GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 19, 2024

Trina Watson
Waterford Oaks Senior Care Inc.
6474 Oak Valley Rd.
Waterford, MI 48237

RE: License #: AL630284310
Investigation #: 2025A0612002
Waterford Oaks Senior Care, Inc.

Dear Ms. Watson:

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) 975-5053.

Sincerely,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadilac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630284310
Investigation #:	2025A0612002
Complaint Receipt Date:	10/04/2024
Investigation Initiation Date:	10/07/2024
Report Due Date:	12/03/2024
Licensee Name:	Waterford Oaks Senior Care Inc.
Licensee Address:	3385 Pontiac Lake Road Waterford, MI 48328
Licensee Telephone #:	(248) 681-4788
Administrator:	Trina Watson
Licensee Designee:	Trina Watson
Name of Facility:	Waterford Oaks Senior Care, Inc.
Facility Address:	3385 Pontiac Lake Rd. Waterford, MI 48328
Facility Telephone #:	(248) 681-4788
Original Issuance Date:	10/12/2007
License Status:	REGULAR
Effective Date:	05/01/2024
Expiration Date:	04/30/2026
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Direct Care Staff are not trained.	No
The facility is understaffed.	Yes
• Incontinence and wellness checks are not performed regularly. • Injuries are undocumented and go unreported to families. • Residents are not being repositioned.	No
Medications are passed incorrectly.	No

III. METHODOLOGY

10/04/2024	Special Investigation Intake 2025A0612002
10/07/2024	Special Investigation Initiated - Letter I made a referral to Adult Protective Services (APS) via electronic file.
10/07/2024	APS Referral Referral made to APS. APS denied the referral for investigation.
11/04/2024	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed assistant manager Tiffany Jones, manager Erica Martin, direct care staff Kiera Stevens, direct care staff Linda Curd, Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F.
11/07/2024	Contact – Document Received Statement from Licensee, Trina Watson received via email.
11/12/2024	Contact - Document Received Facility documentation received: staff trainings, staff phone list, incident reports, Resident G's medical records.
11/14/2024	Contact – Telephone Call Made Telephone interview completed with manager Erica Martin.

11/15/2024	Contact - Document Received Facility documentation received: staff trainings and incontinence logs.
11/18/2024	Exit Conference I placed a telephone call to licensee Trina Watson to conduct an exit conference.

ALLEGATION:

Direct Care Staff are not trained

INVESTIGATION:

On 10/04/24, I received an anonymous complaint. The complaint indicated that the facility is regularly understaffed, and employees are intimidated to comply with understaffed ratios. Incontinence and wellness checks are not performed regularly. Injuries are undocumented and go unreported to families. Residents are not receiving breathing treatments. Residents are not being repositioned. Medications are passed early/late or inaccurately documented (marked as passed and did not administer and PRNs are given to sedate residents). Narcotic counts are inaccurate. Staff are not being trained and retrained annually to state licensing regulations. On 10/07/24, I made a referral to adult protective services (APS) via electronic file. I received written notification that APS denied the referral for investigation.

On 11/04/24, I completed an unscheduled onsite investigation. There are two buildings sharing the same parking lot. Both are Waterford Oaks Senior Care; however, this intake was regarding Waterford Oaks Senior Care (AL630284310). I interviewed assistant manager Tiffany Jones, manager Erica Martin, direct care staff Kiera Stevens, direct care staff Linda Curd, Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F.

On 11/04/24, I interviewed assistant manager Tiffany Jones and manager Erica Martin. Ms. Jones and Ms. Martin consistently stated direct care staff, Alexandra Cooks was recently terminated and since her termination she has been harassing staff and residents, they suspect that these allegations were made by Ms. Cook. Ms. Jones and Ms. Martin consistently stated all direct care staff are adequately trained and agreed to provide proof of all staff training certificates.

On 11/04/24, I interviewed Resident A. Resident A stated the staff treat him well and he has no issues or concerns with their qualifications or level of training.

On 11/04/24, I interviewed Resident B, Resident C, Resident D, and Resident E. Resident E had limited speech and she was unable to answer open ended questions.

