GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 13, 2026

Desiree Santiago
Virtuoso Management, LLC
20298 Beacon Way
Northville, MI 48167

RE: License #: AS820379695
Investigation #: 2026A0992039
Virtuoso Care

Dear Ms Santiago:

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) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
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

License #:	AS820379695
Investigation #:	2026A0992039
Complaint Receipt Date:	06/23/2026
Investigation Initiation Date:	06/25/2026
Report Due Date:	08/22/2026
Licensee Name:	Virtuoso Management, LLC
Licensee Address:	20298 Beacon Way Northville, MI 48167
Licensee Telephone #:	(248) 952-4011
Administrator:	Desiree Santiago
Licensee Designee:	Desiree Santiago
Name of Facility:	Virtuoso Care
Facility Address:	6330 Mcguire Street Taylor, MI 48180
Facility Telephone #:	(248) 952-4011
Original Issuance Date:	08/10/2016
License Status:	REGULAR
Effective Date:	08/10/2025
Expiration Date:	08/09/2027
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive prescribed medication changes or follow-up medical care after staff failed to follow physician orders and schedule recommended appointments.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/23/2026	Special Investigation Intake 2026A0992039
06/25/2026	Special Investigation Initiated - On Site Assistant home manager, Dean-Na Gardner, direct care staff, Ferganu Hartfield, Anna Martin and Resident A.
06/26/2026	Contact - Telephone call made Adult protective services (APS) LaTasha Neal
07/16/2026	Contact - Telephone call made Licensee designee, Desiree Santiago
07/21/2026	Contact - Telephone call made Nurse, Amanda Waite with Psygenics
07/23/2026	Contact - Document Received Resident A's annual physicals for 2025 and 2026.
07/24/2026	Contact - Telephone call made Dean-Na Gardner
08/03/2026	Contact - Telephone call made Representative Sherry with Corewell Health Care Center
08/05/2026	Contact - Telephone call made Dean-Na Gardner was not available. Message left.
08/06/2026	Contact - Telephone call made Ms. Neal was not available. Message left.
08/06/2026	Contact - Telephone call received Ms. Neal

08/11/2026	Contact - Telephone call received Guardian A1, Paul Torony with Faith Connections
08/11/2026	Exit Conference Ms. Santiago

ALLEGATION: Resident A did not receive prescribed medication changes or follow-up medical care after staff failed to follow physician orders and schedule recommended appointments.

INVESTIGATION: On 06/25/2026, I completed an unannounced onsite inspection and interviewed assistant home manager, Dean'na Gardner, direct care staff, Ferganu Hartfield, Anna Martin and Resident A regarding the allegation. Ms. Gardner denied the allegation as it pertains to Resident A not receiving his medication. She stated the medication in question is Elavil Amitriptyline 25mg PO TAB; take one tablet by mouth one time a day at bedtime. Ms. Gardner stated that medication was modified to 12.5mg, take one tablet by mouth one time a day at bedtime. She provided a copy of the prescription; according to the prescription and documented notes, the medication was modified on 04/24/2026. Ms. Gardner explained that the medication does not come in the dosage as prescribed, and that the direct care staff are responsible for cutting the pill in half. I also reviewed Resident A's medications and observed half of pill, which Ms. Gardner explained that the remaining piece of the pill is from the medication that was administered this morning. I reviewed Resident A's medication administration records (MARs) for April, May and June of this year and several medications were not initialed. The MARS did not contain initials for the following:

Pepcid Famotidine 40mg PO TAB, take 1 tablet by mouth one time a day was not initialed on 04/29/2026, 05/01/2026, 05/02/2026, 05/03/2026, 05/13/2026 at 8:00 a.m. No explanation provided or documented.

Elavil Amitriptyline 12.5mg PO TAB; take one tablet by mouth one time a day at bedtime was not initialed on 05/01/2026, 05/02/2026, 05/10/2026, 05/13/2026, 05/17/2026 or 05/25/2026 at 8:00 p.m. No explanation provided or documented.

Prozac Fluoxetine HCL 4mg PO CAP, take 1 capsule by mouth one time a day was not initialed on 05/01/2026, 05/02/2026, 05/03/2026, 05/13/2026, 05/27/2026 at 8:00 a.m. No explanation provided or documented.

Aspirin-low aspirin EC/DR 81mg PO TAB, take 1 tablet by mouth one time a day was not initialed on 05/01/2026, 05/02/2026, 05/03/2026, 05/13/2026, 05/15/2026 at 8:00 a.m. No explanation provided or documented.

