



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 2, 2026

Rochelle Lyons
3145 Lily Trail
Oakland, MI 48306

RE: License #: AL630419259
Investigation #: 2026A0629001
Flourish Collection at Rochester

Dear Ms. Lyons:

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 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 (248) 972-9136.

Sincerely,

A handwritten signature in cursive script, reading "Kellie Garner".

Kellie Garner, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3044 West Grand Boulevard
2nd Floor Annex, Suite 2-730
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630419259
Investigation #:	2026A0629001
Complaint Receipt Date:	06/24/2026
Investigation Initiation Date:	06/25/2026
Report Due Date:	08/23/2026
Licensee Name:	3145 Lily Trail Opco LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(810) 334-8809
Administrator:	Rochelle Lyons
Licensee Designee:	Rochelle Lyons
Name of Facility:	Flourish Collection at Rochester
Facility Address:	3145 Lily Trail Oakland, MI 48306
Facility Telephone #:	(248) 759-8500
Original Issuance Date:	11/20/2025
License Status:	REGULAR
Effective Date:	05/20/2026
Expiration Date:	05/19/2028
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Housekeeping standards are not maintained.	No
- Resident A's topical medication for a skin condition is not being applied as prescribed, resulting in worsening symptoms. - Resident B's medications are not being given as prescribed, including missed doses, late administration, changes to orders, and delayed start dates. - Flourish Collection at Rochester Staff are not trained to operate Resident B's Oxygen.	Yes
Care is not being provided in accordance with assessment plans: - Residents are not being showered. - Resident B was dropped while being transferred. - Resident B requires a two person assist to transfer. There have been instances where only one staff was present to transfer. - Resident B's allergies were not immediately updated in her assessment plan. - Resident B's visual checks are not being completed as outlined in her assessment plan. - Resident B's meal intake percentages and choking/ swallowing incidents are not being monitored.	Yes
The facility threatened to discharge residents, including Resident B, if a new lease was not signed.	No
Resident B requested copies of her resident record, and it was not provided in a timely manner.	No

III. METHODOLOGY

06/24/2026	Special Investigation Intake 2026A0629001
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06/24/2026	APS Referral An Adult Protective Services (APS) referral was not made as there were no allegations of abuse or neglect.
06/25/2026	Special Investigation Initiated - Telephone Telephone interview completed with Reporting Source.
06/25/2026	Inspection Completed On-site I completed an unannounced on-site investigation. I interviewed Wellness Director Deja Gibson, Executive Director Linda Price (by telephone), Resident A, and three direct care staff: Magali Yang, Jamalla Yancey, and Chandrea Anderson.
06/25/2026	Contact - Document Received Wellness Director Deja Gibson provided a copy of Resident A's shower schedule.
06/25/2026	Contact - Telephone call made Telephone interview completed with Complainant 1.
06/29/2026	Contact - Telephone call made Telephone interview completed with medical technician Chandrea Anderson.
07/01/2026	Contact - Telephone call made Telephone interview completed with Executive Director, Linda Price, med tech Janaye Jackson, med tech Jameshia Owens and Complainant 2.
07/01/2026	Contact - Document Received Facility documentation received via email from Executive Director Linda Price (discharge policy, resident care agreements, and cost-of-care summaries).
07/01/2026	Contact - Document Received Email received from Complainant 2.
07/02/2026	Contact - Document Received I received proof of emails exchanged between Flourish Administration team and Resident B's family members sent via email from Executive Director Linda Price.
07/13/2026	Contact - Telephone call made Telephone call to Resident B. Telephone interview completed with nurse practitioner Zach Salaysay of Legacy Medical Group.

07/27/2026	Contact - Telephone call made Telephone interviews completed with Executive Director Linda Price, Wellness Director Deja Gibson, and direct care staff Janaye Jackson.
07/27/2026	Contact - Document Sent Emails exchanged with Relative B1.
07/27/2026	Contact - Document Received Email received from Executive Director, Linda Price which included relevant documentation prescription by Zachary Salaysay of Legacy Medical Group, Resident A Dermatology summary, contact note for Resident A, contact note for Resident B.
08/20/2026	Contact - Document Received Email received from Executive Director, Linda Price which included relevant facility documentation.
08/24/2026	Exit Conference I placed a telephone call to licensee designee Rochelle Lyons to conduct an exit conference.

ALLEGATION:

Housekeeping standards are not maintained.

INVESTIGATION:

On 06/24/2026, I received an intake indicating that staff were not following the resident's care plan. The complainant reported that despite raising concerns multiple times, the Wellness Director offered no resolution and instead asked what the complainant planned to do about the resident's worsening skin rash. Staff were not applying the prescribed topical medication, as confirmed by in-room camera footage. Families have also reported missed medications and showers, and staff are often observed sitting idle despite claiming to be short-staffed. There appears to be no system in place to ensure accountability or adherence to the care plan.

On 06/25/2026, I received a second intake. In summary, the intake stated that the family was threatened with discharge/eviction if the resident did not sign a new lease by 06/26/2026, which contained financial or legal language that the family believed conflicted with existing Power of Attorney (POA) and living trust arrangements. The family's attorney recommended that the lease not be signed in its current form. The intake additionally raised concerns about medication administration, including missed doses, late or out-of-window doses, questions regarding antibiotic and order changes, a delayed start of sodium bicarbonate (order date 06/16/26, start date 06/19/26, despite

the family being told on 06/18/26 that it was being held for an unknown indication), and delayed allergy documentation despite repeated requests. The intake further reported that during a staff meeting, certain residents and families were identified as facing discharge if leases were not signed, and this family was specifically named.

On 06/25/2026, I initiated this investigation with an unannounced onsite investigation at Flourish Collection at Rochester. I completed a second unscheduled onsite inspection on 07/01/2026. During both onsite inspections, the facility was clean, orderly, and presented with no issues or concerns regarding housekeeping standards

On 07/01/2026, I interviewed Complainant 2 via telephone. Complainant 2 confirmed the information regarding Resident B and suggested I contact Relative B1 for additional information.

On 07/27/2026, I exchanged emails with Relative B1. Relative B1 provided written correspondence detailing her complaint. Relative B1 expressed concerns regarding the cleanliness of Resident B's room. Relative B1 provided six photos showing different areas of Resident B's room that were unkept. This included photos of dust on the floor, in corners of the room, and a dirty toilet bowl. Below is a summary of the written correspondence provided for concerns that pertain to this allegation:

Laundry/housekeeping is a part of the care plan. Unfortunately, this is not the first time over the years Flourish has missed a week of cleaning. However, on July 15, 2026, no one came to clean and Resident B's apartment was in very dirty condition for previous weeks poor cleaning efforts. On July 16, 2026, I personally spoke with head of housekeeping who assured me someone would go in that afternoon, or the next morning. No one came. On Monday, July 20, 2026, after elevating the concern and pointing out that a dirty environment can lead to infection, Linda Price said someone would go in to do a touch up that day. No one came. I sent pictures and finally housekeeping came the next day on Tuesday July 21, 2026, to clean. The cleaning was very minimal each week prior. Some weeks we have had to ask for laundry to be done and linens to be changed with our own private aid completing the linens and bedmaking because housekeeping shift ended. Housekeeping and laundry are a contracted commitment as part of the care plan and the monthly fees she pays to live there.

On 08/20/26, I exchanged emails with executive director Linda Price. Ms. Price stated there was a staff emergency resulting in Resident B's apartment not being cleaned on the designated day and the housekeeping supervisor was unable to move things around, as it would have compromised someone else's cleaning. Sunday evening Ms. Price received an email from Relative B1 stating Resident B's apartment had not been cleaned. On Monday, Ms. Price responded saying "they will be coming in today." The apartment was cleaned that evening at approximately 7:45 pm and again that Wednesday. Ms. Price provided email documentation between herself, the housekeeping lead, and Relative B1 discussing the housekeeping issue. The

documentation provided indicates that there was a \$50 credit issued to compensate for the missed cleaning.

