GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 28, 2026

Rochelle Lyons
3145 Lily Trail Opco LLC
3145 Lily Trail
Oakland, MI 48306

RE: License #: AL630419259
Investigation #: 2026A0612019
Flourish Collection at Rochester

Dear Ms. Lyons:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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) 972-9136.

Sincerely,

Johnna Cade

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(248) 302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630419259
Investigation #:	2026A0612019
Complaint Receipt Date:	03/10/2026
Investigation Initiation Date:	03/11/2026
Report Due Date:	05/09/2026
Licensee Name:	3145 Lily Trail Opco LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(810) 334-8809
Administrator:	Rochelle Lyons
Licensee Designee:	Rochelle Lyons
Name of Facility:	Flourish Collection at Rochester
Facility Address:	3145 Lily Trail Oakland, MI 48306
Facility Telephone #:	(248) 759-8500
Original Issuance Date:	11/20/2025
License Status:	TEMPORARY
Effective Date:	11/20/2025
Expiration Date:	05/19/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Staff are not monitoring the residents appropriately: • **On 11/19/25, Resident A fell outside of her apartment and sustained an injury. Staff are not monitoring the residents appropriately.** • **On 12/14/25, Resident A sustained had a cut on her knee/shin it is unknown how the injury occurred.** • **On 03/09/26, Resident A left her walker in the bathroom and went back to bed. It took multiple calls to staff for them to move the walker back to her bedside.**	No
Staff are not trained to transfer residents: • **On 09/08/25, Resident B fell and broke her left hip and femur while being transferred. Staff are not trained to transfer residents.**	No

III. METHODOLOGY

03/10/2026	Special Investigation Intake 2026A0612019
03/11/2026	Special Investigation Initiated - Letter Email sent to Reporting Source A.
03/11/2026	Contact - Telephone call received Telephone interview completed with Reporting Source A.
03/11/2026	Contact - Document Received Reporting Source A sent three photos of Resident A's injuries via text message.
03/12/2026	Contact - Document Received Reporting Source A sent a video of Resident A and staff interaction via email.
03/16/2026	Contact - Telephone call received

	Additional allegations received from Reporting Source B. Telephone interview completed.
04/02/2026	Inspection Completed On-site I completed an unannounced onsite inspection. I interviewed executive director Linda Price and Resident B. While onsite I obtained a copy of Resident A and Resident B's Wellness Evaluation, staff phone numbers, internal incident report form regarding Resident A, and Resident A's MORSE Fall assessment.
04/02/2026	Contact - Document Received I received facility documentation sent via email from executive director Linda Price.
04/03/2026	Contact - Document Received I received a standard AFC Lease for Storypoint sent via email from executive director Linda Price.
04/17/2026	Contact - Document Received Executive Director Linda Price provided a copy of Resident A's lease and associated move in documentation via email.
04/20/2026	Contact - Telephone call made Telephone interviews completed with direct care staff Maurice Adams and Micah Martin.
04/20/2026	Contact - Telephone call made Telephone interview completed with APS worker Angelique Evans.
04/20/2026	Contact - Telephone call made Telephone interview completed with Regional Director of Operations Michael Hamid.
04/20/2026	APS Referral I made a referral to Adult Protective Services (APS) via Centralized Intake regarding the allegation involving Resident B.
04/24/2026	Contact - Document Received Direct care staff Louise Daniels training records received via email from director of operations Michael Hamid.
04/27/2026	Contact - Telephone call made Telephone interview completed with Charter Township of Oakland Fire Captain Andrew Linn.
04/27/26	Contact – Documentation Sent

	FOIA request made to Charter Township of Oakland Fire via email (Incident # 25-1092).
04/27/26	Exit Conference I placed a telephone call to licensee designee Rochelle Lyons to conduct an exit conference.

