GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 27, 2026

Steven Tyshka
Waltonwood at Main, LLC
Suite 200
7125 Orchard Lake Rd.
West Bloomfield, MI 48325

RE: License #: AH630285481
Investigation #: 2026A1027044
Waltonwood at Main

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

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630285481
Investigation #:	2026A1027044
Complaint Receipt Date:	06/02/2026
Investigation Initiation Date:	06/04/2026
Report Due Date:	08/01/2026
Licensee Name:	Waltonwood at Main, LLC
Licensee Address:	Suite 200 7125 Orchard Lake Rd. West Bloomfield, MI 48325
Licensee Telephone #:	(248) 865-1600
Administrator:	Jonathan Hills
Authorized Representative:	Steven Tyshka
Name of Facility:	Waltonwood at Main
Facility Address:	1401 Rochester Rd. Rochester Hills, MI 48307
Facility Telephone #:	(248) 601-7600
Original Issuance Date:	10/04/2006
License Status:	REGULAR
Effective Date:	08/01/2026
Expiration Date:	07/31/2027
Capacity:	114
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided with medications consistent with physician orders. Staff did not know what the medications were for and did not administer medications with gloves. Resident B was not provided with his medications as prescribed.	No
Allegations regarding Resident B's care, environment, personal Items, and catheter management.	No
Resident B's diet and food preferences were not accommodated.	No
Concerns regarding bathroom cleanliness, lack of cleaning supplies, and maintenance issues in Resident B's apartment.	No
Resident B's laundry was not completed.	No
Resident B's apartment temperature was not regulated.	No
Resident A lacked coordination of care.	No
Resident A lacked privacy.	Yes
Alleged unauthorized communication practices with Resident A and authorized representative concerns related to Residents A and B.	No
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

06/02/2026	Special Investigation Intake 2026A1027044
06/04/2026	Inspection Completed On-site
06/04/2026	Contact - Face to Face Complainant and Resident A interviewed while on-site

06/12/2026	Contact - Document Sent Email sent to Jonathan Hills requesting additional documentation
06/16/2026	Contact - Document Received Email received from Jonathan Hills with requested documentation
06/17/2026	Contact - Document Received Additional allegations received by complainant
06/18/2026	Inspection Completed On-site
06/25/2026	Contact - Document Sent Email sent to Jonathan Hills requesting additional documentation
06/25/2026	Contact - Document Received Email received with requested documentation
07/16/2026	Contact - Document Sent Email sent requesting additional documentation
07/17/2026	Contact - Document Received Email received with requested documentation
07/20/2026	Inspection Completed-BCAL Sub. Compliance
07/27/2026	Exit Conference Conducted by email with Steven Tyshka and Jonathan Hills

ALLEGATION:

Resident A was not provided with medications consistent with physician orders. Staff did not know what the medications were for and did not administer medications with gloves.

Resident B was not provided with his medications as prescribed.

INVESTIGATION:

On June 3, 2026, the Department received a complaint alleging that Resident A was provided with incorrect or partial doses of medication and that staff did not wear gloves when administering medications.

On June 4, 2026, an on-site inspection was conducted.

Administrator Jonathan Hills reported that medications were administered according to physician orders and scanned prior to administration. He stated most medications were supplied in bubble-pack cards, allowing staff to pop medications directly into a cup without hand contact. Staff were required to wash or sanitize their hands before and after each administration, and gloves were used only when applying topical medications or when direct contact with medication was required. Staff were also expected to talk through medications and provide education to residents.

Resident A reported that some of her supplements were provided in bottles and stated she was given one pill instead of the prescribed three. She also stated staff were unclear about administering her “water pill,” explaining that she only takes it when she gains three pounds in 24 hours. Relative A1’s statements were consistent with Resident A’s.

On June 17, 2026, the Department received additional information reporting inconsistent and unsafe medication administration for Resident A. Staff reportedly arrived without awareness of her current medication orders, and Resident A was given incorrect dosages on at least two occasions, including by Employee #2, who provided one capsule instead of three. Resident A identified the error herself. It was also reported that staff handled medication cups without wearing gloves due to policy not requiring glove use for medications poured directly into a cup.

The June 17 allegations also read that Resident B experienced a medication interruption after returning from Thanksgiving 2025 vacation. Staff allegedly did not retrieve or resume his medications upon return, resulting in an estimated three- to five-day gap in his prescribed medication regimen.

On June 18, 2026, a second on-site inspection was conducted.