As far as Resident A not attending his follow-up medical appointments as required, Ms. Gardner stated there was a misunderstanding and confirmed Resident A missed

his doctor's appointment in May. She explained that Resident A had an appointment scheduled for 05/05/2026. However, she stated when the visiting nurse met with Resident A, she called the doctor and the doctor wanted to see him before 05/05/2026, so he went on 04/24/2026 instead. Ms. Gardner stated she thought that the 05/05/2026 appointment was cancelled because he was able to be seen sooner. Ms. Gardner identified the visiting nurse, Amanda Waite with Psygenics. She stated she visits Resident A regularly. I reviewed Resident A's after visit summary from the 04/24/2026 appointment and it stated Resident A has an appointment scheduled 05/05/2026 at 2:00 p.m. with Dr. Esther Son. When I pointed this out to Ms. Gardner, she stated she was not aware that appointment remained scheduled. She stated it was a misunderstanding.

I interviewed direct care staff, Ferganu Hartfield. Ms. Hartfield stated she is trained to administer medication and denied having any knowledge of Resident A not receiving his medications as prescribed. Ms. Hartfield stated when the resident's medication is discontinued or changed for any reason, the home manager, Jean'na Gardner or Dean'na Gardner will send out a text blast to all the staff, making them aware of the change, a staff meeting is held and a follow-up text message as a reminder to all staff. Ms. Hartfield stated Resident A's medication was recently changed, specifically the dosage. She stated the staff are very attentive and responsible. Ms. Hartfield stated to her knowledge the residents are receiving their medication as prescribed. Ms. Hartfield explained that she recently returned from a leave of absence but stated prior to her being on leave, she would transport the residents to and from their doctors' appointments and they always attended as required. She denied having any knowledge of Resident A missing a doctor's appointment.

I interviewed direct care staff, Anna Martin. Ms. Martin confirmed she is trained to administer medication. She stated changes were recently made to Resident A's medication. She stated the staff were made aware of the change by Ms. Jeanna Gardner, she stated a staff meeting was held, and a message was sent out via Group Chat to remind all of the staff. Ms. Martin explained that due to the change in Resident A's medication the staff is responsible for breaking the pill in half. She stated a half of pill is administered twice a day. Ms. Martin stated all the residents receive their medication as prescribed. As far as Resident A missing a doctor's appointment on 05/05/2026, Ms. Martin denied having any knowledge of missing an appointment.

I interviewed Resident A. Resident A was very familiar with his medication. He stated he receives his medication regularly. Resident A confirmed he receives half of a pill two times a day. He stated he's been receiving half of a pill for approximately two months. Resident A denied having any knowledge of missing a doctor's appointment. He stated he attends his doctor's appointment as far as he knows and the nurse visits with him regularly too. Resident A denied having any concerns.

On 06/26/2026, I contacted Adult Protective Services (APS) LaTasha Neal regarding the allegation. Ms. Neal confirmed she received the allegation and is actively investigating. She stated based on preliminary information, it seems as though Resident A did miss an appointment, but it seems as though there was a miscommunication. Ms. Neal agreed to follow up with me upon completion of the investigation.

On 07/16/2026, I contacted licensee designee, Desiree Santiago regarding the allegation. She stated she was aware of the allegation. She stated she was contacted by an Office of Recipient Rights (ORR) Investigator, name unknown. Ms. Santiago stated as far as missing a doctor's appointment, she was very instrumental in setting up Resident A's doctor's appointments. She stated he missed an appointment because there were some issues with his insurance and the doctor did not accept his insurance at the time. She stated although he missed the appointment with the primary care physician, he was examined at urgent care for his annual physical. I made Ms. Santiago aware that I reviewed Resident A's after visit summary from the 04/24/2026 appointment and it stated Resident A had an appointment scheduled for 05/05/2026 at 2:00 p.m. with Dr. Esther Son. Ms. Santiago stated she was not aware.

On 07/21/2026, I contacted Resident A's visiting nurse, Amanda Waite with Psygenics regarding the allegation. Ms. Waite confirmed the allegation but stated it seems as though the staff are doing better by making sure Resident A has his medication. She stated the issue was that the staff were not refilling Resident A's medication in time to prevent him from running out of medication and not receiving it. She stated he would miss a pill because he needed a refill, when it could have been prevented if the staff refilled his medication timely. As far as missing a doctor's appointment, Ms. Waite stated it appears as though there were two appointments scheduled. She said one appointment was regarding Resident A's diabetic shoes and she is not sure what the other appointment was for, but she is aware that appointment was canceled. Ms. Waite stated the staff often utilizes urgent care if they are unable to schedule an appointment with Resident A's primary care physician. Ms. Waite stated it seems as though the staff are doing better by making sure Resident A's needs are met, including his medications and doctor appointments.

On 07/23/2026, I received a copy of Resident A's 2025 medical summary and 2026 annual physical. The medical summary was dated 05/15/2025 and the 2026 health care appraisal was dated 06/24/2026. Resident A's file did not contain an annual 2025 health care appraisal.