APPLICABLE RULE	
R 400.647	Safety and maintenance of premises.
	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based upon the information gathered during this investigation there is insufficient information to conclude that housekeeping standards do not present a comfortable, clean, and orderly appearance. On 06/25/2026 and 07/01/2026, I completed an unannounced onsite investigation at Flourish Collection at Rochester. During both onsite inspections, the facility was clean, orderly, and presented with no issues or concerns regarding housekeeping standards. Although there was an incident when Resident B's apartment was not cleaned on its regularly scheduled day, resulting in dust on the floor and a dirty toilet bowl, this was a result of a staff emergency and not an ongoing issue of housekeeping standards resulting in safety and/or routine maintenance issues. Resident B's apartment was cleaned on an alternative day, and she was issued a refund.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Resident A's topical medication for a skin condition is not being applied as prescribed, resulting in worsening symptoms.**
- **Resident B's medications are not being given as prescribed, including missed doses, late administration, changes to orders, and delayed start dates.**
- **Staff are not trained to operate Resident B's oxygen.**

INVESTIGATION:

On 06/25/2026, I interviewed Complainant 1. Complainant 1 confirmed the information reported in the complaint and reported that specifically, on 06/24/2026, Resident A's topical medication Triamcinolone 0.1% Cream was not administered. Complainant 1 did not provide any other dates this medication was not administered. Complainant 1 stated this information is known because they have video cameras installed in Resident A's

bedroom, and on 06/24/2026 they observed an over-the-counter Eucerin cream purchased from Meijer being topically applied to Resident A's skin and not the prescribed Triamcinolone 0.1% Cream.

On 06/25/2026, I conducted an unannounced onsite investigation at Flourish Collection at Rochester. I interviewed Wellness Director Deja Gibson, Executive Director Linda Price (by telephone), and three med techs: Magali Yang, Jamalla Yancey, and Chandrea Anderson. I also interviewed Resident A. At the time of the onsite investigation, I observed med tech Jamalla Yancey complete a simulated medication pass. Ms. Yancey performed this simulated medication administration correctly with regards to the 5 R's (Right patient, Right medication, Right dose, Right route, Right time). There were no concerns.

On 06/25/26, I interviewed Wellness Director, Deja Gibson face to face and Executive Director, Linda Price, who was on telephone. I advised Ms. Gibson and Ms. Price of the complaint that was received. In response to the allegation of medication not being administered as prescribed, she stated that Resident A has a skin condition for which she is prescribed Triamcinolone 0.1% twice daily. She stated the medication is to be topically applied to Resident A's back and buttocks. Ms. Gibson said that Resident A has been out of the home due to an unrelated fall. Resident A was hospitalized at Henry Ford Rochester from 05/19/2026 - 05/22/2026, then transferred to a rehabilitation facility where Resident A was admitted from 05/22/2026 - 06/03/2026. Ms. Gibson stated prior to hospitalization and rehabilitation admission, Resident A's skin condition was clearing up, but after Resident A returned to the home it was noted to have increased inflammation and had noticeably worsened. Wellness Director, Deja Gibson, stated it is unknown whether the prescription medication Triamcinolone 0.1% Cream was being administered to Resident A while she was out of the facility in the care of other health providers, Henry Ford Hospital and the rehabilitation facility.

Ms. Gibson stated that Resident's A Triamcinolone 0.1% Cream was ordered on 06/18/2026 and has not been received as of the date of the onsite inspection on 06/25/2026. Ms. Gibson stated that the medication order was sent to the pharmacy on 06/18/2026 due to it getting low. However, when she called to check the status of the order on 06/24/2026, the pharmacy notified her that the order could not be filled and was canceled. Ms. Gibson stated that the pharmacy advised her that they canceled the order due to Resident A no longer being under the care of the prescribing physician, Dr. Mark Jolette, and now being under the care of a new physician, Joel Buchanan, who would need to send over Resident A's prescription.

Ms. Gibson stated that there was still some of the Triamcinolone 0.1% Cream being applied to Resident A by the med techs, because the med techs slit the side of the tube to get the remaining ointment out to apply to the area of Resident A's skin as prescribed. Ms. Gibson stated that she had spoken to Resident A's daughter about Resident A's skin condition that appeared to be worsened. She stated that she suggested that Resident A be seen by the facility's contracted dermatologist. Ms. Gibson stated that Resident A's daughter declined this recommendation.

Ms. Gibson stated that she had not had the chance to follow up with Resident A's new doctor to request that the prescription for Triamcinolone 0.1% Cream be sent to the pharmacy for filling. During the conclusion of this interview with Ms. Gibson, I observed her on the telephone with the new medical team for Resident A, asking that Dr. Buchanan send over a new prescription to the pharmacy for Triamcinolone 0.1% Cream for Resident A's persistent skin condition. Ms. Gibson advised me that the medication order was put on rush review and ordered by Resident A's new doctor, Joel Buchanan.

On 06/25/26, I interviewed med tech Chandrea Anderson. Ms. Anderson stated that she began working at Flourish on 04/07/2026. She stated that she administers medication in the facility and also works on the floor as direct care staff when needed. She stated that she is assigned to Resident A during some shifts and must administer medications and apply topical prescription ointment to Resident A's lower back and buttocks. Ms. Anderson stated that she was informed that Resident A has eczema and that the Triamcinolone 0.1% Cream is to treat eczema. Ms. Anderson stated that her daughter has eczema, so she is familiar with the skin condition. Ms. Anderson noted that Resident A's skin condition was improving. She said it appeared to be less inflamed and less irritated. Ms. Anderson stated that Resident A was out of the facility for a while due to a fall recently. Ms. Anderson said that when Resident A returned, she was surprised to see Resident A's skin condition had worsened and was flared up. Ms. Anderson stated she only uses the medications as prescribed and does not use over the counter lotions or creams on Resident A's back and buttocks. She uses Resident A's over the counter Eucerin cream on legs only. Ms. Anderson stated that on 06/18/2026, she noticed that the medication was getting low and hard to squeeze out. She electronically submitted for a refill order of the Triamcinolone 0.1% Cream. Ms. Anderson stated that she was off work for a few days due to a death in the family but remembered that she did need to cut a small slit on the side of the Triamcinolone 0.1% Cream tube to get enough medication out to apply topical ointment to Resident A's skin. She did not recall the date she put the slit on the side of the tube to access the ointment.

On 06/29/2026, I completed a second interview with medical technician Chandrea Anderson via telephone. Ms. Anderson stated that she ordered Triamcinolone 0.1% cream on 06/18/2026, but it had not been received as of 06/25/2026. She stated that on an unspecified date, she cut a small slit in the tube because the remaining amount was too low to dispense. Ms. Anderson reported that she has never used any creams, lotions, or ointments on Resident A that were not specifically prescribed.

On 06/25/26, I interviewed med tech Jamalla Yancey. Ms. Yancey stated that she has been with the facility for approximately two years. Ms. Yancey stated she administers medications to residents. She stated that she has worked with Resident A and provided care and supervision, including administering medications. Ms. Yancey stated that she has not applied the topical prescription Triamcinolone 0.1% Cream because there was none available and it was on order.

On 06/25/26, I interviewed med tech Magali Yang. She stated that she has been working at the facility for about a year and a half. She stated that she has been working

as a med tech for the past three months but during some shifts she helps as direct care staff when needed. Ms. Yang stated that she has worked with Resident A and stated that she recently applied Resident A's Triamcinolone 0.1% Cream medication to the prescribed areas, back and buttocks. Ms. Yang stated that the last time she applied the medication there was about half a tube left. She was not able to recall specific dates stating that she is not so good with recalling dates.

