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 #: 2026A0101027
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 #:	2026A0101027
Complaint Receipt Date:	03/23/2026
Investigation Initiation Date:	03/25/2026
Report Due Date:	05/22/2026
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?
On 03/18/2026, Resident B was taken to Garden City Hospital for leg pain. Resident B's left leg femur bone was broken. The cause of the injury is unknown.	Yes

III. METHODOLOGY

03/23/2026	Special Investigation Intake 2026A0101027
03/25/2026	Special Investigation Initiated - Telephone Office of Recipient Rights to collaborate
04/09/2026	Inspection Completed On-site Interviewed direct care staff DeShawn Berry Interviewed med coordinator Tina Jackson Received copies Incident report After Visit Summary Consultation form
04/10/2026	Contact - Document sent to the licensee designee Juile Wiley E-mail sent regarding the additional documentation
04/17/2026	Inspection Completed On-site Interviewed Resident B
04/17/2026	Contact - Document sent Ms. Wiley E-mail sent regarding not receiving the requested documentation
04/17/2026	Contact - Telephone call received Ms. Wiley's administrator/home manager, Maurice Latham
04/22/2026	Contact - Document received from Resident B's case worker. Resident B's treatment plan
04/22/2026	Contact - Document received from Mr. Latham The physician's statement Resident B's AFC Identification Sheet AFC assessment plan

04/23/2026	Contact - Document received from Mr. Latham Resident A's treatment plan.
04/29/2026	Contact - Telephone call made Relative B1
04/29/2026	Contact - Telephone call made Resident B's case manager, Genetta Campbell, Community Living Services
04/30/2026	APS referral
04/30/2026	Contact-Telephone call made Ms. Wiley and Mr. Latham.
05/15/2026	Contact-Telephone call made Mr. Latham
05/15/2026	Contact-Document received from Mr. Latham Resident B's medical exam report dated 02/25/2025.
05/28/2026	Contact-Telephone call made Mr. Latham
05/28/2026	Contact-Document received from Mr. Latham Resident B's 1:1 staff schedule The 1:1 staff names and phone numbers
06/24/2026	Contact-telephone calls made Kourtney Bridgewater Angel Richardson Shyee Herring no answer left message Robyn Bird, former employee, no answer, left message

ALLEGATION: On 03/18/2026, Resident B was taken to Garden City Hospital for leg pain. Resident B's left leg femur bone was broken. The cause of the injury is unknown.

INVESTIGATION: According to the complaint allegations, "The support coordinator was informed by the home manager, Maurice Latham, that [Resident B] was taken to Garden City hospital due to pain in her leg, and she was diagnosed with a broken femur bone on her left leg. The home manager does not know how her leg was broken. The home manager stated that [Resident B] did not fall and was not dropped by the staff, but it might have had something to do with her fracture from her last

home.

The support coordinator spoke with Resident B's sister who is her medical POA [power of attorney] and she informed the support coordinator that the doctor stated that [Resident B's] broken leg was not due to a past fracture and the leg was broken from some type of force."

On 04/09/2026, I conducted an onsite investigation and interviewed, direct care staff, DeShawn Berry. Mr. Berry stated he did not know what happened to Resident B's leg and called the med coordinator, Tina Jackson. Ms. Jackson instructed Mr. Berry to make me a copy of the incident report and the follow-up medical visit report. Ms. Jackson stated that the leg was broken because she has osteoporosis. Ms. Jackson stated that in the documents Mr. Berry copied for me there is a written statement from the doctor indicating that the fracture was the result of osteoporosis. I informed Ms. Jackson that there was no doctor's statement in the documents Mr. Berry copied for me. Ms. Jackson stated that she would forward the document to me tomorrow.

On 04/17/2026, I interviewed Resident B. Resident B stated when a staff was transferring her from the bed to the recliner with her Hoyler Lift that person hit her leg up against the wall. Resident B could not identify which staff caused the injury or the date the injury occurred. However, Resident B stated that when this incident happened, she screamed out loudly and told the staff, "Hey, you hit my leg up against the wall."

On 04/22/2026, I received the physician's written statement from Mr. Latham. The physician's statement reads that the injury "appears to be a low impact fracture secondary to osteoporosis."

On 04/22/2026, I received a copy of Resident B's treatment plan from Resident B's caseworker, Genetta Campbell. According to the treatment plan Resident B's diagnoses are multiple sclerosis and mild intellectual disability. The treatment plan also states Resident B is non-ambulatory and is dependent on staff for all activities of daily living. The treatment plan further states Resident B always requires 1:1 staffing.