ALLEGATION:

Staff are not monitoring the residents appropriately:

- **On 11/19/25, Resident A fell outside of her apartment and sustained an injury.**
- **On 12/14/25, Resident A sustained had a cut on her knee/shin it is unknown how the injury occurred.**
- **On 03/09/26, Resident A left her walker in the bathroom and went back to bed. It took multiple calls to staff for them to move the walker back to her bedside.**

Staff are not trained to transfer residents:

- **On 09/08/25, Resident B fell and broke her left hip and femur while being transferred.**

INVESTIGATION:

On 03/10/26, I received an intake that in summary indicates on 11/19/25, Resident A left her apartment with her walker around 4:00 am - 4:05 am and was later found in the hallway on the floor around 4:50 am bleeding and bruised. The facility has video evidence of her attempts to get back into her apartment (and another resident's apartment due to mistaken identity of room location) and her ultimate fall to the floor. Direct care staff Maurice Adams found Resident A in the hallway after returning from assisting another resident in the bathroom. Executive Director Linda Price stated Resident A was left on the floor for at least 10 - 15 minutes. Resident A sustained a severe skin tear as a result of the fall which required wound care for 4 months to heal. Staff were not monitoring the residents appropriately over an extended period of time.

On 03/16/26, I received a telephone call from Reporting Source B who reported an additional allegation regarding this facility. This allegation is pertaining to Resident B. On 03/20/26, I received an intake regarding this allegation. The allegation was added to this investigation. Reporting Source B stated on 09/08/25, Resident B fractured her left hip and broke her femur while being transferred by staff from her motorized scooter. The staff at this facility are not trained to transfer residents. This has resulted in

Resident B experiencing severe anxiety and financial strain as Resident B and her family have chosen to pursue legal action.

On 03/11/26, I initiated my investigation by sending an email to Reporting Source A requesting additional contact information. Reporting Source A responded providing her telephone number. Additionally, I reviewed the original licensing study report for this facility which indicates the facility consists of 20 apartment style private units with one and two-bedroom floorplans. Resident apartments have a bedroom, bathroom, den, and a kitchen. Further, it is noted that on November 20, 2025, this facility was issued a temporary license as the facility underwent a change of ownership. Flourish Collection at Rochester (AL630419259), Licensee Name: 3145 Lily Trail Opco LLC was in a management agreement with Flourish Collection at Rochester (AL630389144), Licensee Name: Blossom Ridge, LLC.

On 03/11/26, I interviewed Reporting Source A via telephone. Reporting Source A stated Resident A had a camera in the bedroom that her family installed and monitored. On 11/19/25, Resident A was observed getting out of bed at 4:00 am. Resident A went into the bathroom and then she exited her apartment, no longer being able to be seen on the camera. Resident A came back into her bedroom around 4:50 am. Reporting Source A stated her sister received a telephone call from direct care staff Maurice Adams who informed her that Resident A was found on the floor bleeding. Mr. Adams said he did not witness Resident A fall as he was assisting another resident in the bathroom. Reporting Source A stated Resident A sustained a severe skin tear to her forearm. Reporting Source A arrived at the facility around 6:30 am. Resident A's hospice nurse with Hospice of Michigan also arrived and helped dress the wound/injury. Reporting Source A stated it took four months for Resident A's wound to heal and no longer require full time dressing.

Reporting Source A stated she asked executive director Linda Price for the camera footage of Resident A in the hallway, and it took quite some time to obtain the footage. Reporting Source A stated she only received snippets of videos, but it looked like Resident A was on the floor for 10 – 15 minutes in the hallway, located in front of the apartment next door to her apartment. In the video she observed Resident A trying to open the wrong door and when she pushed on the door she fell. Reporting Source A stated when Resident A moved into the facility the family was advised that during the night shift checks would be completed by staff every two hours.

Reporting Source A stated on 12/14/25, Resident A sustained a gash on her shin. It is unknown how the injury occurred. Direct care staff Micah Martin and Maurice Adams were assisting Resident A into bed when Resident A said, "owe." Mr. Adams looked at Resident A's leg and said it was okay. Then, he came back and put a Band-Aid on it. This injury took 3 months to heal. Reporting Source A stated while at the facility she

observed blood on Resident A's pajamas and her sheets, however, they were not notified of how the injury occurred. Reporting Source A stated she treated the wound (per her preference) and at the time of this interview the area was still tender but there was no draining or oozing.