Resident B, Resident C, and Resident D consistently stated the staff at the facility are well trained and take good care of them, the care that is provided is sufficient.

On 11/04/24, I interviewed Resident F. Resident F stated the staff are a good group of people, she has no issues or concerns.

On 11/04/24, I interviewed direct care staff Kiera Stevens. Ms. Stevens stated she has worked at this facility for one month. She works the morning shift from 7:00 am – 3:00 pm. Ms. Stevens stated she has completed all her required trainings. Ms. Stevens stated that she is not trained on medication administration, and therefore, she does not administer medication. Ms. Stevens does not have concerns about staff not being properly trained.

On 11/04/24, I interviewed direct care staff Linda Curd. Ms. Curd has worked at this facility for two years. She works the morning shift from 7:00 am – 3:00 pm. Ms. Curd stated she has completed all her required trainings, and she assists with training new staff when they start working with residents.

On 11/07/24, I received a written statement from the licensee, Trina Watson. In summary, the statement indicated “Waterford Oaks Senior Care, Inc is dealing with a challenging and unfair scenario with the repeated investigations impacting and creating unwarranted concerns for residents and families. This is the fourth investigation of my company since March of 2024. I have also been targeted by terminated employee in the last six months who are using licensing as a tool of harassment against my company. I can prove each state complaint was directly filed after a terminated employee…” Ms. Watson has filed a harassment case against previous employee Alexandrea Cooks and indicated this Special Investigation Report will be a part of her case.

I reviewed the training certificates for direct care staff: Aalaina Johnson, Anastasia Hagerman, Leola Donahue, Donovon Ball, Janosha Boya, Lorene Caldwell, Kiera Stevens, Caresha Reaves, Germany Presley, Lakila Peters, Margarita Villagomez, Marguita Dewberry, Linda Curd, Sheri Cusick, Taylor Mclninch, Carmen Leonard and Julie Johnson. All direct care staff had proof of training for: Reporting requirements, First aid, Cardiopulmonary resuscitation, Personal care, supervision, and protection, Resident rights, Safety and fire prevention and Prevention and containment of communicable diseases.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas:

	(a) Reporting requirements. **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to conclude that the direct care staff are untrained. I reviewed the training certificates for direct care staff: Aalaina Johnson, Anastasia Hagerman, Leola Donahue, Donovon Ball, Janosha Boya, Lorene Caldwell, Kiera Stevens, Caresha Reaves, Germany Presley, Lakila Peters, Margarita Villagomez, Marguita Dewberry, Linda Curd, Sheri Cusick, Taylor Mclninch, Carmen Leonard and Julie Johnson. All the direct care staff had proof of training for Reporting requirements, First aid, Cardiopulmonary resuscitation, Personal care, supervision, and protection, Resident rights, Safety and fire prevention and Prevention and containment of communicable diseases.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The facility is understaffed.

INVESTIGATION:

On 11/04/24, I interviewed assistant manager Tiffany Jones and manager Erica Martin. Ms. Jones and Ms. Martin consistently stated the facility has 18 residents. Previously there were two staff on shift from 7:00 am – 11:00 pm and one staff on shift from 11:00 pm – 7:00 am. Recently, they have been able to increase staffing due to hiring more direct care staff. Ms. Jones and Ms. Martin stated this staffing pattern adequately meets the needs of the residents. On 11/14/24, I completed a second interview with Ms. Martin via telephone. Ms. Martin stated Resident I and Resident J use a Hoyer lift and require a two person assist to transfer. Ms. Martin stated in the event of a fire and/or during a fire drill on the midnight shift the staff from the adjoining AFC facility, Waterford Oaks Senior Care, Inc. West (AL630337056) come over to assist with evacuating residents who require two staff to transfer.

On 11/04/24, I interviewed direct care staff Kiera Stevens. Ms. Stevens stated she works the morning shift from 7:00 am – 3:00 pm. There are two staff on the morning shift. Ms. Stevens stated Resident H, and Resident I use a Hoyer lift which requires two

staff to transfer. However, during the midnight shift Resident I does not get out of bed to toilet, she is changed in bed, and therefore, she does not need to be transferred.

