GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 15, 2026

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

RE: License #: AH630399620
Investigation #: 2026A1019041

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,

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 #:	2026A1019041
Complaint Receipt Date:	06/30/2026
Investigation Initiation Date:	07/01/2026
Report Due Date:	08/30/2026
Licensee Name:	Rochester Care Operations, LLC
Licensee Address:	940 Monroe Ave., NW, Suite 144 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 is left in soiled briefs.	No
Resident A's insulin is not given as prescribed.	Yes
Additional Findings	No

III. METHODOLOGY

06/30/2026	Special Investigation Intake 2026A1019041
07/01/2026	Comment Complaint was forwarded to LARA from APS; APS is investigating.
07/01/2026	Special Investigation Initiated – Letter Emailed assigned APS worker for additional information and status update.
07/07/2026	Inspection Completed On-site
07/07/2026	Inspection Completed BCAL Sub. Compliance

Per administrative rule 325.1918 (6) (c), the complaint made an allegation pertaining to staffing that was investigated within the last 6 months and therefore will not be reinvestigated at this time. This report addresses new allegations for which enough information was provided to investigate under the scope of state licensing.

ALLEGATION: Resident A is left in soiled briefs.

INVESTIGATION:

On 6/30/26, the department received a complaint alleging that Resident A is left in soiled briefs for hours and only gets changed twice per day. Due to the anonymous nature of the complaint, additional information could not be obtained.

On 7/7/26, 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 has significant physical limitations but cognitively is fully alert and oriented and can make her needs known to staff. The administrator and Employee 1 reported that Resident A wear incontinence briefs and relies on staff to change her

briefs. The administrator and Employee 1 reported that Resident A is on a two-hour toileting schedule, however because Resident A can verbalize her care needs, she utilizes her call pendant when she needs staff assistance. The administrator and Employee 1 reported that toileting tasks are not documented by staff but denied that Resident A is only changed twice daily. Employee 1 stated *"[Resident A] is very particular about her care and lets us know her preferences. She would never allow us to only change her twice a day*."

While onsite, I interviewed Resident A. Resident A confirmed she requires staff assistance with toileting given her mobility restrictions. Resident A reported that she utilizes her call pendant when she needs staff assistance and also reported that staff come in to check on her routinely. Resident A reported that there have been times when staff don't respond to her call pendant timely but denies that she is sitting in soiled briefs for hours and is only changed twice a day as the complaint alleges. Resident A stated that she wishes there were more staff available, but that the current staff are helpful and attentive.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Interviews with facility staff and Resident A confirm that she is not left in soled briefs and is changed more than twice daily. Therefore, the allegation is unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A's insulin is not given as prescribed.

INVESTIGATION:

The complaint alleged that Resident A's insulin is given inconsistently and not on time. No dates were provided as to when the allegations occurred. Due to the anonymous nature of the complaint, additional information could not be obtained.

While onsite, I obtained a copy of Resident A's physician's orders, and her medication administration records (MAR) for the previous five weeks. I observed that Resident A is prescribed Lantus and instructed to receive 24 units daily at bedtime. Resident A is also prescribed Novolog and instructed to receive scheduled units surrounding mealtimes and has an order for sliding scale insulin.

The administrator reported that staff have a two-hour window to pass medications, meaning they can administer the medication within an hour before and up to an hour after its scheduled time. Review of Resident A's MAR reveals that her insulin was given outside of these parameters for one or more doses on the following dates during the timeframe reviewed: 6/3/26, 6/4/26, 6/5/26, 6/6/26, 6/7/26, 6/8/26, 6/9/26, 6/10/26, 6/11/26, 6/12/26, 6/13/26, 6/14/26, 6/15/26, 6/16/26, 6/17/26, 6/18/26, 6/19/26, 6/20/26, 6/21/26, 6/23/26, 6/24/26, 6/25/26, 6/26/26, 6/27/26, 6/30/26, 7/1/26, 7/2/26, 7/3/26, 7/4/26, 7/5/26, 7/6/26 and 7/7/26.

APPLICABLE RULE	
R 325.1932	**Resident's medications.**
	(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed healthcare professional.
ANALYSIS:	One or more of Resident A's insulin orders were routinely administered outside of time parameters. Therefore, this allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon completion of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

07/14/2026

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

07/15/2026

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