



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 9, 2025

Deborah Waldo
Elder Empowerment Services Unlimited, LLC
38603 Eight Mile
Livonia, MI 48152

RE: License #: AS820408141
Investigation #: 2026A0901002
Lauren's Greenhouse Living

Dear Deborah Waldo:

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) 456-0439.

Sincerely,

A handwritten signature in black ink that reads "Regina Buchanan". The signature is written in a cursive, flowing style.

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820408141
Investigation #:	2026A0901002
Complaint Receipt Date:	10/15/2025
Investigation Initiation Date:	10/17/2025
Report Due Date:	12/14/2025
LicenseeName:	Elder Empowerment Services Unlimited, LLC
Licensee Address:	38603 Eight Mile Livonia, MI 48152
Licensee Telephone #:	(313) 477-8728
Administrator:	Deborah Waldo
Licensee Designee:	Deborah Waldo
Name of Facility:	Lauren's Greenhouse Living
Facility Address:	20315 Hickory Lane Livonia, MI 48152
Facility Telephone #:	(734) 744-5769
Original Issuance Date:	12/01/2021
License Status:	REGULAR
Effective Date:	06/01/2024
Expiration Date:	05/31/2026
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED ALZHEIMERS
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I. ALLEGATION(S)

	Violation Established?
Staff do not have proper training.	No
Resident A is left in urine-soaked diapers.	No
Resident B slept in a chair.	No
Staff, Anderson Colburn, makes medication errors.	Yes
Staff, Sarah Brown and Anderson Colburn, told Resident A he was going to hell because of his religion.	No

II. METHODOLOGY

10/15/2025	Special Investigation Intake 2026A0901002
10/17/2025	Special Investigation Initiated - On Site
10/23/2025	Contact - Telephone call made Licensee designee, Deborah Waldo
10/25/2025	Adult Protective Services Referral
10/27/2025	Inspection Completed On-site
10/29/2025	Contact - Telephone call made Guardian A1
10/29/2025	Contact - Telephone call made Staff, Anderson Colburn
10/29/2025	Contact - Telephone call made Staff, Imaan Khan
10/31/2025	Contact - Telephone call made

	Guardian B1
10/31/2025	Contact - Telephone call made Staff, Yolanda Lee
10/31/2025	Contact - Telephone call made Guardian C1
11/03/2025	Contact - Telephone call made Son B1
11/07/2025	Contact - Telephone call made Staff, Anderson Colburn
11/13/2025	Contact - Telephone call made Staff, Destiny Lemon
11/14/2025	Contact - Telephone call made Licensee designee, Deborah Waldo
11/15/2025	Contact - Telephone call made Staff, Imaan Khan
11/16/2025	Contact - Document Received Email, hospice notes
12/03/2025	Exit Conference Licensee designee, Deborah Waldo

ALLEGATION:

Staff do not have proper training.

INVESTIGATION:

On 10/17/2025, I conducted an onsite inspection at the facility. The licensee designee, Deborah Waldo, was present. She stated all staff were trained and agreed to send me verification of their training.

On 10/23/2025, I made a telephone call to Deborah regarding the documents I did not receive because the attachments did not come through each time she attempted to email them. I made arrangements to pick up the documents.

On 10/27/2025, I conducted another onsite inspection at the facility to pick up the above information. The documents consisted of each staff person's training log, which included all required trainings.

APPLICABLE RULE	
R 400.629	Direct care staff; qualifications and training.
	<p>(5) 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 trained and competent in all of the following areas before performing assigned tasks independently:</p> <ul style="list-style-type: none"> (a) Reporting requirements. (b) First aid. (c) Cardiopulmonary resuscitation, which includes a hands-on demonstration as part of the training. (d) Personal care, supervision, and protection. (e) Resident rights. (f) Safety and fire prevention. (g) Prevention and containment of communicable diseases including recognizing signs of illness. (h) Food safety, which includes food storage, preparation, distribution, and serving in a safe manner. (i) Nutrition and special diets.
ANALYSIS:	Based on the information obtained during this investigation, there is lack of evidence to confirm the allegations. Documentation was observed that verified staff's completion of the required training. Staff were in-serviced by the licensee designee, Deborah Waldo.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A is left in urine-soaked diapers.

