GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 6, 2026

Julie Wiley
Wormer Residential Care Home, LLC
14420 Wormer
Redford, MI 48239

RE: License #: AS820414650
Investigation #: 2026A0101021
The Wormer Residence

Dear Ms. Wiley:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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) 456-0380.

Sincerely,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820414650
Investigation #:	2026A0101021
Complaint Receipt Date:	02/10/2026
Investigation Initiation Date:	02/13/2026
Report Due Date:	04/11/2026
Licensee Name:	Wormer Residential Care Home, LLC
Licensee Address:	14420 Wormer Redford, MI 48239
Licensee Telephone #:	(248) 991-5775
Administrator:	Julie Wiley
Licensee Designee:	Julie Wiley
Name of Facility:	The Wormer Residence
Facility Address:	14420 Wormer Redford Township, MI 48239
Facility Telephone #:	(313) 740-7551
Original Issuance Date:	04/10/2023
License Status:	REGULAR
Effective Date:	10/10/2025
Expiration Date:	10/09/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The licensee did not provide supervision, protection and personal care as specified in Resident A's assessment plan.	Yes
It was reported that Resident A had multiple falls over the past few weeks and she did not receive treatment until 02/03/2026.	No
Additional Findings	Yes

III. METHODOLOGY

02/10/2026	Special Investigation Intake 2026A0101021
02/11/2026	APS Referral received
02/13/2026	Special Investigation Initiated –Telephone Resident A's guardianship caseworker Paul Toroni, Faith Connection & Adult Protective Services Worker, Latricia Sharp
02/13/2026	Contact– Documents received APS worker Ms. Sharp's notes
02/13/2026	Contact – Document received the licensee designee Julie Wiley, Incident report
03/04/2026	Inspection Completed On-site Interviewed direct care staff, Alicia Terry and Resident A Obtained copies of Resident A's hospital discharge summary and medication log
03/10/2026	Contact – Document received from the licensee designee Julie Wiley Resident A's Geodon prescriptions
03/25/2026	Contact –Telephone call made Mr. Toroni

04/02/2026	Contact – Telephone call made Licensee designee, Julie Wiley and Maurice Latham, administrator/home manager
04/09/2026	Contact – Telephone calls made Direct care staff, Alicia Hendrix, Angela Richardson, Alicia Terry, Diane Carrol and Adult Protective Services Worker, Ms. Sharp.
4/10/2026	Contact – Document sent to the licensee designee Julie Wiley E-mail sent requesting Resident A's 1. AFC Identification Sheet 2. AFC assessment plan 3. Treatment plan 4. Behavioral plan 5. Residential assessment 6. January 25, 2026 -February 7, 2026, staff schedule 7. The date when the Geodon medication was increased
04/14/2026	Contact – Telephone calls made- the licensee designee Julie Wiley Regarding requested documentation not received.
04/22/2026	Contact – Documents received from Julie Wiley Resident A's AFC Identification Sheet, AFC assessment plan, expired treatment plan, residential assessment, her 2:1 staffing schedule and the prescription increasing her Geodon medication.
04/29/2026	Contact –Telephone call made Resident A's caseworker Christina Hadley, Neighborhood Services Organization
04/29/2026	Contact – Document received from Resident A's caseworker Christina Hadley Resident A's treatment plan, with effective date 12/16/2025
04/30/2026	Exit conference With licensee designee, Julie Wiley

ALLEGATION: The licensee did not provide supervision, protection and personal care as specified in Resident A's assessment plan.

INVESTIGATION: According to the complaint allegations, on 02/03/2026, Resident A was brought into Garden City Hospital Emergency Department. "She presented

with right ankle foot pain and found to have significant fracture of the right tibia and fibia and old bruising. The story of how she received these injuries were inconsistent with the injuries."

On 02/13/2026, I interviewed Adult Protective Service Worker (APS), Latricia Sharp. Ms. Sharp stated Resident A's fractured leg could be the result of physical abuse. Ms. Sharp agreed to forward me her written notes she took when she spoke with the orthopedic surgeon. According to Ms. Sharp's notes she "received a call from Dr. Eric Schwiller Garden City Hospital 734-422-8400. Per Dr. Schwiller he stated when he spoke with the group home, they informed him the client was able to walk one day and the next day she was not. He stated due to the limited story he cannot say if the injury occurred due to physical abuse as he does not have all the information. Dr. Schwiller informed Ms. Sharp he can say the fracture pattern matches up with a slip and fall given the client's obesity, but it could also match up with a spiral fracture as if someone twisted on the leg that should not have, or this could be just an unfortunate accident that happened. Dr. Schwiller informed ASW [Adult Service Worker] he can say he did not see any bruising pattern on the leg or skin so it could be an appropriate injury for what was described but he does not have all the information."

