



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

September 17, 2026

Sarah Thomas  
New Heights Assisted Living, LLC  
9402 Michigamme Road  
Clarkston, MI 48348

RE: License #: AS630383028  
Investigation #: 2026A0612034  
New Heights Assisted Living

Dear Ms. Thomas:

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 (248) 972-9136.

Sincerely,

A handwritten signature in cursive script that reads "Johnna Cade".

Johnna Cade, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Place  
3044 West Grand Boulevard  
2<sup>nd</sup> Floor Annex, Suite 2-730  
Detroit, MI 48202

enclosure

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

**I. IDENTIFYING INFORMATION**

|                                       |                                             |
|---------------------------------------|---------------------------------------------|
| <b>License #:</b>                     | AS630383028                                 |
| <b>Investigation #:</b>               | 2026A0612034                                |
| <b>Complaint Receipt Date:</b>        | 09/03/2026                                  |
| <b>Investigation Initiation Date:</b> | 09/04/2026                                  |
| <b>Report Due Date:</b>               | 11/02/2026                                  |
| <b>Licensee Name:</b>                 | New Heights Assisted Living, LLC            |
| <b>Licensee Address:</b>              | 9402 Michigamme Road<br>Clarkston, MI 48348 |
| <b>Licensee Telephone #:</b>          | (248) 660-7014                              |
| <b>Administrator:</b>                 | Sarah Thomas                                |
| <b>Licensee Designee:</b>             | Sarah Thomas                                |
| <b>Name of Facility:</b>              | New Heights Assisted Living                 |
| <b>Facility Address:</b>              | 9402 Michigamme Road<br>Clarkston, MI 48348 |
| <b>Facility Telephone #:</b>          | (248) 660-7014                              |
| <b>Original Issuance Date:</b>        | 02/21/2017                                  |
| <b>License Status:</b>                | REGULAR                                     |
| <b>Effective Date:</b>                | 08/21/2025                                  |
| <b>Expiration Date:</b>               | 08/20/2027                                  |
| <b>Capacity:</b>                      | 6                                           |
| <b>Program Type:</b>                  | AGED<br>ALZHEIMERS                          |

## II. ALLEGATION(S)

|                                                                                                   | Violation Established? |
|---------------------------------------------------------------------------------------------------|------------------------|
| Resident A developed infected leg lesions after staff failed to follow medical care instructions. | Yes                    |
| Resident A is not being fed enough, she is losing weight.                                         | No                     |

## III. METHODOLOGY

|            |                                                                                                                                                                                                                                                |
|------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 09/03/2026 | Special Investigation Intake<br>2026A0612034                                                                                                                                                                                                   |
| 09/03/2026 | APS Referral<br>Referral received from Adult Protective Services (APS).                                                                                                                                                                        |
| 09/04/2026 | Special Investigation Initiated - Letter<br>Email sent to assigned APS worker Brad Edwards.                                                                                                                                                    |
| 09/09/2026 | Contact - Telephone call made<br>Telephone interviews completed with Resident A's medical power of attorney (POA), direct care staff Wendy Mihalek, and direct care staff Nina Alexander.                                                      |
| 09/10/2026 | Inspection Completed On-site<br>I conducted an unscheduled onsite investigation. I interviewed Resident A, Resident B, Resident C, and direct care staff Jennifer Barrett. While onsite, I obtained copies of relevant facility documentation. |
| 09/14/2026 | Exit Conference<br>I placed a telephone call to licensee designee Sarah Thomas to conduct an exit conference.                                                                                                                                  |

### ALLEGATION:

**Resident A developed infected leg lesions after staff failed to follow medical care instructions.**

## **INVESTIGATION:**

On 09/03/26, I received an intake from Adult Protective Services (APS). In summary, the intake indicated Resident A resides in an Adult Foster Care (AFC) and has an activated durable power of attorney for decision making. Resident A is diagnosed with dementia. On an unknown date, Resident A experienced a fall within the facility, resulting in a brace being placed on her leg. At some point, Resident A sustained lesions on her impacted leg due to the AFC staff not following the care instructions provided by medical staff. As a result, the lesions became infected and Resident A had to seek outside medical attention. There are also concerns that Resident A is not being fed enough and losing weight. However, when food is brought to Resident A she will decline at times.

On 09/04/26, I emailed the assigned APS worker Brad Edwards to coordinate. Mr. Edwards stated he completed an onsite inspection; he has no concerns about the condition of the home. Mr. Edwards is substantiating his investigation.

On 09/09/26, I interviewed Resident A's medical power of attorney (POA) via telephone. Resident A's POA stated on Friday, 08/14/26, Resident A was displaying symptoms of a urinary tract infection (UTI). She took Resident A to urgent care. Urgent care prescribed an antibiotic and advised giving Resident A her prescribed "as needed" dose of Seroquel that evening.

