GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 31, 2025

Megan Rheingans
AUBURN HILLS OPCO, LLC
3520 Davenport Avenue
Saginaw, MI 48602

RE: License #: AH630409728
Investigation #: 2025A1035054
Willowbrook Hills

Dear Megan Rheingans:

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.
Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909
(313) 410-3226
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630409728
Investigation #:	2025A1035054
Complaint Receipt Date:	05/19/2025
Investigation Initiation Date:	05/19/2025
Report Due Date:	07/18/2025
Licensee Name:	AUBURN HILLS OPCO, LLC
Licensee Address:	3520 Davenport Avenue Saginaw, MI 48602
Licensee Telephone #:	Unknown
Administrator:	Elizabeth Leone
Authorized Representative:	Megan Rheingans
Name of Facility:	Willowbrook Hills
Facility Address:	3151 E Walton Blvd Auburn Hills, MI 48326
Facility Telephone #:	(248) 282-4094
Original Issuance Date:	09/30/2022
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	102
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's care needs had not been met.	Yes
Additional Findings	No

III. METHODOLOGY

05/19/2025	Special Investigation Intake 2025A1035054
06/16/2025	Contact - Face to Face
09/19/2025	Special Investigation Initiated - Letter
07/31/2025	Inspection Complete. BCAL Sub Compliance.
07/31/2025	Exit Conference.

ALLEGATION:

Resident A's care needs had not been met.

INVESTIGATION:

On May 19, 2025, the Department received a complaint forwarded from Adult Protective Services (APS) which read:

> "The staff are not changing Resident A's diaper regularly. Resident A is left in saturated diapers, which has caused diaper rashes. Last week, Resident A hands were covered in feces, and he had feces under his nails. The staff claimed Resident A would not keep his hands under the water to clean it off. On 05/14/2025, Resident A was lying on a bare mattress. Someone had removed the soiled sheets and left them next to the bed. Resident A's room reeks of urine. Resident A is not being shaved. It does not appear Resident A is being bathed regularly. Resident A has been falling a lot. Resident A presses his call button for help but must wait for staff to come help. Resident A has lost approximately 50 lbs. since residing at the facility. The staff are not bringing Resident A down to his meals or bringing him meals."

On June 15,2025, an onsite investigation was conducted. While onsite, I interviewed Staff Person (SP)1 who states Resident A was discharged related to financial

reasons, not quality of care. SP1 states Resident A had “mental health issues with behaviors.”

While onsite, I interviewed SP2 who states Resident A had poor safety awareness. Resident A would not use his walker, would not take guidance, and has been witnessed placing self on the floor. SP2 states Resident A would repetitively ask for pain medications above his schedule pain medication.

While onsite, I interviewed SP3 who states Resident A was very confused. Resident A was initially able to take self to restroom. Resident A had a significant decline where staff had to “check and change” him every two hours.

While onsite, I interviewed SP4 who states Resident A “slept a lot” was declining prior to discharging from facility. Resident A was able to transfer with a walker. Staff members had to “check and change” Resident A every two hours.

Through record review of the service plan dated December 8, 2024. Service plan states resident receives “minimal” assistance with bathing. Bathing days Thursdays staff “assistance may include reminding/ prompting to bathe, setting up shower/ bath and cleaning up afterwards.

Record review indicates Resident A vital signs taken monthly “no refusals.” Monthly vital signs for the month of May had not been documented.

Record review indicates Resident A should be weighed monthly, for the month of April weight recorded as “unknown”, May weight 155.2lbs.

Through interview and record review call response time should be 7-15 minutes. May 1, 2025, through May 20, 2025, 25 call events occurred longest response time 27 minutes with the average wait time 8 minutes.

Record review of QuickMAR indicates oral care should be documented twice a day. For the month of May Resident A missed 15 opportunities of oral care out of 39 scheduled. Quick MAR indicates staff assist with “toileting” 30 missed documentation out of 77 scheduled toileting times. QuickMAR indicated Resident A’s Laundry Day is Monday, no documented completed laundry in the month of April and May.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(1) Personal care and services that are provided to a resident by the home shall be designed to encourage residents to function physically and intellectually with independence at the highest practical level.

ANALYSIS:	Through interview Resident A had a significant decline and required more care assistance upon return to the facility in April. Through record review, the service plan had not been updated since the residents return to facility from a “rehab center”, there were multiple missed documentation related to oral hygiene, showers, toileting assistance, monthly vital signs, and monthly weight noted. Weekly laundry had not been documented for the month of April and May. Based on the information noted above this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/10/2025

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Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

07/31/2025

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