On 06/25/2026, I interviewed Resident A. Resident A did not report any concerns regarding her care. She stated that she is showered a couple of times each week, receives all of her medications daily and on time, and stated that staff are "really good" about applying her medicated cream and lotion for her dry, itchy skin. Resident A stated that staff apply the topical medications to her skin when she is getting dressed for the day or getting prepared for bed in the evening. Resident A stated that the staff administer her medications usually in the bathroom or bedroom. While visiting Resident A's apartment, I observed the bathroom area where topical medications are said to be administered. A dry erase board displayed written instructions stating to apply Eucerin to Resident A's back and bottom.

On 06/25/26, at the time of the onsite investigation, I observed the Medication Administration Record System (MARs) and the medication cart checking for medication availability and other documentation of administration. The cart was locked and appropriately organized. I also received a hard copy of the MARs electronic record for Resident A.

On 06/25/2026, I reviewed Resident A's Medication Administration Records (MAR). The following is relevant information:

- Resident A is prescribed Triamcinolone 0.1% cream to be applied topically twice daily.
- On 06/22/2026, direct care staff Janaye Jackson documented at 8:00 am that the Triamcinolone was unavailable. Direct care staff Chandrea Anderson documented at 8:00pm that the medication was unavailable.
- On 06/23/2026, direct care staff Janaye Jackson documented at 8:00am that the Triamcinolone was unavailable. However, direct care staff Jamalla Yancey documented administration at 8:00pm.
- On 06/24/2026, Triamcinolone 0.1% cream was not administered at 8:00am or 8:00pm due to it being marked as unavailable.
- On 06/25/2026, the 8:00am administration of Triamcinolone 0.1% cream was documented by Chandrea Anderson as not administered due to it was unavailable.

I continued to review Resident A's MARs. The following is relevant information:

- Resident A is prescribed Vitamin B-12, 1,000 mg, take one tablet daily by mouth every day. Per MARS review, Vitamin B-12 is administered to Resident A at 8:00am daily. Records indicate that on 06/05/2026 at 8:00am Vitamin B-12

1000Mcg was not administered. It was coded by med tech Jameisha Owens as not being administered due to it being unavailable and pharmacy notified.

- On 06/06/2026 at 8:00am, Vitamin B-12 1000Mcg was not administered. It was coded by med tech Janaye Jackson as not being administered due to it being unavailable and pharmacy notified.
- On 06/07/2026 at 8:00am, Vitamin B-12 1000Mcg was not administered. It was coded by med tech Jameisha Owens as not being administered due to it being unavailable and pharmacy notified.
- On 06/08/2026 at 8:00am, Vitamin B-12 1000Mcg was not administered. It was coded by med tech Jameisha Owens as not being administered due to it being unavailable and pharmacy notified.
- On 06/10/2026 at 8:00am, Vitamin B-12 1000Mcg was not administered. It was coded by med tech Jameisha Owens as not being administered due to Resident A refused medication.
- On 06/11/2026, 06/12/2026, 06/15/2026, 06/16/2026, and 06/17/2026 at 8:00am, Vitamin B-12 1000Mcg was not administered. It was coded by med tech Jameisha Owens as not being administered due to “other see nurse notes” Resident A refused medication.
- On 06/18/2026 at 8:00am, Vitamin B-12 1000Mcg was not administered. It was coded by med tech Maurice Adams as not being administered due to it being unavailable and pharmacy notified.
- On 06/24/2026 at 8:00am, Vitamin B-12 1000Mcg was not administered. It was coded by med tech Chandrea Anderson as not being administered due to it being unavailable and pharmacy notified.

On 07/27/2026, I interviewed direct care staff, Janaye Jackson via telephone. Ms. Jackson stated that she has been employed at Flourish Collection since March 2026. She stated that she works as a med tech and has duties as a direct care staff as needed. Ms. Jackson stated that she recalls a time when Resident A did not receive her medications as prescribed. She referred to this period as a “mix up,” with Resident A’s medication following Resident A’s return to the facility from a hospitalization and inpatient rehabilitation admission. Ms. Jackson informed me of the prescription ordering process. She stated that when she or someone on the team notices that a medication for a resident is getting low, they send an order to the pharmacy through the Electronic Medication Administration Record System, (EMARS)- point, click, cart process. Ms. Jackson stated that if the medication has not been received and added to the medication cart, within a couple days of the electronic order, then they make a follow-up telephone call to the pharmacy. During this telephone interview with Ms. Jackson, she stated that she only administers the medications as prescribed and does not apply over the counter lotions or creams to Resident A’s rash areas i.e. buttocks and lower back. Ms. Jackson stated that she is not aware of any concerns with Resident A or Resident B’s prescription medications. She said that both Resident A and Resident B always get their medications as prescribed.

On 07/01/26, I completed a second unscheduled onsite investigation.

On 07/01/2026, I interviewed Executive Director, Linda Price face to face while onsite. Ms. Price stated that Resident B self-administered medication until June 2026, at which time an assessment by the care team and physician determined that she could no longer self-administer. Resident B's medications were added to the MAR system, and Flourish Collection at Rochester staff began administering them on 06/16/2026. Ms. Price stated Resident B was prescribed an antibiotic, Levofloxacin 250 MG for a urinary tract infection on 06/15/2026. Ms. Price stated that Resident B's family requested that the antibiotic end earlier than prescribed. The prescriber adjusted the Levofloxacin 250 MG 1 tablet by mouth every 48 hours twice, canceling the original orders from 06/15/2026 and 06/16/2026 generating this final new order on of the same antibiotic prescription, on 6/20/2026

On 07/29/2026, I received a copy of a written prescription by Zachary Salaysay of Legacy Medical Group dated 11/07/2023. The prescription was sent via email from Executive Director, Linda Price. The prescription indicated that Resident B is authorized to self-administer medications.

On 07/01/2026, I interviewed med techs Janaye Jackson and Jameshia Owens. Ms. Jackson and Ms. Owens consistently stated that they began managing Resident B's medications on June 15, 2026, and that medications were available and administered as prescribed.

On 07/01/2026, I reviewed Resident B's MARs and medications for the month of June 2026. The MARs indicate medications were discontinued for self-administration on 06/15/2026 and ordered by Flourish staff for administration to begin on 6/16/2026.

The following is relevant information:

- Resident B was prescribed Hydralazine 50 Mg one tablet by mouth three times daily. This medication was ordered on 06/15/2026 and discontinued 06/17/2026, adjusted to new prescription Hydralazine 50 Mg one tablet by mouth two times daily *hold if SBP less than 150MMHG ordered on 06/17/2026.
- Resident B is prescribed one Levofloxacin 250 Mg Tablet by mouth every 48 hours at nighttime for 26 DAYS (ATB) * until 07/03/2026 * next dose is 06/17/2026 (indications for use: Antibiotic). This was ordered on 6/15/2026 and discontinued on 6/16/2026. Same prescription for Levofloxacin 250 Mg Tablet by mouth every 48 hours at nighttime for 26 DAYS (ATB) with an earlier end date 07/01/2026 was shown on Resident B's MARS record with an order date of 6/16/2026 and discontinued date of 06/16/2026
- MARS for Resident B further reviewed, Levofloxacin 250 Mg Tablet by mouth adjusted to every 48 hours until 06/29/2026 (indications for use: Antibiotic) was ordered on 6/20/2026 and scheduled to be discontinued on 6/29/2026 as prescribed. This medication was documented on MARS as administered to Resident B

- On 06/23/2026, Staff Jamalla Yancey documented that she administered one Levofloxacin 250 Mg Tablet by mouth at 7:03pm to Resident B.
- On 06/25/2026, Staff, Jamalla Yancey documented that she administered one Levofloxacin 250 Mg Tablet by mouth at 7:24pm to Resident B.
- On 06/27/2026, Staff, Jamalla Yancey documented that she administered one Levofloxacin 250 Mg Tablet by mouth at 8:10pm to Resident B.
- Resident B is prescribed Sodium Bicarbonate 650 Mg tablet, one tablet by mouth every day. PER MARS this medication was ordered by the facility on 06/16/2026. MARS indicates that this medication was first administered by Flourish med techs on 06/19/2026.
- On 07/01/2026, I observed all prescribed medications for Resident B on the medication cart.

