GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 22, 2026

Sharon Cuddington
Trinity Continuing Care Services
Suite 200
20555 Victor Parkway
Livonia, MI 48152

RE: License #: AL610260125
Investigation #: 2026A0579037
Sanctuary at the Oaks #2

Dear Ms. Cuddington:

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.

If you desire technical assistance in addressing these issues, please 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 (616) 356-0100.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W., Unit 13
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL610260125
Investigation #:	2026A0579037
Complaint Receipt Date:	05/14/2026
Investigation Initiation Date:	05/14/2026
Report Due Date:	06/13/2026
Licensee Name:	Trinity Continuing Care Services
Licensee Address:	Suite 200, 20555 Victor Parkway, Livonia, MI 48152
Licensee Telephone #:	(810) 989-7492
Administrator:	DaleTron Thompson
Licensee Designee:	Sharon Cuddington
Name of Facility:	Sanctuary at the Oaks #2
Facility Address:	2nd Floor, 1740 Village Drive, Muskegon, MI 49442-4282
Facility Telephone #:	(231) 672-2700
Original Issuance Date:	04/21/2005
License Status:	REGULAR
Effective Date:	11/23/2025
Expiration Date:	11/22/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED/ ALZHEIMERS/ AGED

II. ALLEGATION(S)

	Violation Established?
Direct care workers refused to perform CPR when Resident A was found unresponsive.	Yes

III. METHODOLOGY

05/14/2026	Special Investigation Intake 2026A0579037
05/13/2026	Special Investigation Initiated - Face to Face Aryana Gregory, Direct Care Worker DaleTron Thompson, Acting Administrator
06/15/2026	Contact- Document Received DaleTron Thompson, Acting Administrator
06/16/2026	Contact- Telephone call made Cortney Ricord, Direct Care Worker
06/16/2026	Contact- Telephone call made Hailey Pierce, Former Direct Care Worker
06/18/2026	Exit Conference Sharon Cuddington, Licensee Designee

ALLEGATION: Direct care workers refused to perform CPR when Resident A was found unresponsive.

INVESTIGATION: On 5/6/26, I received a referral for another license on this campus. The referral noted a resident was found not breathing and the on-call manager was called. A direct care worker (DCW) was advised to give CPR, refused to do it, and then talked about refusing to perform CPR with other DCWs in the home. Details regarding when this occurred, which resident was involved, and which DCWs were involved were not provided. The complainant was anonymous so additional information could not be obtained.

On 5/13/26, I completed an unannounced on-site investigation at the home. Interviews were conducted with DCW Aryana Gregory and acting administrator DaleTron Thompson. They confirmed the reported incident pertained to this facility and not the facility the allegation was originally reported.

Ms. Gregory stated she was working at another facility on this campus the day Resident A was found unresponsive. She stated the DCWs involved were Hailey

Pierce, and Cortney Ricord. She stated she overheard the on-call nurse, LaTonya Hall, advise Ms. Pierce and Ms. Ricord that they needed to provide CPR to Resident A, even though he appeared deceased because he did not have a “do not resuscitate (DNR) order”. She stated she did not witness Ms. Pierce or Ms. Ricord refuse to provide CPR; however, they later came to the facility she was working in and “bragged” about how they did not perform CPR on Resident A even though they were advised to. She stated it bothered her that they were telling everyone how they would not do CPR and “it was wrong” of them to do that.

Ms. Thompson stated she was made aware that Ms. Pierce and Ms. Ricord found Resident A unresponsive with signs of having been deceased for some time, such as being cold and stiff. She stated Resident A did not have a DNR order in place. She stated DCWs are required to perform CPR when a resident is found unresponsive if they do not have a DNR in place. She stated it was reported to her by other DCWs not directly involved in the incident that Ms. Hall, who she reported no longer works for this licensee, advised Ms. Pierce and Ms. Ricord that they needed to perform CPR since there was no DNR in place. She stated Ms. Hall ended her employment prior to being interviewed about what occurred so she was unable to get confirmation whether Ms. Hall advised Ms. Pierce and Ms. Ricord to provide CPR and if they refused. She stated Ms. Pierce and Ms. Ricord told her that Resident A presented as clearly deceased, so it was determined CPR was not needed and they were never told to provide CPR. She stated Resident A’s relatives were advised the night prior to his death that he appeared to not be feeling well. She stated although the on-call nurses did not think he needed immediate emergency medical services, it was suggested to Resident A and his relatives that Resident A might benefit from being observed at the hospital due to feeling generally unwell and it being evening hours. She stated Resident A refused and his relatives supported him in remaining at the home instead of going to the hospital. She stated hospice services were set to begin for Resident A the day he died. She stated although Resident A’s death was not expected, it was also not a surprise, and his relatives did not express concern regarding the care he received at the home that night.