Reporting Source A stated on 03/09/26, at 6:00 am, Resident A left her walker in the bathroom and went back to bed. Reporting Source A stated she called the med tech phone at 6:23 am, 6:24 am, 6:49 am, and 6:50 am, there was no answer. Additionally, she sent text messages and called wellness director Deja Gibson requesting that Resident A's walker be moved back to her bedside. Reporting Source A stated at 6:59 am a midnight staff came into Resident A's bedroom to complete a final check before ending their shift. Reporting Source A spoke over the camera that is in Resident A's bedroom and asked the staff to move Resident A's walker from the bathroom back to her bedside. The staff moved the walker. Reporting Source A stated at 7:07 am she received a text message from the med tech phone; it was a staff on the day shift who said that Resident A's walker had been moved back to her bedside. Reporting Source A stated at 8:00 am her sister noticed that Resident A was not in her bedroom. A call was placed to the med tech phone at 8:19 am asking staff to locate Resident A. Resident A was found in the dining room.

On 03/11/26, Reporting Source A sent three photos via text message. Two photos of the skin tear on Resident A's arm with time stamps of 11/19/25 and 3/11/26 and a photo of a skin tear on Resident A's knee/shin with a time stamp of 12/23/25.

On 03/12/26, Reporting Source A sent a 53 second video via email. The video is dated 12/17/25. In the video a male staff enters Resident A's bedroom greets her and asks to see her leg indicating he was told she had a cut on her leg. Resident A says that she just came out of the bathroom and showed the staff her leg remarking that it hurts really bad. The staff tells Resident A that he is going to get a Band- Aid. Resident A says thank you and the staff exits the bedroom. The video ends.

On 03/16/26, I interviewed Reporting Source B via telephone. Reporting Source B stated on 09/08/25, Resident B fractured her left hip and broke her femur while being transferred from her motorized scooter. This occurred after dinner; Resident B was sitting in her motorized scooter. Direct care Staff Louise Daniels put Resident B's walker in front of her and turned the scooter seat to the side. Ms. Daniles "yanked" Resident B forward to stand up and both Resident B and Ms. Daniles went flying. Reporting Source B stated Resident B uses a gait belt to transfer and although Resident B was wearing the gait belt, Ms. Daniels did not use it to assist Resident B with standing. Instead, she pulled her up while holding her under her arms. Resident B was hospitalized for 4 - 5 days, she had surgery. When she returned to the facility, she and her family obtained

private staffing initially for 24 hours a day, but now it has been decreased to 9:00 am – 9:00 pm. Reporting Source B stated staff are not trained to transfer residents.

On 04/02/26, I completed an unannounced onsite inspection. I interviewed executive director Linda Price and Resident B. While onsite I was informed that Resident A died on 03/23/26. While onsite I obtained a copy of Resident A and Resident B's wellness evaluations, staff phone numbers, an internal incident report regarding Resident A, and Resident A's MORSE fall assessment.

On 04/02/26, I interviewed executive director Linda Price. Ms. Price stated she started her employment in late November 2025, and therefore, she was not present when the allegations regarding Resident A occurred. Ms. Price stated she has since been made aware of the incident and she remarked that Resident A's family expected Resident A to receive one-on-one care, however that is not the level of staffing this AFC provides. Ms. Price stated on 11/19/25, Resident A wandered into the hallway with her walker. When she returned, she was trying to get into another resident's apartment. Direct care staff Mr. Adams observed Resident A on the floor in the hallway and assisted her up. Ms. Price stated Resident A wore an emergency response pendant that she could push to alert staff if she needed assistance. Resident A did not push her emergency response pendant. Ms. Price stated on 03/16/26, her supervisor, Michael Hamid, met with Resident A's family to address their expectations and assess if this setting could continue to meet their needs. The family was offered alternative placements in other settings operated by this provider, they declined. Ms. Price stated the family chose to remain in this facility and placed Resident A on hospice.

Ms. Price stated regarding Resident A leaving her walker in the bathroom and returning to bed without it, Resident A wore an emergency response pendant to alert staff when needed, and there is also a pull cord near her bed and in the bathroom to alert staff if assistance is needed. Resident A did not use any of these safety mechanisms to notify staff about her walker.

Ms. Price stated she has no knowledge of the injury to Resident A's knee/shin. Further there is no written documentation completed by staff regarding the injury.