On 02/13/2026, I interviewed Resident A's guardianship caseworker, Paul Toroni, Faith Connection. Mr. Toroni stated that there are two stories about how Resident A broke her leg and neither story is consistent with the injury. Mr. Toroni stated the first story told was Resident A went to bed and woke up that way and the second story told was that she fell.

On 03/04/2026, I interviewed direct care staff, Alicia Terry. Ms. Terry stated in December 2025, Resident A's Geodon medication was increased. Ms. Terry stated the increase in this medication made Resident A lethargic. Ms. Terry further stated Resident A had fallen on Christmas Day. Ms. Terry stated Resident A did not sustain any injuries or report that she was in pain, therefore, she did not need medical attention. Ms. Terry further stated Resident A fell in the dining area on 02/03/2026. Ms. Terry stated she and the other staff on duty could not get her up; therefore, she called 911. Ms. Terry further stated that she escorted Resident A to the hospital.

On 03/04/2026, I attempted to interview Resident A. Resident A's language is very hard to understand and childlike. Resident A could not tell me what happened to her leg. Ms. Terry kept telling her you fell and hurt your leg.

On 03/10/2026, I interviewed licensee designee, Julie Wiley. Ms. Wiley also stated that the increase in Resident A's Geodon medication had her lethargic. Ms. Wiley further stated that Resident A fell on 02/03/2026, and she is not aware of any other falls.

On 03/25/2026, I interviewed Resident A's guardianship caseworker. Paul Toroni, Faith Connection, again. Mr. Toroni stated if staff was to harm Resident A she would

“raise h_ _ _.”

On 04/02/2026, I spoke with Ms. Wiley and her administrator/home manager, Maurice Latham. According to Mr. Latham, direct care staff, Alicia Hendrix, Angela Richardson, Alicia Terry and Diane Carroll worked on 02/03/2026. Mr. Latham also stated that a healthcare professional was contacted regarding the increase in Resident A’s Geodon medication was making her lethargic. However, he did not name who was contacted or name who supposedly contacted the health care professional. Furthermore, he could not provide any documentation that would verify that a health care professional was contacted.

On 04/09/2026, I interviewed direct care staff, Alicia Hendrix. Ms. Hendrix stated that she and Angela Richardson were Resident A’s 2:1 staff. Ms. Hendrix stated that she and Ms. Richardson escorted Resident A to the hospital on 02/03/2026. Ms. Hendrix stated Resident A did not fall. Ms. Hendrix stated when Resident A woke up, she was in pain and could not bear weight when she attempted to stand up. Ms. Hendrix stated she and Ms. Richardson had to carry Resident A into the bathroom. Ms. Hendrix stated that Resident A was in the middle and she was on one side of Resident A and Ms. Richardson was on the other. Ms. Hendrix stated Resident A wrapped her arm around each of their shoulders and that is how they got her into the bathroom. Ms. Hendrix stated once they were in the bathroom they used another resident’s shower chair to move her. Ms. Hendrix stated she never told anyone that Resident A fell.

On 04/09/2026, I interviewed direct care staff, Ms. Richardson. Ms. Richardson stated Resident A did not fall and she reiterated the information Ms. Hendrix conveyed to me. Ms. Richardson also stated that Resident A’s Geodon medication made her “more sleepy.”

On 04/09/2026, I interviewed direct care staff, Ms. Terry, again. Ms. Terry’s account of what happened drastically changed from the information she conveyed to me on 03/04/2026. Ms. Terry stated Resident A did not actually fall on Christmas day. Ms. Terry stated that her leg only “buckled.” Ms. Terry also stated on 02/03/2026, she did not work. Ms. Terry stated she took the day off.

