GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 13, 2025

Debra Cromwell
Westbrooke Senior Care LLC
457 Aspen Dr
Wixom, MI 48393

RE: License #: AS630418085
Investigation #: 2025A0612024
Westbrooke Senior Care LLC

Dear Ms. Cromwell:

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 (248) 972-9136.

Sincerely,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(248) 302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630418085
Investigation #:	2025A0612024
Complaint Receipt Date:	07/14/2025
Investigation Initiation Date:	07/15/2025
Report Due Date:	09/12/2025
Licensee Name:	Westbrooke Senior Care LLC
Licensee Address:	457 Aspen Dr Wixom, MI 48393
Licensee Telephone #:	(248) 755-7254
Administrator:	Debra Cromwell
Licensee Designee:	Debra Cromwell
Name of Facility:	Westbrooke Senior Care LLC
Facility Address:	1930 N. Hickory Ridge Rd. Highland, MI 48357
Facility Telephone #:	(248) 755-7254
Original Issuance Date:	11/13/2024
License Status:	REGULAR
Effective Date:	05/13/2025
Expiration Date:	05/12/2027
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
On 07/04/25, Resident A's family member visited him in the AFC home. Resident A's family member asked Resident A if he needed to go to the bathroom. An unknown staff member said, "If you want him to go to the bathroom, he's your problem now. You get him up."	No
There is concern that AFC staff have been neglecting to give Resident A his medication as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/14/2025	Special Investigation Intake 2025A0612024
07/15/2025	APS Referral Referral received from Adult Protective Services (APS).
07/15/2025	Special Investigation Initiated – Letter Email sent to assigned APS worker Estelita Horton regarding allegations.
07/17/2025	Contact - Telephone call made Telephone call to Resident A's family member and licensee designee Debbie Cromwell. There was no answer. I left a voicemail requesting a return call.
07/22/2025	Inspection Completed On-site I completed an unannounced onsite investigation. I interviewed direct care staff 1, direct care staff 2, Resident A, Resident B, Resident C, and Resident D.
07/28/2025	Contact - Telephone call made Telephone call to Resident A's family member and licensee designee Debbie Cromwell. There was no answer. I left a voicemail requesting a return call.

07/28/2025	Contact - Telephone call received Telephone interview with licensee designee Debbie Cromwell.
07/31/2025	Contact - Telephone call made Telephone call to Resident A's family member. There was no answer. I left a voicemail requesting a return call.
07/31/2025	Contact - Telephone call received I received two missed calls from Resident A's family member after business hours (7:41 pm and 7:51 pm). There was no voicemail.
07/31/2025	Contact – Documentation received Interview with Resident A's family member received via email from APS worker Estelita Horton.
08/01/2025	Contact - Telephone call made Telephone call to Resident A's family member. There was no answer. I left a voicemail requesting a return call.
08/01/2025	Exit Conference I placed a telephone call to licensee designee Debbie Cromwell to conduct an exit conference.
08/04/2025	Contact - Telephone call received Telephone interview completed with Resident A's family member.

ALLEGATION:

On 07/04/25, Resident A's family member visited him in the AFC home. Resident A's family member asked Resident A if he needed to go to the bathroom. An unknown staff member said, "If you want him to go to the bathroom, he's your problem now. You get him up."

INVESTIGATION:

On 07/14/25, I received a referral from Adult Protective Services (APS). In summary, the referral indicated Resident A has cognitive impairment with dementia. Resident A is medically fragile with hypothyroidism. On 07/04/25, Resident A's family member visited him in the AFC home. Resident A's family member asked Resident A if he needed to go to the bathroom. An unknown staff member said if you want him to go to the bathroom, he's your problem now. You get him up. On 07/10/25, Resident A was rushed to the Huron Valley Hospital, because he could not move. There is concern AFC staff have been neglecting to give Resident A his medication as prescribed.

On 07/15/25, I initiated my investigation with an email to the assigned APS worker Estelita Horton regarding the allegation. Ms. Horton stated she completed an onsite investigation on 07/11/25. Resident A stated the allegations were not true and stated he is not being neglected, and he does not feel neglected. He stated he did go to the hospital, but he could not remember why. Resident A was asked if staff give him his medication and he said that he did not know. Ms. Horton indicated that Resident A was alert, oriented, neat, clean, and free of any visible marks or bruises. The home was observed to be neat, clean, and free of any clutter. There was an ample amount of food in the home.

On 07/22/25, I completed an unannounced onsite investigation. I interviewed direct care staff 1, direct care staff 2, Resident A, Resident B, Resident C, and Resident D.

NOTE: Interviews with direct care staff are coded per their request to maintain their anonymity.

On 07/22/25, I interviewed direct care staff 1. Direct care staff 1 stated she has no information regarding any staff member making any variation of the alleged comment to Resident A's family member. Direct care staff 1 denied that she made the alleged comment to Resident A's family member.

