



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 29, 2026

Angela Joquico
Resilire Neurorehabilitation, LLC
7200 Challis Rd.
Brighton, MI 48116

RE: License #: AS630407488
Investigation #: 2026A0991006
Royal Oak

Dear Ms. Joquico:

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,

A handwritten signature in cursive script that reads "Kristen Donnay". The signature is written in a dark ink and is positioned below the word "Sincerely,".

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630407488
Investigation #:	2026A0991006
Complaint Receipt Date:	12/05/2025
Investigation Initiation Date:	12/08/2025
Report Due Date:	02/03/2026
Licensee Name:	Resilire Neurorehabilitation, LLC
Licensee Address:	7200 Challis Rd. Brighton, MI 48116
Licensee Telephone #:	(810) 227-0119
Administrator:	Angela Joquico
Licensee Designee:	Angela Joquico
Name of Facility:	Royal Oak
Facility Address:	2017 Rochester Rd. Royal Oak, MI 48073
Facility Telephone #:	(248) 546-4810
Original Issuance Date:	06/01/2021
License Status:	REGULAR
Effective Date:	12/01/2025
Expiration Date:	11/30/2027
Capacity:	6
Program Type:	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Direct care worker, Viola Lowe, pushed Resident A onto the bed during a confrontation on 12/02/25 and said, "Don't point your fingers in my face. If you want to point them, then point them down."	Yes

III. METHODOLOGY

12/05/2025	Special Investigation Intake 2026A0991006
12/08/2025	Special Investigation Initiated - Telephone Call to licensee designee, Angie Joquico
12/08/2025	APS Referral Referred to Adult Protective Services (APS) Centralized Intake
12/09/2025	Inspection Completed On-site Unannounced onsite inspection. Interviewed staff and Resident A.
12/22/2025	Contact - Telephone call made Left message for staff, Viola Lowe
01/23/2026	Contact - Telephone call made Left message for staff, Viola Lowe
01/26/2026	Contact - Telephone call made Interviewed staff, Viola Lowe
01/26/2026	Contact - Telephone call made Left message for licensee designee, Angie Joquico, re: exit conference
01/27/2026	Exit Conference Via telephone with licensee designee, Angie Joquico

ALLEGATION:

Direct care worker, Viola Lowe, pushed Resident A onto the bed during a confrontation on 12/02/25 and said, “Don’t point your fingers in my face. If you want to point them, then point them down.”

INVESTIGATION:

On 12/05/25, I received a complaint which stated on 12/02/25, direct care worker, Viola Lowe, contacted the home manager, Ashley Thornton, to let her know that Resident A shoved her and was yelling at her and pointing in her face. The manager contacted the licensee designee, Angie Joquico, regarding the reported incident. They agreed to have Viola Lowe switch assignments with the other staff on shift, Diane Rutledge. The following day, Resident A reported to staff, Sonya Pickett and Tamika Stanley, that yesterday while in her bedroom with her assigned 1:1 staff, Viola Lowe, Viola pushed her onto the bed and said, “Don’t point your fingers in my face. If you want to point them, then point them down.” Viola was removed from the schedule pending an investigation. The complaint was referred to Adult Protective Services (APS), but it was not assigned for investigation.

I initiated my investigation on 12/08/25 by contacting the licensee designee, Angie Joquico. Ms. Joquico stated that she conducted an internal investigation regarding the incident, but she could not substantiate anything. On 12/02/25, Resident A did not want to put her shoes on before going outside to smoke. There was some back and forth between Resident A and Viola Lowe, who was assigned to be Resident A’s 1:1 staff. Ms. Lowe initially called the home manager that day and stated that Resident A hit her. There were two other staff on shift, Shahandat Salim and Diane Rutledge, who did not directly observe the incident. The following day, Resident A reported to Sonya Pickett and Tamika Stanley that Ms. Lowe pushed her on the bed. Ms. Joquico stated that Resident A could not recall a lot about the incident when she spoke to her. Her story did not make a lot of sense, as she gets things mixed up. She stated that staff, Viola Lowe, was transferred to another home.