On 07/24/2026, I contact Ms. Dean'na Gardner and explained that a health care appraisal is required annually and asked about Resident A's 2025 health care appraisal. Ms. Gardner stated she is going to contact the doctor and try to obtain a copy.

On 08/06/2026, I contacted representative Sherry with Corewell Health Care Center regarding Resident A's appointments. I asked if Resident A had been attending all his appointments as scheduled, and Sherry said no. She explained that Dr. Esther Son is Resident A's primary care physician, and she has a complicated schedule. She stated Dr. Son's shifts are split between family medicine and pediatrics, so scheduling an appointment can be tricky sometimes. She confirmed Resident A was seen on 04/24/2026; she stated he was a "no show" on 05/05/2026; and Dr. Son canceled the appointment scheduled for 07/09/2026. Sherry explained that the office policy only allows the patient to miss 3 out of 15 appointments. She stated currently Resident A is at 20%, once he reaches 51% he will no longer be allowed to schedule an appointment and can only do same day appointments. She stated if for any reason that resident is unable to make it, has a bad day or anything like that the staff can call the office two hours in advance, and it won't count against the patient. She stated otherwise it will count and the patient will be penalized.

On 08/06/2026, I made follow-up contact with Ms. Neal. Ms. Neal stated she did substantiate the allegation and the case is closed.

On 08/11/2026, I contacted Guardian A1, Paul Torony with Faith Connections regarding the allegation. Mr. Torony stated he was aware of the appointment July 2026 was rescheduled. As it pertains to medication, Mr. Torony stated he wasn't aware of Reisdent A not receiving his medication. He stated he visited with Resident A on 08/10/2026 and he did not express any concerns. He said Resident A is doing well.

On 08/11/2026, I conducted an exit conference with Ms. Santiago. I explained that I reviewed Resident A's medication administration records (MARs) for April, May and June of this year and there were several medications that were not initialed. Also, as it pertains to Resident A's discharge summary dated 04/24/2026, a follow-up doctor's appointment was scheduled for 05/05/2026; Corewell Health Care Center staff confirmed Resident A was a no show. I reviewed Resident A's 2025 medical summary/physical was not on a health care appraisal form. I explained that as a result of the violations identified in the report, a written corrective action plan is required. Ms. Santiago agreed to submit the corrective action plan upon receipt of the report.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(b) Complete an individual medication log that contains all of the following:** **(i) Medication name.** **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) Initials of the individual who administered the medication at the time given.** **(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.**
ANALYSIS:	During this investigation, I interviewed licensee designee, Desiree Santiago; home manager, Jeanna Gardner; assistant home manager, Deanna Gardner; direct care staff, Ferganu Hartfield and Anna Martin; APS, LaTasha Neal; Guardian A1, Paul Torony with Faith Connections and Resident A regarding the allegation. I interviewed Resident A. He was very familiar with his medications and stated he received his medication as prescribed. Resident A denied having any concerns. I reviewed Resident A's medication administration records (MARs) for April, May and June of this year and there were several medications that were not initialed. Based on the findings, there is sufficient evidence to support the allegation that the individual who administered the medication failed to initial the MARs at the time given. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	During this investigation, I interviewed licensee designee, Desiree Santiago; home manager, Jeanna Gardner; assistant home manager, Deanna Gardner; direct care staff, Ferganu Hartfield and Anna Martin; APS, LaTasha Neal; Guardian A1, Paul Torony with Faith Connections and Resident A regarding the allegation. Resident A stated he attends his doctor's appointment as far as he knows. He stated the nurse visits with him regularly too. Resident A denied having any concerns. I reviewed Resident A's after visit summary from the 04/24/2026 appointment and it stated Resident A has an appointment scheduled 05/05/2026 at 2:00 p.m. with Dr. Esther Son. Corewell Health Care Center staff confirmed Resident A was a no show on 05/05/2026. Based on the findings, there is sufficient evidence to support the allegation that licensee, Desiree Santiago did not follow the instructions and recommendations of a resident's physician or other designated health care professional. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 07/23/2026, I received a copy of Resident A's 2025 medical summary and 2026 annual physical. The medical summary was dated 05/15/2025 and the 2026 health care appraisal was dated 06/24/2026. Resident A's file did not contain an annual 2025 health care appraisal.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(10) A resident or resident's designated representative shall provide a written health care appraisal or a medical discharge summary by an appropriate health care professional that is completed within the 90-day period before admission. A written health care appraisal must be completed at least annually thereafter. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be completed no later than 30 days after admission.
ANALYSIS:	Resident A's file did not contain an annual 2025 health care appraisal.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/11/2026

Denasha Walker — Date
Licensing Consultant

Approved By:

08/13/2026

Ardra Hunter — Date
Area Manager