GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 20, 2026

Desiree Santiago
Virtuoso Management, LLC
20298 Beacon Way
Northville, MI 48167

RE: License #: AS820379695
Investigation #: 2026A0992035
Virtuoso Care

Dear Desiree Santiago:

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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820379695
Investigation #:	2026A0992035
Complaint Receipt Date:	05/20/2026
Investigation Initiation Date:	05/22/2026
Report Due Date:	07/19/2026
Licensee Name:	Virtuoso Management, LLC
Licensee Address:	20298 Beacon Way Northville, MI 48167
Licensee Telephone #:	(248) 952-4011
Administrator:	Desiree Santiago
Licensee Designee:	Desiree Santiago
Name of Facility:	Virtuoso Care
Facility Address:	6330 Mcguire Street Taylor, MI 48180
Facility Telephone #:	(248) 952-4011
Original Issuance Date:	08/10/2016
License Status:	REGULAR
Effective Date:	08/10/2025
Expiration Date:	08/09/2027
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
An employee was allegedly sleeping during shifts, yelled at developmentally disabled residents, and dragged two residents down a hallway, though no injuries were observed.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/20/2026	Special Investigation Intake 2026A0992035
05/22/2026	Special Investigation Initiated - On Site Direct care staff; Jeremy McQuiller and Anna Martin, Residents A, B, C, and D.
06/05/2026	Contact - Telephone call made Office of Recipient Rights, Michelle Livous
06/05/2026	Contact - Telephone call made Home Manager, Jeanna Gardner was not available. Message left.
06/05/2026	Contact - Telephone call made Licensee designee, Desiree Santiago
06/05/2026	Contact - Telephone call made Ms. Gardner
06/08/2026	Contact - Telephone call received Assistant Home manager, Deanna Gardner
06/09/2026	Contact - Document Received Resident D's medical discharge summary
06/10/2026	Contact - Document Received Incident reports
06/11/2026	Contact - Document Received Picture of new mattress
06/17/2026	Contact - Telephone call made Adult Protective Services, Alex Fisher

07/16/2026	Exit Conference Ms. Santiago was not available. Message left.
07/16/2026	Contact - Telephone call made Former direct care staff, Roshawndra McGowan was not available. Message left.
07/16/2026	Contact - Telephone call made Relative D1
07/16/2026	Contact - Telephone call received Ms. McGowan
07/16/2026	Exit Conference Ms. Santiago

ALLEGATION: An employee was allegedly sleeping during shifts, yelled at the residents, and dragged two residents down a hallway, though no injuries were observed.

INVESTIGATION: On 05/22/2026, I completed and unannounced onsite inspection and interviewed direct care staff; Jeremy McQuiller and Anna Martin, Residents A, B, C, and D. I interviewed direct care staff, Jeremy McQuiller regarding the allegation. Mr. McQuiller stated he works with Roshawndra “Roshawn” McGowan on Friday and Saturday. He stated he observed Roshawn escort Resident D down the hallway by his shirt. He stated she didn’t drag him, but she did have him by the collar of his shirt. Mr. McQuiller stated he also witnessed her sleeping on shift. He showed me a picture of a female sleeping on a blow-up mattress. He stated Roshawn often slept on during her shift.

I interviewed direct care staff, Anna Martin, regarding the allegation. Ms. Martin stated she’s worked with Roshawn on various shifts. She stated she has never witnessed her dragging or being physically aggressive with any of the residents. She stated Roshawn does yell at the residents a lot. Ms. Martin stated she has witnessed Roshawn sleeping on shift multiple times. Ms. Martin stated Resident D has limited communication skills and may not be able to be interviewed.

I interviewed Resident A regarding the allegation. He stated that he’s treated well but there is one staff member that is always yelling. He identified that staff as Roshawn. He stated Roshawn doesn’t always treat him well and she makes him angry. Resident A was unable to explain how Roshawn makes him angry or what she does to make him feel that way. He denied witnessing Roshawn dragging any of the residents down the hallways or pulling anyone. Resident A denied having any knowledge of any staff sleeping on shift. He stated he feels safe in the home.

Resident A identified Guardian A1, Paul Torony with Faith Connections as his guardian.

