



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 2, 2026

Nichole Landers
Landers & Landers Home for the Aged, Inc.
PO Box 33202
Bloomfield Hills, MI 48303

RE: License #: AS820400269
Investigation #: 2026A0121022
Mayfield Home #3

Dear Mrs. Landers:

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,

A handwritten signature in blue ink that reads "K. Robinson". The signature is fluid and cursive, with the first letter of each name being capitalized and prominent.

K. Robinson, MSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820400269
Investigation #:	2026A0121022
Complaint Receipt Date:	07/08/2026
Investigation Initiation Date:	07/10/2026
Report Due Date:	09/06/2026
Licensee Name:	Landers & Landers Home for the Aged, Inc.
Licensee Address:	15565 Northland Dr, Ste. 503 East Southfield, MI 48075
Licensee Telephone #:	(313) 632-0757
Administrator:	Nichole Landers
Licensee Designee:	Nichole Landers
Name of Facility:	Mayfield Home #3
Facility Address:	15324 Mayfield St., Livonia, MI 48154
Facility Telephone #:	(313) 632-0757
Original Issuance Date:	12/03/2019
License Status:	REGULAR
Effective Date:	05/20/2026
Expiration Date:	05/19/2028
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 7/6/26, Resident A wandered out of the facility around 8pm. Direct care staff (DCS), Ashley admits the resident walked out of the house when she was not looking.	Yes
On 7/7/26, DCS Ashley took Resident B's gaming controller and put it in the cupboard.	Yes

III. METHODOLOGY

07/08/2026	Special Investigation Intake 2026A0121022
07/08/2026	APS Referral
07/10/2026	Special Investigation Initiated - Letter Email to DWIHN
07/10/2026	Referral - Recipient Rights
07/15/2026	Inspection Completed On-site Interviewed direct care staff (DCS), Joshua Harris
07/23/2026	Inspection Completed On-site Interviewed manager, Arthur Pitts and Resident A
07/30/2026	Inspection Completed On-site No one home.
07/30/2026	Contact - Telephone call made Left message for Direct care staff, (DCS) Ashley Taylor
07/30/2026	Contact - Telephone call made Mrs. Landers
07/31/2026	Contact - Telephone call received Return call from Ms. Taylor
07/31/2026	Contact - Telephone call made APS worker, A. Rasberry

07/31/2026	Contact - Document Sent Email to licensee
08/03/2026	Contact - Document Sent Email to Mrs. Landers
08/03/2026	Contact - Telephone call made Mrs. Landers
08/05/2026	Inspection Completed-BCAL Sub. Compliance Interviewed Resident A and B, DCS Bernita Gates
08/18/2026	Contact - Telephone call made Manager Arthur Pitts
08/18/2026	Contact - Telephone call made Left message for Ms. Rasberry
08/18/2026	Contact - Telephone call made Saad Uddin, case manager
08/18/2026	Contact - Document Sent Email to Mrs. Landers
08/26/2026	Contact - Telephone call made Follow up call to Mr. Pitts
08/28/2026	Exit Conference Mrs. Landers

ALLEGATION: On 7/6/26, Resident A wandered out of the facility around 8pm. Direct care staff (DCS), Ashley admits the resident walked out of the house when she was not looking.

INVESTIGATION: I conducted onsite inspections at the facility on 7/15/26, 7/23/26, 7/30/26, and 8/5/26. Resident A acknowledged that he is not allowed to go in the community alone; however, Resident A insisted that he was only gone from the home 15 minutes. Resident A reported that he went to the courthouse adjacent to the facility. Resident A also reported staff did not come looking for him, only Resident B and C.

Resident B confirmed that he walked across the street to search for Resident A because he didn't want Resident A harmed. Resident B stated that direct care staff,

(DCS) Ashley Taylor instructed him and Resident C to “go look for {Resident A}”. Resident C was not available for interview on the days of inspection.

