



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

December 9, 2025

Holly Heath  
Community Opportunity Center NPHC  
14147 Farmington Rd  
Livonia, MI 48154

RE: License #: AL820007566  
Investigation #: 2026A0992005  
Garden City Opportunity Manor

Dear Holly Heath:

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 (313) 456-0439.

Sincerely,

A handwritten signature in black ink, appearing to read "Denasha Walker". The signature is fluid and cursive, with a prominent initial "D" and "W".

Denasha Walker, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Pl. Ste 9-100  
3026 W. Grand Blvd  
Detroit, MI 48202  
(313) 300-9922

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AL820007566
<b>Investigation #:</b>	2026A0992005
<b>Complaint Receipt Date:</b>	11/13/2025
<b>Investigation Initiation Date:</b>	11/13/2025
<b>Report Due Date:</b>	12/13/2025
<b>LicenseeName:</b>	Community Opportunity Center NPHC
<b>Licensee Address:</b>	14147 Farmington Road Livonia, MI 48154
<b>Licensee Telephone #:</b>	(734) 838-0536
<b>Administrator:</b>	Holly Heath
<b>Licensee Designee:</b>	Holly Heath
<b>Name of Facility:</b>	Garden City Opportunity Manor
<b>Facility Address:</b>	6337 Central Garden City, MI 48135
<b>Facility Telephone #:</b>	(734) 425-0203
<b>Original Issuance Date:</b>	04/19/1985
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/26/2024
<b>Expiration Date:</b>	03/25/2026
<b>Capacity:</b>	15
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A did not receive his medication as prescribed; the pill was missing and not in his bubble pack.	Yes

**III. METHODOLOGY**

11/13/2025	Special Investigation Intake 2026A0992005
11/13/2025	Special Investigation Initiated - Telephone Office of Recipient Rights, Frank Lewis
11/14/2025	Inspection Completed On-site Acting site manager, Nancy Merehouyias; home manager, Ferrari Griffin; direct care staff, Susan Clay; direct care staff, Verlinda Senior and Resident A.
12/03/2025	Contact - Telephone call made Direct care staff, Kyra Parrom.
12/03/2025	Contact - Telephone call made Licensee designee, Holly Heath was not available. Message left.
12/03/2025	Contact - Telephone call made Resident A's guardian, Paul Torony with Faith Connections.
12/03/2025	Contact - Telephone call made Mr. Lewis
12/04/2025	Contact - Telephone call made Ms. Heath was not available. Message left.
12/08/2025	Contact - Telephone call made Ms. Heath

**ALLEGATION: Resident A did not receive his medication as prescribed; the pill was missing and not in his bubble pack.**

**INVESTIGATION:** On 11/13/2025, I contacted Office of Recipient Rights (ORR), Frank Lewis regarding the allegation. Mr. Lewis confirmed he is actively investigating the allegation, and the investigation is relatively new. He stated he will follow-up with me once he obtains more information.

On 11/14/2025, I completed an unannounced on-site inspection and interviewed acting site manager, Nancy Merehouyias; home manager, Ferrari Griffin; direct care staff, Susan Clay; direct care staff, Verlinda Senior and Resident A regarding the allegation. Ms. Merehouyias stated she was not on shift when the incident occurred but stated she is familiar with the allegation. She stated when direct care staff Kyra Parrom went to pass Resident A's afternoon medication, his Trileptal Oxcarbazepine 600MG PO TAB, take 1 tablet by mouth twice a day was not in the bubble pack. She stated Ms. Parrom contacted home manager, Ferrari Griffin and made her aware of the situation. I asked if there is a medication coordinator that verifies the medication, and she stated yes. However, she stated there is a staff on each shift that verifies the medication at the start of the shift. She stated on 11/07/2025, direct care staff, Susan Clay verified the medications at the start of her shift and there were no missing pills at that time. She stated Ms. Clay worked from 1:00-9:00p.m. along with Ms. Parrom and direct care staff, Marsha Harvey. Ms. Merehouyias provided me with a copy of Resident A's medication administration records (MARs). I reviewed October through November 2025. No discrepancies were noted on October's MARs. As for November, Resident A's Trileptal Oxcarbazepine 600MG PO TAB, take 1 tablet by mouth twice a day was not initialed on 11/07/2025 at 7:30 p.m. In fact, 11/07/2025 was circled and above the box were the initials KP. Ms. Merehouyias provided me with a copy of the incident report that was completed by Ms. Parrom, stating that while passing Resident A's medication, it was discovered that his Trileptal Oxcarbazepine 600MG PO TAB was not in the bubble pack. Ms. Merehouyias contacted Ms. Griffin, and I interviewed her by telephone.