Employee #2 confirmed she administered one supplement capsule from a bottle when the resident’s order required three. Resident A identified the error, and the full dose was given as prescribed. Employee #2 stated the order was later changed to one capsule, which was verified by reviewing the June 16, 2026, updated order.

Employees #2 and #3 could not recall any concerns or gaps in Resident B’s medications around Thanksgiving. Employee #3 explained that Resident B’s family would have signed documentation confirming receipt of his medications for administration while away, and again upon return. She stated families received original blister packs.

Resident A’s service plan, updated June 11, 2026, read she moved into the home on August 28, 2025, and staff were responsible for administering her medications.

Review of her April 2026 medication administration records (MARs) showed she self-administered medications until April 21, 2026. The MARs documented medication doses as administered or provided reasons for missed doses. Resident A's May 2026 MAR noted she was out of the facility May 8–10 and was prescribed Magnesium Glycinate, three capsules daily, with staff documenting administration or reasons for missed doses (often awaiting delivery or new prescription from the physician).

Additionally, the MAR documented a prescription for Furosemide: one tablet by mouth daily with daily weight checks from May 28 to June 2. Two PRN (as needed) Furosemide orders were also in place: one from May 15 to May 28 and another from May 28 to June 2, each read to administer one tablet by mouth if Resident A gained three pounds within a 24-hour period. There was no documentation indicating that either PRN order was administered.

Resident B's November 2025 MAR documented he was out of the facility November 26–December 1. His December 2025 MAR reflected that morning medications on December 1 were not administered due to being out of the facility, and subsequent doses were documented as given. Tamsulosin was not administered from December 4–6 due to awaiting delivery. Progress notes confirmed Resident B left the community with Resident A and that a medication technician signed out his medications.

Review of the home's Medication Administration policy (December 2025) read medications were to be popped or poured directly from packaging into a medication cup without staff or resident hand contact. Gloves were required only for transdermal products, lotions, or gels.

APPLICABLE RULE	
R 325.1932	**Resident's medications.**
	(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed healthcare professional.

ANALYSIS:	Staff interviews confirmed a single documented incident in which Employee #2 initially provided one pill instead of three; however, Resident A received the correct dose. Review of Resident A's MARs did not support that she failed to receive prescribed medications. Review of Resident B's MARs similarly did not indicate missed or unadministered medications outside the documented reasons. The home's policy does not require staff to wear gloves when medications are popped or poured into a cup; therefore, this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Allegations regarding Resident B's care, environment, personal Items, and catheter management.

INVESTIGATION:

On June 3, 2026, the Department received a complaint alleging multiple concerns related to Resident B's care. These included:
• A moldy cup of water found in Resident B's apartment which he nearly drank.
• Catheter bags being improperly cleaned and hung on bathroom grab bars, and staff refusing to change them.
• Feces smeared in Resident B's bathroom.
• Loss of Resident B's personal belongings, including a comforter.
• Resident B's cell phone being laundered.

On June 4, 2026, an on-site inspection and staff interviews were conducted.

Administrator Jonathan Hills reported that these concerns were first brought to his attention via email on June 1, 2026, and addressed in a four-hour meeting with Resident A and Relative A1 on June 2, 2026. Regarding the alleged moldy cup, he stated Resident B frequently retrieved disposable cups from the hydration station and that none were present in his room on June 2. He stated that Resident A and Employee #1 had seen the cup, but Employee #1 was off duty at the time. He noted it may have contained food residue, as Resident B often chewed food while carrying cups.

Regarding catheter care, the administrator stated staff were responsible for emptying the catheter bag and switching between leg and overnight bags. After

concerns were raised, Resident B's reusable catheter bag was discontinued and replaced with disposable bags provided by his hospice agency.

Concerning laundry, he explained residents are responsible for labeling their clothing, and misplaced items are returned when found. Staff misplaced Resident B's comforter and the administrator offered reimbursement. Resident B's cell phone was washed inadvertently; staff did not check pockets and would not have searched for a phone given Resident B resides in memory care. Reimbursement was not offered.

During the inspection, Resident B was observed well-groomed and wearing clean clothing. No cups were observed in his apartment. Both beds in Resident B's apartment were made.

