GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 29, 2026

David Phillips
Meadow Valley
5143 North Long Lake Rd
Traverse City, MI 49684

RE: License #: AH280407697
Investigation #: 2026A1010044
Meadow Valley

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 (877) 458-2757.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH280407697
Investigation #:	2026A1010044
Complaint Receipt Date:	04/24/2026
Investigation Initiation Date:	04/28/2026
Report Due Date:	06/24/2026
Licensee Name:	Oakleaf Village of Traverse City, LLC
Licensee Address:	Suite 200 160 West Main Street New Albany, OH 43054
Licensee Telephone #:	(614) 863-4640
Authorized Representative/Administrator:	David Phillips
Name of Facility:	Meadow Valley
Facility Address:	5143 North Long Lake Rd Traverse City, MI 49684
Facility Telephone #:	(614) 552-5627
Original Issuance Date:	11/06/2024
License Status:	REGULAR
Effective Date:	08/01/2026
Expiration Date:	07/31/2027
Capacity:	137
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell on 04/16/2026 and staff did not respond to assist her.	No
Staff are not properly trained to provide care to residents.	No
Additional Finding	Yes

III. METHODOLOGY

04/24/2026	Special Investigation Intake 2026A1010044
04/28/2026	Special Investigation Initiated - Letter Email sent to the complainant
04/30/2026	Contact - Document Received Email from the complainant received
05/04/2026	Inspection Completed On-site
05/04/2026	Contact - Document Received Received staff training documents and resident service plans
05/06/2026	Contact – Document Received Email from the administrator received
06/29/2026	Exit Conference

ALLEGATION:

Resident A fell on 04/16/2026 and staff did not respond to assist her.

INVESTIGATION:

On 04/24/2026, the Bureau received the complaint. The allegations read that on 04/19/2026, "[Resident A] had fallen and had been on the ground in her bathroom for about 10-20 minutes as her call button was going off [Resident B] had discovered her (he also lives in Assisted Living) had needed to walk to the reception desk to alert staff as none [sic] had responded yet."

On 04/28/2026, I emailed the complainant for additional information.

On 05/04/2026, I interviewed the administrator at the facility. The administrator reported Resident A and Resident B are a married couple and reside in the facility, however they have separate rooms. The administrator stated Resident A was able to make her needs known and used her pendant to summon staff for assistance when she resided in the facility. The administrator explained Resident A had a stroke on 04/23/2026 and was transported to the hospital. The administrator reported Resident A did not return to the facility, she was admitted to the Munson Hospice House after she was discharged from the hospital. The administrator said Resident A passed away at the Munson Hospice House.

The administrator denied knowledge regarding staff not responding to Resident A when she pushed her pendant to summon them for assistance on 04/19/2026. The administrator reported staff are trained to respond to a resident's pendant within minutes. The administrator stated that prior to Resident A's stroke, she was ambulating with a walker and a wheelchair as needed. The administrator said Resident B was often present in Resident A's room and attempted to "dictate" how staff assisted Resident A during the provision of her care.

The administrator provided me with a copy of Resident A's incident report dated 04/19/2026 at 2:35 pm for my review. The *Description* section of the plan read, "Resident's spouse came to the front desk to report that resident had fallen in her bathroom; spouse did not witness the fall. When staff arrived, they witnessed resident lying on her back, on her bathroom floor, with her head under the sink and her feet pointed toward her toilet. Resident stated that she landed on her bottom and then leaned back. No sign of a head or body injury present and resident denied pain. At the time of the fall, resident was wearing proper footwear but she had not been utilizing her walker. Upon standing, resident was a bit shaky. BP 160/65, HR 87, R 14, T 98.3, SpO2 97% on RA, neuro check WDL. Resident was assisted into her bed for a rest. BP is scheduled to be retaken, hourly checks will be performed. DON and [Relative A1] updated." The report read there were "no injuries or concerns."

The administrator explained there are incidents in which staff respond to a resident's pendant and forget to clear it. The administrator explained that as a result, some pendant response times appear longer than they were. The administrator stated there have been some issues with the pendant system functioning, and the system has had to be reset to get it to function properly. The administrator said when a resident pushes their pendant, an alert is sent to the staff tablets, and the computer monitors in the nurses' stations and reception desks.

The administrator provided me with a copy of Resident A's service plan for my review. The *Mobility/Ambulation* section of the plan read, "Minimal: Resident may require prompts/cues to use assistive device. Walker Wheelchair." The *Fall Potential* section of the plan read, "Falls within the last 90 days No falls, Gait/Balance Uses assistive device, Environmental room safety issues Adequate with or without devices, Sensory/Vision/Hearing Mild impairment."

On 05/04/2026, I interviewed Staff Person 1 (SP1) at the facility. SP1's statements were consistent with the administrator. SP1 reported that prior to the incident on 04/19/2026, Resident A did not have a history of falls.

On 05/04/2026, I interviewed SP2 at the facility. SP2's statements were consistent with the administrator and SP1.