On 07/22/25, I interviewed direct care staff 2. Direct care staff 2 stated she was previously interviewed by APS worker Estelita Horton. At the time of her interview with Ms. Horton she did not know who made the alleged statement to Resident A's family member. However, after she spoke to Ms. Horton she talked to licensee designee Debra Cromwell regarding the allegations. Direct care staff 2 stated Ms. Cromwell told her that she made the alleged comment to Resident A's family member.

On 07/22/25, I interviewed Resident A. Resident A was observed sitting in a recliner chair in the living room. He was well groomed and dressed appropriately for the weather. Resident A stated he does not recall anyone making this comment to him or his family member. Resident A stated he has no issues or concerns with the care he is receiving.
On 07/22/25, I observed Resident B asleep in a chair in the living room. Resident B did not wake up to be interviewed.

On 07/22/25, I interviewed Resident C. Resident C was sitting in a recliner chair in the living room, she had just taken a shower. Resident C stated she enjoys living in this home. The staff are nice. Resident C reports no issues or concerns.

On 07/22/25, I interviewed Resident D. Resident D was observed lying in bed. Resident D stated she moved into this home not too long ago, the staff are nice. Resident D has no issues or concerns.

On 07/28/25, I interviewed licensee designee Debbie Cromwell via telephone. Ms. Cromwell stated on July 4, 2025, she was on shift when Resident A's family member visited the home. Ms. Cromwell stated Resident A was sitting in the recliner chair in the living room, his family member was standing in front of him holding a baby. Resident A stood up to take himself to the bathroom. Ms. Cromwell asked Resident A's family member if she could watch him while he walked to the bathroom. Ms. Cromwell explained that Resident A uses a walker, however they keep eyes on him while he is walking to ensure his safety. Ms. Cromwell stated Resident A can toilet himself, however she met him at the bathroom and stayed within a close distance, which allowed her to hear if he should require assistance. Ms. Cromwell denied saying any variation of the phrase, "if you want him to go to the bathroom, he's your problem now. You get him up," Ms. Cromwell reiterated that Resident A toilets himself independently and he initiated the trip to the bathroom not his family member.

I made several attempts to interview Resident A's family member. There was no answer. I left voicemails requesting return calls. On 07/31/25, APS worker Estelita Horton emailed me her interview with Resident A's family member. The interview indicated:

> APS received a return call from the client's daughter. APS addressed the allegations with her, and she stated they were not true. She stated she knows who called the complaint in and that they have some mental health issues going on. She stated the reporting source is over dramatic and she does not know why they called and said those things. APS informed her APS could not confirm or deny who called the complaint in and she reiterated she knew who did. She stated her father is perfectly fine and she has no concerns about him being neglected. She stated staff did not say any of those things to her and that her father does receive his medications as prescribed. She stated she lives close by, and she visits her father just about every other day. She stated she saw him yesterday and will be going back to visit with him today. She stated her brother John is his Power of Attorney (POA), and she is sure he does not have any concerns either. APS informed her APS left a message with him. She stated her brother is probably at work but he will contact APS back if APS left a message. She stated her father is safe and well taken care of and stated, "Sorry for wasting your time". She had no questions. APS informed her of case closure.

On 08/04/25, I received a return call from Resident A's family member. She stated that she knows who made this complaint and indicated that they have some mental health issues going on. Resident A's family member denied the allegations and stated she has no concerns regarding the care Resident A receives. Resident A's family member stated she visits Resident A often, he is safe, happy, and well taken care of. She has no issues or concerns.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(11) A licensee, direct care staff, and an administrator shall be willing to cooperate fully with a resident, the resident's family, a designated representative of the resident and the responsible agency.
ANALYSIS:	Based on the information gathered during this investigation there is insufficient information to conclude on 07/04/25, Resident A's family member asked Resident A if he needed to go to the bathroom. An unknown staff member said, "If you want him to go to the bathroom, he's your problem now. You get him up." Resident A and Resident A's family member denied the allegation. Licensee designee Debbie Cromwell who was the accused staff on shift, also denied the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

There is concern that AFC staff have been neglecting to give Resident A his medication as prescribed.

INVESTIGATION:

The referral indicated that there is concern that AFC staff have been neglecting to give Resident A his medication as necessary.

On 07/22/25, I completed an unannounced onsite investigation. I interviewed direct care staff 1, direct care staff 2, Resident A, Resident B, Resident C, and Resident D. While onsite I observed the medication cart. The cart was locked. The content of the cart was organized. I reviewed the physical medications and the medication administration records.

On 07/22/25, I interviewed direct care staff 1. Direct care staff 1 stated Resident A was in U of M Hospital from 07/13/25 – 07/17/25, his family took him to the hospital after he woke up that morning and he was unable to get off the toilet without assistance. The facility notified Resident A's physical therapist (PT), and a home visit was completed. The PT recommended ice and stretching, however, the family chose to take Resident A to the hospital. Direct care staff 1 stated medications are administered as they are prescribed. There have been no medication errors or issues.

On 07/22/25, I interviewed direct care staff 2. Direct care staff 2 stated she does not pass medication therefore she does not have any information regarding this allegation.