On 11/04/24, I interviewed direct care staff Linda Curd. Ms. Curd stated she works the morning shift from 7:00 am – 3:00 pm. There are usually two to three staff on the morning shift. Ms. Curd stated Resident J and Resident K use a Hoyer lift and require a two-person assist to transfer.

On 11/04/24, I interviewed Resident A. Resident A was unable to report how many staff are on each shift however, he stated he feels like there is always enough staff available to assist him.

On 11/04/24, I interviewed Resident B, Resident C, Resident D and Resident E. Resident E had limited speech and she was unable to answer open ended questions. Resident B, Resident C, and Resident D consistently stated there is a shortage of staff which sometimes means they have to wait longer for care. The residents consistently stated staff complete room checks regularly.

On 11/04/24, I interviewed Resident F. Resident F stated she has no concerns with the staffing levels.

I reviewed the AFC assessment plans for all 18 residents who reside in this facility. The following was noted, Resident J uses a Hoyer lift and is completely dependent on staff to transfer. Resident H uses a wheelchair and needs assistance with mobility. She is unable to ambulate independently. Resident H uses a Hoyer lift to transfer. Resident I uses a Hoyer lift to transfer and is completely dependent on staff for mobility. Resident K uses a wheelchair and requires staff assistance to ambulate.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the information gathered through my investigation there is sufficient information to conclude one staff is not sufficient staffing during the midnight shift. There are multiple residents who use a Hoyer lift and require two staff to transfer. Resident J uses a Hoyer lift and is completely dependent on staff to transfer. Resident H uses a wheelchair and needs assistance with mobility. Resident H uses a Hoyer lift to transfer. Resident I uses a Hoyer lift to transfer and is completely dependent on staff for mobility. Resident K uses a wheelchair and requires staff

	assistance to ambulate. Manager Erica Martin stated in the event of a fire and/or during fire drills on the midnight shift the staff from the adjoining AFC facility, Waterford Oaks Senior Care, Inc. West (AL630337056) will come over to assist with evacuating the residents who require two staff to transfer.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Incontinence and wellness checks are not performed regularly.**
- **Injuries are undocumented and go unreported to families.**
- **Residents are not being repositioned.**

INVESTIGATION:

On 11/04/24, I interviewed assistant manager Tiffany Jones and manager Erica Martin. Ms. Jones and Ms. Martin consistently stated direct care staff conduct incontinence and wellness checks every two hours. During the incontinence checks the residents are toileted and repositioned. In each resident's bedroom there is also a call cord that resident can use to call for assistance with toileting. Ms. Jones and Ms. Martin explained that none of the residents currently have specific repositioning guidelines such as pillow repositioning. All the residents can move slightly to readjust themselves, none of the residents have bedsores. Ms. Jones and Ms. Martin stated there is no concern that resident injuries are not being documented. Direct care staff complete incident reports as needed and inform family members when appropriate. There has only been one incident recently, it was two or three weeks ago, Resident G fell. EMS was called and she was taken to the hospital. An incident report was completed, and her family as notified. When Resident G returned from the hospital, she had a follow up appointment with her primary care doctor and the behavioral health nurse who comes twice a week. Resident G also had a physical therapy evaluation and completed lab work. Ms. Jones and Ms. Martin consistently stated documentation is routinely monitored and there have been no notable concerns. Ms. Jones and Ms. Martin stated residents are offered a shower twice a week, they have the right to decline. If a resident declines to shower it is documented.

On 11/04/24, I interviewed direct care staff Kiera Stevens. Ms. Stevens stated she completes incontinence checks at 7:30 am, after breakfast, after lunch, and around 2:30 pm before her shift ends. She has no concerns that these checks are not regularly being conducted. Ms. Stevens stated there have been no recent incidents to report other than Resident G's fall. Ms. Stevens reported she was on shift when Resident G fell, EMS was called, an incident report was written, and her family was notified. Ms. Stevens stated she has no concerns that documentation is being falsified. Ms. Stevens works Monday – Friday and every other weekend. She gives two residents a shower every day and appropriately completes the shower log. Ms. Stevens stated none of the

residents require specific repositioning however when the residents are changed, they are also repositioned in bed.