On 04/29/2026, I interviewed Relative B1. Relative B1 stated, "The home is not a good fit, but my sister likes it there." Relative B1 also stated last year her sister had a cut on her leg and it required stitches. She also stated that medical appointments are not being scheduled in a timely manner and sometimes she has to make the appointments.

On 04/29/2026, I interviewed Resident B's case manager, Ms. Genetta Campbell, Community Living Services. Ms. Campbell expressed her concerns with the home. Ms. Campbell stated that she has in-serviced the home manager, Maurice Latham, and informed the staff multiple times that 1:1 staff should be within arm's length of Resident B at all times. However, when I reviewed Resident B's treatment plan it did

not state the proximity of the 1:1 staff to Resident B. Ms. Campbell further stated, when she visits the home, the staff are always at the dining room table on their phones.

Furthermore, when I interviewed Resident B on 04/17/2026, in her bedroom, there was no 1:1 staff with her upon my arrival and departure. However, at the time of the interview I was not aware that Resident B was to have 1:1 staffing.

On 05/15/2026, I spoke with Mr. Latham. Mr. Latham stated no one on his staff reported hitting Resident B's leg up against the wall or know how the injury occurred. Mr. Latham further stated according to Resident B's neurologist that she saw in May of 2025, "Resident A has always had a fracture, and she will always have it." Mr. Latham forwarded me a copy of the report. The report states, "The patient also has a baseline fracture of the left leg which has contributed to her ambulatory difficulties." The report also sates, "The patient is currently wheelchair bound and cannot ambulate."

On 05/15/2026, I conducted an exit conference with Ms. Wiley and Mr. Latham. We discussed that the baseline fracture caused Resident B's left leg to be fragile and more susceptible to injury. However, it does not negate what the physician wrote in his written statement, the injury "appears to be a low impact fracture secondary to osteoporosis." Ms. Wiley asked, "Is the violation because the leg was broken?" I explained to her the violation is Resident B is supposed to have 1:1 staffing at all times and according to Mr. Latham no one on your staff reported or knows how her leg was injured. Furthermore, we know Resident B could not have caused the injury because she cannot use her legs. If Resident B was receiving 1:1 staffing at all times, as specified in her treatment plan, someone should know how the leg was injured.

On 06/24/2026, I reviewed Resident B's 1:1 staff schedule for the month of March 2026 and spoke with them. Direct care staff Kourtney Bridgewater stated when she arrived at work on 03/18/2026, at 2:00 p.m., Resident B requested to go to the hospital because her leg was hurting. Ms. Bridgewater stated she thought the leg was broken because Resident B has brittle bones. Ms. Bridgewater stated she did not know anything else about Resident B's broken leg. Furthermore, direct care staff Angel Richardson stated she does not know how Resident B's leg was injured.

On 06/25/2026, I conducted a second exit conference with Ms. Wiley because of the interviews with staff. I informed Ms. Wiley that information conveyed in the first exit conference remains unchanged.

APPLICABLE RULE	
R 400.671	**Resident rights; licensee responsibilities.**
	(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 required supervision, protection, and personal care as specified in Resident B's assessment plan. Not providing the required supervision protection and personal care as specified in Resident B's treatment plan jeopardized her health, safety and well-being. Resident B's left leg femur bone was broken, and no one knows how she sustained this injury. According to the physician's statement the injury "appears to be a low impact fracture secondary to osteoporosis." Resident B stated a staff hit her leg up against the wall. According to Resident B's assessment plan she is supposed to have 1:1 staffing at all times. According to Mr. Latham no one on his staff reported hitting Resident A's leg up against the wall or knows how the injury occurred. Furthermore, direct care staff De Shawn Berry, Kourtney Bridgewater and Angel Richardson all stated they did not know how the injury to Resident B's leg happened. The support coordinator reported that the home is not providing Resident B's 1:1 staffing at all times. The support coordinator stated that when she visits the home the staff are always at the dining room table on their phone. On 04/17/2026, I observed that Resident A did not have a 1:1 staff with her.
CONCLUSION:	**VIOLATION ESTABLISHED "REPEATED"**

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan I continue to recommend modification of the license to a provisional license. SIR #

2026A0101021 dated 07/06/2026.

06/24/2026
Edith Richardson Date
Licensing Consultant

Approved By:

07/06/2026
_____
Ardra Hunter Date
Area Manager