Ms. Price stated Resident B's family is suing the facility as they have accused staff Louise Daniels of not using a gait belt to transfer Resident B from her motorized scooter to her walker. Ms. Price remarked, "We do not agree with the accusations." She further explained that when EMS arrived, they witnessed the gait belt on Resident B. Ms. Price stated she is unaware if Ms. Daniels was trained in transferring residents prior to this incident as there was a change of ownership completed around this time and Ms. Price was not employed under the previous company. However, she can confirm that all staff have since been trained.

On 04/02/26, I interviewed Resident B. Resident B stated direct care staff Louise Daniels was in her apartment helping her get out of her motorized scooter and use her walker. Resident B stated she cannot remember if she was wearing her gait belt, but Ms. Daniels was not standing near her as she transferred, Ms. Daniels was standing near the door of her apartment, and she was in the kitchen area. Resident B stated she cannot remember if/ how Ms. Daniels assisted her up into a standing position. However, Resident B stated while transferring she went flying across the floor. She was taken to the hospital where she stayed for a week, she had to have a blood transfusion. Resident B stated her recovery from this injury has been hard, she has even had to participate in physical therapy.

On 04/17/26, I interviewed direct care staff Louise Daniels. Ms. Daniels stated she has worked at this facility for 4 years. She works second shift 3:00 pm – 11:30 pm. Ms. Daniels stated on 09/08/25, Resident B returned to her apartment after dinner they were in the kitchen area, and she was assisting Resident B with transferring from her motorized scooter to her walker. Ms. Daniels stated she put Resident B's gait belt on and turned the scooter seat to the side. Resident B's walker was in front of her. Ms. Daniels stated she assisted Resident B to stand using two hands on her gait belt. Ms. Daniels denied pulling Resident B up under her arms. Ms. Daniels stated Resident B began to stumble to the side, her feet were not stable, Ms. Daniels remarked that sometimes Resident B is weaker than others. Ms. Daniels stated she tried to prevent the fall by pulling Resident B towards her, but her weight was too much for Ms. Daniels to bear. Ms. Daniels and Resident B both fell to the floor. Ms. Daniels stated she called her supervisor, Janet Densy. Ms. Densy called 911, Resident B's daughter, and took Resident B's vitals. Ms. Daniels stated she began her employment when the facility was operated by Blossom Ridge LLC. At that time, she received training to transfer residents from Ms. Densy, who was her supervisor. Since this incident all staff have received additional training on transfers under the new licensee.

On 04/20/26, I interviewed direct care staff Maurice Adams via telephone. Mr. Adams stated he began his employment in March 2025; he works on the midnight shift from 11:00 pm – 7:00 am. Mr. Adams stated visual checks/rounds are completed on residents every two hours. On 11/19/25, Mr. Adams stated he completed rounds at 2:00 am, Resident A was asleep in bed. Around 3:00 am Mr. Adams was on his way to the bathroom when he discovered Resident A on the floor in the hallways outside of her apartment. Mr. Adams stated he approached Resident A and asked her what happened, she said she was not sure. He asked if she could stand up and she said yes so Mr. Adams assisted Resident A up and into her apartment. Mr. Adams stated he called for the other staff on shift, Micah Martin, who checked Resident A's brief and took her vitals. Mr. Adams stated Resident A was wearing a white long-sleeved shirt and her arm was bleeding. The sleeve of the shirt was soaked in blood and attached to the skin

on Resident A's arm. Mr. Adams stated he called Resident A's daughter who arrived at the facility quickly. Resident A's daughter took over care of the wound per her preference as she is a nurse. Mr. Adams stated they had to cut Resident A's shirt off her arm to expose the wound because pulling up her sleeve caused her pain. Mr. Adams stated he estimates that Resident A was probably in the hallways for 10 – 20 minutes, because although rounds are completed every 2 hours, he tends to walk the hallways in between rounds and had not seen Resident A out of her bedroom while walking the halls. Mr. Adams stated Resident A was wearing her emergency response pendant when he found her in the hallway, however, she did not push the button for staff assistance. Regarding the injury to Resident A's knee Mr. Adams confirmed that it was him seen in the video dated 12/14/25. Mr. Adams was also shown the picture of Resident A's knee injury, he stated he has no memory of how Resident A sustained this injury.

