



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2026

Sara Dickendeshher
Springvale Assisted Living
4276 Kroger Street
Swartz Creek, MI 48473

RE: License #: AH250382043
Investigation #: 2026A1019016

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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,

A handwritten signature in blue ink, appearing to read "Elizabeth Gregory-Weil".

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

| | |
|---------------------------------------|--|
| License #: | AH250382043 |
| Investigation #: | 2026A1019016 |
| Complaint Receipt Date: | 02/03/2026 |
| Investigation Initiation Date: | 02/03/2026 |
| Report Due Date: | 04/05/2026 |
| Licensee Name: | Kroger Street Opco LLC |
| Licensee Address: | 4500 Dorr Street Toledo, OH 43615 |
| Licensee Telephone #: | (419) 247-2800 |
| Administrator: | Stephanie Surinck |
| Authorized Representative: | Sara Dickendesher |
| Name of Facility: | Springvale Assisted Living |
| Facility Address: | 4276 Kroger Street Swartz Creek, MI 48473 |
| Facility Telephone #: | (810) 230-6644 |
| Original Issuance Date: | 08/15/2017 |
| License Status: | REGULAR |
| Effective Date: | 08/01/2025 |
| Expiration Date: | 07/31/2026 |
| Capacity: | 73 |
| Program Type: | ALZHEIMERS AGED |

II. ALLEGATION(S)

| | Violation Established? |
|--|-----------------------------------|
| The facility failed to provide proper care for Resident A's skin issues. | Yes |
| Additional Findings | No |

III. METHODOLOGY

| | |
|------------|---|
| 02/03/2026 | Special Investigation Intake 2026A1019016 |
| 02/03/2026 | Special Investigation Initiated - Letter Emailed administrator requesting resident roster. |
| 02/10/2026 | Inspection Completed On-site |
| 02/10/2026 | Inspection Completed BCAL Sub. Compliance |

ALLEGATION: The facility failed to provide proper care for Resident A's skin issues.

INVESTIGATION:

On 2/3/26, the department received a complaint alleging that the facility has not met Resident A's needs because they have inadequately treated her skin issues. The complaint alleged that Resident A has skin tears in her genital area and on her buttocks that have not been properly addressed.

On 2/10/26, I conducted an onsite inspection. I interviewed administrator Stephanie Surinck at the facility. The administrator reported that Resident A requires staff assistance with activities of daily living, is visually impaired and has some memory impairment. The administrator reported that she cannot speak to Resident A's skin issues, and that Employee 1 would be able to provide more detail.

On 2/10/26, I interviewed Employee 1 at the facility. Employee 1 reported that Resident A requires staff assistance with toileting due to incontinence and mobility limitations but reported that Resident A is able to communicate and make her needs known. Employee 1 reported that Resident A wears an incontinence brief and is on a toileting schedule every 2 hours. Employee 1 reported that Resident A has an ongoing issue with protruding hemorrhoids, recently developed some irritation in her

vaginal area and also has two small skin abrasions to her inner thigh. Employee 1 reported that Resident A has been seen by Employee 2 and has received treatment for all three issues. Employee 1 reported that skilled nursing home care has also been consulted to assist with treatment, but they have not started their services yet.

On 2/10/26, I interviewed Employee 2 at the facility. Employee 2 verbalized knowledge of Resident A's skin issues and similarly to Employee 1's attestation, reported that all areas have been treated. Employee 2 reported that he will be evaluating Resident A today, but he last saw her on 2/3/26 and she denied any concerns with her vaginal area and stated it was no longer bothering her, and he has considered that issue to be resolved. Employee 2 reported that he believes that the facility staff have done a good job of monitoring the situation and keeping him informed. Employee 2 reported that he has deemed all treatment given as appropriate and he would not have done anything different.

While onsite, I reviewed Resident A's medication administration record (MAR) for the previous five weeks. Resident A was prescribed a hemorrhoidal ointment on 1/29/25 and is instructed to "*apply 1 application liberally into rectum twice a day scheduled*". I observed that Resident A was administered this ointment as prescribed during the entire timeframe reviewed. Resident A was prescribed vagisil cream on 1/12/26 and is instructed "*apply 4 grams to vaginal area three times a day for 5 days*". I observed that she received two doses of the medication on 1/14/26, and three doses of the medication on 1/15/26, 1/16/26 and 1/17/26. Resident A was prescribed calmoseptine ointment on 2/2/26 and is instructed "*apply a small amount of ointment topically to affected area on buttock three times a day.*" I observed that Resident A was administered this ointment as prescribed during the entire timeframe reviewed.

In follow-up correspondence, the administrator submitted the following timeline of events:

January 1st- WD [wellness director] reached out to Nurse Practitioner to let him know she is having itching in her private area.

January 6th- Nurse Practitioner saw resident as a regularly scheduled visit, NP noticed her itching in her private area and stated he was going to send Vagisil as a trial for 5 days to see if that would help improve the itching. NP discussed other options regarding medication however the other medication discussed would have an interaction with Plavix that she currently is taking so it was decided that NP would move forward with Vagisil to start treatment.

January 12th- WB reached out to NP to let him know the Vagisil was delivered and she was starting medication. After the 5 days were completed, WD did a follow up with resident and when asked about itching resident denied any issues or concerns. The following week (week of 19th-24th) it was brought to WD attention that the resident was observed by staff itching in that area, at that time

NP was notified to add resident on to schedule. NP saw resident on the 27th and denied any itching.

February 3rd- NP and escort saw patient and was examined with noted small thigh irritation, it was at that time NP recommended skilled nursing and to utilize barrier cream in thigh area. Skilled nursing was ordered through Corso care home care and said they would be coming out 2/11/26 to evaluate.

February 9th- Resident complained of pain in thigh area and family consulted, resident sent to ER for assessment. Resident return [sic] to facility around 4:00am, no new orders were sent with resident.

February 10th- NP and WD followed up with resident after hospital visit, upon arrival resident was calm, sleeping in recliner, resident did state she had irritation to left thigh. Resident was assisted to toilet with WD NP present, at this time she also complained of burning sensation while urinating but unable to determine if it was secondary to irritation site, she is incontinent at times. Urinalysis will be order [sic] to rule out any infection. NP did attempt to reach out to [Relative A] but did not answer. NP ordered calmoseptine barrier cream to buttocks and thigh area, skilled nursing is set to start and open February 11th. When resident returned from hospital no paperwork was given, NP and WD requested records to be sent so we can review findings or new orders. WD did receive a phone call from [Relative A] in afternoon, ED [executive director] was present during call where [Relative A] went over findings from hospital and expressed her gratitude for the care she receives at Springvale.

| APPLICABLE RULE | |
|------------------------|---|
| R 325.1932 | Resident's medications |
| | (2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional. |
| ANALYSIS: | While staff interviews and supporting documentation provided reveal knowledge of and treatment to Resident A's skin issues, Resident A did not receive her full course of vagisil ointment as prescribed. Based on the instructions on the physician's order, Resident A should have received 15 administrations of the ointment, but staff documented that she only received 11. |
| CONCLUSION: | VIOLATION ESTABLISHED |

IV. RECOMMENDATION

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



02/12/2026

Elizabeth Gregory-Weil
Licensing Staff

Date

Approved By:



03/11/2026

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

Date