



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 17, 2026

Pusha Iambor
6084 28 Mile Rd
Washington, MI 48094

RE: License #: AF500411402
Investigation #: 2026A0604022
House On The Hill

Dear Ms. Iambor:

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 "Kristine Cilluffo".

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3044 West Grand Boulevard
2nd Floor Annex, Suite 2-730
Detroit, MI 48202
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF500411402
Investigation #:	2026A0604022
Complaint Receipt Date:	07/01/2026
Investigation Initiation Date:	07/01/2026
Report Due Date:	08/30/2026
Licensee Name:	Pusha Iambor
Licensee Address:	6084 28 Mile Rd Washington, MI 48094
Licensee Telephone #:	(586) 610-9508
Administrator:	N/A
Licensee Designee:	Pusha Iambor
Name of Facility:	House On The Hill
Facility Address:	6084 28 Mile Rd Washington, MI 48094
Facility Telephone #:	(586) 557-3495
Original Issuance Date:	01/29/2024
License Status:	REGULAR
Effective Date:	07/29/2024
Expiration Date:	07/28/2026
Capacity:	6
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A has a lack of a care plan, reduced personal care services, inadequate nutrition, and alleged neglect.	No
Additional Findings	Yes

III. METHODOLOGY

07/01/2026	Special Investigation Intake 2026A0604022
07/01/2026	APS Referral
07/01/2026	Special Investigation Initiated - Letter Completed referral to Adult Protective Services (APS)
07/06/2026	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Licensee Pusha Iambor and Berenice Iambor. Resident A no longer resides in home. Observed Resident B.
07/06/2026	Contact - Telephone call received Received message from APS Worker, Deborah Walbecq
07/07/2026	Contact- Document Sent Email to and from Deborah Walbecq
07/24/2026	Contact- Document Sent Email to and from Deborah Walbecq
07/24/2026	Contact - Telephone call received Received message from APS Worker, Deborah Walbecq. APS is closing case and not substantiating allegations.
07/31/2026	Contact - Telephone call made TC to Complainant
08/03/2026	Contact - Document Sent Emailed request to licensee for resident records

08/11/2026	Contact - Document Sent Sent second request to licensee for resident records
08/12/2026	Contact - Document Received Received resident records by email from licensee
08/13/2026	Contact - Document Sent Email to licensee. Documents received
08/18/2026	Contact - Telephone call received Received message from Complainant
08/20/2026	Contact - Document Sent Email to and from Berenice Iambor
08/20/2026	Contact - Telephone call made Returned call from Complainant
09/08/2026	Contact- Document Sent Email to Berenice Iambor.
09/10/2026	Exit Conference Left message for Licensee. Sent email to licensee with findings

ALLEGATION:

Resident A has a lack of a care plan, reduced personal care services, inadequate nutrition, and alleged neglect.

INVESTIGATION:

I received a complaint regarding House on the Hill on 07/01/2026. The Complainant alleged that Resident A has no care plan and that staff withdrew resident's services, like showers and hair cutting. The Complainant alleged that Resident A was being neglected and not receiving proper foods to eat.

On 07/06/2026, I completed an unannounced onsite investigation. I interviewed Licensee Pusha Iambor, Berneice Iambor and observed Resident B. The licensee stated that Resident A moved out of the home on 06/25/2026 and his current placement is unknown. During the onsite inspection, I observed a large supply of food in the home.

On 07/06/2026, I interviewed Licensee, Pusha Iambor. She indicated that Resident A is no longer living at House on the Hill. They currently have one resident. Resident A received hospice services while residing at the home and they came to bathe him twice per week. Ms. Iambor indicated that Resident A's wife is his POA. They tried to feed

Resident A while he was at the home. This wife wanted him to have different foods than they served.

On 07/06/2026, I interviewed Beatrice Iambor. She indicated that they tried to feed Resident A healthy foods. They provide residents with breakfast, lunch, dinner and snacks. He was eating and drinking with assistance as he could not feed himself. He liked things such as beef liver. His wife wanted him to have McDonalds. She felt the food was too healthy and wanted him to have things like a Big Mac and canned soup. Ms. Iambor stated that Resident A's wife asked if she could cut his hair. She lets families know that she can cut hair if needed. His wife sent pictures of how she wanted his hair, however, later had complaints. She told her to stop and that barber would come out to fix it. She indicated that a complaint was also made regarding how hospice shower aid cut his mustache. She stated that shower aid came twice a week. Hospice did not have any concerns regarding the care they provided. Resident B's family is also happy with the care they provide.

On 07/06/2026, I observed Resident B at the home. He was sleeping in chair in the living room. Licensee indicated that he has lived at home for two years.

On 07/06/2026, the licensee provided me with a copy of Resident A's assessment plan dated 03/25/2026 and copy of resident information record. The plan indicated that Resident A needs assistance with sitting, standing, walking, bathing, using toilet and getting into bed. Resident A uses a walker and wheelchair. The plan was signed by licensee, however, was not signed by resident or designated representative.