On 07/22/25, I interviewed Resident A. Resident A stated he is not neglected, his medications are given as prescribed, he has food, and he feels comfortable living in this home.

On 07/22/25, I observed Resident B asleep in a chair in the living room. Resident B did not wake up to be interviewed.

On 07/22/25, I interviewed Resident C. Resident C stated she enjoys living in this home. The staff are nice, her medication is given to her as prescribed, she reports no issues.

On 07/22/25, I interviewed Resident D. Resident D stated she is receiving her medication as prescribed; she has no issues or concerns.

While onsite, I reviewed Resident A's July 2025 Medication Administration Record (MAR). The following was noted:

- Resident A is prescribed Acetaminophen 500 Mg. The instructions indicate take one tablet by mouth twice daily. The MAR is not signed on the following dates for the 7:00 pm dose: 07/09/25, 07/18/25, and 07/21/25. The pills remain in the blister pack.
- Resident A is prescribed Levothyroxine sodium 175 mcg. The instructions indicate take one tablet by mouth daily. The MAR is not signed on 07/19/25.

While onsite I reviewed Resident A's U of M Hospital discharge paperwork dated 07/13/25 - 07/17/25. Resident A was hospitalized for general weakness.

On 07/28/25, I interviewed licensee designee Debbie Cromwell via telephone. Ms. Cromwell stated Resident A moved into the home on May 19, 2025. In early July 2025, Resident A had back pain. He was sent to the hospital via EMS for treatment. He returned home the same day. The hospital made changes to Resident A's medication. Then on 07/13/25, Resident A was not able to move. It took him 7 minutes to walk from the bathroom to the recliner chair in the living room. Ms. Cromwell stated she contacted Resident A's son and made him aware. Resident A's son came to the home, and he chose to take Resident A to U of M Hospital for treatment. Resident A returned home on 07/17/25. Ms. Cromwell stated Resident A's medications were changed again. Since returning from the hospital Resident A has been doing well. He has not mentioned having pain in his back at all. Ms. Cromwell stated Resident A's medications are being administered as they are prescribed there have been no issues. Ms. Cromwell stated Resident A's Levothyroxine sodium 175 mcg was discontinued by his doctor; he is no

longer taking it. Regarding Resident A's Acetaminophen 500 Mg, Ms. Cromwell stated if the MAR was not signed and the medication remains in the blister pack Resident A likely refused it. Ms. Cromwell stated at times Resident A will refuse the Acetaminophen if he does not feel like he needs it.

On 08/04/25, I interviewed Resident A's family member via telephone. Resident A's family member denied the allegations and stated she has no concerns regarding Resident A's medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Based on the information gathered during this investigation there is sufficient information to conclude that Resident A's July 2025 Medication Administration Record was not appropriately completed. Resident A is prescribed Acetaminophen 500 Mg. The instructions indicate take one tablet by mouth twice daily. Resident A's MAR is not signed on the following dates for the 7:00 pm dose: 07/09/25, 07/18/25, and 07/21/25. The pills remain in the blister pack. Additionally, Resident A is prescribed Levothyroxine sodium 175 mcg. The instructions indicate take one tablet by mouth daily. The MAR is not signed on 07/19/25. Licensee designee Debbie Cromwell stated the medication was discontinued by Resident A's doctor however, the MAR does not reflect this change. The medication was not in Resident A's medication basket.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/22/25, I completed an unannounced onsite investigation. While reviewing the medication cart I observed three clear medication cups, each cup contained pills. The cups were sitting on sticky notes that were labeled "(Resident's name) meds nighttime." There was a cup for Resident A, Resident C and Resident D. Although the medication was locked in the medication cart they were removed from the pharmacy containers. Direct care staff 1 stated that the medications were pre-prepped so that the staff who is working on the night shift can administer the medication.

On 07/28/25, I interviewed licensee designee Debbie Cromwell via telephone. Ms. Cromwell stated after speaking to the staff it is her understanding that the medications were preset up because direct care staff 3, who was working the night shift on 07/22/25, was running late. Ms. Cromwell stated she was out of town when this occurred.

On 08/01/25, I placed a telephone call to licensee designee Debbie Cromwell to conduct an exit conference and review my findings. Ms. Cromwell was notified that a corrective action plan is required, she acknowledged and agreed.

APPLICABLE RULE	
R 400.14312	**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 the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on my observation while conducting an unscheduled onsite inspection on 07/22/25, there is sufficient information to conclude that all medications were not kept in the original pharmacy-supplied container. Resident A, Resident C and Resident D's nighttime medications were pre-prepped and put into clear unlabeled medication cups.
CONCLUSION:	**VIOLATION ESTABLISHED**

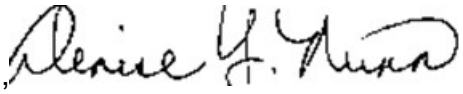
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change to the status of the license.

08/04/2025

Johnna Cade — Date
Licensing Consultant

Approved By:



08/13/2025

Denise Y. Nunn — Date
Area Manager