Ms. Griffin's statements were consistent with the statements Ms. Merehouyias provided to me during my interview with her. She stated Ms. Parrom discovered the medication was not in the bubble pack while she was in the process of administering medication. She stated Ms. Parrom and the other staff on shift looked around thinking the pill might have fallen out of the bubble pack, but they were unable to locate it. Ms. Griffin stated Resident A did not receive his 7:30p.m. Trileptal Oxcarbazepine 600MG PO TAB medication on 11/07/2025.

I conducted a face-to-face interview with Ms. Clay. Ms. Clay confirmed she worked the afternoon shift on 11/07/2025, along with Ms. Parrom and Ms. Harvey. She explained that the medication books are divided into two separate books, book #1 and #2. She stated one staff is responsible for administering medications from book

#1 and the other staff is responsible for book #2. Ms. Clay stated on the day in question, she was responsible for book #2 and Ms. Parron was responsible for book #1. She stated Resident A's medications are in book #1. She stated Ms. Parron was in the process of administering Resident A's medication when she discovered the pill was not in the bubble pack. She stated she helped Ms. Parron look for the pill, thinking maybe it had fallen out of the bubble pack, but they were unable to find it. Ms. Clay stated she checked all the medications at the start of her shift, and all the medications were there. She stated the bubble pack foil is flimsy and it is possible it fell out, but they could not find it. Ms. Clay stated Ms. Parron immediately contacted the medication coordinator, Nyuntae Green, and notified her. Ms. Clay stated there is a medication verification process in place. She stated each staff assigned to administer medication is supposed to check behind the other staff, to ensure there are no errors.

I conducted a face-to-face interview with direct care staff, Verlinda Senior. Ms. Senior stated she was not on shift when it was discovered that the pill was not in the bubble pack. She stated she worked the morning shift (7:00a.m. – 5:00p.m.) on 11/07/2025. She stated during the morning shift she was responsible for administering medication from book #1. Ms. Senior stated prior to administering medication, she checked all the medication and none of the bubble packs looked punctured or tampered with. She stated all the medication was in the bubble pack when she checked. Ms. Senior stated the bubble packs are fragile. However, she stated when Ms. Clay came in for her shift, she checked the medications too and did not notice any medications missing. She stated Ms. Clay always checks the medications at the start of her shift.

I conducted a face-to-face interview with Resident A. Resident A stated he receives his medication everyday day at the same time. He stated there was a time when he did not receive his Trileptal pill, but it only happened once. Resident A stated the staff takes good care of him and makes sure he has what he needs.

On 12/03/2025, I contacted direct care staff, Kyra Parron regarding the allegation. Ms. Parron confirmed she was administering Resident A's medication when she discovered his Trileptal Oxcarbazepine 600MG PO TAB was not in the bubble pack. She stated she immediately contacted Ms. Griffin and made her aware. She stated the bubble pack foil was damaged and although she looked for the pill, she could not find it. She stated Resident A did not receive his medication and he did not experience any adverse effects. She stated she contacted Ms. Griffin and made her aware of the situation. She stated the next day he received his medication as prescribed. Ms. Parron stated after the fact, Ms. Ferrari advised her that if she ever encounters this situation again, to give the resident the next pill in the pack so that the resident does not miss their medication.

On 12/03/2025, I contacted Resident A's guardian, Paul Torony with Faith Connections regarding the allegation. Mr. Torony stated he was not aware of the allegation. However, he stated he does not have any concern regarding the quality-

of-care Resident A's receiving. He stated the staff is very efficient and if they have any concerns they do not hesitate to contact him. He stated the bubble packs are very fragile and it possible the pill fell out.

On 12/03/2025, I contacted Mr. Lewis regarding the status of his investigation. He stated he is still actively investigating and was unable to provide an update at this time.

On 12/08/2025. I contacted licensee designee, Holly Heath regarding the reported allegation. She stated she was previously made aware of the situation and Ms. Griffin addressed the issue. She stated corrective measures have been taken to ensure that it will not happen again. Ms. Heath agreed to provide me with a written corrective action plan.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.</b>
<b>ANALYSIS:</b>	<p>During this investigation, I interviewed licensee designee, Holly Heath; home manager, Ferrari Griifin; acting manager, Nancy Merehouyias; direct care staff, Susan Clay, Verlinda Senior and Kyra Parrom; ORR, Frank Lewis; Resident A's guardian, Paul Torony with Faith Connections and Resident A regarding the allegation. All of which confirmed the allegation.</p> <p>I reviewed Resident A's MARs, for November and his Trileptal Oxcarbazepine 600MG PO TAB, take 1 tablet by mouth twice a day was not initialed on 11/07/2025 at 7:30 p.m. In fact, 11/07/2025 was circled and above the box were the initials KP.</p> <p>Based on the findings there is sufficient evidence to support the allegation that Resident A's medication was not given, taken, or applied as prescribed.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same



12/8/2025

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Denasha Walker  
Licensing Consultant

Date

Approved By:



12/9/2025

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Ardra Hunter  
Area Manager

Date