errors, rather than missing medication. She stated nursing staff verify counts when discrepancies arise, and the count consistently matches what is in the home after nursing staff review. She denied any fentanyl

being maintained in the home during her employment and denied DCWs arriving under the influence of marijuana. She confirmed DCW training and ongoing support as Ms. Thompson had reported.

Ms. Cockrell assisted with reviewing narcotics. I observed locked storage and verified that a random sample of counts matched the medications present.

Ms. Gregory confirmed fentanyl patches used by a previous resident were managed by hospice. She stated DCWs were only responsible for ensuring they did not become detached and reporting concerns to hospice. She denied that DCWs arrive under the influence or are allowed to pass medications if impaired. She stated there is always on-call nursing available and any suspected DCW impairment would be reported immediately.

Ms. Gregory confirmed that issues involving narcotics involved counting errors, rather than missing medications. She noted new packages are sometimes not entered into the E-MAR promptly, but nursing staff correct this. She stated errors are addressed, explained to staff, and have not resulted in missing narcotics.

Ms. Gregory described receiving a medication class, in-person training from three DCWs, medication passes supervised by nursing staff, and stated nursing staff—including Ms. Thompson—are always available for questions. She stated she believes DCWs receive adequate training on the medications they manage for residents.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Relative B reported that DCWs arrive smelling of marijuana and are still permitted to pass medications. Ms. Gregory, Ms. Thompson, and Ms. Cockrell denied that DCWs come to the home under the influence of substances or are allowed to pass medications while impaired. Ms. Gregory, Ms. Thompson, and Ms. Cockrell stated medication counting errors have occurred; however, nursing staff have always identified the source of the error, medication counts have remained accurate, and there has been no

	indication of misuse or theft. I observed narcotic medications stored in a locked drawer and verified counts were correct. Ms. Gregory and Ms. Thompson stated that there were previous issues with a resident's fentanyl patch coming off. Hospice managed the medication. DCWs were instructed to ensure patches were not lost in clothing or linens and to report concerns to hospice. Ms. Gregory, Ms. Thompson, and Ms. Cockrell reported DCWs receive medication management training through classes, observation of trained staff, supervised medication passes, and nursing staff clearance before administering medications independently and nursing staff are available for support as needed. Based on the interviews, there is insufficient evidence to support the allegations or indicate that DCWs are not properly trained in medication handling and administration.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A's behaviors are not always managed by direct care workers.

INVESTIGATION: On 5/6/26, I reviewed this referral which alleged that Resident A wanders at night, can be combative, and recently accessed the second floor, which is not part of the licensed program, without supervision. It was reported that DCWs lack guidance from management on managing his behaviors and cannot adequately supervise him while caring for other residents. DCWs were also advised not to seek medical treatment after Resident A had falls. The referral also alleged some DCWs are verbally abusive toward residents. The complainant was anonymous, so follow-up was not possible.

On 5/6/26, I received a second referral alleging that Resident A entered Resident B's room in April 2026 and again on 5/2/26 around 8:00 p.m., at which time he was difficult to remove, and it is unclear whether any physical contact occurred. A week later, he entered Resident B's room while Relative B was present; no DCWs were available to assist. DCWs told Relative B that Resident A had recently reached the second floor unsupervised.

On 5/7/26, I reviewed SIR #2026A0579031 regarding Resident A's behaviors and the safety of other residents in the home. The allegations were not substantiated. During that investigation, staff acknowledged Resident A wanders and can be combative with DCWs but stated DCWs are trained, interventions are in place, and a

new placement is being sought. It was confirmed Resident A entered two resident rooms during an incident in April 2026 seeking his wife, though Resident B and her room were determined not to have been a part of the incident.

On 5/7/26, Relative B confirmed the allegations as reported in the second referral and stated DCWs verbally mistreat Resident B, though she could not specify what was said by DCWs to Resident B during these incidents.

On 5/13/26, Ms. Thompson stated Relative B never reported an incident of Resident A entering Resident B's room without DCWs available to redirect him and she does not have knowledge of Resident A ever wandering into Resident B's room. She said she provided her personal phone number to Relative B for direct communication, but Relative B continues reporting concerns to DCWs, administration, and other agencies. She stated when she directly asks Relative B, Relative B reports to her that "everything's fine."