On 04/20/26, I interviewed direct care staff Micah Martin via telephone. Ms. Martin began her employment in October 2025; she works on the midnight shift from 11:00 pm – 7:00 am. Ms. Martin expressed due to the length of time that has passed since the date of the incident she had difficulty recalling details. Ms. Martin stated on 11/19/25, Resident A fell in the hallway outside of her apartment. Ms. Martin did not see her fall. Resident A was found on the floor by Mr. Adams. Mr. Adams called Ms. Martin to assist. Ms. Martin stated she and Mr. Adams assisted Resident A up off the floor and back into her apartment. Then, they contacted Resident A's daughter, their supervisor, and completed an incident report. Ms. Martin stated Resident A's daughter arrived at the facility quickly and treated the wound. Resident A's shirt had to be cut as they were unable to pull up her sleeve because the blood had soaked through her shirt and her skin was attached to the sleeve of her shirt. Ms. Martin stated she cannot recall what time this incident occurred however, she estimates that it was around morning hours. Mr. Martin stated rounds are completed every two hours during the midnight shift, Resident A was not outside of her apartment during rounds.

On 04/20/26, I spoke to APS worker Angelique Evans. Ms. Evans stated she had an investigation opened regarding Resident A. Due to Resident A's death the investigation was closed. Ms. Evans stated the level of supervision Resident A's family was requesting is not what is provided by this AFC home.

On 04/20/26, I interviewed regional director of operations Michael Hamid. Mr. Hamid stated he met with Resident A's family and discussed AFC guidelines and rules that must be followed including things staff can and cannot do at an AFC home. This included Resident A's daughter's request to immediately move Resident A's walker back to her bedside if she was to leave it in the bathroom. Mr. Hamid stated he discussed with the family that Resident A wears an emergency response pendant and advised that Resident A push it if she needs staff assistance with moving her walker

back to her bedside. Resident A's daughter said Resident A would not push the button. As such, Mr. Hamid suggested to the family that Resident A move to a memory care facility for increased safety and a higher level of care. The family was offered residency at The Oakland Home which is a memory care facility located near this facility. Mr. Hamid stated Resident A's daughter said how dare he make this suggest "at a time like this" (referring to end stages of life). As the family declined to move Resident A to a memory care facility Mr. Hamid offered an alternative to increasing the level of care Resident A was receiving by means of implementing a toileting schedule for Resident A. Staff would assist Resident A with toileting every 2 hours. This would mitigate the risk of falls, assure Resident A was using her walker, and that it is returned to the bedside. Resident A's daughter declined, indicating that she does not want Resident A's sleep disrupted during the night. Mr. Hamid remarked that the family had unrealistic expectations for an AFC environment. Regarding Resident A's fall outside of her apartment, Mr. Hamid stated Resident A is not restricted to her apartment, she is able to come and go as she pleases. She exited her apartment and fell; staff found her and assisted her up. Hospice was notified and wound care treatment was provided. Mr. Hamid stated the family did not express concern at the time of the incident. It was not until recently that concern surrounding the fall was mentioned. Mr. Hamid stated he has no information regarding the injury to Resident A's knee/shin, it was not mentioned to him.

Mr. Hamid stated regarding Resident B's fall he was not directly involved when the incident occurred as he began his employment in late September 2025, however, since the incident he has been made aware of the situation and he was informed that the EMS report indicates Resident B was wearing her gait belt when EMS arrived on scene. Mr. Hamid further stated Story Point has trained all staff in transfers. Staff complete an orientation process and a skills check-off.

On 04/27/26, I interviewed Charter Township of Oakland Fire Captain Andrew Linn via telephone. Mr. Linn stated Charter Township of Oakland Fire responded to the scene on 09/08/25, due to Resident B falling while getting out of her motorized scooter with a caregiver. Mr. Linn stated the record does not contain documentation regarding the use of a gait belt. Mr. Linn recommended requesting a copy of the record via Freedom of Information Act (FOIA). I made a request via email for the documentation on 04/27/26.