On 7/31/26, I interviewed Ms. Taylor phone. Ms. Taylor no longer works at the facility; she was employed there approximately 1 year. According to Ms. Taylor, Resident A “eased outside” while she cleaned the home. Ms. Taylor stated that upon discovering Resident A was missing, she began to panic and called home manager, Arthur Pitts. Per Ms. Taylor, Mr. Pitts told her, “Don’t call the police just yet because {Resident A} does this a lot.” Ms. Taylor said Mr. Pitts instructed her to send Resident B to look for Resident A. Because the courthouse is in close proximity to the home, Ms. Taylor reported she could visibly see the residents from the facility. Resident A and B reported Resident A returned to the facility unharmed.

On 8/18/26, I contacted Resident A’s case manager, Saad Uddin with Wayne Center. Mr. Uddin stated, “He has to have staff available,” referring to Resident A. Mr. Uddin recommends Resident A receive 1:1 support 11-14 hours per day. Mr. Uddin explained Resident A’s need for supervision is plain to see due to the resident’s unsteady gait, hearing impairment, and behavior problems, like yelling, kicking, and using profanity. In addition, on 7/30/26, licensee designee, Nichole Landers disclosed, Resident A requires 1:1 supervision while eating because he poses a choking risk. Mrs. Landers stated, Resident A should be within “arm’s length” of staff, but she hasn’t been able to meet the staffing requirement since she is “not getting those clock hours for him.”

On 8/5/26, I observed DCS Bernita Gates was the only staff on duty caring for Resident A, B, D, and E. Resident A did not have 1:1 staffing at the time of the inspection. Ms. Taylor informed me that she routinely worked shifts alone. I reviewed Resident A’s AFC Assessment Plan dated 3/31/26, Wayne Center Individual Plan of Service dated 9/1/25, and Wayne Center Functional Behavior Assessment Behavior Treatment Plan dated 7/31/25. It is well documented that Resident A does require 1:1 supervision.

On 8/18/26, I conferenced the case with adult protective services worker, Ashley Rasberry. Ms. Rasberry reported that she substantiated the case for neglect because Resident A was not provided sufficient staffing when he eloped from the facility.

I completed an exit conference with Mrs. Landers on 8/28/26. Mrs. Landers agrees that Resident A would benefit from 1:1 staffing although the authorization was declined. Mrs. Landers stated she will ask Detroit Wayne Integrated Health Network to remove that language if authorization is not granted with the new plan.

APPLICABLE RULE	
R 400.671	Resident care.
	(1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.
ANALYSIS:	Mrs. Landers failed to provide sufficient staffing to meet Resident A's needs in accordance with the resident's assessment plan and individual plan of service.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: On 7/7/26, DCS Ashley took Resident B's gaming controller and put it in the cupboard.

INVESTIGATION: On 7/31/26, Ms. Taylor admitted she took Resident B's gaming controller. Ms. Taylor reasoned, "I did take the controller from him because he was disturbing the other resident." According to Ms. Taylor, Resident A woke up around 4:00AM to complain about Resident B having the TV volume up loud. It should be noted that Resident A and B are roommates. Resident B said Ms. Taylor told him that "it was too late to play the game," so she took his gaming controller. Resident B indicated that he now understands it is inconsiderate to Resident A to have the TV on late at night. Ms. Taylor stated she put the controller in the staff office, and that her relief staff, Ms. Gates returned it to Resident B during awake hours around 7:00AM.

On 8/28/26, I completed an exit conference with Mrs. Landers. Mrs. Landers did not dispute the findings associated with this allegation.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(3)(k) Have reasonable access to and use of personal clothing and belongings.
ANALYSIS:	Mrs. Landers did not ensure Resident B was afforded reasonable access to his personal belonging on 7/7/26.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.



09/01/26

Kara Robinson
Licensing Consultant

Date

Approved By:



09/02/26

Ardra Hunter
Area Manager

Date