Additional written allegations were received on June 17, 2026. The complainant submitted written allegations documenting additional concerns including:

- On May 29, 2026, Resident A observed Resident B drink from a cup heavily contaminated with mold; staff reportedly agreed it was mold.
- Catheter complications beginning soon after admission, including an incident on November 2, 2025 acknowledged by the administrator and Employee #2, and multiple UTIs in November 2025, repeated concerns about bags hung on grab bars. The issues reportedly continued February 19, 2026, the catheter tube was found unattached, the urine bag was repeatedly full, and clean pants were soaked as a result. The complaint also alleged that catheter collection bags were repeatedly hung on bathroom grab bars despite multiple requests to correct this practice. Resident B experienced recurrent UTIs (documented in February and March 10, 2026), which the complainant attributed to poor catheter care. On March 16, 2026, Resident B's urologist determined he was not a candidate for surgery or anesthesia and ordered that the catheter be flushed daily by someone experienced, along with the use of D-mannose and probiotics. Since approximately March 2026, Resident B's catheter care has been provided by an outside agency, Amber Care.
- Resident B being found in dirty clothing, wet pants, or wearing clothing that did not belong to him, particularly during his first two months in the home.
- Resident B's comforter was missing for several weeks and later replaced. His cell phone was laundered and not replaced. Towels and washcloths were also reported missing.
- Delayed setup of Resident B's new bed purchased by the family.
- Resident B's bed being left unmade, including on June 9, 2026.
- The apartment temperature being 77 degrees on June 9, 2026.

• Concerns about lack of supervision, including extended periods without staff checking on Resident B.

On June 18, 2026, a second on-site inspection was conducted.

Regarding the moldy cup allegation, Employee #1 stated Resident A reported Resident B drank from a moldy cup. Employee #1 could not confirm whether the substance was mold. Staff noted Resident B frequently brought food and drinks into his apartment. Employee #3 stated she cleaned his refrigerator weekly. Observation revealed two drinks in his refrigerator with no mold present.

Regarding catheter care, Employee #1 stated catheter bags were emptied frequently because Resident B drank large amounts of liquid. Employee #2 confirmed frequent emptying and noted Resident B often touched or attempted to remove his own catheter, increasing infection risk; he removed his catheter most recently on June 16, 2026. Amber Home Health provided catheter changes and did not report concerns to the home. Employee #2 stated staff received catheter-care training upon hire, and all staff completed an in-service on catheter care, infection control, and hand hygiene on January 29, 2026.

Review of staff training confirmed instruction on multiple catheter types, daily care steps, nighttime vs. leg bags, proper handling and hanging of bags (including directions to hang bags in showers), and indicators requiring physician or nurse notification.

Regarding concerns about Resident B’s clothing, staff stated Resident B often attempted to empty his own Foley bag and sometimes left the clamp open, causing wet pants. Staff also reported Resident B frequently snacked, resulting in dirty clothing. Staff reported his clothing was labeled and changed often. Employee #3 noted Resident B was to be shaved by staff but sometimes refused.

Employees #2 and #3 confirmed the administrator purchased a replacement comforter.

Employee #3 stated Resident B had a bed in his apartment and his family purchased a second bed. She stated Resident B’s second bed was not a hospital bed, but was purchased from Amazon by Resident A. She stated resident’s family were responsible for setting any purchased items; however, his family asked staff to set it up. Employee #3 stated maintenance staff were responsible for those requests and would prioritize them accordingly. Observation of Resident B’s second bed revealed it was a standard bed, not a hospital bed.

Regarding bed-making, Employee #3 stated beds were made in the morning but may be unmade if Resident B returned to bed after meals. Observation at 10:50 a.m. showed both beds made.

Regarding temperature, Employee #3 stated Resident B adjusted his thermostat previously, and staff corrected it as needed. The room temperature observed during inspection was 72 degrees Fahrenheit.

Regarding supervision for Resident B, Employee #1 stated staff conducted hourly checks including during family visits. Employee #2 confirmed Employee #1's statements, adding that Resident A appeared to stay with Resident B for a meal or to watch one television show often at night. Employee #3 stated Resident B frequently moved between his room and common areas, so he was often within sight of staff.

Employees #2 and #3 confirmed the home charts by exception and did not maintain activities of daily (ADL) logs.

Resident B's admission contract dated August 28, 2025, and signed by Resident A read residents agree to obtain and carry a policy of "Renters Insurance" adequately insuring all of his or her personal property and possessions and will look to their insurer for reimbursement of damage or losses due to theft, fire, flood, storm damage, water damage, power surge, smoke damage or damage caused by other residents or any other damage or loss that is not caused by the intentional act or negligence of Waltonwood, its associates or agents.