On 04/09/2026, I interviewed direct care staff, Diane Carroll. Ms. Carroll stated that she has no knowledge regarding Resident A falling. Ms. Carroll stated she just wrote the incident report. Ms. Carroll stated no one told her Resident A fell but she “had to have fallen.” Furthermore, the incident report Ms. Carroll wrote was inconsistent with Ms. Hendrix’s and Ms. Richardson’s accounts of what occurred when they took Resident A to the hospital. The incident report also stated that the increase in Resident A’s Geodon medication was causing her to be lethargic.

On 04/09/2026, I interviewed Adult Protective Service Worker, Latricia Sharp. Ms. Sharp stated that Resident A could not tell her what happened to her leg. Ms. Sharp stated that Resident A stated something about some ice and staff Ms. Terry

interrupted and stated no you didn't. Ms. Sharp stated that Resident A is very aggressive with staff. Ms. Sharp forwarded to me 16 incident reports documenting Resident A's physical and verbal aggression toward staff. According to the incident reports Resident A will attack, spit on and throw furniture and other objects at staff.

On 04/29/2026, I interviewed Resident A's caseworker, Christina Hadley, Neighborhood Services Organization. Ms. Hadley stated that Resident A is very aggressive with staff and requires 2:1 staffing at all times, 24 hours a day. Ms. Hadley stated she in-serviced the home manager, Maurice Latham, on Resident A's treatment plan and he is responsible for in-servicing his staff. Ms. Hadley stated there should always be two sets of eyes on Resident A at all times, one staff shall be within arm's length of Resident A and the other staff must be within eyesight of Resident A. Ms. Hadley stated she explained this to Mr. Latham when she in-serviced him on Resident A's treatment plan. Ms. Hadley also stated she explained to the staff the 2:1 staffing requirements "over and over again" when she visited the home and found Resident A without 2:1 staffing. Ms. Hadley further stated that she thought Resident A would be able to communicate how she obtained the injuries, but she also stated that Resident A is childlike.

On 04/29/2026, I reviewed Resident A's treatment plan effective date 12/16/2025. Resident A's treatment plan states Resident A shall have 2:1 staffing at all times. However, the treatment plan did not indicate the requirements of the 2:1 staffing as the caseworker stated, should be one staff within arm's length and the other staff must be within eyesight of Resident A at all times.

On 04/30/2026, I conducted an exit conference with Ms. Wiley. Ms. Wiley reluctantly agreed with my findings. I explained to Ms. Wiley it is not concluded that staff caused the injury, however, the level of supervision and protection that is specific in her assessment plan was not provided. Resident A has 2:1 staffing at all times and no one knows how or when the injuries occurred.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	Based upon the preponderance of evidence the licensee did not provide the supervision, protection, and personal care as specified in Resident A's assessment plan. Not providing the supervision and protection as specified in Resident A's treatment plan jeopardized her health, safety and well-being. Resident A's right tibia and fibia were fractured and no one knows how she sustained these injuries. According to Resident A's treatment plan she shall have 2:1 staffing at all times. Ms. Hadley stated there should always be two sets of eyes on Resident A at all times, one staff shall be within arm's length of Resident A and the other staff must be within eye sight of Resident A. Ms. Hadley stated she explained this to Mr. Latham and the staff whenever she found Resident A without 2:1 staffing. Even though Resident A should have 2:1 staffing at all times the staff do not know how she fractured her right tibia and fibia.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: It was reported that Resident A had multiple falls over the past few weeks and she did not receive treatment until 02/03/2026.

INVESTIGATION: On 03/04/2026, I interviewed direct care staff, Alicia Terry. Ms. Terry stated Resident A fell on Christmas day. According to Ms. Terry Resident A was not injured when she fell on Christmas day, therefore, medical care was not needed. However, Ms. Terry later recanted that Resident A fell on Christmas day.

On 03/10/2026, I interviewed licensee designee, Julie Wiley. Ms. Wiley stated that Resident A fell on 02/03/2026, and she is not aware of any other falls. Ms. Wiley further stated she did not see Resident A fall, however, an incident report was written stating that she had fallen. According to Ms. Wiley there are no other incident reports regarding Resident A falling.

On 04/09/2026, I interviewed direct care staff, Alicia Hendrix and Angela Richardson. They stated that they have never seen Resident A fall.

On 04/09/2026, I interviewed direct care staff, Diane Carroll. Ms. Carroll stated that she has no knowledge regarding Resident A falling. Ms. Carroll stated she just wrote the incident report. Ms. Carroll stated no one told her Resident A fell but she "had to

have fallen."