On 07/02/2026, Executive Director, Linda Price, forwarded emails between Flourish Administration team and Resident B's family members to my attention. One of the emails dated 06/30/2026 from Resident B's daughter advised that Resident B's Dr. Heddershetti is sending one dose of the prescription Levofloxacin 250 Mg Tablet by mouth to OneCare pharmacy for administration on 07/01/2026 to make-up the missed dose on 06/21/2026 during course treatment. Resident B's daughter confirmed that Dr. Heddershetti's office had already spoken with Ms. Gibson to verify this.

Upon another review of Resident B's MARS record, there is a prescription for one time dose of Levofloxacin 250 Mg Tablet by mouth ordered on 06/30/2026.

On 07/13/2026, a telephone call was placed to Resident B. The call was answered by an individual who identified herself as Tia. She stated that Resident B was not available, declined to answer personal questions, and said she would relay the message.

On 07/13/2026, I interviewed nurse practitioner Zach Salaysay of Legacy Medical Group via telephone. Mr. Salaysay stated that he is not the primary prescriber for residents at Flourish Collection at Rochester. He stated that Resident B's infectious disease doctor is the primary prescriber for her antibiotic Levofloxacin 250 MG, 1 tablet taken by mouth every 48 hours and her kidney specialist is the prescriber for sodium bicarbonate. Mr. Salaysay provides ongoing monitoring. Regarding a missed dose of the antibiotic, he stated that on June 17, 2026, Resident B's daughter was informed that the infectious disease doctor would assess whether any additional doses were required after the antibiotic course ended on June 29, 2026. However, Resident B was hospitalized 06/30/2026 for another health matter before an assessment could be made if another dose would be needed on 07/01/2026, indicating antibiotic treatment and follow-up would be completed during Resident B's hospitalization.

On 07/27/2026, I interviewed Executive Director, Linda Price and Wellness Director, Deja Gibson via telephone. Ms. Price stated that Resident B was out of the facility due to hospitalizations from May 20, 2026, to June 5, 2026, and again from June 30, 2026, to July 7, 2026. Ms. Gibson stated that Resident B signed up for One Care on 06/15/2026 for medication orders to be sent to pharmacy for medication management

by Flourish Staff. Ms. Gibson stated that the medications for Resident B were reviewed and they spoke with doctors to get specific medication. Wellness Director stated that some medications had hold dates for ordering due to Resident B being scheduled for surgery. Ms. Gibson stated she could not immediately confirm Resident B's Sodium Bicarbonate 650 Mg tablet prescription because she could not verify the prescribing physician, Dr. Christopher Webster as Resident B's daughter did not provide written prescription or other medical documentation to support this prescription. Ms. Gibson stated that she requested more verification for this doctor in order to validate the prescription.

Ms. Gibson reviewed the process for ordering and reordering residents' prescriptions. She stated that all med techs can order medications for residents through EMARS. She stated that med techs are trained to reorder medications whenever medications are "low." Ms. Gibson was unable to identify what was considered "low" when discussing creams or topical prescriptions. She stated that medications ordered from EMARS go directly to their pharmacy, OneCare. Ms. Gibson said that if prescriptions are ordered Monday-Friday before 2pm, then the medications are delivered to the facility between 11p-12a on that same day. She stated that if a medication is ordered after 2-4pm on a Friday, then that medication will be delivered to the facility on Monday. Ms. Gibson stated that if medications are not delivered to Flourish within the acknowledged time frames, then the next step would be to contact the pharmacy to learn more about the medication delivery delay. She reported that if there is a concern with the prescription, she contacts the resident's prescribing physician or Primary Care Physician (PCP) for a resolution or a new prescription, if needed.

On 07/27/2026, I exchanged emails with Relative B1. Relative B1 provide written correspondence detailing her complaint, including concerns regarding medication administration. Relative B1 provided a Medication Administration Audit dated 06/16/2026–06/23/2026, and a detailed Medication Passing Audit. Below is a summary of the written correspondence provided for concerns that pertain to this allegation:

- On July 16, 2026, Resident B's private companion and Resident B pushed her button to get help with her oxygen machine. No Flourish Collection aid knew how to use the oxygen or could help. I notified both Linda Price and Deja about this, and I have received no response. There are multiple residents in assisted living on Oxygen. It is also a line item in her care plan that the Flourish Collection team is to assist with oxygen treatments. How is it possible that they do not know how to work the oxygen devices.
- On June 27, 2026, the private companion was present when an aid came into Resident B's room with another resident's full pill cup and set it down on the counter. On July 20, 2026, as I entered Resident B's room, I noticed a red syringe looking device on her shelf outside her door. Upon entering her room there were two aids who I questioned about that piece of medication sitting out on the hallway shelf. They stated it was oral medicine intended for another resident, and it was better to leave it outside on the shelf (unattended) than to bring it into another resident's room.

- Deja has stated that the Flourish Collection medication administration window is one hour before or after a med pass time. I have MAR data from only two weeks (one in June and one in July) and you will find numerous times Resident B is being dosed outside the medication window.
 - June 18th **MISSED 8am and 4pm pass.** We left the building at 9:45am for a procedure. No one came by deadline of 9am, or even by 9:45 to give Resident B her meds. We returned to the building at 12:30pm. No one came to give her the 4pm pass that day. At 8:30pm that night I emailed Linda Price and Deja Gibson asking if Resident B would be getting medication at all that day. Deja did not acknowledge the missed 4pm pass, only commenting that no one was late for a 8pm pass yet. A few weeks later on July 6, 2026, Linda Price stated in an email that Resident B did in fact get her 4pm meds that day. You can see on the MAR she did not. I have still not received a reason or explanation why she did not get her 8am meds or her 4pm meds that day. We were in the building during both administration windows.
 - Sodium Bicarbonate: Nephrologist sent Rx to OneCare Pharmacy on 06/16/26. I spoke with OneCare the morning of 06/17/26 and they confirmed it was on the cart that morning for Resident B. I learned on 06/18/26 that Deja Gibson was holding that medication for "indication" - yet she never called the prescribing doctor for the indication - just withheld the medication from Resident B for two days. How is this appropriate protocol? (Resident B is in kidney failure and was getting dialysis. I never received an explanation or reason why Deja would withhold kidney medication!)
 - Levofloxacin - June 21 missed dose - I was present that evening and noticed the aid did not give Resident B this medication. I brought it to Deja's attention on June 23 at an in-person meeting. Deja and Linda blame it being a weekend and a computer system glitch as to why it was not given. This was a critical antibiotic Resident B needed. If Deja returned to work on Monday June 22 and saw Resident B did not get this needed med on Sunday June 21 - why didn't she do something? On June 23 - all she said was that Resident B would get her next dose that evening - 96 hours after the last dose). Deja did not place a call to the prescribing Infection Disease doctor asking what reparations could be put in place to correct the course of treatment. I finally got in touch with the Infectious Disease doctor, and sure enough, the doctor added one more dose at the end of the course of treatment to make up for the error on June 21.
 - Please note the other LATE medication passes which fall outside of Flourish Collections own policy.
 - July 16: **dosed medications 5 hours apart** instead of the required 8 hour span

- July 19: 8am pass - aid told my mom she is getting Tylenol. There is no Tylenol on the MAR. Also, mom's BP registers above 150 which requires Hydralazine. No record of hydralazine given.
- July 20: *Administering same medications 4 hours apart* instead of 8.