Resident B's service plan updated on May 26, 2026, read in part, he had severe memory impairment, that he was an elopement risk and wandered, required moderate assistance with bathing, grooming, and personal hygiene. It read he had leg bags with anti-reflux valve provided by family which would be always used and a change to occur weekly on Mondays. Staff to complete per-care to include outer catheter tube cleansing, along with general peri-care. Leg bags should be checked frequently and emptied as needed. He required assistance changing and emptying the bag. An outside agency nursing was responsible for his catheter and notify them with changes.

Review of Resident B's monthly task logs for May and June 2026 read consistent with staff interviews at the June 18, 2026, inspection.

Review of Resident B's progress notes from September 5, 2025, through June 18, 2026, read in part incidents where staff conducted safety checks and identified that he had fallen. Staff identified on September 29, 2025, that Resident B had no urine output for 6 hours along with abdominal pain and was sent to the hospital, then subsequently the next day a catheter blockage and sent back to the hospital. There

were times when Resident B reported catheter pain, staff contacted Resident A, and Resident B was transported to the hospital. Note dated October 25, 2025, read Employee #3 spoke with Resident A about Resident B's catheter care. Resident A reported his catheter bag was not being emptied enough and that he is not being changed immediately after a bowel movement. Employee #3 wrote a note with instructions on checking the urine bag and changing his brief immediately after a bowel movement. The notes confirmed Resident B had UTIs with prescribed antibiotics. Note dated November 4, 2025, read Resident A, Employees #2 and #3, and the home care nurse discussed concerns related Resident B's UTIs, and that they did not want bags cleaned and reused. Education was provided with best practice guidelines. Resident A requested a leg bag be left on overnight for Resident B. Education was provided that the leg bags were high risk for UTIs without a reflux valve. Resident A located leg bags with anti-reflux system, so the plan was for Resident A to provide the leg bags, and they will be changed weekly on Mondays. An order was obtained for a home health care nurse. The notes indicated changes of condition for Resident B when staff observed changes of his urine color, notifying Resident A and his home care agency. There were instances where Resident B was observed and escorted by staff attempting to exit the memory care. Incidents in April 2026 read in part Resident B had episodes of diarrhea in which staff provided him showers. A note dated June 10, 2026, read in part that Employee #3 spoke with care staff about Resident B changing the thermostat temperature day and night, moving furniture, turning off lights, and sometimes becoming verbally aggressive when redirected.

Review of Resident A's handwritten personal notes regarding Resident B read in part that on 2/19/2026 at 1:00 PM, Resident B's bed was not made in which upon request staff completed. Additionally, Resident B's urine bag was full and emptied, pants were changed. A note not dated read in read Resident B's dirty pants were changed and Relative A1 made his bed. On March 10, 2026, it was noted at 4:15 PM his urine bag was full, and he needed his brief changed in which staff completed. Additionally, he was not clean shaven. On March 12, 2026, it was noted that Resident B was not clean shaven. On May 31, 2026, Resident A wrote that almost every time she sees Resident B that he has on dirty shirt and is not clean shaven.

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:	Regarding the allegation of a moldy cup left in Resident B's room, staff interviews and on-site observations indicated that it could not be confirmed the cup contained mold. Resident B's catheter bags were cleaned according to the home's training protocol prior to transitioning to leg bags only. Although Resident A documented instances when the catheter bag appeared full, staff attestations and observations showed that Resident B drank liquids frequently, and the bag was emptied consistently. Resident B's comforter was misplaced and subsequently replaced. Per the admission contract, residents are responsible for insuring personal belongings through renters' insurance. Resident A's notes described occasions when Resident B wore a dirty shirt, wet pants, or was not shaved. Staff reported that Resident B frequently snacked, contributing to soiled clothing, and often attempted to empty his own catheter bag but did not close the valve, causing his pants to become wet. Staff also noted he sometimes refused to be shaved. Progress notes corroborated these explanations. Resident B's second bed was purchased by the family and was therefore their responsibility to set up; maintenance assisted when available. Resident A's notes documented instances when Resident B's bed was unmade, but it could not be determined whether staff had made the bed and Resident B subsequently returned to it, and residents retain the right to leave their rooms in their preferred condition. Based on all available information, there is insufficient evidence to indicate Resident B lacked protection, safety, or care consistent with his service plan. Therefore, these allegations were not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B's diet and food preferences were not accommodated.