On Sunday, 08/16/26, Resident A's POA was informed that Resident A was making her bed with the assistance of direct care staff Nina Alexander. Resident A started to fall. Ms. Alexander grabbed her to try and stop the fall. However, Resident A fell and hit her left knee. She could not bear weight on that leg. Resident A's POA stated after the fall, it was determined that Resident A was given a dose of Seroquel on Saturday evening at 8:44 pm. This was not communicated to Ms. Alexander, and it was not documented in the shift notes. Seroquel makes Resident A feel groggy and may have caused or contributed to her falling.

After the fall, Resident A's POA took Resident A to urgent care to be assessed. X – Rays were completed and showed that Resident A did not have any broken bones. It was advised that she follow up with her primary care provider (PCP). Resident A's POA stated she took Resident A to an appointment with her PCP on Monday, 08/17/26. It was recommended that she follow up with an orthopedic specialist. Resident A had an appointment with the orthopedic specialist on 08/19/26. They advised that she follow the RICE method (rest, ice, compression, elevate) and they prescribed a knee brace. Written instructions for how to use the brace were provided. However, the brace had to be ordered and picked up on a later date. Resident A's POA stated she picked up the

brace on 08/22/26 and took it to New Heights Assisted Living. She provided the written instructions and pictures which illustrated how to use the brace.

On 08/30/26, Resident A's POA stated she went to the home to visit Resident A. She observed lotion "cacked on" Resident A's knee. Her knee was swollen and hot to the touch. Resident A's POA stated Resident A was not prescribed any cream or lotion for this injury. Resident A's POA stated she was informed that the Friday before, direct care staff Wendy Mihalek felt like the brace was not fitting Resident A's knee correctly. As such, Ms. Mihalek put a cream on Resident A's knee. By Sunday it was infected. Resident A's POA took Resident A back to urgent care.

On 09/01/26, Resident A's POA went to the home to visit Resident A with a friend. While visiting she observed an ace bandage on Resident A's knee. Ms. Mihalek was working. Resident A's POA stated Resident A was not to have an ace bandage on her knee until it was completely healed. Resident A's POA stated she asked Ms. Mihalek for the care instructions to confirm that she was not to be using an ace bandage at this point in her recovery. Ms. Mihalek informed her that she did not put the ace bandage on Resident A's knee and further explained that it was being used to hold on a warm compress. Ms. Mihalek removed the ace bandage; there was no warm compress on Resident A's knee. Resident A's POA stated she asked Ms. Mihalek to leave Resident A's pant leg up so that it could get air. Ms. Mihalek appeared bothered by this request as she wanted to pull Resident A's pant leg down.

On 09/09/26, in collaboration with APS worker Brad Edwards I interviewed direct care staff Wendy Mihalek via telephone. Ms. Mihalek stated she was not present when Resident A fell on 08/16/26, however, she heard that Resident A fell while making her bed with direct care staff Nina Alexander. Resident A hurt her left knee. Ms. Mihalek stated Resident A's POA took her to urgent care. Urgent care advised that she follow up with her PCP and follow the RICE method. Resident A's POA took Resident A to an appointment with her PCP. The PCP recommended that she follow up with an orthopedic specialist. The orthopedic specialist prescribed a knee brace. Ms. Mihalek stated in her opinion the brace did not fit well. She further explained that Resident A's POA provided written instructions that included photos of how to put the brace on and off Resident A's leg. Ms. Mihalek stated instead of using the instructions that were provided, she used Google to look up instructions on how to use the brace. Ms. Mihalek stated per Google, the brace was supposed to be put on Resident A's leg while her leg was straight. Not while the leg was bent. Ms. Mihalek explained she had been putting the brace on Resident A's leg while she was sitting on the toilet and her leg was bent. Ms. Mihalek stated this written directions provided did not indicate if the leg was to be bent or straight when putting on the brace.

Ms. Mihalek stated one day while putting on Resident A's brace she noticed two red marks on her leg the size of a pencil eraser. She applied Calmoseptine ointment to the area. Ms. Mihalek stated that Calmoseptine ointment was not prescribed to Resident A. This was a "house medication" to be used by any resident as needed. Ms. Mihalek then put a clean pillowcase over Resident A's leg to act as a barrier between her leg and the brace. Ms. Mihalek clarified that she chose to apply Calmoseptine ointment and a pillowcase to Resident A's leg. There were no written or verbal instructions directing her to do so.

Ms. Mihalek stated the next morning she was informed that the staff working observed that the area had blistered. Ms. Mihalek stated Resident A's POA took her to urgent care. She was prescribed an antibiotic and advised to use a warm compress on the area. The written discharge instructions from urgent care further indicate to apply an ace bandage to the knee, under the brace, in one week, once the infection is healed.

