GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 24, 2025

Debra Cromwell
Westbrooke Senior Care LLC
457 Aspen Dr
Wixom, MI 48393

RE: License #: AS630418085
Westbrooke Senior Care LLC
1930 N. Hickory Ridge Rd.
Highland, MI 48357

Dear Ms. Cromwell:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. 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 dates 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 licensee or licensee designee or home for the aged authorized representative and a date.

Upon receipt of an acceptable corrective plan, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result.

Please contact me with any questions. In the event that I am not available and you need to speak to someone immediately, you may contact the local office at (248) 975-5053.

Sincerely,

Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AS630418085
Licensee Name:	Westbrooke Senior Care LLC
Licensee Address:	457 Aspen Dr Wixom, MI 48393
Licensee Telephone #:	(248) 755-7254
Licensee/Licensee Designee:	Debra Cromwell
Administrator:	Debra Cromwell
Name of Facility:	Westbrooke Senior Care LLC
Facility Address:	1930 N. Hickory Ridge Rd. Highland, MI 48357
Facility Telephone #:	(248) 755-7254
Original Issuance Date:	11/13/2024
Capacity:	6
Program Type:	AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 04/15/2025

Date of Bureau of Fire Services Inspection if applicable: N/A

Date of Health Authority Inspection if applicable: Inspection report requested 04/16/25

No. of staff interviewed and/or observed 1
No. of residents interviewed and/or observed 3
No. of others interviewed Role:

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.
- Medication(s) and medication record(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☒ No ☐ If no, explain.
- Meal preparation / service observed? Yes ☐ No ☒ If no, explain.
  It was not meal time during the onsite.
- Fire drills reviewed? Yes ☒ No ☐ If no, explain.
- Fire safety equipment and practices observed? Yes ☒ No ☐ If no, explain.
- E-scores reviewed? (Special Certification Only) Yes ☐ No ☐ N/A ☒
  If no, explain.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.
- Incident report follow-up? Yes ☐ No ☒ If no, explain.
  N/A
- Corrective action plan compliance verified? Yes ☐ CAP date/s and rule/s:
  N/A ☒
- Number of excluded employees followed-up? N/A ☒
- Variances? Yes ☐ (please explain) No ☐ N/A ☒

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:

R 400.14204 Direct care staff; qualifications and training.

(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas:

(a) Reporting requirements.

During the onsite, I reviewed staff member Jasmin Allen employee file. Ms. Allen start date was 01/13/25. To date, Ms. Allen has not completed the required reporting requirements training.

R 400.14204 Direct care staff; qualifications and training.

(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas:

(d) Personal care, supervision, and protection.

During the onsite, I reviewed staff member Jasmin Allen employee file. Ms. Allen start date was 01/13/25. To date, Ms. Allen has not completed the required personal care, supervision, and protection training.

R 400.14205 Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.

(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the physician's knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.

Staff member Jasmin Allen hire date is 01/13/25. Ms. Allen did not receive a physical within 30 days of her hire date. Ms. Allen last physical was on 07/05/24.

R 400.14301 Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.

(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.

Resident B's initial physical was not dated by the doctor therefore; it is unknown when the physical was completed. Resident C was admitted on 04/02/25 and a physical was not completed and/or reviewed in her file.

R 400.14301 Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.

(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

Resident B's initial assessment plan was not signed by the licensee designee Debra Cromwell or by Resident B's guardian. Resident C was admitted on 04/02/25 however; her assessment plan was not signed by Mrs. Cromwell. Resident C's guardian signed the assessment plan on 04/14/25 which is not at the time of admission.

R 400.14301 Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.

(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party.

Resident B was admitted on 03/10/25 however; the licensee designee Debra Cromwell, and Resident B's guardian signed the resident care agreement on 03/12/25 which is not at the time of admission.

R 400.14306 Use of assistive devices.

(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.

During the onsite, I observed prescriptions for Resident C's shower chair, walker, wheelchair, and hospital bed. However, Resident C's assessment plan did not indicate that she had any assistive devices.

R 400.14306 Use of assistive devices.

(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.

Resident A has a wheelchair and a walker. Resident B has a cane and a walker. There were no prescriptions obtained for Resident A or Resident B's assistive devices.

R 400.14312 Resident medications.

(2) Medication shall be given, taken, or applied pursuant to label instructions.