I reviewed Medication Administration Audit dated 06/16/2026–06/23/2026, and a detailed Medication Passing Audit provided by Relative B1. In summary, the following was noted:

- On 06/16/2026, during the 8:00 AM pass, Folic Acid was administered late at 9:46 AM, exceeding the policy window. On 06/17/2026, during the 8:00 AM pass, Folic Acid was administered late at 09:36:00, exceeding the policy window. On 06/18/2026, during the 8:00 AM pass, the scheduled dose of Folic Acid was missed.
- On 06/16/2026 during the 8:00 AM pass, Hydralazine was administered late at 9:46 AM, exceeding the policy window. On 06/17/2026, during the 8:00 AM pass, Hydralazine was administered late at 9:45 AM, exceeding the policy window. On 06/18/2026, during the 8:00 AM pass, the scheduled dose of Hydralazine was missed. On 06/22/2026, during the 8:00 AM pass, Hydralazine was administered late at 9:01 AM, exceeding the policy window.
- On 06/16/2026 during the 8:00 AM pass, Omeprazole was administered late at 09:46:00, exceeding the policy window. On 06/17/2026, during the 8:00 AM pass, Omeprazole was administered late at 9:36 AM, exceeding the policy window. On 06/18/2026, during the 8:00 AM pass, the scheduled dose of Omeprazole was missed.
- On 06/16/2026 during the 8:00 AM pass, Ursodiol was administered late at 09:46:00, exceeding the policy window. On 06/17/2026, during the 8:00 AM pass, Ursodiol was administered late at 9:37 AM, exceeding the policy window. On 06/17/2026, during the 4:00 PM pass, Ursodiol was administered late at 8:14 PM, exceeding the policy window. On 06/18/2026, during the 8:00 AM pass, the scheduled dose of Ursodiol was missed. On 06/18/2026, during the 4:00 PM pass, Ursodiol was administered late at 8:46 PM, exceeding the policy window. On 06/19/2026, during the 4:00 PM pass, Ursodiol was administered late at 8:56 PM, exceeding the policy window.
- On 06/16/2026 during the 8:00 AM pass, Vitamin C was administered late at 9:46 AM, exceeding the policy window. On 06/17/2026, during the 8:00 AM pass, Vitamin C was administered late at 9:36 AM, exceeding the policy window. On 06/18/2026, during the 8:00 AM pass, the scheduled dose of Vitamin C was missed.
- On 06/16/2026, during the 8:00 AM pass, Vitamin D3 was administered late at 9:46 AM, exceeding the policy window. On 06/17/2026, during the 8:00 AM pass, Vitamin D3 was administered late at 9:36 AM, exceeding the policy window. On 06/18/2026, during the 8:00 AM pass, the scheduled dose of Vitamin D3 was missed.

- On 06/21/2026 during the 8:00 PM pass, the scheduled dose of Levofloxacin was missed.
- On 06/19/2026, during the 4:00 PM pass, Eliquis was administered late at 8:55 PM, exceeding the policy window.
- On 06/19/2026, the administration of Sodium Bicarbonate raised a policy concern: New start - but doctor called in prescription on 06/16/26 - it was on cart 06/17/2026 - but Ms. Gibson withheld administration for an indication, Resident B did not receive this medicine on 06/17/26 or 06/18/26.

On 07/27/26, I received an email from Executive Director Linda Price that contained Resident A Dermatology summary. The following is relevant information:

- Date: 07/02/26
Findings: Erythematous eczematous patches and erosions on the left superior medial midback; worsening. BSA 9%, itch NRS 8.
Differential Diagnosis: Atopic Dermatitis vs drug eruption vs Bullous Pemphigoid.
Counseling: Skin care with lukewarm bathing, mild cleanser, moisturize immediately after. Avoid scented detergents, keep nails short, avoid excessive hand washing.
Expectations: Chronic condition; may worsen with stress, soaps, detergents, scratching, dryness, weather changes, infections.
Instructions: Contact office if worsening or signs of infection such as yellow crusts or cold sores.
- Date: 07/16/26
History: Follow-up for dermatitis on left superior medial midback. Living in home care facility; aides assist with topicals. DTR (RN) concerned about worsening rash. PCP discontinued blood pressure medication suspected of causing pruritus. Recent IM steroid injection one week prior.
Biopsies: Punch biopsy performed. Pathology A: Excoriated perivascular dermatitis with eosinophils. Pathology B (DIF): Negative for immune deposition.
Discussed results — consistent with drug eruption.
Findings: Biopsy-proven erythematous macules coalescing into patches; itch 7/10. BSA now 15%. Condition inadequately controlled.
Treatment Changes: Begin cetirizine 10 mg BID (previously daily). Continue clobetasol 0.05% ointment compounded with Cerave. Discontinue plain clobetasol ointment. Modify prednisone to 20 mg QAM (2 tablets).
Long-Term Plan: Removing suspected medication trigger expected to help resolution. Continue prednisone for one month. Pharmacy confirmed ability to compound clobetasol/Cerave mixture.
Counseling: Detailed education on: skin care regimen, chronic nature of condition, triggers, infection signs. Risks of prednisone including weight gain, mood changes, diabetes, infection susceptibility, glaucoma, blood pressure. Risks of topical steroids including telangiectasia, hypopigmentation, atrophy. Patient verbalized understanding.
Prescriptions: Prednisone 10 mg tablet, 2 tablets QAM with food for one month (60 tablets). Compounded clobetasol/Cerave mixture — apply to affected areas

BID x2 weeks then PRN.

Photo Documentation: Photos obtained for clinical comparison

On 07/27/26, I received an email from executive director Linda Price that included a contact note for Resident B. Below is a summary of relevant information.

On 06/16/2026, Relative B1 visited the community requesting wound care supplies that had been left by Better You, as well as lozenges removed from the resident's apartment. Relative B1 also inquired about text messages related to her mother's medication. A clarification email was sent addressing questions about medications, supplies, the medication list, and resident care. A meeting was requested to further discuss the resident's current needs and to review changes to the evaluation and care plan. On 06/18/2026, communication continued with Relative B1 regarding One Care Pharmacy, physician orders, partnership communication, companion services, wound care supplies, and the NRA. Relative B1 expressed dissatisfaction and misunderstandings involving One Care and physician communication. Relative B1 also believed the NRA document gave her permission to administer her mother's medications; it was clarified that the document instead outlined concerns. A meeting was again recommended to provide additional clarification and support.

On 07/27/26, I received an email from executive director Linda Price that included a contact note for Resident A. Below is a summary of relevant information.

On 06/24/2026 at 16:49, writer contacted One Care Pharmacy regarding triamcinolone 0.1% cream reordered on 06/18/2026 but not delivered. Pharmacy reported it was discontinued in their system upon resident's return, though not discontinued by the community. A new prescription was required and physician was notified.

On 06/25/2026 at 16:30, writer contacted physician's office. Michelle asked if a refill was needed; writer clarified a new prescription was required. Michelle stated she would relay request to physician on call.

On 06/26/2026 at 15:47, writer followed up with resident's daughter, Complainant 1, regarding concerns about resident's back. Complainant 1 stated lack of cream during LOA caused condition. Dermatology appointment confirmed for 07/02/2026 at approx. 3 p.m.

On 06/26/2026 at 16:00, writer contacted Dr. Buchanan's office. Michelle confirmed request submitted 06/25/2026 as high priority but not yet approved. She would resubmit to triage team. Office closes at 4 p.m.; after-hours calls route to on-call provider. Writer planned continued follow-up.