Ms. Mihalek stated on an unknown date, Resident A's POA came to the home for a visit. While visiting, Resident A's POA discovered an ace bandage on Resident A's knee. Ms. Mihalek stated she did not put the ace bandage on Resident A's knee, and she did not know that it was there because she did not get Resident A dressed that day. Ms. Mihalek stated this incident occurred prior to one week, and the infection was not healed. As such, the ace bandage should not have been on Resident A's knee. Ms. Mihalek stated she removed the ace bandage and went to pull Resident A's pant leg down. Resident A's POA said that she wanted the pant leg kept up so that the area could get air.

On 09/09/26, in collaboration with APS worker Brad Edwards I interviewed direct care staff Nina Alexander via telephone. Ms. Alexander stated on 08/16/26, she was assisting Resident A with making her bed. Resident A was standing next to her, elbow to elbow, when she fell. She hit her left knee. Ms. Alexander stated she assisted Resident A up, wrote an incident report, and notified Resident A's POA.

Ms. Alexander stated after the fall she discovered that Resident A was given a Seroquel the night prior. Although this was documented in the medication administration record it was not documented in the staff notes and the staff who administered the medication, Ms. Mihalek, did not inform her at shift change. Ms. Alexander stated Seroquel could cause drowsiness, if she had known that Resident A took a Seroquel the evening before she would not have had her standing to help make the bed, which could have prevented the fall.

Ms. Alexander stated Resident A's POA took her to urgent care after the fall. Ms. Mihalek was off work for a week following the incident and therefore she does not have first-hand knowledge of what occurred after the fall. Ms. Alexander stated she was told that Resident A's knee got infected, but she has no further details. Ms. Alexander

observed the instructions on how to use the brace that was at the home, but stated she only had to remove the brace once. Ms. Alexander stated she never observed an ace bandaged on Resident A's knee.

On 09/10/26, I conducted an unscheduled onsite investigation. I interviewed Resident A, Resident B, Resident C, and direct care staff Jennifer Barrett. While onsite, I obtained copies of relevant facility documentation (weight records, urgent care paperwork, instructions for knee brace, and Resident A's Medication Administration Record).

On 09/10/26, I interviewed Resident A. Resident A was observed sitting at the dining room table in a wheelchair. She was appropriately dressed and well groomed. Resident A was eating breakfast. She ate a bagel, boiled egg, and fruit. Resident A could not recall how she injured her knee however she stated it is feeling better, she has no pain.

On 09/10/26, I interviewed direct care staff Jennifer Barrett. Ms. Barrett stated Resident A has dementia. At times she forgets her knee was injured. Ms. Barrett stated she was aware that there was an investigation regarding Resident A however, she has no information to provide regarding the allegation.

On 09/10/26, I interviewed Resident B. Resident B was observed sitting in the living room. She was appropriately dressed and well groomed. Resident B stated she is having a good day, but she is upset that due to recent falls she has to use a walker now. Resident B reports no issues with the care she is receiving.

On 09/10/26, I interviewed Resident C. Resident C was observed sitting in the living room. She was appropriately dressed and well groomed. Resident C stated she misses living with her family, but she has no issues or concerns with the care that she is receiving.

On 09/10/26, I reviewed Resident A's Medication Administration Record for Seroquel. Resident A received 1, 25 mg tablet on the following dates: 08/13/26 (7:53 pm), 08/14/26 (8:03 pm), and 08/15/26 (8:44 pm).

On 09/10/26, I reviewed instructions from Pine Knob Urgent Care. In summary, the instructions indicate a brace was previously fitted after a fall. The brace should not be placed back on until the lesions have healed (roughly 1 week). Use ACE wrap under the brace to protect skin.

On 09/10/26, I reviewed the web reaction knee brace written instructions which included a photo of the brace on Resident A's knee.

| <b>APPLICABLE RULE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>R 400.689</b>       | <b>Resident health care.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                        | <b>(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>ANALYSIS:</b>       | <p>Based upon the information gathered during this investigation there is sufficient information to conclude that instructions and recommendations from Resident A's physician were not followed resulting in Resident A developing infected leg lesions</p> <p>Direct care staff Wendy Mihalek admitted that she observed two red marks on Resident A's leg, the size of a pencil eraser. She applied Calmoseptine ointment to the area. Calmoseptine ointment was not prescribed to Resident A. This was medication on hand at the house. Ms. Mihalek then put a clean pillowcase over Resident A's leg to act as a barrier between her leg and her leg brace. Ms. Mihalek stated there were no written or verbal instructions directing her to apply Calmoseptine ointment and a pillowcase to Resident A's leg. The next day, the area blistered. Urgent care paperwork indicates there were lesions on Resident A's leg.</p> |
| <b>CONCLUSION:</b>     | <b>VIOLATION ESTABLISHED</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

**ALLEGATION:**

**Resident A is not being fed enough, she is losing weight.**

**INVESTIGATION:**

On 09/03/26, I received an intake from Adult Protective Services (APS). In summary, the intake indicated there are concerns that Resident A is not being fed enough and losing weight. However, when food is brought to Resident A she will decline at times.