INVESTIGATION:

On 10/17/2025, I conducted an onsite inspection at the facility. Sarah Brown, the home manager, was present. She stated she normally works midnight and has never had an issue with the residents being left in urine-soaked diapers by the

previous staff. She also stated none of the family members have complained about this either. Sarah informed me that some staff were recently fired and since then, complaints have been made about the facility. The licensee designee, Deborah Waldo, arrived during this onsite inspection. She also denied the allegations. She stated no one complained to her about any of the residents being left in urine-soaked diapers. Deborah said she also works at the facility and never observed this and that when on duty, she changes them through the night.

During this onsite inspection, Resident A was in the hospital and only Residents B and C were at the facility. They both have dementia and were receiving hospice care and could not be interviewed. They were observed to be clean and neatly groomed. Neither smelled of urine nor their bedrooms and the facility did not have an odor.

On 10/29/2025, I made a telephone call to Resident A's guardian, Guardian A1. She stated she had absolutely no concerns with the care Resident A was provided. She reported that staff was diligent in keeping him clean and changing his diaper. Guardian A1 also said she communicated with other families and never heard anyone complain about poor care. She said due to his health getting worse, he would not be returning to the facility.

On 10/29/2027, I made a telephone call to staff, Anderson Colburn, but there was no answer. I left a voice message, but the call was not returned. I made another call on 11/07/2025 and interviewed Anderson. He denied the allegations. He stated the residents were always well cared for and he never had an issue with changing Resident A or the other residents. He reported Resident A urinated more frequently, so he needed to be changed more than the others. Anderson stated sometimes Resident A would refuse staff assistance, but they would keep trying until he cooperated.

On 10/29/2025, I made a telephone call to staff, Imaan Khan, and left a message with the person who answered to ask her to call me. The call was not returned so I called again on 11/15/2025 and interviewed Imaan. She stated she has not worked at the facility since 10/30/2025 but during the time she was there, she never observed any of the residents being left in urine-soaked diapers. She stated staff were pretty good at keeping them changed.

On 10/31/2025, I made a telephone call to Resident C's guardian, Guardian C1. She said she had no concerns with the care staff provided. Guardian C1 stated she visited frequently, and Resident C was always clean and appeared well cared for. She stated sometimes staff could not change Resident C immediately due to doing

other things, but they always attended to her and never left her unchanged for long periods of time.

On 10/31/2025, I made a telephone call to staff, Yolanda Lee. She stated she never observed any of the residents being left in urine-soaked diapers and when she comes on shift, they have been changed by the previous shift.

On 10/31/2025, I made a telephone call to Resident B's guardian, Guardian B1. She stated Resident B was currently deceased. She had no knowledge of Resident B's diapers not being changed.

On 11/03/2025, I made a telephone call to Resident B's son, Son B1. He spoke highly of the facility and stated the care staff provided to Resident B was awesome. He reported he was there often, and the facility was always clean and Resident B was always clean.

On 11/13/2025, I made a telephone call to staff, Destiny Lemon. She denied any of the residents being left in urine-soaked diapers. She stated she only recalled once coming on shift and the previous staff had forgotten to change someone.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on the information I obtained during this investigation, there is a lack of evidence to confirm the allegations. There is no indication that Resident A was not provided with the personal care he required. Guardian A1 denied the allegations and had no concerns with the care staff provided. In addition to this, staff denied the allegations and the other guardians did not report any concerns.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident B slept in a chair.

INVESTIGATION:

On 10/31/2025, I made a telephone call to Resident B's guardian, Guardian B1. She expressed concern that during Resident B's final days before she died, she slept in a reclining chair while she was transitioning.

On 11/03/2025, I made a telephone call to Resident B's son, Son B1. He stated during Resident B's final days at the facility she remained in a reclining chair. He said to his understanding, the purpose was for her comfort.

On 11/14/2025, I made a telephone call to the licensee designee, Deborah Waldo. She confirmed Resident B slept in a chair while she was transitioning. She stated it fully reclined for sleeping and it was approved by Heart to Heart Hospice that she could remain in it. Deborah said she would send me documentation from Heart to Heart.