On 06/26/2026 at 18:41, order received from Dr. Buchanan's office for triamcinolone 0.1% every 12 hours as needed for two weeks.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based upon the information gathered during this investigation, there is sufficient information to conclude that Flourish Collection at Rochester did not ensure that medications for Resident A and Resident B were administered as prescribed, resulting in missed doses, delayed administration, improper substitutions, and worsening symptoms. Regarding Resident A, the home did not administer the prescribed topical medication Triamcinolone 0.1% Cream as ordered. Medication Administration Records show multiple dates in June 2026 when the medication was documented as unavailable and not given. Staff confirmed that the tube was nearly empty, and med techs attempted to retrieve remaining cream by cutting the tube. The order for refill was entered on 06/18/2026 but never filled due to a lapse in communication with the pharmacy and the prescribing physician. During this period, Resident A's rash worsened significantly, as later confirmed in dermatology evaluations showing increased inflammation and progression of symptoms. Additionally, Complainant 1 observed staff applying over the counter Eucerin cream in place of the prescribed Triamcinolone on 06/24/2026. The facility did not ensure timely coordination with the new physician to secure the new prescription and did not maintain adequate supply of the prescribed medication, resulting in Resident A's condition worsening without the ordered treatment. Similarly, Resident B's medications were not administered as prescribed. MAR reviews revealed missed doses, late administration beyond the facility's stated one hour medication window, delays in the start of newly prescribed medications, and inconsistent documentation. Resident B's Sodium Bicarbonate, ordered by her nephrologist, was withheld for two days despite being available on the medication cart. Staff also missed the critical Levofloxacin antibiotic dose on 06/21/2026 and did not notify the prescribing physician to determine corrective treatment. Late doses of multiple medications, including Hydralazine, Omeprazole, Ursodiol, Vitamin C, Vitamin D3, and others, were documented repeatedly. Audit information provided

	by Relative B1 supported these findings and aligned with MAR inconsistencies reviewed by the department. The facility did not maintain consistent medication availability, did not adhere to prescribed administration times, and did not follow proper procedures for addressing missed or delayed doses. The facility failed to administer Resident A's and Resident B's medications as prescribed. These failures resulted in worsening skin symptoms for Resident A and multiple missed, late, and improperly managed medications for Resident B.
CONCLUSION:	VIOLATION ESTABLISHED

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:	Based up on the information gathered during this investigation, there is sufficient information to determine that staff were not trained to operate Resident B's oxygen equipment. On July 16, 2026, Resident B and her companion requested assistance with her oxygen machine, but responding staff were unable to operate it or provide support. Oxygen use is included in Resident B's care plan, yet no staff demonstrated knowledge or training related to oxygen operation.
CONCLUSION:	VIOLATION ESTABLISHED

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: (e) Not adjust or modify a resident's prescription medication without instructions from a physician, physician assistant, advanced practice nurse, or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record in writing any instructions regarding a resident's prescription medication.

ANALYSIS:	Based upon the information reviewed and received during this investigation, there is sufficient information to conclude that Flourish Collection at Rochester did not administer Resident B's medications as prescribed, resulting in missed doses, late administration, altered orders, and delays in starting required medications. Review of Resident B's Medication Administration Records (MARs), staff interviews, and documentation from Relative B1 revealed repeated medication management errors. Resident B missed multiple scheduled doses of her prescribed medications. Several medications were repeatedly administered outside the facility's designated medication window. In addition, Sodium Bicarbonate was withheld for two days despite being available, without any documented consultation with the prescribing physician. The medication audits provided by Relative B1 confirmed numerous late administrations and missed doses across multiple dates. Staff documentation also showed inconsistencies in order changes, including multiple discontinued antibiotic orders and delayed implementation of revised prescriptions. Despite staff statements indicating that medications were administered as prescribed, MAR reviews demonstrated ongoing discrepancies between prescribed orders and actual administration practices.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Care is not being provided in accordance with assessment plans:

- **Residents are not being showered.**
- **Resident B was dropped while being transferred.**
- **Resident B requires a two person assist to transfer. There have been instances where only one staff was present to transfer.**
- **Resident B's allergies were not immediately updated in her assessment plan.**
- **Resident B's visual checks are not being completed as outlined in her assessment plan.**
- **Resident B's meal intake percentages and choking/ swallowing incidents are not being monitored.**

INVESTIGATION:

On 06/24/2026, I received an intake that in summary indicates that staff were not following the resident's care plan. Families reported missed showers, and there appears to be no system in place to ensure accountability or adherence to the care plan.

On 06/25/2026, I conducted an unannounced onsite investigation at Flourish Collection at Rochester. I interviewed Wellness Director Deja Gibson, Executive Director Linda Price (by telephone), and three med techs: Magali Yang, Jamalla Yancey, and Chandrea Anderson. I also interviewed Resident A.

On 06/25/2026 I interviewed wellness Director, Deja Gibson regarding the frequency of showers and the schedule for showering residents. Ms. Gibson stated that all residents have a shower schedule and stated that it is included in their resident care plan. Ms. Gibson stated that Resident A is given two showers weekly. She said the team tries to accommodate each residents preferred time to shower. She stated some residents prefer morning showers while others prefer evening showers. She said that if a resident is offered a shower and refused at that time, they are offered a shower opportunity later in the day. Ms. Gibson stated that Resident A is often groggy in the morning and prefers showers at later times during the day. Ms. Gibson stated that Resident A's guardian, prefers Resident A to be on a regimented schedule with morning showers and community activities during the day. Ms. Gibson stated that they do their best to accommodate Resident A's guardian's request and still respect Resident A's preferences.

On 06/25/2026, Ms. Gibson provided me with a copy of Resident A's shower schedule. The schedule indicates that Resident A is showered on Wednesdays and Saturdays in the AM (no specific time noted for the shower). The schedule notes that Resident A is a 1 Person Assist. The shower schedule also includes a note that shower make-up day, is Sunday, in the event a shower is not performed as scheduled. It also notes that if showers are refused by residents, staff should document the refusal in the resident's file and notify the Wellness Director.

On 06/25/2026, I interviewed med tech, Chandrea Anderson. Ms. Anderson stated that Resident A is always clean and presentable. She stated Resident A takes her hygiene and appearance seriously and she and other staff always ensure that Resident A is showered as directed in Resident A's care plan. Ms. Anderson stated that if for some reason Resident A does not shower on the assigned days, Wednesdays and Saturdays, Resident A is offered a shower on Sunday as a make-up day.

On 06/25/2026, I interviewed med tech, Magali Yang. Ms. Yang stated she showered Resident A once. Ms. Yang stated that she recalls assisting Resident A, with a shower because, "someone called," saying that Resident A had not been showered that day. Ms. Yang stated that she remembers assisting Resident A with a shower in the evening but does not recall the specific date.

On 06/25/2026, I interviewed Resident A. Resident A did not report any concerns regarding her care. Resident A reports being showered a couple of times each week.

On 07/27/2026, I interviewed med tech, Janaye Jackson via telephone. Ms. Jackson stated that she is responsible for showering Resident A when assigned. Ms. Jackson reported that Resident A has a shower scheduled and is showered twice weekly. She stated that Resident A is usually showered in the mornings.

On 07/27/2026, I exchanged emails with Relative B1. Relative B1 provide written correspondence detailing her complaint. Relative B1 provided a detailed summary of issues related to Resident B being dropped, Resident B's allergy information not being immediately updated in her care plan, medication being withheld, missing, or dosed too close together, medications intended for other residents, assurance checks, oxygen use, housekeeping/laundry, 2 person assist, and concerns related to swallowing. Below is a summary of the written correspondence provided for concerns that pertain to this allegation.

