



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 19, 2026

Josephine Uwazurike  
Allied Continuing Care Inc  
23999 Northwestern Hwy, Suite 200  
Southfield, MI 48075

RE: License #: AS820269544  
Investigation #: 2026A0119016  
Rose Manor

Dear Josephine Uwazurike:

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,

A handwritten signature in cursive script that reads "Shatonla Daniel".

Shatonla Daniel, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Pl. Ste 9-100  
3026 W. Grand Blvd  
Detroit, MI 48202  
(313) 919-3003

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS820269544
<b>Investigation #:</b>	2026A0119016
<b>Complaint Receipt Date:</b>	01/16/2026
<b>Investigation Initiation Date:</b>	01/22/2026
<b>Report Due Date:</b>	03/17/2026
<b>Licensee Name:</b>	Allied Continuing Care Inc
<b>Licensee Address:</b>	23999 Northwestern Hwy Suite 200 Southfield, MI 48075
<b>Licensee Telephone #:</b>	(248) 569-1040
<b>Administrator:</b>	Josephine Uwazurike
<b>Licensee Designee:</b>	Josephine Uwazurike
<b>Name of Facility:</b>	Rose Manor
<b>Facility Address:</b>	16216 Middlebelt Romulus, MI 48184
<b>Facility Telephone #:</b>	(734) 941-4801
<b>Original Issuance Date:</b>	10/28/2004
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/06/2025
<b>Expiration Date:</b>	09/05/2027
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL



**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A missed a required behavioral medication injection.	Yes

**III. METHODOLOGY**

01/16/2026	Special Investigation Intake 2026A0119016
01/16/2026	APS Referral Received
01/22/2026	Special Investigation Initiated - On Site Staff- Martin Ojomiue and observed Resident A
01/22/2026	Contact - Telephone call made Home Manager- Lanetria Gibson
01/25/2026	Contact - Document Received Resident A's Individual Plan of Services (IPOS) Easter Seals/ MORC
03/18/2026	Referral Recipient Rights Made
03/18/2026	Exit Conference Licensee Designee- Josephine Uwazurike
03/19/2026	Contact- Telephone call made Resident A's case manager- Latasha Burleigh with Easter Seals

**ALLEGATION:**

**Resident A missed a required behavioral medication injection.**

**INVESTIGATION:**

On 01/22/2026, I completed an unannounced on-site inspection and interviewed Staff- Martin Ojomiue regarding the above allegations. It should be noted that I observed Resident A and he could not be interviewed due to his disability. Martin

stated Resident A went to receive his medication injection on 01/21/2026 at Easter Seals/ Macomb Oakland Reginal Center (MORC). Martin stated Resident A goes regularly to get his injection monthly.

I reviewed Resident A's medication administrator record for January 2026 and there was no indication of the date Resident A receives his medication injection.

On 01/22/2026, I telephoned and interviewed home manager- Lanetria Gibson regarding the above allegations. Lanetria stated Resident A did miss his January 6, 2026 appointment. Lanetria stated she notified Resident A's case manager- Latasha Burleigh with Easter Seals/ MORC once she discovered Resident A had missed his appointment. Lanetria stated the Staff- Darlington Aguwa did not write the January 2026 appointment on the calendar. Lanetria stated Darlington took Resident A to his December 2025 appointment. Lanetria stated Darlington no longer works at the facility.

On 01/25/2026, I received Resident A's individual plan of service, dated 11/01/2025 from Easter Seals/ MORC. It indicates Resident A requires full assistance from staff to administer medication as he is not aware of what pills to take, how many to take and when to take them. It further states staff will ensure that all of Resident A's medical needs are being met and schedule all medical appointments as needed, including follow-ups as determined by his physicians. The plan indicates Resident A needs full assistance from staff to follow his medication treatment plan.

On 03/18/2026, I complete an exit conference with licensee designee- Josephine Uwazurike regarding the above allegations. Josephine stated she was surprised that Darlington did not the appointment put on the facility calendar as directed. Josephine stated Resident A did missed his medical injection appointment. Josephine stated Resident A did receive his medical injection a few days later from Easter Seals.

On 03/19/2026, I telephoned and interviewed Resident A's case manager- Latasha Burleigh with Easter Seals regarding the above allegations. Latasha stated she was notified by Easter Seals clinic that Resident A missed his medical injection appointment. Latasha stated she informed Lanetria about Resident A's missed medical injection appointment. Latasha stated Lanetria was not aware of the missed medical injection appointment and she instructed Lanetria to schedule Resident A another medical injection appointment. Latasha stated Resident A has not missed any prior medical injection appointments.

<b>APPLICABLE RULE</b>	
<b>R 400.671</b>	<b>Resident care.</b>
	(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.
<b>ANALYSIS:</b>	<p>Licensee designee- Josephine Uwazurike, home manager- Lanetria Gibson, and case manager- Latasha Burleigh stated Resident A missed his medical injection appointment.</p> <p>Resident A's IPOS indicates that staff will ensure that all of Resident A's medical needs are met and schedule all medical appointments as needed, including follow-ups as determined by his physicians. The plan indicates Resident A needs full assistance from staff to follow his medication treatment plan.</p> <p>Latasha stated she notified Lanetria that Resident A's missed medical appointment. Latasha stated Lanetria was not even aware that Resident A missed his medical injection appointment.</p> <p>Therefore, Resident A was not provided with supervision and protection as indicated in his assessment plan.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

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

*Shatonla Daniel*

03/19/2026

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Shatonla Daniel  
Licensing Consultant

\_\_\_\_\_  
Date

Approved By:

*A. Hunter*

03/19/2026

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Ardra Hunter  
Area Manager

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Date