GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 31, 2026

Katelyn Fuerstenberg
Flourish Collection at Oakland Charter Twp
3215 Silverbell Rd.
Oakland Twp, MI 48306

RE: License #: AH630396969
Investigation #: 2026A1035050
Flourish Collection at Oakland Charter Twp

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.

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,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 410-3226

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630396969
Investigation #:	2026A1035050
Complaint Receipt Date:	07/09/2026
Investigation Initiation Date:	07/09/2026
Report Due Date:	09/08/2026
Licensee Name:	3215 Silverbell Rd Opco LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	Unknown
Administrator:	Andrea Flood
Authorized Representative:	Katelyn Fuerstenberg
Name of Facility:	Flourish Collection at Oakland Charter Twp
Facility Address:	3215 Silverbell Rd. Oakland Twp, MI 48306
Facility Telephone #:	(248) 601-0505
Original Issuance Date:	11/23/2020
License Status:	REGULAR
Effective Date:	08/01/2026
Expiration Date:	07/31/2027
Capacity:	56
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The Facility did not provide transportation as stated to a doctor's appointment.	No
Resident A did not receive appropriate prompt care when blood was reported in urine.	Yes
Additional Findings	No

III. METHODOLOGY

07/09/2026	Special Investigation Intake 2026A1035050
07/09/2026	Special Investigation Initiated - Telephone
07/30/2026	Contact - Face to Face
08/31/2026	Inspection Complete. BCAL Sub Compliance.
08/31/2026	Exit Conference.

ALLEGATION:

The Facility did not provide transportation as stated to a doctor's appointment.

INVESTIGATION:

On July 9, 2026, the Department received a complaint through the online complaint system which stated, "Resident A was not offered transportation for appointments like advertised."

On July 30, 2026, an onsite investigation was conducted. While onsite I interviewed Katelyn Fuerstenberg Authorized Representative who states "normally the facility does offer transportation service. Unfortunately, the facility transportation driver resigned from the position. An email was sent to family members and residents which stated:

> *"Hello families,*
>
> *I've completed several interviews for our Transportation position, but I have not yet found the right person for our community. Because of that, we do*

need to place a temporary pause on transportation services until this role is filled.

If you already have an appointment scheduled this week, we will still honor it. Any appointments after this week will need to be paused for now.

OPC is a local company that can provide transportation if you need it in the meantime. Please note that you must make a reservation directly with them to secure a ride.

I will keep you updated and let you know as soon as we hire someone who is the right fit for this important position."

Through record review, it was confirmed that residents and their families were notified of the temporary disruption in transportation services.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(3) At the time of an individual's admission, a home or the home's designee shall complete a written resident admission contract between the resident, the resident's authorized representative, or both, and the home. The resident admission contract shall, at a minimum, specify all of the following: **(d) The transportation services that are provided, if any, and the fees for those services.**
ANALYSIS:	The facility provided notification to residents and their families that transportation services would be suspended until a driver could be hired. The notification was emailed on May 19, 2026. Proper notice was provided; therefore, the allegation was not substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive appropriate prompt care when blood was reported in urine.

INVESTIGATION:

On July 9, 2026, the Department received a complaint through the online complaint system which alleged Resident A “was not seen by doctor when she presented with blood in her urine.”

While onsite I interviewed Staff Person (SP)1 who states she was informed that Resident A had “blood” in her urine on June 16, 2026. SP1 states she informed the assigned physician via text message on June 16, 2026. On June 17, 2026, SP1 called the physician office at 2:42 p.m. and was informed he was on vacation. SP1 monitored Resident A’s urine for blood in the time but had not observed blood in the urine. Resident A’s family member took her to urgent care on June 26, 2026, related to symptoms. SP1 states she believes the urinalysis came back negative at that time. On July 3, 2026, Resident A’s daughter moved her out.

Through record review there is no notation of reported symptoms or concerns related to “blood” being observed in the urine. No documentation was documented related to physician notification and follow up action or plan. The facility was unable to provide documentation of physician guidance or directive.

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: **(a) Assume full legal responsibility for the overall conduct and operation of the home.** **(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:	Facility charts by exception. The facility was unable to provide documentation regarding the reported concern of “blood” being observed in Resident A’s urine. The facility was also unable to provide documentation that the physician was notified or that physician guidance or directives were obtained regarding the potential presence of blood in the urine. Record review indicates that Resident A experienced a delay in care related to the potential presence of “blood” in the urine. Based on the lack of documentation demonstrating that physician notification, follow-up, and appropriate interventions occurred, the allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/12/2026

Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

08/31/2026

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