On 09/09/26, I interviewed Resident A's medical power of attorney (POA) via telephone. Resident A's POA stated that there are no known issues with Resident A losing weight.

On 09/09/26, in collaboration with APS worker Brad Edwards I interviewed direct care staff Wendy Mihalek via telephone. Ms. Mihalek stated the last time she weighed Resident A she had lost ten pounds in two months. Ms. Mihalek stated Resident A has

not been eating as much. Ms. Mihalek explained that Resident A has not been wanting to wear her top dentures, which could be contributing to her change in eating habits.

On 09/09/26, in collaboration with APS worker Brad Edwards I interviewed direct care staff Nina Alexander via telephone. Ms. Alexander stated she is unaware if Resident A is losing weight. Ms. Alexander stated Resident A's appetite fluctuates sometimes she will just pick at food and other times she will eat everything.

On 09/10/26, I conducted an unscheduled onsite investigation. I interviewed Resident A, Resident B, Resident C, and direct care staff Jennifer Barrett. While onsite, I obtained copies of relevant facility documentation.

On 09/10/26, I interviewed Resident A. Resident A was observed sitting at the dining room table in a wheelchair. She was appropriately dressed and well groomed. Resident A was eating breakfast. She ate a bagel, boiled egg, and fruit.

On 09/10/26, I interviewed direct care staff Jennifer Barrett. Ms. Barrett stated she had noticed Resident A's appetite has decreased. As of recent, Resident A's dentures are not fitting correctly, and this might be the reason for the change to her appetite.

On 09/10/26, I interviewed Resident B and Resident C. They consistently reported no issues or concerns with the care that they are receiving.

On 09/10/26, I reviewed Resident A's weight records. The following is relevant information:

06/02/26 – 139 lbs.  
07/02/26 – 138 lbs.  
08/01/26 – 134 lbs.  
09/07/26 – 128 lbs.

On 09/14/26, I placed a telephone call to licensee designee Sarah Thomas to conduct an exit conference and review my findings. Ms. Thomas was advised that a corrective action plan is required. She acknowledged and agreed. Ms. Thomas stated direct care staff Wendy Mihalek had been with the company for six years; she was previously the home manager. As of a week ago she is no longer the home manager. Ms. Thomas stated she has determined that there are gaps in her communication with Ms. Mihalek and she understands and agrees that staff must follow the physicians' care plan/ instructions. Regarding Resident A's weight, Ms. Thomas stated the scale at the home

shows a ten-pound weight loss in the last two months. However, it is important to note that due to Resident A's left knee injury she was unable to bear weight on her left leg, making it challenging for her to stand on the scale to be weighed. Ms. Thomas remarked that she had been standing in a "flamingo pose" to be weighed. Additionally, Ms. Thomas stated Resident A has been experiencing discomfort with her dentures.

Two days ago, Resident A's POA scheduled her a dentist appointment. The appointment is scheduled for 09/15/26, at 2:00 pm. Ms. Thomas stated that they have noticed Resident A has been eating 50 – 75% of most meals. This has been consistently documented. Ms. Thomas stated the residents have access to any food they request and they help prepare meals when they are able.

| <b>APPLICABLE RULE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>R 400.663</b>       | <b>Nutrition; adoption by reference.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                        | <b>(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>ANALYSIS:</b>       | <p>Based on the information gathered during the investigation, there is insufficient information to conclude that Resident A is not receiving adequate nutrition or that inadequate food intake is contributing to her weight loss.</p> <p>Although Resident A has experienced weight loss, the evidence does not indicate that this is due to a lack of nutritious meals. In August 2026, Resident A fell and injured her leg and is currently unable to bear weight on that leg while being weighed, which may contribute to inaccurate weight measurements. Additionally, Resident A has reported discomfort with her dentures, which has affected her ability and interest in eating. A dentist appointment has been scheduled to address this concern.</p> <p>During the onsite inspection on 09/10/26, I observed Resident A eating a balanced breakfast. Furthermore, no concerns were reported regarding Resident A's access to nutritious meals.</p> |
| <b>CONCLUSION:</b>     | <b>VIOLATION NOT ESTABLISHED</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

#### IV. RECOMMENDATION

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



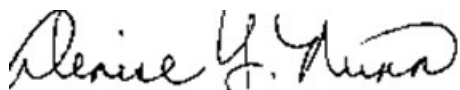
09/14/2026

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Johnna Cade  
Licensing Consultant

Date

Approved By:



09/17/2026

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Denise Y. Nunn  
Area Manager

Date