GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 24, 2026

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

RE: License #: AH280407697
Investigation #: 2026A1021046
Meadow Valley

Dear David Phillips:

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 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 (517) 335-5985.

Sincerely,

Kimberly Horst

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH280407697
Investigation #:	2026A1021046
Complaint Receipt Date:	06/14/2026
Investigation Initiation Date:	06/17/2026
Report Due Date:	08/14/2026
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
Administrator/ Authorized Representative:	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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not checked on.	Yes
Resident A had a medication error.	No
Additional Findings	Yes

III. METHODOLOGY

06/14/2026	Special Investigation Intake 2026A1021046
06/17/2026	Special Investigation Initiated - Letter email sent to the complainant
07/06/2026	Inspection Completed On-site
07/08/2026	Contact-Document Received Received Resident A's documents
07/24/2026	Exit Conference

The complainant alleged another resident was neglected. This was investigated under SIR AH280407697_SIR_2026A1010044.

ALLEGATION:

Resident A was not checked on.

INVESTIGATION:

On 06/14/2026, the licensing department received a complaint with allegations Resident A was not checked on. The complainant alleged that Resident A was found deceased in his room at 2:00am on 06/13/2026. The complainant alleged that Resident A was not checked on hours before his death.

On 07/06/2026, I interviewed the administrator David Phillips at the facility. The administrator reported he worked the floor the evening that Resident A passed away. The administrator reported that Resident A was observed to be sleeping in his bed at around 10:45pm and was found deceased in his room at approximately 2:15am. The administrator reported that there was a full internal investigation and there was no wrongdoing. The administrator reported that Resident A was a high fall

risk due to medical conditions. The administrator reported that Resident A would unexpectedly lose consciousness and fall. The administrator reported that Resident A was mostly independent but was in memory care for increased supervision. The administrator reported that Resident A would not always use his call pendant for assistance. The administrator reported that Resident A had a urinal near his bed so that he would not have to get up in the middle of the night. The administrator reported that Resident A was to be checked on at least once every two hours.

I reviewed Resident A's care plan. The care plan read,
"Continent bladder 2 hour frequency. Fall risk."

I reviewed camera footage of 06/13/2026. The camera footage revealed that caregivers entered Resident A's room at approximately 10:30pm and exited the room at 10:36pm. The footage revealed caregivers entered Resident A's room again at 2:10am.

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.**
For Reference: R 325.1901	**Definitions.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Interviews conducted and review of Resident A's service plan revealed Resident A had a high risk of falls and required two-hour checks. Review of camera footage revealed Resident A was not checked on for approximately 3.5 hours. The facility failed to ensure the protection of Resident A by not providing adequate two-hour safety checks.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A had a medication error.

INVESTIGATION:

The complainant alleged Resident A's death could have been caused by a medication error.

The administrator reported on 06/13/2026 that the medication technician called in third shift, but the shift was covered by another medication technician. The administrator reported no knowledge of a medication error.

I reviewed Resident A's medication administration record (MAR) for June 2026. The MAR revealed the medications were administered as prescribed.

APPLICABLE RULE	
R 325.1932	**Resident 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:	Review of Resident A's MAR revealed lack of evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's MAR revealed medication technician documented that medications were administered on 06/13/2026 at 08:00am.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following:

	(b) Complete an individual medication log that contains all of the following information: **(v) The initials of the individual who administered the prescribed medication.**
ANALYSIS:	Review of Resident A's MAR revealed medication technicians incorrectly documented that Resident A received medications after Resident A's death.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Interviews conducted revealed Resident A was active with Hospice of Michigan.

Review of Resident A's service plan revealed this information was omitted from the service plan.

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:	Review of Resident A's service plan revealed the service plan was not updated to accurately reflect the current care needs and involvement of hospice with Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of Resident A's service plan revealed the service plan omitted information about who was responsible for medication administration.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) A service plan must identify prescribed medication to be self-administered or managed by the home.

ANALYSIS:	Review of Resident A's service plan revealed the service plan did not identify who was responsible for medication administration.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/23/2026

Kimberly Horst Date
Licensing Staff

Approved By:

07/23/2026

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