Resident A is prescribed Aspirin 81mg in the morning. I observed Resident A's bubble packet for her Aspirin and saw that the pill for today (04/15/25) was still in the bubble packet.

R 400.14312 Resident medications.

(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

(b) Complete an individual medication log that contains all of the following information:

(iii) Label instructions for use.

(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.

During the onsite, I observed that Resident A's Diltiazem label instructions did not match the MAR. The label instructions state to take one tablet by mouth every day. Resident A's MAR for the month of February state administer this medication if the heart rate is over 120. Resident A's MAR for the month of March state administer this medication if the heart rate is over 98 and; the MAR for the month of April state administer this medication if the heart rate is over 130. The licensee designee Debra Cromwell, did not obtain an updated prescription specifying when to administer this medication based on Resident A's heart rate.

Resident A's label instructions for her Lidocaine did not match the MAR as well. The instructions are to apply one patch topically every day to the left knee for 12 hours and take off for 12 hours for seven days. According to the MAR, this medication is listed as a PRN. Resident B label instructions for Fluorometholone .1% did not match the MAR. The instructions are to put one drop in the right eye daily. The MAR states to administer this medication in the evening. Resident B

label instructions for Systane balance .6% did not match the MAR. The instructions are to instill 1-2 drops in both eyes three times a day as needed. The MAR states this medication should be administered daily and not as a PRN.

I observed Resident A's MAR for the month of March 2024. There was a missing staff initial for Resident A's Aspirin on 03/05/25. I observed Resident C's MAR for the month of April, and there were no staff initials for her Miralax which is prescribed daily.

R 400.14312 Resident medications.

(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

(c) Record the reason for each administration of medication that is prescribed on an as needed basis.

Resident B is prescribed Allergen CAL-AMO as a PRN. Resident B was administered this medication on 04/13/25, 04/14/25, and 04/15/25. There was no documentation of the reason why this medication was administered. Resident C is prescribed Seroquel as a PRN. Resident C was administered this medication on 04/14/25. There was no documentation of the reason why this medication was administered.

R 400.14313 Resident nutrition.

(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.

During the onsite, I observed the menu and found that it was not written in it's entirety at least one week in advance. The menu was dated for 04/14/25 – 04/20/25. However, there were two days on the menu where it only said "chefs special" and; there was one day on the menu where it said "leftover".

R 400.14315 Handling of resident funds and valuables.

(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.

Resident A funds part I section A was left blank and section B was not completed in it's entirety as the section where it ask to identify the person

responsible for managing the account was left blank. Resident B funds part I section B was not completed in it's entirety as the section where it ask to identify the person responsible for managing the account was left blank.

Resident D funds part I section B was not completed in it's entirety as the section where it ask to identify the person responsible for managing the account was left blank. Resident C funds part I section B was not completed in it's entirety as the section where it ask to identify the person responsible for managing the account was left blank and; none of the boxes where checked.

R 400.14316 Resident records.

(1) A licensee shall complete, and maintain in the home, a separate
record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information:

(a) Identifying information, including, at a minimum, all of the following:

(viii) Funeral provisions and preferences.

Resident A and Resident C identification record did not include any burial provisions.

R 400.14316 Resident records.

(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information:

(b) Date of admission.

According to the resident register, Resident A was admitted on 02/01/25. It is documented on Resident A's identification record that she was admitted on 01/28/25. The licensee designee Debra Cromwell confirmed that the date on the identification record is incorrect.

R 400.14318 Emergency preparedness; evacuation plan; emergency transportation.

(5) A licensee shall practice emergency and evacuation procedures during daytime, evening, and sleeping hours at least once per quarter. A record of the practices shall be maintained and be available for department review.

Prior to the home receiving a temporary license on 11/13/24, Resident D was admitted on 09/29/24. According to the fire drill records, a fire drill was not completed in November 2024 or December 2024. One fire drill was completed on 01/05/25. There were no fire drills completed in February or March of 2025.

R 400.14401 Environmental health.

(2) Hot and cold running water that is under pressure shall be provided. A licensee shall maintain the hot water temperature for a resident's use at a range of 105 degrees Fahrenheit to 120 degrees Fahrenheit at the faucet.

The water temperature was 125 degrees Fahrenheit.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, renewal of the license is recommended.

04/16/25
Date

Licensing Consultant