I interviewed Resident B regarding the allegation. Resident B stated most of the staff members treat him well. He stated Roshawn often yells and makes him feel bad. He stated he has never witnessed Roshawn drag any of the residents down the hallway or hit anyone. He reiterated that she yells a lot. Resident B stated he feels safe in the home and doesn't have any concerns. Resident B denied he has ever witnessed any of the staff asleep on shift. He stated he does not have a guardian.

I interviewed Resident C regarding the allegation. He stated he gets along well with the staff. However, he stated Roshawn yells a lot at Resident D regarding his hygiene. When asked if he witnessed any of the staff dragging a resident down the hallway, Resident C stated he cannot see, he's blind. He stated Resident D is his roommate and he often hears Roshawn yelling at Resident D. Resident C denied having any knowledge of staff sleeping on shift.

I attempted to interview Resident D. Resident D has limited communication and did not engage in the interview. Resident D was unable to be interviewed. No marks or bruises were observed at this time.

While onsite I observed Resident B's bed mattress was severely bowed, and not in good repair. The mattress was not flushed with the boxspring, each end of the mattress was in midair.

On 06/05/2026, I contacted Office of Recipient Rights (ORR), Michelle Livous, regarding the allegation. Ms. Livous stated she was unable to substantiate as it pertains to physical abuse. She stated she did substantiate for physical neglect for Roshawn sleeping on shift and failure to treat the residents with dignity for being verbally aggressive towards the residents.

On 06/05/2026, I contacted licensee designee, Desiree Santiago regarding the allegation. Ms. Santiago stated she was contacted by ORR on or about 05/19/2026 regarding the allegation. She stated Roshawn was immediately removed from the schedule and an internal investigation was completed. Ms. Santiago stated she discovered Roshawn was sleeping on shift and she was not administering medication properly as required by Virtuoso Management. She stated the investigation also revealed Roshawn was yelling at the residents. She stated staff meetings are held regularly, and no one ever reported her yelling at the residents. Ms. Santiago stated adult protective services (APS) were also involved, but she couldn't remember the APS worker's name. I made Ms. Santiago aware that while onsite I observed Resident B's mattress was severely bowed, and not in good repair. I explained that the mattress was not flushed with the boxspring and needed to be replaced. Ms. Santiago explained that she has replaced Resident B's mattress on multiple occasions. I reiterated that the mattress needs to be replaced.

On 06/05/2026, I contacted home manager, Jeanna Gardner, regarding the allegation. Ms. Gardner stated she is familiar with the allegation. She stated she was on vacation but once she returned, assistant home manager, Deanna Gardner made her aware that during a staff meeting the allegation was brought to her attention. She stated Deanna Gardner informed her that during the meeting, the direct care staff disclosed Roshawn's behaviors including yelling at the residents, being aggressive towards the residents and being condescending towards the staff. Jeanna Gardner stated it seems as though most of the staff were intimidated by Roshawn. Jeanna Gardner suggested I contact assistance manager, Deanna Gardner, for additional information.

On 06/08/2026, I contacted assistant home manager, Deanna Gardner, regarding the allegation. Deanna Gardner stated she has never worked with Roshawn directly. She explained that she is in the process of being trained in management and was overseeing operations. She stated during a staff meeting, it was brought to her attention that a certain staff was being verbally aggressive towards the residents and the staff. Deanna Gardner stated no names were mentioned, she stated it seems as though the staff were fearful and/or intimidated. Deanna Gardner stated she addressed the issue in a staff meeting with the entire staff, so that no one felt targeted. She stated soon thereafter a complaint was received from ORR alleging Roshawn was being verbally aggressive towards the residents, including collaring the residents, hitting Resident D and putting them in time-out. Deanna Gardner stated Roshawn was immediately removed from the schedule. She stated it was also reported that Roshawn hit Resident D with a broom. Deanna Gardner stated she observed Resident D's eye being puffy and red, but it didn't appear that he was hit. She stated she contacted Relative D1 and requested she take him to be examined. She stated once he returned from urgent care, his eye appeared to be puffier and he stated it hurt. Deanna Gardner stated she believes Ms. Martin asked what happened in the presence of Resident D and he responded by saying "broom, Shawn broom." Deanna Gardner stated, "what broom" and Resident D stated "broom," a couple times and then he stated, "Shawn hit." Deanna Gardner stated an internal investigation was conducted and Roshawn was terminated. She stated Resident D was treated at Corewell Health Taylor Hospital.