INVESTIGATION:

On June 17, 2026, the Department received additional allegations which read that Resident B lacked teeth and could not chew, and that minced food had been repeatedly requested beginning February 16, 2026, but was not consistently provided. The allegation further stated that as recently as May 31, 2026, Resident B was served a cut-up hamburger instead of minced food, creating a choking and swallowing risk.

The complaint also alleged that for approximately one month, staff informed kitchen employees that Resident B was not permitted ice cream or soda. As of June 9, 2026, no physician order had been provided to support any dietary restrictions. The complainant noted ice cream was one of Resident B's favorite comforts.

On June 18, 2026, a second on-site inspection was conducted, including staff interviews.

> Employee #3 reported that all diet orders must come from the licensed healthcare provider and that changes are made only with a physician's order. She stated Resident B had a speech evaluation completed, and the resulting prescription placed him on a regular diet. Regarding ice cream and soda, she stated Resident A had asked staff not to provide sweets because excessive sugar reportedly caused accidents for Resident B. Employee #3 played a voicemail from Resident A dated June 14, 2026, at 11:38 a.m., requesting that Resident B receive "no sweets." She stated the home followed Resident A's stated preference.
>
> Employee #1's statements were consistent with Employee #3. He added that Resident B preferred hamburgers without buns, and staff chopped them for easier chewing.
>
> During the inspection, Resident B was observed eating lunch without any difficulty.

Resident B's service plan dated May 26, 2026, indicated he was on a regular, no-added-salt, easy-to-chew diet with regular food and liquid consistency. His diet order dated September 5, 2025, was consistent with the service plan. Progress notes from admission through June 17, 2026, did not reflect staff concerns regarding his ability to chew or swallow food, and documented that he often searched for food at night.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(2) A home shall work with residents when feasible to accommodate individual preferences. **(4) Medical nutrition therapy, as prescribed by a licensed health care professional and which may include therapeutic diets or special diets, supplemental nourishments or fluids to meet the resident's nutritional and hydration needs, shall be provided in accordance with the resident's service plan unless waived in writing by a resident or a resident's authorized representative.**
ANALYSIS:	Resident B's diet orders were consistent with staff statements and his service plan. Dietary preferences communicated by Resident A were accommodated by the home. Based on this information, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Concerns regarding bathroom cleanliness, lack of cleaning supplies, and maintenance issues in Resident B's apartment.

INVESTIGATION:

On June 3, 2026, the Department received a complaint alleging that feces were smeared in Resident B's bathroom and that a broom and cleaning supplies were not available when requested. The complaint also read that the bathroom had a flickering light and a broken shower-head holder.

On June 4, 2026, an on-site inspection and staff interviews were conducted.

Administrator Jonathan Hills reported these concerns had been brought to his attention on June 1, 2026, and were addressed in a meeting with Resident A and Relative A1 on June 2, 2026. He stated housekeeping provides weekly cleaning including bathroom cleaning, vacuuming, and dusting and that Resident B's housekeeping services were increased to twice weekly at no charge. Staff also assist with daily upkeep of apartments as needed.

During the inspection, Resident B's apartment and bathroom appeared clean, with no debris or feces observed. A sign on Resident B's door listed Monday as his housekeeping day.

Additional allegations received on June 17, 2026, indicated Resident A and Relative A1 had observed feces smeared on the floor, shower, and counter in Resident B's bathroom. The complainant reported staff directed family members to clean the bathroom themselves and denied them access to basic cleaning supplies. It was further alleged that bathroom floors were found in poor condition weekly and that staff sometimes deferred cleaning until housekeeping could arrive, though Employee #3 cleaned the bathroom after concerns were escalated.

These allegations also reported that Resident B's bathroom had a flickering light and a broken shower-head holder that were unaddressed for about a week.

On June 18, 2026, a second on-site inspection was conducted.

Employees #2 and #3 reported that housekeeping staff performed daily rounds in memory care due to frequent food debris. Regarding maintenance issues, Employee #3 stated work orders were submitted through the receptionist and completed based on priority and safety.

Employee #1's statements were consistent with Employees #2 and #3 regarding the home's work order process.

Employee #1 reported Resident B sometimes attempted to toilet himself, leading to feces smears, and that staff cleaned the area or contacted housekeeping. She stated cleaning supplies were available in the locked memory-care storage area, which is secured for resident safety but accessible to staff.

During the inspection, Resident B's bathroom appeared clean, both lights were functioning, the shower-head holder was intact, and extra supplies were observed in the locked storage area.