On 05/04/2026, I interviewed Resident B at the facility. Resident B was able to recall the incident on 04/19/2026, Resident B stated he found Resident A on the floor in her bathroom when he entered her room. Resident B reported he alerted staff to the incident and staff responded in a timely manner. Resident B said he and Resident A utilized their pendants and staff responded timely during each incident. Resident B denied concerns regarding staff at the facility. Resident B stated there are enough staff at the facility to meet resident care needs and respond to pendants in a timely manner.

On 05/04/2026, I was unable to interview Resident A at the facility because she is deceased.

On 05/06/2026, I received an email from the administrator that contained the staff response times for Resident A and Resident B's pendants for 04/01/2026 through 05/05/2026. Resident A's pendant response times read her pendant was pressed 37 times with an average response time of seven minutes and ten seconds. Resident B's pendant response times read his pendant was pressed six times with an average response time of one minute and two seconds.

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:	The interviews with the administrator, SP1, SP2, along with review of Resident A and Resident B's pendant response times from 04/01/2026 through 05/05/2026 revealed staff have responded to their pendants within ten minutes. Resident B reported staff responded timely when he summoned them for assistance on 04/19/2026 when he found her on the floor in her room. There is insufficient evidence to suggest the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff are not properly trained to provide care to residents.

INVESTIGATION:

On 04/24/2026, the complaint read that the facility has "had many residents requiring full time skilled nursing level of care such as the need of a Hoyer Lift for all transfers (although many have now passed). Such as the now passed resident in 101 who came back with a Hoyer lift then passed 3-4 days later on March 24th in the time they were back a majority of the staff working could not provide ANY cares as most did not know how to use a Hoyer lift."

On 04/28/2026, the complainant reported resident lift training was not provided to staff until a resident required the use of a lift to transfer. For example, the complainant explained that a "manual Sara Steady lift" training was not provided until a resident required the use of one to safely transfer. The complainant said catheter care training was also not provided. The complainant stated staff often must seek out other staff to get assistive devices training and catheter care training.

On 05/04/2026, the administrator stated the facility does not admit residents who require the use of an assistive lift device to transfer. The administrator said the facility also does not admit residents who require the use of a catheter. The administrator explained that if a resident transitions to needing such devices as these, they can continue to reside in the facility, and staff will accommodate such a need so the resident can remain in place. The administrator said staff receive lift training upon hire at the facility. The administrator explained that the only time Hoyer lift devices are permitted in the facility is when a resident is receiving hospice care and hospice orders the Hoyer lift.

The administrator reported that initial catheter care training is not provided to staff upon hire at the facility. The administrator stated that as a resident remains in place and transitions to needing a catheter, catheter care training is provided by Staff Person 1 (SP1). The administrator said there are currently three to four residents

who resides in the facility who have catheters in place. The administrator reported SP1 recently provided catheter care training to staff. The administrator denied knowledge regarding any care staff not receiving lift or catheter care training. The administrator stated there have been no staff persons who have reported being uncomfortable using lift devices or providing catheter care.

On 05/04/2026, SP1's statements were consistent with the administrator. SP1 said she also recently provided additional lift training to staff. SP1 reported these trainings often occur during staff "in service" meetings. SP1 stated the staff sign in sheets are kept to document who attended the trainings.

SP1 provided me with a copy of the "staff meeting" sign in "sheets" dated 04/15/2026 and 04/16/2026. The "sheets" read that the topics covered were "job duties, Yardi, Hospice, and Hospice and end of life education. There were two additional staff sign in "sheets" that were not dated and did not include the topics covered during the staff training/meeting. SP1 reported one of these trainings/meetings covered catheter care. SP1 provided me with a copy of the *Managing Your Urinary Catheter* document that was covered and provided to care staff during one of the trainings/meetings.

SP1 provided me with a copy of the *Orientation Checklist PCA Skill Demonstration* document that all newly hired staff must complete for their resident personal care training. The document read staff must complete, "Mobility assistance, Ambulation: assistive devices/walker/cane/gait belt use, Transfer: Body Mechanic, Bed to chair, Pivot turn, use of gait belt, Range of motion: Active/passive" trainings before they can transition to providing direct resident care.

On 05/04/2026, SP2's statements were consistent with the administrator and SP1.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(c) Personal care.**

ANALYSIS:	The interviews with the administrator, SP1, and SP2, along with review of staff training documents revealed that staff receive assistive devices training for resident transfers upon hire at the facility. SP1 and SP2 stated staff received catheter care training when residents in the facility transitioned to needing them. There is insufficient evidence to suggest the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 05/04/2026, SP1 reported individual record of catheter care training are not maintained in individual employee records. SP1 stated there was no documentation within employee records to demonstrate staff received catheter care training. SP1 said the staff "sign in" sheets for the staff trainings/meetings did not outline that catheter care training was completed.

APPLICABLE RULE	
R 325.1944	**Employee records and work schedules.**
	(1) A home shall maintain a record for each employee, which shall include all of the following: **(d) Summary of experience, education, and training**
ANALYSIS:	The interview with SP1, along with review of the staff training documents revealed catheter care training documentation was not kept in the individual employee records. The facility had no way to verify staff received catheter care training. As a result, the facility was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with the facility's authorized representative on 06/29/2026.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

06/02/2026

Lauren Wohlfert Date
Licensing Staff

Approved By:

06/29/2026

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