GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 18, 2025

Vijay Sahore
Assured Senior Living Group, LLC
25180 Lahser Road
Southfield, MI 48033

RE: License #: AH630382886
Investigation #: 2025A0628004
Royal Oak House

Dear Licensee:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.
Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

Rebekah Looney

Rebekah Looney, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630382886
Investigation #:	2025A0628004
Complaint Receipt Date:	07/07/2025
Investigation Initiation Date:	07/10/2025
Report Due Date:	09/09/2025
Licensee Name:	Assured Senior Living Group, LLC
Licensee Address:	25180 Lahser Road Southfield, MI 48033
Licensee Telephone #:	(248) 262-2205
Administrator:	Laura Smigielski
Authorized Representative:	Vijay Sahore
Name of Facility:	Royal Oak House
Facility Address:	1900 N. Washington Ave. Royal Oak, MI 48073
Facility Telephone #:	(248) 585-2550
Original Issuance Date:	03/01/2018
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	57
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents are not getting changed. They are left in soiled briefs or without any briefs.	No
Residents are not getting showered as scheduled.	Yes
Resident laundry is not completed timely and was lost.	No
The facility was not clean and smelled.	No
Residents that require feeding assistance do not receive it timely.	No
Additional Findings	No

III. METHODOLOGY

07/07/2025	Special Investigation Intake 2025A0628004
07/10/2025	Special Investigation Initiated - On Site
08/20/2025	Exit Conference Conducted via email with Vijay Sahore and Laura Smigielski

ALLEGATION:

Residents are not getting changed. They are left in soiled briefs or no briefs.

INVESTIGATION:

On 07/07/2025, the Department received an anonymous complaint with allegations that residents were not being changed, and they were left in soiled briefs or no briefs. Due to the anonymous nature of the complaint, additional details could not be provided.

On 7/10/2025, I conducted an on-site inspection and interviewed the administrator.

The administrator stated she had not been made aware of the complaints prior. I walked around the facility several times and interviewed residents.

I interviewed Resident A and Resident B and observed 10 additional residents in the building. Both Residents A and B stated they have not seen residents sitting

in soiled briefs or with no briefs. Resident A stated that staff helps you timely if you need it. All residents I observed and spoke to appeared well-groomed and appropriately dressed.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Through interviews with residents and additional observation of residents while I was in the building, I noted nobody sitting in soiled briefs for a long time, or without briefs. Residents expressed no concerns about themselves or other residents not being changed timely. Therefore, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are not getting showered as scheduled.

INVESTIGATION:

On 07/07/2025, the Department received an anonymous complaint that alleged residents are not getting showered as scheduled. Due to the anonymous nature of the complaint, additional information could not be obtained.

On 07/10/2025, I conducted an on-site inspection and interviewed the administrator.

The administration provided a copy of the shower schedule. Additionally, she stated showers were documented.

Employee# 1 stated that residents are scheduled for two showers per week, except for Hospice residents who are technically scheduled for four showers per week, as Royal Oak House staff provide two showers, while hospice staff provided two showers as well. Employee # 1 reported that none of the residents receiving hospice services have more than two showers per week, at the request of their family/responsible party. Employee #1 reported that there should be

documentation in the shower book for every date that the resident is scheduled for a shower, even if the resident refuses the shower.

I reviewed the facility shower book. Five residents had no documentation that they had received, or refused, any showers up to this point in July. In addition, ten residents were missing one or two dates of shower documentation for the month.

Resident A reported that his brother comes and assists him with showers.

Resident B reported that he gets showers when needed and staff helped him. It was noted in the shower book that Resident B often refuses showers.

Employee #3 reported that the staff needed to do better at documenting showers.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Per the facility's policy, staff were to document residents' showers; however, they were unable to provide documentation that residents were receiving showers twice per week.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident laundry is not getting completed timely and was lost.

INVESTIGATION:

On 07/07/2025, the Department received an anonymous complaint which alleged resident laundry was not completed timely and was lost. Due to the anonymous nature of the complaint, additional information could not be obtained.

On 07/10/2025, I conducted an on-site inspection and interviewed the administrator, who provided me with a laundry schedule.

Resident A reported that his family does his laundry. Resident A reported he has not heard anyone complain about not having clean laundry or having their laundry lost.

Resident B reported that the laundry was done on time.

I observed ten resident rooms and noted no overflowing dirty laundry receptacles. I observed ten additional residents who all appeared to be adequately dressed, in clean and appropriate clothing.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(3) The home shall make adequate provision for the laundering of a resident's personal laundry.
ANALYSIS:	Through interviews with residents, review of the laundry schedule and visual observations of resident apartments, there were no laundry concerns noted. Residents stated their laundry is done on time. Residents appeared properly dressed in clean clothing and no laundry bins were noted as overflowing with dirty laundry. Given this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility was not clean and smelled.

INVESTIGATION:

On 07/07/2025, the Department received an anonymous complaint which alleged the facility is not clean and smelled of urine and feces. The complaint also alleged the floors are sticky. Due to the anonymous nature of the complaint, additional information could not be obtained.

On 07/10/2025, I conducted an on-site inspection.

While in the building I noticed no odor. I also did not notice any of the floors to be sticky. Additionally, the main hallways, dining room and common areas of the building did not appear to be dirty.

Employee #2 reported that there were two housekeepers scheduled during the week and one housekeeper on the weekends. Employee #2 reported there was

a cleaning schedule and explained how it was divided into daily, as well as weekly tasks. Employee #2 reported that they were doing additional cleaning of "high touch" surfaces because they have had a recent increase in respiratory illness in the building.

I reviewed the facility cleaning schedule. The cleaning schedule had all cleaning tasks assigned per day and per housekeeper.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Through visual and sensory observations of the facility, the facility lacked foul odors and sticky floors. Staff were actively cleaning and followed a cleaning schedule. Additionally, the housekeeping staff increased their cleaning tasks due to a recent respiratory illness in the building. Given this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents that require feeding assistance do not receive it timely.

INVESTIGATION:

On 07/07/2025, the Department received an anonymous complaint which alleged residents who require feeding assistance were not being assisted timely.

On 07/10/2025, I conducted an on-site inspection.

I observed lunch trays being delivered to resident rooms.

I reviewed the service plans for Residents C and D. Both service plans read the residents needed to be fed by staff. Within five minutes of lunch trays being delivered, Resident C was being fed by a care provider. Additionally, I witnessed a care provider deliver a lunch tray to Resident D and attempt to wake her up so she could have lunch. However, the care provider was having difficulty waking Resident D. Employee #1 reported that Resident D was receiving hospice services.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Based on visual observations, there is no evidence that residents that require assistance with feeding are not getting assisted timely; therefore, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

Rebekah Looney 07/23/2025

Rebekah Looney Date
Licensing Staff

Approved By:

Andrea L. Moore 08/18/2025

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