- On March 18, 2026, Resident B returned from a one month stay in the hospital then a sub-acute rehab. She has since required a Hoyer for transfers. On March 19, 2026, the Flourish aids did not charge her Hoyer. An inexperienced aid tried to pick her up/transfer her themselves from her wheelchair to her la-z-boy chair. They dropped her to the ground. It was shocking. I texted wellness director Deja Gibson to ask for a meeting. She did not respond for two days and offered me a meeting in the hallway outside Resident B's door with the lead caregiver who was present for that incident. Deja Gibson said the incident was documented and reported.
- Resident B's care plan indicates that she is a 2 person assist at all times. On June 30, 2026, only one Flourish aid came in to move Resident B via the hoist. She could not complete the move alone and asked our private companion to please help her pull her into position above the chair while she lowered her. The care plan indicates two Flourish Collection people always - as this is part of Level 6. I brought this to the attention of Linda Price and Deja Gibson via email, and I have not received a reason or response.
- On March 21, 2026 – for shower night – aids put a gait belt on Resident B's bare torso and lifted causing extreme pain to Resident B's fragile skin and injured her shoulder. Resident B had weeks of pain in that shoulder as a result.
- On 04/23/26 I informed Deja Gibson that Resident B was extremely allergic to Dilaudid and that it was not listed on her care plan. I had to ask her again on two more occasions via email (06/12/26 and 06/16/26) then again on 06/18/26 in person to please update her information. It was finally done after nearly two months of asking for a critical allergy to be indicated on her chart. This posed a serious concern as the care plan allergy and medication information is immediately given to EMS when they come to take Resident B to the ER – and not having this allergy updated is alarming. No reason was given as to why she repeatedly would not update the chart.
- Up until June 26th - The care plan policy stated that assurance checks would be made every 2 hours. I notified Deja Gibson in June of day and

times when this policy was not being followed. No reason given, other than “two aids are coming down the hall now.” When Deja moved Resident B to Level 6 - she also widened the assurance check window to every 2-3 hours. I notified both Deja Gibson and Linda Price of multiple days in July where no assurance checks were being done within this promised window and that Resident B’s back hurt because no one was coming to move her out of her chair or reposition her during the days or change her brief. No response or reason given.

- Resident B’s two most recent care plans indicate that Deja Gibson and her caregiving staff will document all meal intake records and percentages and choking swallowing incidents. I asked for this documentation on July 20th. The response from Flourish Collection indicated that Storypoint does not perform meal intake records or percentages. This typically occurs in a skilled nursing facility. If abnormal eating behaviors are observed or increased difficulty arises, the team will raise that observation/ concern. She also has the benefit of her companion who is with her during meals so if she observes anything it is expected that she would notify the care dept of any change of condition. In increasing her to Level 6 this became a new line item in her care plan, that is why I am inquiring. Deja apparently had to have assessed and documented that Resident B had a swallowing concern with coughing and aspiration risk serious enough to include it as a formal care plan focus area. Flourish Collection created this obligation as it was news to us in the Level 6 care plan. The facility documented a care obligation they have no intention of fulfilling. By documenting this as an issue for her, and a new line item for Level 6, it seems Flourish Collection created and accepted responsibility for monitoring it. One cannot write aspiration risk into a care plan and then say monitoring for it is beyond your scope, nor importantly shift the responsibility to our companion. If meal intake monitoring and formal swallowing documentation are beyond the scope of what Storypoint/Flourish provides as an assisted living facility, then FC should not have included swallowing as a formal care plan focus area.

On 08/20/26, I exchanged emails with executive director Linda Price. Regarding these allegations, Ms. Price stated Resident B returned from Shelby Crossing Rehab on March 18, 2026. Per an investigation completed with staff, it was reported that the Hoyer was delivered on March 19, 2026, and had not been sufficiently charged yet. Staff continued to use known transfer methods for Resident B. Multiple staff were in Resident B’s apartment to assist due to her inconsistency with cooperating with transfers. Resident B was safely lowered to the floor. Wellness Director was away from the community on March 19, 2026, and March 20, 2026, but followed up with designated representative on March 21, 2026, in person regarding this matter. Every care team member upon hire receives hands on training for transfers which includes use of Hoyers’ as well as going through Relias online training modules. Additional training is being arranged in partnership with TCT our third-party physical therapy group.

Regarding the alleged care plan violation on June 30, 2026, when it was reported that despite the care plan requiring a two-person assist at all times, only one aide attempted a hoist transfer and asked the family's private companion to assist, Ms. Price stated Resident B was sitting in her chair and insisted on going to bed. Other staff were helping other residents with their care at that time. The private aide was present at the time and offered assistance so that Resident B did not have to wait and avoid Resident B getting upset, which would occur if she had to wait for any amount of time.

Regarding the allegation of improper and harmful shower handling on March 21, 2026 that alleged aides used a gait belt directly on Resident B's bare torso, causing significant pain and a shoulder injury that lasted weeks, Ms. Price stated the community nor Zach Salaysay, AGPCNP-BC have any record of a shoulder complaint or injury. The gait belt was required to transfer Resident B into the shower and there were multiple care staff there to assist. Resident B had history of inconsistent willingness to assist with transferring. Ms. Price provided proof of an email sent from PCP Salaysay that indicates his note from 03/20/26, Resident B did not complain to me of shoulder injury at that time. She did complain of shoulder pain in February.

Regarding the allegation that there was a delay with updating Resident B's critical allergy (Dilaudid), Ms. Price stated Wellness Director, Deja Gibson, did not have supported clinical documentation and shared this request multiple times with designated representative. Upon further investigation it was learned that the clinical documentation was not required and Wellness Director was able to enter it as an intolerance due to it not having an anaphylactic reaction.

Regarding the allegation of the facilities' failure to perform required assurance checks Ms. Price stated daytime checks: Storypoint standard is for assurance checks to be done every 2-3 hours. This was explained to Resident B and designated rep. including that if checks were needed more often than that, 1:1 care with a private aide/companion would be required. The resident did have a companion to serve this purpose. Resident was of sound mind and their own decision maker and was capable of making needs known as was her private aide/companion and always reminded them to push their pendant. Resident B used pendant regularly for needs requests. During meetings with the residents and the family it was reviewed that she did not want overnight checks or changes. This issue and community concern was discussed during the July 1, 2026, meeting with LARA, AFC Licensing Consultants, Kellie Garner and Johnna Cade. It was also outlined by the community in their July 2, 2026, care plan. Resident B was their own person and fully capable of decision making during this time per their physician. The family was made aware that these were the resident's wishes on more than one occasion. Community representatives were concerned about the refusal to the point of having an internal "flag" call. Due to residents declining health and communities desire to provide overnight checks a negotiated risk agreement was presented to Resident B with the designated representative present on July 29, 2026. During that meeting, the resident agreed to allow staff to do overnight checks and changing if needed.

Regarding the allegation of care plan obligations not followed regarding swallowing and meal monitoring, Ms. Price stated staff are expected to monitor the residents during the provision of care and report any observed concerns including coughing or choking during meals, meal refusal, and consumption below 75%. Concerns were documented when identified as evidenced on July 27, 2026. Ms. Price provided an email response from herself and Resident B's designated representative regarding this matter. Ms. Price wrote that due to the resident having a 1:1 companion, they are able to observe the resident continually during their meals when they were with them and let us know of any concerning observations/changes. This is an expectation of all private aids that support residents in the community. Community staff remained responsible for monitoring and documenting specific concerns in this area but do not maintain continuous observation or documentation. Wellness Director Deja Gibson met with resident and designated representative to discuss the care plan on July 29, 2026, and clarified the parameters surrounding the above concern. Designated representative did not discuss concerns regarding swallowing during this meeting.

On 08/20/26, I reviewed Resident B's assessment plan covering February 2026 to the present. Provided via email from executive director Linda Price.

