GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 24, 2025

Eric Simcox
Oakleigh of Macomb
49880 Hayes Road
Macomb, MI 48044

RE: License #: AH500394648
Investigation #: 2025A1019080

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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 authorized representative 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 #:	AH500394648
Investigation #:	2025A1019080
Complaint Receipt Date:	08/12/2025
Investigation Initiation Date:	08/14/2025
Report Due Date:	10/11/2025
Licensee Name:	Oakleigh Macomb Operations, LLC
Licensee Address:	40600 Ann Arbor Road, Suite 201 Plymouth, MI 48170
Licensee Telephone #:	(586) 997-8090
Administrator:	Richard Fritz
Authorized Representative:	Eric Simcox
Name of Facility:	Oakleigh of Macomb
Facility Address:	49880 Hayes Road Macomb, MI 48044
Facility Telephone #:	(586) 997-8090
Original Issuance Date:	12/18/2019
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	101
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A is being neglected.	No
Resident A's room is dirty.	No
Additional Findings	Yes

III. METHODOLOGY

08/12/2025	Special Investigation Intake 2025A1019080
08/14/2025	Special Investigation Initiated - Face to Face
08/14/2025	Inspection Completed On-site
08/14/2025	Inspection Completed BCAL Sub. Compliance

ALLEGATION: Resident A is being neglected.

INVESTIGATION:

On 8/12/25, the department received a complaint outlining care concerns with Resident A. The complaint alleged that Resident A is left in his wheelchair, which has caused a pressure ulcer on this foot. The complaint alleged that Resident A has had numerous falls due to lack of staff supervision and that Resident A is left in soiled briefs for hours.

On 8/14/25. I conducted an onsite inspection. I interviewed administrator Richard Fritz and Employee 1. The administrator and Employee 1 reported that Resident A exhibited a decline in the previous month, with increased confusion and fatigue and has experienced a few falls. The administrator and Employee 1 reported that Resident A is currently in the hospital due to his change in condition as of 8/10/25.

Regarding falls and staff supervision, the administrator and Employee 1 acknowledge that Resident A has fallen recently. The administrator reported that staff conduct hourly rounding in memory care and denied that Resident A isn't supervised often enough. Per Employee 1, he is alert and oriented and can make his needs known, however has physical limitations. Employee 1 reported that staff use a Hoyer lift to transfer him but once in his wheelchair, Resident A can usually propel

himself. The administrator and Employee 1 reported that Resident A has a call pendant and can appropriately use it to summon staff when assistance is needed. The administrator and Employee 1 reported that Resident A spends most of his time in the common area of the memory care unit, often doing puzzles and participating in various activities.

While onsite, incident report documentation and progress notes were obtained for the previous six weeks. The documentation revealed that Resident A fell on 7/18/25, 7/27/25 and 8/3/25. Per progress note documentation, Resident A went to the hospital following the fall on 7/27/25 and 8/3/25; he received no new orders upon being discharged.

Regarding the pressure ulcer, Employee 1 reported that Resident A had ongoing skin breakdown and wound issues throughout the duration of his residency and was at the facility to help treat these issues. The administrator reported that facility staff are not tasked with any dressing changes or medications to his wounds and all of the wound care is completed by outside parties. The administrator provided me with a copy of Resident A's physicians' orders, and no orders were listed pertaining to the wounds. Documentation was provided from VNA home care that read Resident A signed on to receive home care services beginning 11/19/23. The documentation outlined a wound to Resident A's right heel, with an onset date of 1/16/25. Review of the documentation revealed ongoing assessment and treatment of Resident A's wound twice weekly by home care staff without improvement. In July 2025, additional wound care specialists were consulted and also began treating the wound. The documentation revealed that Resident A also has lymphedema and type 2 diabetes which can contribute to delayed healing. In follow up correspondence with VNA staff, they confirmed no orders were written for staff to follow but gave verbal instruction to elevate his feet and legs as much as possible. VNA staff also documented that staff were applying heel protecters to Resident A as directed.

Regarding toileting, Employee 1 reported that Resident A requires staff assistance to get onto the toilet, but that he will verbalize to staff when he needs to go. The administrator reported that Resident A is not on a toileting schedule, but staff regularly check in with him during their rounds. The administrator and Employee 1 deny that Resident A would be left in soiled briefs for hours given that he is alert and oriented to say when he needs to use the bathroom.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.**
ANALYSIS:	Staff attestation revealed that Resident A is alert and oriented and can make his needs known. Staff conduct hourly rounding and safety checks on the resident. Resident A has had some unwitnessed falls, however per staff, he can appropriately use his call pendant for assistance and is able to be left alone in between staff rounding. Resident A can and does verbalize to staff when he needs to use the restroom and does not require a toileting schedule at this time. Home care documentation revealed a pressure ulcer on Resident A's right foot since January 2025 that they are consistently monitoring and treating. Despite continued oversight of the wound, it has not improved, likely due to his limited mobility and other medical conditions that can affect the healing process. Per the administrator, all care pertaining to Resident A's wounds is the responsibility of home care and review of home care documentation and attestation from home care staff, there are no orders written that staff are to follow regarding the wounds.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A's room is dirty.

INVESTIGATION:

The complaint alleged that Resident A's room isn't being cleaned, that it smells like urine that there are blood stains on his carpet.

The administrator reported that rooms are cleaned by housekeeping staff weekly and that care staff are responsible for tidying up resident rooms daily, including making the beds. The administrator reported that residents' laundry is done weekly for standard clothing items and bedding is typically changed on residents assigned shower days, or more often if items get soiled, which is tended to immediately.

While onsite I observed Resident A's room. The room was cluttered with personal effects but was not dirty. The bed was made, the bathroom was clean and orderly, and no odor was present. Resident A's carpet had some visible staining. I interviewed maintenance staff [Employee 2] who reported that Resident A's carpet has been deep cleaned several times, however the stains are permanent. [Employee 2] reported that Resident A's carpets were last cleaned on 8/4/25.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	While there was some staining present to Resident A's carpet, despite recent deep cleaning, and observed clutter from Resident A's personal belongings, visual inspection of his room and bathroom revealed that it was kept clean and no odors were present. Staff attestation revealed routine housekeeping services.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

During interview, Employee 1 reported that staff use a Hoyer lift to transfer Resident A and a Hoyer lift was observed in Resident A's room during the onsite visit. Review of Resident A's service plan revealed that it was not updated to include the device or provide any instruction to staff on its use with Resident A.

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:	Resident A's service plan was not updated to include the use of a Hoyer lift when he is being transferred.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/25/2025

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

09/24/2025

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