GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 19, 2025

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

RE: License #: AL820244666
Investigation #: 2025A0778017
Rose Cottage

Dear Ms. Wallace:

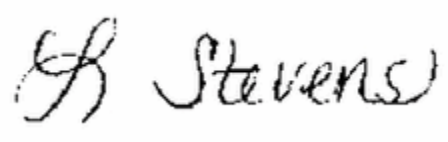
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2025A0778017
Complaint Receipt Date:	01/21/2025
Investigation Initiation Date:	01/23/2025
Report Due Date:	03/22/2025
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

II. ALLEGATION(S)

	Violation Established?
Resident A is being neglected by staff. Staff does not get her out of bed, she is not encouraged to eat. Resident A has not eaten in over a week. She is left in soiled diapers all day.	No
Additional Findings	Yes

III. METHODOLOGY

01/21/2025	Special Investigation Intake 2025A0778017
01/21/2025	APS Referral Referral received
01/23/2025	Special Investigation Initiated - Telephone Telephone call with APS Jodi Nicoletti and consultant S. Daniel
01/29/2025	Inspection Completed On-site
03/17/2025	Contact - Telephone call made Telephone call to Guardian A (Resident A's guardian)
03/17/2025	Exit Conference Telephone exit conference with licensee designee, Breana Wallace
03/17/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A is being neglected by staff. Staff does not get her out of bed, she is not encouraged to eat. Resident A has not eaten in over a week. She is left in soiled diapers all day

INVESTIGATION: This complaint was initially assigned to consultant Shatonla Daniel prior to being transferred to myself. On 01/23/2025, Ms. Daniel completed a telephone interview with Adult Protective Services, Jodi Nicoletti. Ms. Nicoletti indicated she is not substantiating her complaint.

On 01/29/2025, I completed an unannounced onsite inspection. I interviewed staff, Tammy Koval, David Haliburton and Rushanda Barnett. Tammy identified herself as a direct care worker staff, David identified himself as a nurse and Rushanda identified herself as agency. I asked Rushanda to explain "agency" and she stated she was not directly hired through the facility. I then asked her if she was trained in all required areas, and she indicated she had over 15 years of experience. I then asked her about specific trainings, and I did not receive a specific answer. During my onsite inspection I observed Resident A and the other residents to be neat in appearance and without odor. At the time of my inspection Resident A was roaming throughout the common area of the facility but she did not remain there. Upon receiving her lunch, she went directly to her room. Resident A was encouraged to remain in the dining area, and she refused. I attempted an interview with Resident A but she refused. Resident A appeared to be flustered and frustrated during the attempt to interview. I observed Resident A's room to be very clean and fresh smelling. Her room was also equipped with a food tray/stand. Per Tammy, Resident A has anxiety and does not like to be around others. I reviewed Resident A's medication log, and she is currently prescribed medication for anxiety. Per Tammy, hygiene rounds are completed every two hours however, Resident A will let someone know if she needs to be changed before then. I observed the hygiene and toileting chart. I did not observe any significant gaps.

On 03/17/2025, I completed a telephone interview with Resident A's guardian. Guardian A indicated Resident A passed away on March 16, 2025, on hospice. She indicated the facility was not neglectful. She stated Resident A was provided good care. According to the guardian Resident A did not like to be around people and preferred to eat in her room. She stated on two occasions she asked staff to clean Resident A's bathroom. However, that was not an ongoing or constant issue.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	There is no evidence Resident A is not being treated with dignity and respect. I observed Resident A to be neat in appearance. I observed her bedroom to be organized and fresh smelling. During my onsite Resident A refused to eat with others but took her food into her room. I observed Resident A's medication log and noted she is prescribed medication for anxiety. Resident A's guardian indicated the facility is not neglectful and provided good care to Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: During my onsite inspection, Rushanda Barnett described herself as an agency worker. When asked about her training she stated she had over 15 years of experience. When asked about specific trainings she did not have an answer. During my onsite I completed a face to face with licensee designee, Breana Wallace. Ms. Wallace indicated the facility has a contract with an agency called Vibrus Staffing Service. Ms. Wallace indicated she is not provided a training log but would contact the agency to obtain a copy.

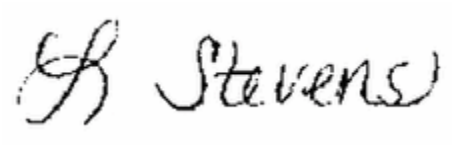
On 03/17/2025, I completed a telephone exit conference with Breana Wallace. Ms. Wallace stated she was unable to obtain a training log but was informed providing a copy of her contract with Vibrus would be sufficient. I informed Ms. Wallace I will be substantiating lack of staff training because she could not specifically provide documentation of completed trainings in all required areas prior to Rushanda' s assumption of duty. She stated she understood. In addition, I informed Ms. Wallace the remaining portion of this investigation will not be substantiated. I informed her there is no evidence Resident A was not treated with dignity and respect including personal needs and protection.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.**

	(e) Resident rights. **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	While completing an onsite inspection Rushanda Barnett could not specify trainings received. Furthermore, Ms. Wallace could not provide a log of trainings in all required areas demonstrating that Ms. Barnett was determined competent before performing assigned tasks.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



03/18/2025

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LaKeitha Stevens Date
Licensing Consultant

Approved By:

03/19/2025

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Ardra Hunter Date
Area Manager