Resident B's admission contract dated August 28, 2025, read staff would maintain the apartment through weekly housekeeping services, including bathroom cleaning, vacuuming, dusting, daily bed making, and trash removal.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Staff attestations aligned with the contract, adding that Resident B received increased housekeeping services to meet his needs. Cleaning supplies were available to staff; however, it could not be determined why supplies were not provided when requested

	by the family. Nonetheless, Resident B's contract was followed, and this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B's laundry was not completed.

INVESTIGATION:

On June 17, 2026, the Department received additional allegations which read that Resident B's laundry went unwashed for up to two weeks, accumulating in his room. The complainant reported the laundry continued to pile up until the family raised the concern which they photographed on June 1, 2026. Staff reportedly stated they would only wash items placed in a hamper, a task Resident B- who has advanced Alzheimer's disease—could not reliably perform.

On June 18, 2026, a second on-site inspection was conducted.

Employee #2 stated each resident had a scheduled laundry day, but laundry could also be completed as needed. She explained Resident B required frequent clothing changes due to soiling.

Employee #3 stated the home employs staff dedicated to completing laundry six days per week for eight-hour shifts, except Sundays. She explained that staff are expected to notify laundry personnel if a resident requires laundry outside their designated laundry day.

Employee #1's statements were consistent with previous interviews. She reported laundry staff were contacted when a resident's hamper was full or if a resident lacked clean clothing.

During the inspection, a sign posted on Resident B's door indicated Tuesday as his laundry day. Resident B's hamper contained dirty clothing and was nearly full; Employee #3 stated laundry staff would be contacted to complete his laundry since his designated day was not until the following week.

Resident B's admission contract dated August 28, 2025, signed by Resident A, read staff would launder bed linens, bath linens, and personal laundry once per week.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(2) The home shall make adequate provision for the laundering of a resident's personal laundry.
ANALYSIS:	There was no evidence indicating Resident B's laundry was not completed as required. His apartment had no visible dirty clothing other than items placed appropriately in the hamper, and procedures were in place for completing laundry as needed. Because this concern relates to a specific timeframe and appears to have been resolved, the allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B's apartment temperature was not regulated.

INVESTIGATION:

On June 17, 2026, the Department received an additional allegation which read that on June 9, 2026, Resident B's apartment temperature was found to be 77 degrees Fahrenheit.

On June 18, 2026, a second on-site inspection was conducted.

Employee #3 explained that each resident apartment, including those in the memory care unit, has its own adjustable thermostat. She reported Resident B had adjusted his thermostat several times in the past, and staff subsequently reset it to a comfortable temperature. She stated staff adjusted the thermostat on June 9, 2026, once they identified he had changed it. She noted Resident B often stays in his apartment with the door closed and then ambulates into common areas with staff; therefore, staff would identify temperature changes when providing care.

Employee #1's statements were consistent with Employee #3.

While onsite, Resident B's apartment temperature was observed to be 72 degrees Fahrenheit. Additionally, other memory care resident's apartments were also observed to be 72 to 75 degrees Fahrenheit.

APPLICABLE RULE	
R 325.1973	**Heating.**
	(1) A home shall provide a safe heating system that is designed and maintained to provide a temperature of at least 72 degrees Fahrenheit measured at a level of 3 feet above the floor in rooms used by residents. **(2) A resident's own room or rooms in the home shall be maintained at a comfortable temperature.**
ANALYSIS:	Resident B's apartment temperature was observed at 72 degrees Fahrenheit, which meets regulatory requirements; however, neither his personal comfort level nor the circumstances at the time of the allegation could be determined. Based on the information gathered and the applicable rules, there was insufficient evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A lacked coordination of care.

INVESTIGATION:

On June 17, 2026, the Department received additional allegations which read that in April 2026, Resident A developed significant edema in her right leg accompanied by redness. On April 19, 2026, Employee #2 reportedly observed redness that appeared consistent with cellulitis and commented that antibiotics would likely be needed; while clarifying she could not diagnose the condition. Resident A reported she had been told to call a doctor for antibiotics but did not understand the reason and could not recall the instructions. The complaint alleged the facility relied on Resident A to arrange medical care on her own despite her difficulty retaining medical guidance.

On June 18, 2026, a second on-site inspection was conducted.