Ms. Thompson reported that since my involvement in April 2026, Resident A has begun receiving hospice services, which has decreased his wandering and agitation. She stated hospice has also adjusted his medications. She said Relative A did not respond to the placement assistance she provided in April, delaying Resident A moving to a skilled facility. She stated she is again following up with Relative A to discuss moving Resident A to a skilled facility and stated a discharge notice may be necessary if there is no response this time.

Ms. Thompson expressed no concerns regarding DCWs' ability to care for Resident A or other residents. She acknowledged Resident A has higher needs than most residents placed in this home but stated DCWs follow his assessment plan and respond promptly to his behaviors. She denied knowledge of any verbal mistreatment by staff. Ms. Thompson reported one incident in which Resident A accessed a secure internal stairway during a situation where one DCW was assisting a resident with a medical emergency and arranging transport, another DCW became agitated and caused a disruption, and an outside door alarm sounded simultaneously. She stated that a DCW checked the door that the alarm alerted for but did not see Resident A so DCWs assumed he had opened the door but not gone outside. She stated shortly after that, Resident A was found in a stairwell leading to the second floor. She stated she was extremely concerned that Resident A could have had a serious, unwitnessed fall in the stairway so she reenacted the incident with DCWs. She stated in the reenactment, she learned that when one alarm is alerted, if a second alarm alerts, it is only a brief announcement. She stated it is likely staff did not hear the announcement for the second stairway alarm because of everything that was occurring.

Ms. Thompson stated Resident A's Lewy Body Dementia causes falls. She said all his falls are now reported to hospice. She stated before hospice involvement, if Resident A fell without injury, she advised against emergency treatment since it was not needed and to preserve his financial resources, as transport would have

required an ambulance. She stated if he was injured during any prior fall, he would have been sent for immediate care.

I observed Resident A eating lunch. He presented as lucid, talkative, and happy. He denied any concerns regarding his care.

Ms. Thompson provided Resident A's assessment plan. Resident A's assessment plan notes he requires redirection from doors, advises engaging him in activities and doing puzzles, encouraging restroom use in his room after lunch, and calling his wife when he seeks her. The assessment plan also notes daily checks of Resident A's wander alert device.

Ms. Gregory stated it can be challenging but DCWs' can care for Resident A and the other residents in the home. She stated at times, Resident A wanders into rooms searching for his wife and may become combative with DCWs during redirection. She stated he is not aggressive toward other residents. Her only concern is that Resident A benefits from one-on-one interaction, which reduces wandering and behavioral issues as it distracts him. She stated hospice visitation has helped. She stated she cannot provide extended one-on-one time due to caring for other residents, but she tries to spend one-on-one time with him when she works.

Ms. Gregory stated she has never witnessed Relative B requesting DCW help to remove Resident A from Resident B's room. She stated she does not believe Resident A would wander into Resident B's room, as Resident B is stern and would likely not be welcoming of Resident A in her room. She stated while Resident A and Resident B do not dislike each other, Resident A prefers other residents in the home and seeks his wife. She stated Resident B does not look like Resident A's wife.

Ms. Gregory was not interviewed in SIR #2026A0579031 but the DCWs interviewed in that investigation also reported they do not believe Resident A would wander into Resident B's room or that Resident A would tolerate him entering her room.

Ms. Gregory stated she was present when Resident A accessed the second floor through the interior stairwell. She stated she was responsible for supervising Resident A but was simultaneously managing another resident's medical emergency and coordinating ambulance transport. She stated at the same time, another DCW became upset, caused a disruption, and quit during her shift. She stated while this was occurring, an outside door alarm sounded, and another DCW checked the area but did not see Resident A, so they assumed he remained inside. She stated someone on the second floor located Resident A, revealing he had eloped through the stairwell. She stated no one realized a brief stairwell-door alarm announcement had also sounded at the same time the outside-door alarm was sounding until Ms. Gregory later reenacted the incident with Ms. Thompson.

Ms. Gregory stated Resident A falls due to his diagnosis of dementia but he has not obtained injuries from these falls. She stated he was not previously sent out for

emergency medical care after falling because he was not injured during these falls. She stated now his falls are reported to hospice.