I reviewed the following documentation in regard to the allegations concerning Resident A:

On 04/24/26, I reviewed two clips from the facilities surveillance cameras of Resident A in the hallway. The videos were sent via text message from director of operations Michael Hamid. Mr. Hamid stated the camera footage is only stored for 30 days so these are the only clips of the incident. The second video clip does not contain a date

and/or time stamp. The first video has a date stamp of 11/19/25. At 4:14 am Resident A can be seen walking down the hallway with her walker approaching an apartment door attempting to open it. Resident A then walks out of the camera view. Resident A returns to the apartment door now sitting on her walker using her feet to propel it. She approaches the apartment door. Resident A appears to make several attempts to stand up. At 4:25 am Resident A slides off her walker onto the floor landing on her buttock, and the walker slides out behind her. In a second video clip direct care staff Maurice Adams approaches Resident A in the hallway and assists her up off the floor and into a standing position. Resident A takes ahold of her walker and with assistance from Mr. Adams she is seen walking down the hallway back to her apartment. Note: Resident A appears to be wearing her emergency response pendant on her wrist in the videos.

On 04/02/26, I reviewed Resident A Wellness Evaluation, effective date 01/14/26. In summary, the evaluation indicates Resident A is able to transfer from a chair or bed without reminder or assistance. Resident A is able to complete all activities of daily living without assistance. Resident A is independent with safety awareness and may be outside on grounds and leave campus unsupervised as desired.

On 04/02/26, I reviewed an internal incident report (IR) regarding Resident A. Date of incident 11/19/25 at 5:00 am. In summary, the IR indicates overnight staff observed Resident A sitting on the hallway floor outside of her apartment. Staff assisted Resident A to stand and return to her apartment. There was a skin tear on resident's arm observed. Resident was cleaned up; Resident A's daughter and hospice were contacted. They came to dress the skin tear/wound. Resident not taken to hospital.

On 04/02/26, I reviewed Resident A's MORSE Fall assessment dated 01/25/26. The assessment indicates Resident A is high risk for falls.

On 04/03/26, I received and reviewed a standard AFC Lease for Storypoint sent via email from executive director Linda Price. The lease was provided as an example, it is blank/incomplete. However, the lease indicates to keep resident members happy, healthy, and informed each apartment has a pull cord in the bathroom and bedroom. The lease also includes notification and consent of receipt of an emergency response pendant. On 04/17/26, executive director Linda Price provided a copy of Resident A's lease and associated move in documentation. Resident A moved to the community in June 2024, the facility was operated by Blossom Ridge, LLC. The move in documentation indicates that Resident A received and was charged for receipt of an emergency response pendant and pull cords. The residency agreement indicates that the community is not a licensed nursing home, this is an AFC group home. Resident A was assessed for requiring level 1 care. The residency agreement is signed by Resident A's Power of Attorney on 06/13/24.

I reviewed the following documentation in regard to the allegations concerning Resident B:

On 04/24/26, I reviewed direct care staff Louise Daniels training records dated 2023 - 2026 sent via email from director of operations Michael Hamid. Ms. Daniels completed the following relevant trainings: Mobility 11/06/23, Incident Management and Reporting Requirements 07/12/24, Ambulating a Resident with a Walker 08/12/25, Moving with The STEP Program (safety based transfer & movement ergonomic program – LIFT) 03/13/26, Incident Management and Reporting Requirements 03/10/26.

On 04/02/26, I reviewed Resident B's Wellness Evaluation, effective date 01/23/26. In summary, the evaluation indicates Resident B is a one person assist with transfers (including standby) for the duration of the task.

On 04/02/26, I received facility documentation sent via email from executive director Linda Price. The documentation consists of Resident B's statement showing payment for cost of care, progress notes, care transition discharge checklist, Corewell Health Hospital after care summary, Resident B's 2024 health care appraisal, Resident B's wellness evaluations dated: 06/18/25 and 03/04/25, Resident B's fall risk assessments dated: 04/03/25, 12/28/24, and 09/28/24, Resident B's safety/evacuation assessments dated: 04/03/25, 12/23/24, and 09/28/24, assisted living resident evaluation, and Resident B's information and identification record. I reviewed all documentation provided. The following is relevant information:

Progress note dated 09/08/25, written by Janet Denys, nursing certified medication aide/ tech in summary indicates at approximately 5:45 pm Louise took Resident B back to her room. The gait belt was put on, and Louise was in front of her with the walker between them as they were transferring from scooter chair to walker to go to the bathroom. Louise had two hands on the gate belt, helping her to her feet. Resident B stood but was not stable and leaned to her left side. Louise tried to correct, but Resident B was too much, and they both went hard to the ground with a walker between them. Louise immediately called for help over the radio. I responded to the call. Upon entering the room, I found Louise kneeling on the floor next to Resident B. Resident B was screaming in pain that her leg hurt and that she broke her hip. I called 911 and Resident B's daughter and put a pillow under her head and waited for EMS. Resident B yelled and called for help, her daughter, and pain meds. I stayed with them and assured her that help was on the way. I called Helen to inform her of the allegations that we were not using the gate belt. Note: Janet Denys and Helen (last name unknown) are no longer employed at this facility.