Employee #2 stated Resident A managed her own healthcare and received medical care from an outside physician. She explained that outside physician offices require the resident or authorized representative to contact them regarding medical needs since they would not provide the home's staff with medical information. Employee #2 stated that Resident A had historically managed her own medical care and frequently sought treatment at urgent care

facilities; however, if Resident A had requested assistance, staff would have provided it.

A progress note dated April 21, 2026, documented that Resident A went to urgent care for left-leg pain, redness, and warmth. She was diagnosed with cellulitis of the left distal leg, and new antibiotic orders were sent to One Care Pharmacy. A note dated May 3, 2026, indicated Resident A was doing well, had completed her antibiotics, and had returned to baseline.

Review of Resident A's admission contract dated August 28, 2025, indicated the resident may seek medical treatment or consultation with a healthcare professional for any condition observed by Waltonwood staff.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.**
ANALYSIS:	Resident A obtained medical evaluation and treatment in accordance with her established pattern of managing her own care. Staff followed the expectations outlined in her admission contract. Based on the information gathered, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A lacked privacy.

INVESTIGATION:

On June 17, 2026, the Department received additional allegations which read on Saturday, June 6, 2026, the administrator assured Relative A1 in writing that no further unannounced visits would occur with Resident A. However, on the following night, at approximately 10:00 p.m. on Sunday, June 7, 2026, Employee #4 allegedly entered Resident A's apartment unannounced, told her he worked with Resident B, introduced himself, and left. Resident A was startled to find an unfamiliar staff member in her room at that hour.

The allegation read that this entry violated a posted directive on Resident A's door reading: "NO wellness checks between 9pm-9am. Wellness waiver is on file." The complainant reported the sign had been posted since fall 2025 but was partially covered by a wreath at the time of Employee #4's entry (the wreath has since been removed and the sign photographed). When Relative A1 raised the concern, Employee #3 characterized Employee #4 as a first-floor caregiver conducting a check, which did not match Resident A's account that he said he worked in Memory Care. Employee #3 stated overnight checks would no longer occur but did not provide a clear explanation for Employee #4's entry.

Additional allegations reported that on the morning of June 10, 2026, Resident A told staff she did not want housekeeping in her apartment while she was away for a medical procedure; however, housekeeping had cleaned the apartment by the time she returned. The housekeeper stated she had not been informed.

Later that night, on June 10, 2026, at approximately 10:00 p.m., Employee #5 entered Resident A's room. Resident A pointed out it was past 9:00 p.m. and asked whether Employee #5 had seen the posted sign. Employee #5 reportedly apologized, stated she thought the sign said 10:00 p.m., and left.

On June 18, 2026, a second on-site inspection was conducted.

> Employee #2 stated Employee #4 had been assigned to Resident A's hallway on June 7, 2026, and that he told her he was conducting rounds. She reported she verbally re-educated Employee #4 regarding Resident A's preference for no checks between 9:00 p.m. and 9:00 a.m. Employee #2 also stated Employee #6 acknowledged forgetting to inform housekeeping of Resident A's request on June

10, 2026. Additionally, Employee #2 confirmed Employee #5 was a current staff member assigned to care for Resident A.

During the inspection, the posted sign reading “NO wellness checks between 9pm-9am. Wellness waiver is on file” was observed on Resident A’s apartment door.

Review of Resident A’s service plan updated June 11, 2026, showed no documentation of her request to decline wellness checks between 9:00 p.m. and 9:00 a.m.

Resident A’s contract dated August 28, 2025, read the resident authorizes Waltonwood associates or agents to enter the apartment for housekeeping, maintenance, repairs, inspection, or in the event of an emergency.

APPLICABLE RULE	
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	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(d) A patient or resident is entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity and individuality.**

ANALYSIS:	Because the posted sign on Resident A's door was partially covered at the time of Employee #4's entry, the allegation regarding the incident on June 7, 2026, cannot be substantiated. Additionally, there is insufficient evidence to show Resident A routinely declined housekeeping services, and the June 10 housekeeping issue appears to have been an isolated misunderstanding. However, the allegation that Employee #5 entered Resident A's apartment after her requested no-check hours on June 10, 2026, is substantiated. Resident A's preference was not incorporated into her service plan nor consistently communicated to staff, resulting in a breach of her stated privacy preference.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Alleged unauthorized communication practices with Resident A and authorized representative concerns related to Residents A and B.

INVESTIGATION:

During the first on-site inspection on June 4, 2026, the administrator reported he met with Resident A and Relative A1 on June 2, 2026, to address concerns about care. He stated multiple care conferences had previously been held that included Relative A1.