On 12/09/25, I conducted an unannounced onsite inspection at the Royal Oak home. I interviewed direct care worker, Sonya Pickett. Ms. Pickett stated that she has worked in the home for two years. Ms. Pickett stated that she was with Resident A last week when Resident A told her that the “new lady” pushed her onto her bed and told her not to move. She told Ms. Pickett that this happened before the staff was going to go call the manager, Ashley. Ms. Pickett stated that the staff, Viola Lowe, told the manager that Resident A hit her and put her hands on her. Ms. Pickett stated that Resident A is “spicy” and will talk back, but she has never seen her shove or hit anyone. She stated that Resident A does not typically lie, and she did not believe that she would make

something up. Ms. Pickett stated that she never saw Viola Lowe being aggressive towards clients and she was not rude when she was talking, but she “did not care for her energy.” Ms. Pickett stated that she did not observe any marks or bruises on Resident A.

On 12/09/25, I interviewed direct care worker, Tamika Stanley. Ms. Stanley stated that she has worked in the home for nine months. She was not working on the day the alleged incident occurred. The following day, they were at the day treatment center. Sonya Pickett was assigned as Resident A’s 1:1 staff. She stated that they were talking and Sonya asked her if she heard what happened. Resident A then told Ms. Stanley that the lady who was working with her yesterday pushed her. She stated that Viola told her to stop pointing her fingers in her face and told her to point them down instead. Resident A told Ms. Stanley and Ms. Pickett that she did not know what she meant. She stated that Viola made her feel “like a little boy.” Resident A said this happened when Viola was trying to get her to put her shoes on. She stated that she was in her bedroom and Viola pushed her onto her bed. She told Ms. Stanley that she did not want to be with Viola anymore. Ms. Stanley stated that she did not observe any marks or bruises on Resident A. Ms. Stanley stated that Resident A is not aggressive and is never physically aggressive towards staff. She stated that she has a mouth on her and will point her fingers, but not in an aggressive manner. She stated that Resident A does not have a history of lying or making up stories. Ms. Stanley stated that Viola had only worked in the home for a few weeks, so she did not have many interactions with her. She stated that she never observed her being physically or verbally aggressive. None of the other residents reported any concerns about her. She stated that on one occasion, Viola left Resident A sitting in the waiting area at the center while she was talking on the phone in the vestibule. Ms. Stanley stated that she told Viola that she cannot leave her unattended.

On 12/09/25, I interviewed direct care worker, Shahadat Salim. He stated that he has worked in the home for four years. He stated that he was working on 12/02/25 with Viola Lowe and Diane Rutledge. He stated that he was in the kitchen area when Viola came out and said that they needed to come help with Resident A, because she was being rude. He stated that they went to Resident A’s bedroom and there was a lot of back and forth between Viola and Resident A. Viola was stating that Resident A pushed her onto Resident A’s walker, and Resident A was saying, “No, I didn’t.” He stated that they continued to go back and forth arguing for a while. He was trying to calm Resident A down, because she will have seizures if she is agitated. He stated that during the back and forth, he never heard Resident A say that Viola pushed her. He stated that Viola eventually left the area and Diane took Resident A outside to smoke. Viola or Diane called the manager, Ashley, to tell her what happened. Ashley told Diane to take over as Resident A’s 1:1 staff for the remainder of the shift. Viola completed an incident

report. Mr. Salim stated that Viola was a new staff person and had been working in the home for about a week at the time of this incident. He stated that he never saw her being verbally or physically aggressive towards anyone. She interacted nicely with the residents. He stated that during the incident Viola did not yell or swear, but she had a hard tone when she was speaking to Resident A. He stated that there was just a lot of back and forth between Viola and Resident A with Viola stating, "You did do it," and Resident A stating, "I didn't do it." Mr. Salim stated that he and Diane comforted Resident A and got her to calm down. He stated that Resident A does not have a history of aggression and has never hit or pushed staff.

