



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 30, 2026

Kimberly Wozniak
River Oaks Senior Living
500 E University Dr
Rochester, MI 48307

RE: License #: AH630399620
Investigation #: 2026A1019021

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 responsible party 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 #:	AH630399620
Investigation #:	2026A1019021
Complaint Receipt Date:	03/02/2026
Investigation Initiation Date:	03/03/2026
Report Due Date:	05/01/2026
Licensee Name:	Rochester Care Operations, LLC
Licensee Address:	144 940 Monroe Ave., NW Grand Rapids, MI 49503
Administrator:	Elizabeth Mahoney
Authorized Representative:	Kimberly Wozniak
Name of Facility:	River Oaks Senior Living
Facility Address:	500 E University Dr Rochester, MI 48307
Facility Telephone #:	(248) 601-9000
Original Issuance Date:	01/01/2020
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	117
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A lacked adequate supervision.	No
Staffing concerns in the memory care unit.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/02/2026	Special Investigation Intake 2026A1019021
03/04/2026	Contact- Document Received Additional information received via the BCHS intake unit
03/11/2026	Inspection Completed On-site
03/11/2026	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A lacked adequate supervision.

INVESTIGATION:

On 3/2/26 and 3/4/26, licensing staff received complaints with supervision concerns pertaining to Resident A. The first complaint read that on 2/26/26, staff were unaware of Resident A's whereabouts and Resident A's family found her on the floor without pants on. The second complaint read that Resident A sustained another fall on 3/1/26. The complaints read that Resident A's family was not notified timely of either fall, concerned that Resident A is not monitored close enough, and fall prevention measures have been insufficient or nonexistent.

On 3/11/26, I conducted an onsite inspection. I interviewed administrator Elizabeth Mahoney and Employee 1 at the facility. The administrator and Employee 1 reported that Resident A resided in the memory care unit and required monitoring every two hours for safety. Both staff attested that Resident A had a recent decline and needed more hands-on assistance than her baseline. The administrator and Employee 1 reported that Resident A exhibited a cognitive decline due to disease progression and was experiencing increased episodes of agitation and restlessness. The administrator and Employee 1 reported that Resident A could no longer safely ambulate on her own and required staff assistance while in her wheelchair but

acknowledged that Resident A frequently would attempt to get up on her own and required a lot of redirection. The administrator and Employee 1 reported that due to her recent decline, they coordinated with hospice prior to the 2/26/26 fall in order to obtain a geri chair, fall mat, bed alarm, and requested medication changes. The administrator also reported that Resident A moved out of the facility on 3/5/26 into a small group home.

While onsite, I reviewed incident report and progress note documentation for the falls in question; no documentation or reporting existed for the 2/26/26 incident. The administrator reported that staff did not follow protocol and confirmed that the event was not documented. The administrator reported that she became aware of the incident on the morning of 2/27/26 by Resident A's husband. The administrator reported that she was shown a picture taken by Resident A's son showing Resident A on the floor as described in the complaint. Regarding the 3/1/26 incident, an incident report read "*While finishing up my last rounds of checks/changes I heard a thud and [Resident A] crying, she had fallen in the hallway near her room I quickly went assets [sic] her and I got help, there was a small skin tear on her wrist.*" Staff documented that Resident A was given a bandage for her skin tear and calming music was put on to help with her agitation as the interventions that staff completed. The incident report read that hospice and Resident A's husband were contacted but did not list the date or time of notification. The administrator confirmed that both were contacted that same day.

In follow-up correspondence, the administrator reported that she conducted an investigation into what occurred on 2/26/26. She reported that video camera footage confirmed that staff were seen pushing Resident A in her wheelchair at 6:42pm. The administrator reported that Resident A's son was seen arriving at the memory care unit at 6:53pm and staff were seen assisting the resident off the floor at 7:00-7:05pm. Camera footage was also reviewed for the fall on 3/1/26. The administrator reported that staff were seen conducting rounds on Resident A at 4:37am. Then at 5:08am, she reported that Resident A was seen attempting to ambulate out of her room and fell in her doorway. The administrator reported that she observed staff tending to Resident A immediately at 5:09am. The administrator reported that staff were present in the memory care unit during both instances. The administrator also provided text messages with hospice staff confirming that medication changes had been requested in addition to the ger chair, fall mat and bed alarm.

APPLICABLE RULE	
R 325.1921	Governing bodies, administrators, and supervisors.
	(1) The owner, operator, and governing body of a home shall do all of the following:
	(b) Assure that the home maintains an organized program to provide room and board, protection,

	supervision, assistance, and supervised personal care for its residents.
ANALYSIS:	While it is irrefutable that Resident A sustained falls on 2/26/26 and 3/1/26, staff attestation and video surveillance footage confirm that staff were in the unit and that Resident A was not unattended for extended periods of time during the times in question as the complaints allege. Staff also made efforts to reduce fall risk by coordinating medication changes and obtaining fall prevention equipment as evidenced by text messages between the facility and hospice.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 325.1924	Reporting of incidents, quality review program.
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident’s authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident’s record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	Resident A’s family was present when Resident A was discovered on 2/26/26, so additional notification was not needed. On 3/1/26, staff documented that hospice and Resident A’s husband were contacted but lacked a day/time of when the notification occurred. The administrator attested that both were contacted that same day. In both instances, notification was provided to one or both parties within the 48-hour required timeframe.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staffing concerns in the memory care unit.

INVESTIGATION:

The submitted complaints raised concerns that there may be a staffing deficiency in the memory care unit. The administrator reported that the memory care unit housed 9 residents and that there should be two staff on first and second shift and one staff on third shift. The administrator reported that there are times when float staff are present and during certain hours, there are additional support staff such as dining services, concierge, life enrichment and administrative staff to assist the residents.

While onsite, I reviewed staff schedules for the previous five weeks and found staffing below those levels on the following dates/shifts:

- 2/2/26- second shift
- 2/3/26- second shift
- 2/18/26- first shift
- 2/19/26- first shift
- 2/21/26- second shift
- 3/2/26- second shift
- 3/4/26- second shift
- 3/6/26- first and second shift

Additionally, on numerous dates throughout the timeframe reviewed, the memory care staff were listed as float staff and were splitting their time between the memory care unit and another assisted living floor leaving no permanent staff stationed in memory care. For example, during third shift on 2/1/26, 2/3/26, 2/4/26, 2/5/26, 2/6/26, 2/13/26, 2/14/26, 2/15/26, 2/17/26, 2/18/26, 2/19/26, 2/20/26, the sole third shift memory care staff was listed as also working on the assisted living third floor. This practice was also observed throughout the schedules for other dates and shifts.

APPLICABLE RULE	
R 325.1931	Employees; general provisions.
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.

ANALYSIS:	Facility schedules revealed numerous instances where only one staff was listed in memory care while simultaneously splitting their time on another floor, leaving no staff stationed in memory care.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

While onsite, I reviewed Resident A's service plan. I observed that a level of care assessment was completed on 2/17/26 due to a "change in condition." Resident A's service plan lacked information pertaining to her recent increased agitation, did not contain specific methods of redirection and also did not contain the fall prevention methods that were recently added by hospice.

APPLICABLE RULE	
R 325.1922	Admission and retention of residents.
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Resident A's service plan was not updated to accurately reflect her specific care needs.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During review of the facility schedules, the administrator reported that there were additional staff working during some dates and shifts that were not reflected on the schedule.

