GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 6, 2025

Breana Wallace
The Village of Westland, A Senior Living Community
32001 Cherry Hill Road
Westland, MI 48186-7902

RE: License #: AL820244666
Investigation #: 2025A0778010
Rose Cottage

Dear Ms. Wallace:

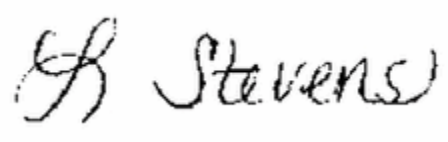
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



LaKeitha Stevens, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3055

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820244666
Investigation #:	2025A0778010
Complaint Receipt Date:	01/06/2025
Investigation Initiation Date:	01/07/2025
Report Due Date:	03/07/2025
Licensee Name:	The Village of Westland, A Senior Living Community
Licensee Address:	32001 Cherry Hill Road Westland, MI 48186-7902
Licensee Telephone #:	(734) 762-8969
Administrator:	Breana Wallace
Licensee Designee:	Breana Wallace
Name of Facility:	Rose Cottage
Facility Address:	32111 Cherry Hill Road Westland, MI 48186
Facility Telephone #:	(734) 762-8885
Original Issuance Date:	06/19/2002
License Status:	REGULAR
Effective Date:	08/29/2023
Expiration Date:	08/28/2025
Capacity:	20
Program Type:	AGED ALZHEIMERS

ALLEGATION(S)

	Violation Established?
Staff Kimberly White is neglectful of the resident by not properly handling medication.	Yes

II. METHODOLOGY

01/06/2025	Special Investigation Intake 2025A0778010
01/07/2025	Referral - Recipient Rights Referral made to ORR
01/07/2025	Special Investigation Initiated - Telephone Telephone call received from Brian Harris of ORR regarding compliant
01/07/2025	APS Referral referral made by ORR
01/23/2025	Inspection Completed On-site Face to face with staff, Rushanda Barnett
01/29/2025	Contact - Face to Face Face to face with Breana Wallace, licensee designee
02/10/2025	Contact - Telephone call received Telephone call from Adult Protective Services Worker, Alexa Fisher
02/12/2025	Contact - Document Received Received requested documents
02/28/2025	Contact - Telephone call made Telephone interview with staff, Kimberly White
03/04/2025	Inspection Completed-BCAL Sub. Compliance
03/04/2025	Exit Conference Telephone exit conference with licensee designee Breana Wallace

ALLEGATION: Staff Kimberly White is neglectful of the resident by not properly handling medication

INVESTIGATION: On 01/23/2025, I completed an unannounced onsite inspection. I interviewed staff, Rushanda Barnett. Ms. Barnett stated staff, Kimberly White received disciplinary action for not properly following the procedure to administer medication. I asked Ms. Barnett for Ms. White's schedule. Ms. Barnett stated Ms. White is frequently at the facility because she works a lot of overtime and picks up additional shifts.

On 01/29/2025, I completed an unannounced onsite inspection. Staff, Ms. Barnett was on shift. She stated Ms. White is currently on medical leave. While onsite I completed a face-to-face interview with Breana Wallace, licensee designee. Ms. Wallace stated Ms. White was observed to initial medication as administered but did not actually give the medication to the residents. I asked Ms. Wallace to forward me the contact information for Ms. White.

On 02/10/2025**,** I received a Telephone call from Adult Protective Services Worker, Alexa Fisher. Ms. Fisher indicated she will be substantiating her complaint.

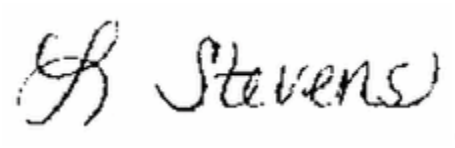
On 02/28/2025, I completed a telephone interview with staff, Ms. Kimberly White. Ms. White stated the allegations are true. According to Ms. White she initialed medication on the log as administered on 12/6/2024 and 12/9/2024, but did not actually administer it. She stated she did not want to go into further detail because she has been reprimanded, is currently on medical leave and does not want to lose her job. Ms. White indicated this will not happen again.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for specified resident in accordance with requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Complied Laws, kept with the equipment to administer it a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	There is evidence staff Kimberly White did not administer resident medication as prescribed by the licensed physician. Licensee designee, Breana Wallace indicated she was made aware of staff, Kimberly White initialing medication as administered without passing medication. Staff Kimberly White indicated she initialed medication as administered. However, the residents did not receive the medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

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



03/06/2025

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LaKeitha Stevens Date
Licensing Consultant

Approved By:

03/06/2025

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Ardra Hunter Date
Area Manager