On 11/16/2025, I received an email from Deborah. It was visitation notes from Heart to Heart Hospice. During the 10/14/2025 visit the nurse noted that Resident B was declining and should be kept in the chair or the bed.

APPLICABLE RULE	
R 400.661	Bedroom furnishings.
	(2) The bed and mattress in subrule (1) of this rule can be removed from the bedroom if the resident or resident representative requests that it be removed, the resident's health care professional approves an alternative sleeping arrangement, and it is documented in the assessment plan.
ANALYSIS:	Based on the information obtained during this investigation, there is a lack of evidence to confirm the allegations. Although a bed was not used for resting, Resident B's health care professional, Heart to Heart Hospice, gave approval for her to remain in the chair due to her declining health.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff, Anderson Colburn, makes medication errors.

INVESTIGATION:

On 10/17/2025, I conducted an onsite inspection at the facility. The home manager, Sarah Brown, was present. She stated she was not aware of any medication errors. During this inspection, the licensee designee, Deborah Waldo, arrived. She also stated she was not aware of any medication errors and that she is normally there when staff, Anderson Colburn, works and assists him. I reviewed the residents' medication log sheets and noticed several blank spaces, in which staff did not initial to verify that the medications were administered and there was no documentation explaining the blank spaces. I showed the log sheets to Deborah and she planned to re-train her staff.

On 10/31/2025, I made a telephone call to staff, Yolanda Lee. She stated she was not aware of any medication errors.

On 11/07/2025, I made a telephone call to Anderson. He denied making medication errors.

On 11/13/2025, I made a telephone call to staff, Destiny Lemon. She said she was not aware of any medication errors, but that staff sometimes forgot to sign the medication log after administering.

On 11/15/2025, I made a telephone call to staff, Imaan Khan. She stated she was not aware of any medication errors, besides staff sometimes forgetting to initial the medication logs.

APPLICABLE RULE	
R 400.675	Resident medications.
	<p>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:</p> <ul style="list-style-type: none"> (a) Be trained in the proper handling and administration of medication. (b) Complete an individual medication log that contains all of the following: <ul style="list-style-type: none"> (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:	Based on the information obtained during this investigation, the residents' medication log sheets were not filled out properly with all the above required information. I observed several blank spaces in which staff did not initial the logs to verify that the medications were administered. This issue was also reported by staff, Destiny and Imaan.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Staff, Sarah Brown and Anderson Colburn, told Resident A he was going to hell because of his religion.

INVESTIGATION:

On 10/17/2025, I conducted an onsite inspection at the facility. The home manager, Sarah Brown, was present. She denied the allegations and stated she would never disrespect the residents. During this inspection, the licensee designee, Deborah Waldo, arrived. She denied any knowledge of staff disrespecting Resident A and

talking ill of his religion. She stated no one expressed concern to her and Deborah and also said it was out of character for her staff to do that.

On 10/29/2025, I made a telephone call to Guardian A1. She stated she had no concerns of mistreatment and that Resident A never complained to her about staff talking to him inappropriately.

On 11/07/2025 I made a telephone call to staff, Anderson Colburn. He denied the allegations and stated he never witnessed his coworkers being disrespectful or talking inappropriately to Resident A either.

On 11/15/2025, I made a telephone call to Imaan. She stated one day while on shift, she heard Anderson and Sarah talking about Resident B's religion. They stated since his religion was different from theirs, he was going to hell. She said they were not talking directly to Resident B but were close enough distance to him that it was likely he heard them.

On 12/03/2025, I made a telephone call to Deborah and conducted an exit conference. I informed her of my investigative findings, which she understood and agreed to send a corrective action plan.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on the information obtained during this investigation, there is lack of evidence to corroborate the allegations. Although Imaan reported hearing Sarah and Anderson say Resident A was going to hell because of his religion, they denied the allegations and there were no other witnesses.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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



Regina Buchanan
Licensing Consultant

12/08/2025
Date

Approved By:



Ardra Hunter
Area Manager

12/09/2025
Date