On 12/09/25, I interviewed the residential program manager, Ashley Thornton. Ms. Thornton stated that she received a phone call from Viola Lowe on 12/02/25. Viola Lowe reported that she was trying to take Resident A outside to smoke. She told Resident A to put her shoes on, but she did not want to wear shoes. Resident A got up, walked towards her walker, and pushed Viola. Ms. Thornton stated that she instructed the other staff on shift, Diane Rutledge, to be Resident A's 1:1 staff for the remainder of the shift. She instructed Viola to write an incident report. She stated that Resident A was upset, so they called the nurse and gave her a PRN medication for agitation. Resident A has seizures and will have a seizure if she is stressed. Ms. Thornton stated that she spoke to Resident A briefly that night. Resident A was upset with how Viola spoke to her, and was saying, "No one should do that. No one should talk to me that way." She stated that Resident A did not say anything about being pushed or shoved. It was staff who stated that Resident A pushed her.

Ms. Thornton stated that the following day they received a call from staff, Tamika Stanley, who reported that while at day treatment center Resident A told staff that Viola pushed her down on the bed yesterday. She told staff that she did not like the way Viola was talking to her and that Viola made her feel like a little boy or a little kid. Ms. Thornton stated that she spoke to Resident A with the licensee, Angie Joquico, and Resident A told them that Viola shoved her on the bed. She used her hand to motion towards her shoulder to show how she pushed her. Ms. Thornton stated that Resident A did not tell Diane or Shahadat that she was pushed on the night of the incident. She stated that Diane is one of Resident A's favorite people, so she would typically tell Diane if something happened. Ms. Thornton stated that Resident A does not have a history of being aggressive. She stated that she has a brain injury and can be verbally aggressive at times. She will point her fingers in your face. Ms. Thornton stated that none of the other residents or staff reported any concerns about Viola Lowe. Viola was new to the home and had only worked a few shifts there. She was moved to another home as a precaution.

On 12/09/25, I interviewed Resident A. Resident A stated that she got into it with one of the new staff who had just started working in the home. She could not recall the staff

person's name. She stated that she was going to go do something with her, which might have been going outside. The staff started making a big issue about something and was arguing with her. Resident A stated that the staff said that Resident A hit her. Resident A stated that she did not hit her. She has never hit anybody. She stated that the staff person pushed on her shoulder to make her sit on the bed. It was not hard, but it was "just shocking." She stated that the staff person kept on yelling and arguing with her. She could not remember exactly what she was saying, but she was talking loud and raising her voice. She stated that she could not remember if the staff person swore at her. Resident A stated that she would not stop hollering, so she told her to get out of her room. She had to tell her a couple of times, because she would not leave. Resident A stated that staff was saying that she pushed her, but she never pushed staff. Resident A stated that Diane and Shah were there when the staff person was arguing with her.

I reviewed the incident tracking notes completed by Viola Lowe, which note that she was instructed not to let Resident A wear her house shoes outside for safety reasons. Resident A stated that she was allowed to wear house shoes outside by Ashley. Ms. Lowe told Resident A that she was told by Ashley to not allow her to do so. Resident A stood up and started to approach her walker. Ms. Lowe went to grab her safety belt and Resident A shoved her and started to yell at her, stating, "Who do you think you are? You are not my mom." Ms. Lowe noted that she redirected the conversation and remained calm until Resident A sat down. She went to inform the other staff what happened. Another note completed by Viola Lowe indicates that Resident A stated that Ms. Lowe was new and doesn't know what she is talking about. She stated that Ms. Lowe was lying on her. She told Ms. Lowe, Diane, and Shahadat that she was not told that she could not go outside in her house shoes and that this is what she has always done. Another note in the chart indicates that Resident A was very upset and emotional over what happened. She stated that she asked staff to leave her room and staff would not go, which made her very upset and emotional.

A summary of the incident in Resident A's chart indicates that Resident A was in her room and asked the staff to take her outside for a smoke. The staff instructed Resident A to put on her shoes, as slippers were not appropriate for the wet and potentially slippery conditions outside. The staff reported that Resident A became upset and shoved them. The notes indicate that it is important for staff to avoid engaging in back-and-forth exchanges with clients. Resident A can become easily angered. In such situations, staff should remove themselves and seek assistance from another team member, rather than turning it into a power struggle. The notes indicate that the primary responsibility is to care for the clients, not to be right. Staff will receive training on how to de-escalate situations when a client exhibits challenging behaviors.