Resident B's Corewell Health Hospital after care summary in summary indicates Resident B was hospitalized 09/08/25 – 09/15/25. Resident B's admitting diagnosis was a closed left hip fractur.

Resident B's wellness evaluations dated 06/18/25 and 03/04/25 indicate Resident B is a one person assist with transfers (including standby) for the duration of the task. Resident B requires daily assistance to get in and out of bed, chair, car, etc. Resident B requires the use of a walker and a gait belt. Resident B is at risk of falls due to drop foot. Resident B is encouraged to call for assistance when needed and not attempt to ambulate without assistance.

On 04/27/26, I placed a telephone call to licensee designee Rochelle Lyons to conduct an exit conference and review my findings. There was no answer. I left a voicemail notifying Ms. Lyons that there were no substantial rule violations found.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based upon the information gathered during this investigation there is insufficient information to conclude that Resident A and/or Resident B did not receive supervision, protection, and personal care as specified in their respective assessment plans. Reporting Source B alleged staff at this facility are not trained to transfer residents indicating on 09/08/25, Resident B fractured her left hip and broke her femur while being transferred by direct care staff Louise Daniels from her motorized scooter to her walker. I reviewed direct care staff Louise Daniels training records. Ms. Daniels completed several training courses regarding how to transfer residents. The trainings are as follows: Mobility 11/06/23, Incident Management and Reporting Requirements 07/12/24, Ambulating a Resident With a Walker 08/12/25, Moving with The STEP Program (safety based transfer & movement ergonomic program – LIFT) 03/13/26, and Incident Management and Reporting Requirements 03/10/26. Reporting Source B stated, despite Resident B wearing the gait belt, Ms. Daniels did not use it to assist Resident B with standing. Instead, she pulled her up while holding her under her arms. Ms. Daniels denied the allegation stating she assisted Resident B to stand using two hands on her gait belt. Resident B began to stumble to the side. Ms. Daniels stated she tried to prevent the fall by pulling Resident B towards her, but her

	weight was too much for her to bear. Ms. Daniels and Resident B both fell to the floor. This was further documented in the progress note written at the time of the incident on 09/08/25, by Janet Denys, nursing certified medication aide/ tech. When interviewed Resident B stated she cannot remember if/ how Ms. Daniels assisted her up into a standing position. Reporting source A alleged that staff are not monitoring the residents appropriately. Further indicating that on 11/19/25, Resident A fell outside of her apartment and sustained an injury. On 12/14/25, Resident A sustained a cut on her knee/shin and on 03/09/26, Resident A left her walker in the bathroom and went back to bed requiring multiple calls to staff for them to move the walker back to her bedside. Per Resident A's Wellness Evaluation, effective date 01/14/26, Resident A is able to transfer from a chair or bed without reminder or assistance. Resident A is able to complete all activities of daily living without assistance. Resident A is independent with safety awareness and may be outside on grounds and leave campus unsupervised as desired. Resident A wore an emergency response pendant, and her apartment was equipped with pull cords to alert staff when assistance is needed. On 11/19/25, Resident A exited her apartment and fell; staff found her in the hallway in between rounds and assisted her up. Resident A did not have enhanced staffing (1:1, within eyesight, etc.) requiring staff to know her whereabouts sooner than the routine rounds which were completed every two hours. As the wellness evaluation suggests Resident A had sufficient safety awareness with access to established safety measures that support timely staff notification when assistance is required the information obtained during this investigation indicates that supervision was provided in alignment with the residents assessed level of independence.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend that this special investigation be closed with no change to the status of the license.

04/28/26

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Johnna Cade Date
Licensing Consultant

Approved By:

For 04/28/2026

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Denise Y. Nunn Date
Area Manager