On 04/30/2026, I conducted an exit conference with Ms. Wiley. Ms. Wiley agreed with my findings.

APPLICABLE RULE	
R 400. 689	**Resident health care.**
	In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	There is no evidence to conclude that Resident A had multiple falls over the past few weeks, and she did not receive treatment until 02/03/2026. According to the staff no one witnessed Resident A fall.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 03/04/2026, during my interview with direct care staff, Alicia Terry, she stated Resident A's Geodon medication was increased. Ms. Terry further stated that the Geodon medication made Resident A lethargic.

On 03/10/2026, I interviewed the licensee designee Julie Wiley. Ms. Wiley stated Resident A's Geodon medication was increased and it made her lethargic.

On 04/02/2026, I spoke with Ms. Wiley and her administrator/home manager, Maurice Latham. According to Mr. Latham, direct care staff, Alicia Hendrix, Angela Richardson, Alicia Terry and Diane Carroll worked on 02/03/2026. Mr. Latham also stated that a health care professional was contacted regarding the increase in Resident A's Geodon medication was making her lethargic. However, he did not name who was contacted or name who supposedly contacted the health care professional. Furthermore, he could not provide any documentation that would verify that a health care professional was contacted.

On 04/09/2026, I interviewed direct care staff, Ms. Richardson. Ms. Richardson stated that she and Ms. Hendrix escorted Resident A to the hospital on 02/03/2026. Ms. Richardson stated Resident A did not fall. Ms. Richardson stated when Resident A woke up, she was in pain and could not bear weight when she attempted to stand up. Ms. Richardson stated she and Ms. Hendrix had to carry Resident A into the

bathroom. Ms. Richardson stated that Resident A was in the middle and she was on one side of Resident A and Ms. Hendrix was on the other. Ms. Richardson stated Resident A wrapped her arm around each of their shoulders and that is how they got her into the bathroom. Ms. Richardson stated once they were in the bathroom they used another resident's shower chair to move her. Ms. Richardson stated she never told anyone that Resident A fell. Ms. Richardson also stated that Resident A's Geodon medication made her "more sleepy."

On 04/09/2026, I interviewed direct care staff, Diane Carroll. Ms. Carroll stated that she has no knowledge regarding Resident A falling. Ms. Carroll stated she just wrote the incident report. Ms. Carroll stated no one told her Resident A fell but she "had to have fallen." Furthermore, the incident report Ms. Carroll wrote was inconsistent with Ms. Hendrix's and Ms. Richardson's accounts of what occurred when they took Resident A to the hospital. The incident report also stated that the increase in Resident A's Geodon medication was causing her to be lethargic.

On 04/22/2026, I reviewed the prescription increasing Resident A's Geodon medication. The prescription was written on 10/20/2025.

On 04/30/2026, I conducted an exit conference with Ms. Wiley. Ms. Wiley agreed with my findings.

APPLICABLE RULE	
R 400.685	**Admission, progress, health, and discharge records.**
	(11) A licensee shall contact a resident's health care professional for instructions as to the care of the resident if the resident requires the care of a health care professional. The licensee shall record in the resident's record any instructions for the care of the resident.

ANALYSIS:	Based upon the preponderance of evidence, the licensee did not contact Resident A's health care professional for instructions when she became lethargic due to the increase in her Geodon medication. Not immediately contacting a health care professional when Resident A became lethargic jeopardized her health safety and well-being. Being in a lethargic state can interfere with one's ability to safely ambulate. Ms. Wiley and Ms. Terry stated that the increase in Resident A's Geodon medication made her lethargic. Ms. Richardson stated when Resident A's Geodon medication was increased it made her "more sleepy." Ms. Carroll stated in the incident report that the increase in Resident A's Geodon medication made her lethargic Mr. Latham stated that a health care professional was contacted regarding the increase in Resident A's Geodon medication was making her lethargic. However, he did not name who was contacted or name who supposedly contacted the health care professional. Furthermore, he could not provide any documentation that would verify that a health care professional was contacted.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan I recommend the status of the license be modified to a provisional license.

06/24/2026

Edith Richardson
Licensing Consultant

Date

Approved By:

07/06/2026

Ardra Hunter
Area Manager

Date