On 01/26/26, I interviewed direct care worker, Viola Lowe. Ms. Lowe stated that she had been working at the Royal Oak home for about two weeks at the time of the incident but

worked for the company since May 2025. She stated that Resident A did not want to put her shoes on before going outside to smoke. She told Resident A that she was informed by the supervisor that she needed to put her shoes on and could not go outside in her house shoes. She stated that Resident A was standing on the side of her and Resident A shoved her. She stated that she got Resident A to sit back down on the bed, and went to report the behavior issue to the other employees on shift. She stated that she did not push Resident A onto the bed. She spoke with her and told her to sit down. She did not make any physical contact with Resident A. She stated that it did not hurt her when Resident A shoved her, and she was not in harm's way, but she was instructed to report behavior issues. She stated that the other two employees came to the back, and she was telling them what happened. Resident A stated that she did not push her, and Ms. Lowe stated that she shoved her. Ms. Lowe stated that she told Resident A, "Yes, you did," two times. Ms. Lowe stated that they called the manager to report the incident, and she was removed from being Resident A's 1:1 staff for the rest of the shift. Following the incident, they were going to move her to another home, but she declines the offer and no longer works for the company. Ms. Lowe stated that the problem escalated when she reported Resident A's behavior. If she could do it over again, she would have calmed down Resident A on her own, as Resident A became more agitated after she reported it. Ms. Lowe stated that she did tell Resident A not to point her fingers at her, as Resident A was pushing her finger towards her. She stated that she was verbally redirecting Resident A and telling her that it is not cool to do that. Ms. Lowe stated that she did not feel she was adequately trained on how to handle resident behaviors. She stated that she was mostly trained on the daily routines at the home.

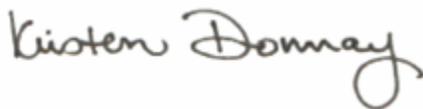
On 01/26/26, I contacted the licensee designee, Angie Joquico to conduct an exit conference. Ms. Joquico was not available, so I left a message and requested a return phone call. On 01/27/26, I received a return call from the licensee designee, Angie Joquico. I reviewed the findings with her and she agreed to submit a corrective action plan. Ms. Joquico confirmed that Viola Lowe is no longer working in the home and that all staff are trained not to engage in power struggles with residents.

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 gathered through my investigation, there is insufficient information to conclude that staff, Viola Lowe, pushed Resident A. Resident A stated that staff pushed her on her shoulder to get her to sit on the bed. She reported this to staff the day after an incident, in which Viola Lowe was

	<p>accusing Resident A of pushing her. The other staff on shift did not see Ms. Lowe push Resident A. Resident A did not tell the staff on shift at the time of the incident that Viola Lowe pushed her, she only indicated that she was upset about the way Ms. Lowe was speaking to her. Resident A did not have any marks or bruises.</p> <p>There is sufficient information to conclude that Ms. Lowe did not treat Resident A with dignity and respect when she engaged in a verbal power struggle with Resident A. She continued to accuse Resident A of shoving her, when Resident A was denying that she did so. Resident A has a seizure disorder, and seizures can be triggered when she is upset and agitated. The staff on shift stated that they observed Ms. Lowe engaging in a verbal back and forth with Resident A in which she was using a harsh tone. Resident A stated that she asked Ms. Lowe to leave her room several times and Ms. Lowe did not leave. Ms. Lowe made Resident A feel like a child when going back and forth with her. Staff at the home are trained to not engage in power struggles with residents, but to walk away and seek assistance from another team member.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

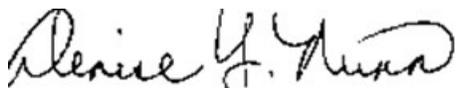


01/27/26

Kristen Donnay
Licensing Consultant

Date

Approved By:



01/29/2026

Denise Y. Nunn
Area Manager

Date