On 06/09/2026, I received Resident D's medical discharge summary. Resident D was examined on 05/25/2026 at Corewell Health Taylor Hospital. Reason for visit was eye injury. His diagnoses were right eye injury, initial encounter; traumatic iritis and contusion of scalp, initial encounter.

On 06/17/2026, I contacted APS, Alex Fisher regarding the allegation. She confirmed she investigated the allegation and substantiated for physical abuse. She stated it was reported Roshawn hit Resident D with a broom. She stated Resident D was examined and sustained injury. She stated the medical discharge report supported the allegation. Ms Fisher stated she submitted a law enforcement notification (LEN) to Taylor police department.

On 07/16/2026, I contacted Relative D1 regarding the allegation. Relative D1 stated she is not Resident D's guardian and that she has power of attorney for him; she stated she is working on getting guardianship. Regarding the allegation, Relative D1 stated she has some knowledge of Roshawn sleeping on shift but never witnessed it. She stated Roshawn hit Resident D with a broom causing injury to his right eye. She stated she was concerned he was going to lose his vision. Relative D1 stated she received a call from one of the staff (staff name unknown), stating Resident D's eye was red and that it could possibly be pink eye; she stated the staff suggested she take him to urgent care. Relative D1 stated she took him to urgent care, he was treated for pink eye, and he returned to the home. Relative D1 stated on 05/24/2026 she received a call from Jeanna Gardner (she believes), stating Roshawn McGowan broke the broom, hitting Resident D, and she suggested she take him to the hospital to be examined. Relative D1 stated she was in the process of doing something and couldn't get to him until the next day. She stated on 05/25/2026 she took him to the hospital, and his eye was bloodshot red. She stated he was examined and diagnosed with a concussion. She also stated he had an abrasion near his right eye. Relative D1 stated she has been in contact with a Detective from Taylor police department and the warrant has been submitted to the Wayne County prosecutor. She stated she was not contacted by Ms. Santiago regarding this issue and the only contact she had with her was regarding Resident D's prorated cost of care. Relative D1 stated she removed Resident D from the facility, and he is happy at the new location. Relative D1 stated she is not pleased with the way Resident D was treated.

On 07/16/2026, I received a call from former direct care staff, Roshawndra McGowan. I interviewed her regarding the allegation, which she denied. She stated on 05/16/2026, she worked alone with three residents from 6:00 a.m. to 10:00 p.m. She stated her shift went smoothly without any incidents. She stated she cooked dinner, fed the residents and recorded a video with the residents stating how things were going swell. She stated at that time Resident D did not have any marks or bruises. She stated later in the evening; she cleaned the home and while sweeping the broom broke. She stated during this time most of the staff had gone to Jeanna Gardner's wedding, so she didn't want to bother them by sending a text stating the broom was broken. She stated she returned to work on Sunday night from 10:00 p.m. to 2:00 p.m. She stated she worked along with Delorean and due to the strained relationship between them, she went into the room with Residents C and D and went to sleep. She stated she often slept in the room with them because Resident C requires 1:1 staffing. She stated the next morning (5/18/2026), Resident D's eye was a little red; and it looked like pinkeye, but she wasn't sure if he had been rubbing it or not. She stated at that time she did not observe marks or bruises on or near Resident D's eye. She stated her shift ended at 2:00 p.m. and she has not returned since. She stated she was notified that she was suspended and was later terminated. She stated she would often sleep on shift but stated she never hit any of the residents or touch them in any assaultive manner. She stated all the staff slept on shift; she wasn't the only one. She stated it wasn't until she reported the other staff were sleeping on shift that the allegation was brought against her. She

stated most of the employees are family. She went on to say that she was contacted by a detective from Taylor police department regarding this issue