On 6/15/26, I received the *Incident/Accident Report* form regarding this incident. It listed Ms. Pierce and Ms. Ricord as the DCWs involved in the incident. It was signed as completed by Ms. Thompson on 4/8/26. It noted Ms. Ricord entered Resident A’s room at 6:40 a.m. to provide morning care and found Resident A “unresponsive, cold, and stiff”. It was noted that 911 and a “nurse manager” were contacted. Ms. Thompson reported that Ms. Pierce is no longer employed by the licensee and provided the contact information for Ms. Ricord and Ms. Pierce.

On 6/16/26, I completed a telephone interview with Ms. Ricord who stated Ms. Pierce was responsible for caring for Resident A in the morning on 4/8/26 and she had responded to a resident’s call pendant so she was in another area in the facility. She stated after Ms. Pierce entered Resident A’s room, Ms. Pierce came to find her and reported that she had discovered Resident A deceased. She stated she went to Resident A’s room and checked his pulse and checked for responsiveness. She

stated Resident A had clearly been deceased for some time because he was cold and stiff. She stated she called Ms. Hall who advised them to call 911. She stated Ms. Hall did not advise her to perform CPR, even though she advised Ms. Hall that Resident A did not have a DNR order. She stated she called 911 and reported Resident A was unresponsive and appeared to be deceased and they did not provide instruction to perform CPR. She stated when emergency medical services arrived, they did not attempt to perform any life saving measures on Resident A due to him clearly being deceased. She stated she also felt attempting CPR on him would have only “made things worse” and done damage to his deceased body, it would not have resuscitated him.

Ms. Ricord stated she and Ms. Pierce did not have concerns regarding Resident A’s health and were not made aware of any concerns regarding Resident A’s health when they came into work the day he expired, nor did Resident A require special or enhanced supervision. She stated she was aware that had Resident A not died that morning, he would have started hospice services that day. Ms. Ricord denied bragging or telling anyone that she and Ms. Pierce refused to perform CPR when Ms. Hall advised them to. She stated there was a Team Lead DCW at a different license on this campus so she told her what happened and the Team Lead came to the home to confirm Resident A appeared deceased. She stated other than that, she did not discuss the incident with anyone at another facility and did not tell anyone she refused to perform CPR. She stated she feels this claim is just a rumor that staff have spread and it is untrue. She expressed concern that DCWs often spread untrue rumors on this campus.

On 6/16/26, I attempted a telephone interview with Ms. Pierce. A voicemail message was left requesting a return phone call. A return phone call was not received by the time this report was completed.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Ms. Ricord reported Ms. Pierce found Resident A unresponsive, cold, stiff, and appeared to have been deceased for some time and she observed this too. She denied that she or Ms. Pierce refused to perform CPR when advised to do so. She stated due to Resident A being clearly deceased, she was not advised to perform CPR even though she was aware that Resident A did not have a do not resuscitate (DNR) order in place. Ms. Gregory stated she overheard on-call nurse LaTonya Hall advise Ms. Ricord and Ms. Pierce to perform CPR on Resident

	A. They refused and then told other direct care workers (DCWs) on the campus that they refused. Ms. Thompson stated Ms. Ricord and Ms. Pierce reported Resident A was found unresponsive and presented as deceased and they were not advised to perform CPR. She stated Ms. Hall is no longer employed by the licensee so she could not confirm what occurred with Ms. Hall. She stated it was reported by DCWs who did not have direct knowledge of the incident that Ms. Ricord and Ms. Pierce refused to perform CPR on Resident A when advised to do so. She stated when a resident is unresponsive, DCWs are expected to perform CPR if there is not a DNR on file. Ms. Pierce is no longer employed by the licensee. A telephone interview was attempted with her but a response was not received by the time the report was completed. Based on the interviews completed, there is sufficient evidence that needed health care was not obtained when Resident A was found unresponsive even though he did not have a DNR on file.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/18/26, I completed an exit conference with Ms. Cuddington who did not dispute my findings or recommendations.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend that the license remains the same.

Cassandra Duursma 06/18/2026

Cassandra Duursma Date
Licensing Consultant

Approved By:

Jerry Hendrick 06/22/2026

Jerry Hendrick Date
Area Manager