Ms. Gregory denied DCWs verbally mistreat residents. She stated Relative B often targets and falsely accuses DCWs of verbally mistreating Resident B immediately upon entering the home, even when Resident B does not appear upset. She stated these accusations are unfounded, Relative B could not have heard what DCWs were saying to Resident B because she had just entered the home, and Resident B did not appear upset at the times Relative B insisted she was. She stated this allegation is untrue.

On 6/17/26, I reviewed the file for this home. It was determined there was a previous citation for a resident receiving a bruise and skin tear when a DCW forcefully pulled a Hoyer lift sling out from under her. The allegations were received 6/17/25, the licensing study report was completed 8/13/25, and the corrective action plan noting training and monitoring would be provided to ensure DCWs appropriately utilized a Hoyer lift sling was accepted on 8/15/25.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Relative B confirmed the allegations as reported. Ms. Thompson and Ms. Gregory denied concern regarding DCWs verbally mistreating Resident B. Ms. Thompson and Ms. Gregory denied Resident A needing medical intervention after falling due to him not being injured or needing medical treatment. Resident A denied concerns regarding his care. Ms. Thompson and Ms. Gregory confirmed Resident A was able to elope through an interior stairwell in the home. Resident A's assessment plan notes he requires redirection from doors. Based on the interviews completed and documentation reviewed, there is sufficient evidence that Resident A was not protected and safe when he was able to elope into a secure stairwell.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR#2025A0356044-6/17/25, LSR-8/13/25, CAP-8/15/25**

ALLEGATION: Direct care workers do not respect resident privacy.

INVESTIGATION: On 5/6/26, I reviewed the referral which stated staff had reported to Relative B that Resident A left the home through a stairwell. This incident was determined not to have involved Resident A. SIR#2026A0579031 also indicated Relative B had been informed of a separate incident in April 2026 involving Resident A's behaviors, which did not involve Resident B.

On 5/7/26, I contacted Ms. Thompson and raised concerns that DCWs may be violating Resident A's privacy based on recent referrals. I asked for her assistance in determining how this information was being shared with Relative B.

On 5/7/26, I requested, from Relative B, the names of DCWs who provided her with information about Resident A's wandering to the second floor. Relative B denied receiving information directly from DCWs and stated she was listening to DCW conversations and overheard it and she does not recall which DCWs she overheard.

On 5/8/26, I interviewed Ms. Thompson, who reported she had provided HIPAA training to DCWs on 5/4/26 and was ensuring all staff were updated on resident privacy rules. She agreed she would investigate how Relative B was obtaining information regarding Resident A.

On 5/13/26, Ms. Thompson reported she spoke with DCWs about concerns relating to Resident A's privacy and she does not believe anyone is intentionally violating HIPAA or resident rights. She stated when she raised general concerns about discussing resident information with or near visitors, DCWs immediately stated they knew she was referring to Relative B, even though she did not discuss Relative B by name. She stated DCWs reported that Relative B intentionally listens to conversations about residents who are not her relative and frequently engages with other residents' visitors. Ms. Thompson stated she instructed DCWs to speak more quietly and in private areas.

Ms. Gregory stated that Ms. Thompson discussed concerns about visitors obtaining resident information with DCWs. She stated it was clear the concern related to Relative B, even though she was not named. Ms. Gregory said she does not believe DCWs intentionally violate resident privacy. She reported that Relative B intentionally stays near DCWs, medical staff, and other visitors to listen to discussions and ask questions. She stated while she was working, she witnessed Relative B ask visiting medical staff questions about care for a resident, who was not Resident B, and she had to be advised she was not entitled to that information. She stated DCWs have increased their efforts to speak more quietly or in private since Ms. Thompson spoke to them, but the home layout makes private conversations difficult.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**

	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.**
ANALYSIS:	Relative B stated she learned information about Resident A by listening to and overhearing DCW conversations, not because staff provided it to her. Ms. Thompson and Ms. Gregory reported they do not believe DCWs share information about residents other than Resident B with Relative B but she intentionally listens to conversations in the home and asks visitors questions. Based on the interviews completed, there is insufficient evidence that Resident A is not treated with consideration for his need for privacy by direct care workers.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 6/18/26, I completed an exit conference with Ms. Cuddington who did not dispute my findings or recommendations.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend that the status of the license remains the same.

Cassandra Duursma 06/18/2026

Cassandra Duursma Date
Licensing Consultant

Approved By:

Jerry Hendrick 06/22/2026

Jerry Hendrick Date
Area Manager