On 07/16/2026, I conducted an exit conference with Ms. Santiago. I made Ms. Santiago aware that throughout the course of the investigation it was also reported that Roshawn hit Resident D with a broom. Ms. Santiago stated she was made aware of that allegation after the fact. She stated by the time that was reported to her Roshawn had already been terminated. I explained to her that based on the findings there is evidence that Roshawn was sleeping on shift and failed to provide the residents with supervision, personal care, and protection. Residents reported being yelled at by Roshawn and feeling sad and angry, they were not treated with dignity and respect. Resident D sustained an injury to his eye and contusion to his scalp and stated he was hit by Roshawn. I explained that as a result of the violations identified in the report, a written corrective action plan is required. Ms. Santiago agreed to submit the corrective action plan upon receipt of the report.

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:	During this investigation, I interviewed licensee designee, Desiree Santiago; home manager, Jeanna Gardner; assistant home manager, Deanna Gardner; direct care staff, Jeremy McQuiller and Anna Martin; former direct care staff, Roshawndra McGowan; APS, Alexa Fisher; ORR, Michelle Livous; Relative D1; and Residents A, B, C regarding the allegation. I attempted to interview Resident D. Resident D has limited communication and did not engage in the interview. Resident D was unable to be interviewed. Direct care staff, Jeremy McQuiller, Anna Martin and Residents A, B, and C confirmed the allegation stating Roshawn would often yell at the residents. Residents A and B reported feeling sad and angry when Roshawn yelled at them. Resident C disclosed hearing Roshawn often yells at Resident D, who has limited communication skills. Direct care staff, Jeremy McQuiller, Anna Martin reported witnessing Roshawn sleeping on shift and not administering medication. Roshawn admitted to sleeping on shift. Based on the findings, there is sufficient evidence to support the allegation Roshawn did not treat the residents with dignity and respect. She slept on shift and failed to provide the residents with supervision, personal care, and protection. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.641	**Resident rights; licensee responsibilities.**
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.

ANALYSIS:	During this investigation, I interviewed licensee designee, Desiree Santiago; home manager, Jeanna Gardner; assistant home manager; direct care staff, Jeremy McQuiller and Anna Martin; APS, Alexa Fisher; ORR, Michelle Livous; Relative D1; and Residents A, B, C regarding the allegation. I attempted to interview Resident D. Resident D has limited communication and did not engage in the interview. Resident D was unable to be interviewed. Relative D1 stated she observed Resident D's eye, and it was bloodshot red. She stated she accompanied him to the hospital, and he sustained a concussion and an abrasion to his eye. I reviewed Resident D's medical discharge summary. Resident D was examined on 05/25/2026 at Corewell Health Taylor Hospital. Reason for visit was eye injury. His diagnoses were right eye injury, initial encounter; traumatic iritis and contusion of scalp, initial encounter. I reviewed incident reports, which were consistent with the statements reported during this investigation. Based on the findings, there is sufficient evidence to support the allegation that Resident D was mistreated. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 05/22/2026, while onsite I observed Resident B's bed mattress was severely bowed, and not in good repair. The mattress was not flushed with the boxspring, each end of the mattress was midair.

On 06/05/2026, I contacted licensee designee, Desiree Santiago, regarding the allegation. I made her aware that I observed Resident B's mattress was severely bowed, and not in good repair. I explained that the mattress was not flushed with the boxspring and needed to be replaced. Ms. Santiago explained that she has replaced Resident B's mattress on multiple occasions. I reiterated that the mattress needs to be replaced.

On 06/11/2026, I received confirmation that a new mattress was purchased.

APPLICABLE RULE	
R 400.661	**Bedroom furnishings.**
	(1) Bedroom furnishings must include all of the following: **(a) A bed that is not less than 36 inches wide and not less than 72 inches long with a foundation that is clean, in good condition, and provides adequate support.**
ANALYSIS:	On 05/22/2026, I observed Resident B's bed mattress was severely bowed, and not in good repair. The mattress was not flushed with the boxspring, each end of the mattress was midair. Since the onsite inspection, a new mattress was purchased. **Corrective action plan is not required**.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/17/2026

_____

Denasha Walker Date
Licensing Consultant

Approved By:

07/20/2026

_____

Ardra Hunter Date
Area Manager