On 11/04/24, I interviewed direct care staff Linda Curd. Ms. Curd stated she completes incontinence checks every two hours. During resident checks the residents are repositioned and changed. None of the residents have a specific repositioning schedule. Ms. Curd stated she has no concern that documentation is being falsified. She completes logs as instructed and she has not observed any issues or concerns with how any other staff is documenting in the logs.

On 11/04/24, I interviewed Resident A. Resident A stated he has no issues or concerns. Staff check on him regularly, they assist him with toileting, he can shower regularly, and staff assist him as needed.

On 11/04/24, I interviewed Resident B, Resident C, Resident D and Resident E. Resident E had limited speech and she was unable to answer open ended questions. Resident B, Resident C, and Resident D consistently stated they do not require assistance with being repositioned or toileting. They have no concerns that incidents are not being reported. The residents consistently stated staff complete wellness checks on them regularly throughout the day and night.

On 11/04/24, I interviewed Resident F. Resident F stated she has no issues or concerns to report.

On 11/04/24, I completed an unscheduled onsite investigation, while onsite I reviewed three incident reports regarding Resident G. The incident reports were thoroughly completed and indicate that Resident G's guardian was notified regarding each incident. Resident G fell on 10/13/24, there was a laceration on her forehead. She was taken to Trinity Hospital.

I reviewed the Trinity Hospital after visit summary dated 10/13/24, which indicated Resident G was seen for a fall.

I reviewed Impact progress note dated 10/17/24, that indicated Resident G was seen by the nurse practitioner following a fall. The note indicated that Resident G's family is aware of the fall and inquired about hospice services.

I reviewed the AFC assessment plans for all 18 residents who reside in this facility. The assessment plans do not indicate a need for any resident to be physically repositioned at a specific duration or frequency.

I reviewed the October 2024 wellness check logs for all 18 residents. The log indicates wellness checks are completed hourly throughout the morning (7a -3p), afternoon (3p-11p), and midnight shifts (11p – 7a).

I reviewed the October 2024 shower logs logs for all 18 residents All residents are being showered one to two times weekly by staff at this facility.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to conclude incontinence and wellness checks are not performed regularly, injuries are undocumented and go unreported to families and/or residents are not being repositioned. Assistant manager Tiffany Jones, manager Erica Martin, direct care staff Linda Curd and direct care staff Kiera Stevens denied the allegations. Resident A stated staff check on him regularly, they assist him with toileting, he can shower regularly, and staff assist him as needed. Resident B, Resident C, and Resident D consistently stated they do not require assistance with being repositioned. They have no concerns that incidents are not being reported. The residents consistently stated staff complete wellness checks on them regularly throughout the day and night. Resident F stated she has no issues or concerns to report. I reviewed the AFC assessment plans for all 18 residents who reside in this facility. The assessment plans do not indicate a need for any resident to be physically repositioned at a specific duration or frequency. I observed that the facility is regularly completing incident reports which includes notifying families and obtaining medical care as needed at the time of an incident. It was consistently reported that wellness and incontinence checks are regularly completed. The documentation provided supports that these checks are being completed on all shifts.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Medications are passed incorrectly.

INVESTIGATION:

On 11/04/24, I interviewed assistant manager Tiffany Jones and manager Erica Martin. Ms. Jones stated she conducts regular audits of resident medication. Previously, she was completing medication audits weekly. However, there were no issues, so the audits have been decreased from weekly to biweekly or monthly. Ms. Jones stated that audits continue to be perfect and without issue or concern. Ms. Jones and Ms. Martin stated they have no concerns that residents are being given PRNs to sedate them. All narcotics are being administered as they are prescribed, and the counts are accurate. Ms. Jones and Ms. Martin stated Resident D is prescribed a nebulizer due to her diagnosis of Chronic obstructive pulmonary disease (COPD) and lung cancer. The nebulizer is prescribed as needed; Resident D does not ask to use it. The machine is in her bedroom and whenever she wants to use it staff will get the medication and assist her in taking a treatment.