On June 10, 2026, the Department was copied on email correspondence involving Resident A, Relative A1, and home's leadership staff. An email sent from Resident A's account read, in part, that she was of sound mind, making decisions freely, and designating Relative A1 as her advocate and authorized representative. The email read that all communication regarding her care and Resident B's care should be directed to both her and Relative A1, preferably in writing due to the ongoing investigation.

On the same day, an email from Randy LeMaster read the community would work directly with Resident A because she "is her own person and the POA for Resident B," and that they did not plan to return email messages. He stated this practice had been followed over the prior 10 months.

On June 17, 2026, the Department received an allegation which read that on the morning of June 5, 2026, the administrator entered Resident A's room unannounced and spoke with her privately while she was still in bed, without her representative present. During this interaction, he reportedly told Resident A that moving to another community would require restarting her MetLife long-term care insurance approval process. Per Resident A's MetLife representative later confirmed this information was inaccurate.

The allegation read that the administrator spoke negatively about a senior living community the family was considering, made personal and emotional comments to Resident A, and questioned her reliance on Relative A1 after she said she needed to consult with her before making decisions.

On the same day, the Department was copied on email correspondence from Relative A1 to the home's leadership stating she was the authorized representative for both Residents A and B, had been listed as such since August 2025, and had now been designated in writing by Resident A for all communication. She offered to provide a notarized copy of the designation.

Also on June 17, 2026, authorized representative Steven Tyshka responded in writing that Waltonwood's position was that Relative A1 was not legally entitled to make decisions for Resident B. He stated Resident A had been appointed the authorized representative and court-appointed guardian for Resident B, and those roles remained unchanged. He expressed concerns about Relative A1's involvement, noting she had sent an email from Resident A's account. He wrote that these actions raised concerns about her influence and attempts to intercept communication.

Relative A1 replied on the same day, clarifying she used Resident A's email only because she did not have access to her own computer at the time, and that Resident A was present and approved of the communication. She stated all communication regarding Residents A and B was done with Resident A's knowledge and consent.

On June 18, 2026, a second on-site inspection was conducted.

> Employee #2 stated Relative A1 was the point of contact for Resident A, although Resident A remained her own decision-maker. She stated Resident A was the point of contact for Resident B, but Relative A1 was often included in communication as well.

Review of Resident A's residency agreement dated August 28, 2025, indicated she had designated Relative A1 as her durable power of attorney and authorized

representative, granting authority to sign agreements and make decisions on her behalf. The agreement was signed and dated Resident A.

Review of Resident B's contract dated August 28, 2025, indicated his durable power of attorney and authorized representative was Resident A. The language matched that of Resident A's contract.

Review of Resident A and B's face sheets revealed they both moved into the home on August 28, 2025. Relative A1 was listed as the primary emergency contact for Resident A; Resident A was listed as the primary emergency contact for Resident B.

Resident A's progress notes documented that Relative A1 participated in care conferences, including one on April 21, 2026. Resident B's progress notes dated November 4, 2025, noted a meeting regarding catheter management that also included Resident A and Relative A1. A note dated June 16, 2026, documented Resident B's assessment results and confirmed both Resident A and Relative A1 were notified.

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MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(g) A patient or resident is entitled to exercise his or her rights as a patient or resident and as a citizen, and to this end may present grievances or recommend changes in policies and services on behalf of himself or herself or others to the health facility or agency staff, to governmental officials, or to another person of his or her choice within or outside the health facility or agency, free from restraint, interference, coercion, discrimination, or reprisal. A patient or resident is entitled to information about the health facility's or agency's policies and procedures for initiation, review, and resolution of patient or resident complaints.**

ANALYSIS:	The records confirm that Resident A remained her own decision maker, as shown by her signing and dating her own residency agreement, even though she designated Relative A1 as her authorized representative. Resident A also served as Resident B's guardian and authorized representative, signing his residency agreement in that role. The records show Relative A1 was included in communication regarding both residents. On June 10, 2026, Resident A requested in writing that staff communicate with Relative A1 on behalf of both herself and Resident B. Documentation reflects that Resident B's assessment results were communicated to both Resident A and Relative A1 on June 16, 2026. Based on the contractual designations and legal roles identified in the records, staff were not obligated to communicate directly with Relative A1, though she was included in care-planning communication both before and after Resident A's written request. Given this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

07/20/2026

Jessica Rogers Date
Licensing Staff

Approved By:

07/27/2026

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