APPLICABLE RULE	
R 400.677	Resident hygiene, clothing.
	(2) A licensee shall ensure the resident receives or has access to all of the following: (a) Bathing at least weekly.
ANALYSIS:	Based upon the information gathered during this investigation there is insufficient information to conclude residents do not have access to bathing at least weekly. Resident A did not report any concerns regarding her care. Resident A reports being showered a couple of times each week. All staff interviewed reported that Resident A was showered regularly.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	Based upon the information gathered during this investigation there is sufficient information to conclude care is not being provided in accordance with assessment plans. Resident B's care plan requires two person assist for transfers. On 06/30/26, only one Flourish staff performed a Hoyer transfer and requested assistance from Resident B's private companion. Although the facility provided an explanation, the two person assist transfer was not fulfilled. Additionally, the facility acknowledged that that meal intake percentage are not routinely documented despite the care plan identifying meal intake monitoring and documentation of choking/swallowing incident as care obligations. Other allegations, including the March transfer incident, and assurance checks, were not sufficiently established based on the available evidence.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

The facility threatened to discharge residents, including Resident B, if a new lease was not signed.

INVESTIGATION:

On 07/01/2026, I interviewed Complainant 2 via telephone. Complainant 2 confirmed the information regarding Resident B and provided details related to concerns about cost of care, discharge policy, and the facility's communication with families about updated care agreements. Complainant 2 stated that the family felt pressure to sign documents quickly and believed the facility had not clearly explained the financial changes.

On 07/01/26, I received an email from Complainant 2. Below is a summary of his concerns regarding this allegation. Complainant 2 indicated the family experienced significant pressure from the facility to sign a lease containing false statements. Despite raising concerns in April and being assured that follow-up would occur, no action was taken until June when they were told to sign without changes or face eviction. They requested only two essential corrections: restoring the reference to the mother's \$6,200 deposit and correcting a clause inaccurately stating that no one else had financial control over the resident's assets, despite the existence of a trust and designated power of attorney. With guidance from their attorney, the family added clarifying language and submitted the lease to avoid eviction. Although the Wellness Director threatened eviction for any changes, the facility ultimately accepted the edited lease, and the family is now awaiting the fully executed copy. The family also learned that during a staff

meeting, their family and others were named as facing eviction if leases were not signed promptly. They are deeply concerned because lease disputes or discharge status are sensitive matters that should only be shared with individuals who have a legitimate need to know. They view the disclosure as inappropriate and retaliatory, especially given their objections to signing a lease containing false information.

On 07/01/2026, I interviewed Executive Director, Linda Price. Ms. Price provided documentation of Flourish Collection at Rochester's discharge policy, resident care agreements, and cost-of-care summaries. She stated that Resident B's level of care had increased, resulting in a cost increase. She stated that no residents had been issued discharge notices. Ms. Price reported that she met with families individually and emailed them to explain the need for annual signatures on resident care agreements and reviewed the discharge policy. Ms. Price stated that all pending agreements were signed by June 29, 2026. She explained that a family member of Resident B handwrote notations that were added to the family agreement because Resident B's security deposit of \$6200 from June 2019 had not been accounted for in the current resident care agreement, and administration accepted the family's correction. The \$6200 security deposit has been carried over and added to the agreement for Resident B.

On 07/02/2026, Executive Director, Linda Price forwarded emails between Flourish Administration team and Resident B's family members to my attention. The following is a summary of the information provided. Beginning on May 5, 2026, communication from Flourish and Storypoint leadership focused on the requirement for residents and families to complete Adult Foster Care regulatory documents. Executive director Linda Price reminded families that these forms including health appraisals, care agreements, leases, and POA documents were mandatory for ongoing residency and needed to be submitted by May 12. A follow-up message on May 18 reinforced the urgency and stated that unsigned documents could lead to a 30-day discharge, as an AFC audit was scheduled for the following week. Families expressing concerns about changes from prior ownership were told that Flourish was obligated to follow State of Michigan AFC regulations without exception. During May and June, the family communicated repeatedly with Linda Price regarding the lease agreement. Their concern centered on financial-control language that appeared inconsistent with Resident B's existing POA and trust arrangements. Despite multiple requests for clarification, Storypoint stated the lease could not be revised and confirmed on June 26 that failure to sign would result in a 30-day discharge. Later correspondence confirmed that a signed agreement had been received and that Resident B's refundable deposit of \$6,200 would be returned within 30 days of terminating residency, minus any outstanding fees or damages.

APPLICABLE RULE	
R 400.687	Resident admission and discharge policy; house rules; change of residency; provision of resident records.
	(4) A licensee shall provide a resident and resident's designated representative with a 30-day written notice before discharge from the facility. The notice must state the

	reasons for discharge and a copy of it be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	Based upon the information gathered during this investigation, there is insufficient information to conclude that Flourish Collection at Rochester made threats to Resident B's family and/or violated their discharge policy communication. Communications with Resident B's family were consistent with routine administrative requirements related to annual care agreements, leases, and regulatory compliance before an AFC audit. The facility met with families, explained required documents, accepted the family's corrections regarding the security deposit and financial-control language, and did not issue any discharge notice. Although Resident B's family felt pressured and disagreed with certain lease terms, the information reviewed showed the facility's actions were administrative in nature.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident B requested copies of her resident record, and it was not provided in a timely manner.

INVESTIGATION:

On 07/27/2026, I exchanged emails with Relative B1. Relative B1 provided written correspondence detailing her complaint, including concerns about documents not being provided in a timely manner when requested. Below is a summary of the written correspondence provided for concerns that pertain to this allegation:

On June 23, 2026, Resident B completed the required form to request her eMAR data for June 16-June 23. Exactly 30 days later we still had not received the documentation. After contacting Linda Price, she did deliver an eMAR on the 31st day but it was the incorrect month's data. So, on day 34 we finally got the June eMAR information we originally requested. Realistically, there is no reason they needed to take more than 30 days to comply with our request.

On 08/20/26, I exchanged emails with executive director Linda Price. Ms. Price stated Storypoint has a formal process for record requests. The appropriate party fills out the request form and sends it back to the community Executive Director or Wellness Director. It is then submitted to the company's legal department who then approves the release of the records. While there is no stated delivery timeline on the request form or regulation on when the records should be provided, Storypoint strives to provide them in a 30-day period which was communicated to resident and designated representative. Resident B made a record request on June 23, 2026. Requested records were sent on Friday July 24, 2026. Unfortunately, records with an incorrect date range were mistakenly emailed and Ms. Price was notified by family at 10:02 pm that Friday. The error was rectified with the correct date range being sent to the resident on Sunday, July 26, 2026, with an apology.

On 08/24/2026 I placed a telephone call to licensee designee Rochelle Lyons to conduct an exit conference and review my findings. I advised her of the allegations and concerns. Ms. Lyons did not have any additional information to provide regarding the investigation and findings at this time. She stated that she will review the information with the team at Flourish Collection.

APPLICABLE RULE	
R 400.687	Resident admission and discharge policy; house rules; change of residency; provision of resident records.
	(10) A licensee shall provide copies of resident records when requested by the resident and resident's designated representative. A fee that is charged for copies of resident records must not be more than the cost to make the copies.
ANALYSIS:	Based upon the information gathered during this investigation there is insufficient information to conclude that the licensee failed to provide copies of the resident's records upon her request. Although Relative B1 indicates that the request took longer than she felt was necessary to process it was consistently reported that the request for records was fulfilled.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

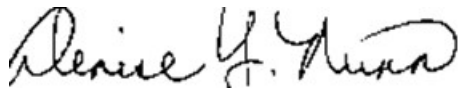


08/24/2026

Kellie Garner
Licensing Consultant

Date

Approved By:



09/01/2026

Denise Y. Nunn
Area Manager

Date