On 11/04/24, I interviewed direct care staff Kiera Stevens. Ms. Stevens stated she does not administer medication as she is not trained to do so. Ms. Stevens reported she has no concerns that medications are being passed incorrectly or that PRNs are being given to sedate residents.

On 11/04/24, I interviewed direct care staff Linda Curd. Ms. Curd stated medications are administered as they are prescribed. There has been no issues or concerns regarding medication being administered incorrectly. Ms. Curd stated Resident D is on oxygen and she has a nebulizer that is prescribed PRN. Resident D never asks to use the nebulizer, but she can ask if she wants to use it. Ms. Curd stated she has no concerns that PRN medications are being administered to sedate residents.

On 11/04/24, I interviewed Resident A. Resident A stated he receives his medication as prescribed. Resident A has no concerns with being overmedicated.

On 11/04/24, I interviewed Resident B, Resident C, Resident D and Resident E. Resident E had limited speech and she was unable to answer open ended questions. Resident B, Resident C, and Resident D consistently stated their medications are administered as they are prescribed. They have no concerns with being overmedicated. Resident D stated she has a nebulizer, she does not ask staff to use it, but she understands that if she wants to use it staff will set it up for her.

On 11/04/24, I interviewed Resident F. Resident F stated she receives her medication as prescribed. Resident F has no concerns with being overmedicated.

On 11/04/24, I completed an unscheduled onsite investigation. I observed the medication cart. The cart was locked. The content of the cart was organized and medications were stored properly. I reviewed the physical medications and the medication administration record. There were no observed discrepancies between the medication administration record and the physical medications. The bubble packs of medication were in good condition. No residents at the facility appeared sedated or

heavily medicated. I reviewed and counted the narcotic medications. The physical medication count was consistent with the documented narcotic count. I observed direct care staff Linda Curds complete a medication pass. Ms. Curds completed the medication pass sufficiently and without issue she observed the five rights of medication administration. I observed Resident D's nebulizer. The medication is prescribed as needed it is available on site if Resident D chooses to use it. Per Resident D's medication administration record she has not taken a treatment.

On 11/18/24, I conducted an exit conference with licensee designee, Trina Watson via telephone to review my findings. Ms. Watson acknowledged the rule violation and the recommendation to submit a corrective action plan. However, Ms. Watson stated that she disagrees with the rule violation. Ms. Watson stated that one staff on the midnight shift is sufficient staffing as there is a floating staff at Waterford Oaks Senior Care, Inc. West (AL630337056) that is available to assist if needed. I discussed with Ms. Watson that floating staff or other staff that are on duty and working at another facility cannot be considered part of this facility's staff -to- resident ratio or expected to assist in providing supervision, protection, or personal care to the resident population.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered through my investigation there is insufficient information to conclude medications are not being given, take, or applied, pursuant to label instructions. Assistant manager Tiffany Jones, manager Erica Martin, direct care staff Kiera Stevens, direct care staff Linda Curd, Resident A, Resident B, Resident C, and Resident D denied the allegation. During the unscheduled, onsite investigation completed on 11/04/24, I reviewed the med cart. There were no observed discrepancies between the medication administration record and the physical medications on hand. I reviewed and counted the narcotic medications. The physical medication count was consistent with the documented narcotic count. I observed direct care staff Linda Curds complete a medication pass. Ms. Curds completed the medication pass sufficiently and without issue. No residents appeared sedated or heavily medicated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

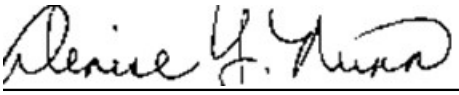
IV. RECOMMENDATION

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

11/18/2024

Johnna Cade — Date
Licensing Consultant

Approved By:



11/19/2024

Denise Y. Nunn — Date
Area Manager