On 07/06/2026, the Licensee provided a copy of letter from Resident A's doctor at Washington Family Medicine dated 04/23/2026. The letter states that prior to (Resident A) going into a group home, his wife presented him with a list of concerns regarding (Resident A's) health including abnormal weight loss, extreme anger upon being denied the ability to drive a vehicle and refusal to use a cane or walker which is required due to weakness. The letter indicates that doctor recently went to see Resident A at the private group home and was very impressed with the facility. It was clean, well-managed, and well-staffed with people who are very attentive to the patient's needs. The letter also states that the facility offers Ensure for nutrition and can feed him which will help with his abnormal weight loss and weakness. These are things that his wife cannot do for him at home.

On 07/07/2026, I received an email from APS Worker, Deborah Walbecq. Ms. Walbecq indicated that she has no concerns at this point. She spoke with hospice nurse who said she has worked with home before and believes they provide excellent care.

On 07/24/2026, I received message from APS Worker, Deborah Walbecq. She indicated that she would be closing her case and not substantiating allegations.

On 07/31/2026, I spoke to Complainant by phone. The Complainant indicated that Resident A was placed at House on the Hill for 90 days. The Complainant reported that

Resident A was eating liver in all his meals because the licensee thought it would make him stronger. Resident A was on hospice, and they thought it would make him better. Resident A always ate in his recliner while at House on the Hill. The Complainant indicated that Resident A lost 26 pounds while at the home. The Complainant stated that Resident A gained three pounds in two weeks at his new placement. He is doing better in his new placement. The Complainant indicated that they never seen an assessment plan. They indicated that all of his hair and mustache was cut off and was told it was not hygienic. Due to complaints, they said they were no longer providing service. Resident A felt isolated in home. The hospice service was very questionable. Hospice did not properly treat bed sores or regularly take vitals. They said he was thriving and that House on the Hill was one of the best homes they had been too. Resident A has a new hospice provider.

On 08/12/2026, I received copies of Hospice Communication forms for Resident A from Licensee. Hospice notes reviewed do not indicate any concern regarding the care provided at home. Notes also indicate that Resident A's eating fluctuated. A note was also provided from Roseanne Ruehlen, BS RN, Executive Director of Bay Hospice. Ms. Ruehlen stated that per referral, Resident A had a 50-pound weight loss in past year and a half. Upon admission, his wife reported he had a weight loss of 20 pounds in over four months. Patient was at moderate risk for nutritional decline due to difficulty chewing, shallowing and changes in taste of food per patient. Resident A also had periods of agitation where he would refuse to eat. Ms. Ruehlen indicated a case conference was held with hospice, provider and Resident A's wife due to frequent complaints including the food served. A copy of Resident A's weight record was requested but not received.

APPLICABLE RULE	
R 400.663	Nutrition; adoption by reference.
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	There is not enough information to determine that Resident A did not receive adequate nutrition. On 07/06/2026, I completed an unannounced onsite investigation and observed a large supply of food in the home. Letters were provided from Resident A's doctor and hospice nurse which indicated that Resident A had a documented history of recent weight loss and difficulty eating. The Licensee, Complainant and hospice nurse all reported that there were complaints made regarding the type of food that was served in the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.677	Resident hygiene, clothing.
	(1) A licensee shall offer a resident appropriate opportunity, access to, and instructions for the following daily: (a) Bathing or showering, or both. (b) Shaving. (c) Oral care. (d) Grooming. (2) A licensee shall ensure the resident receives or has access to all of the following: (a) Bathing at least weekly. (c) Assistance with resident hygiene as needed.
ANALYSIS:	There is not enough information to determine that Resident A did not receive adequate assistance with hygiene while placed in the home. Resident A received hospice services where an aid visited weekly to assist with bathing and hygiene. The licensee indicated that Resident A's wife did report concerns regarding haircut and shaving.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	There is not enough information to determine that Resident A did not receive adequate personal care, supervision and protection in the home. Resident A was seen regularly by hospice provider while placed at The House on the Hill and no concerns regarding care were reported. In addition, Resident A's doctor visited the home and did not have any concerns. APS Worker, Deborah Walbecq, did not substantiate allegations of neglect and case was closed. Resident A is no longer placed at The House on the Hill.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

On 07/06/2026, the licensee provided me with a copy of Resident A's assessment plan dated 03/25/2026. The plan was signed by licensee, however, was not signed by the resident or designated representative.

On 08/03/2026 and 09/08/2026 requests were sent for Resident A's weight record. As of 09/10/2026, a copy of his weight record has not been received.

I attempted to complete an exit conference by phone with Licensee, Pusha Iambor, on 09/10/2026. I left message for Ms. Iambor. I also sent email to Ms. Iambor on 09/10/2026 with findings. I informed her that a corrective action plan would be requested and a copy of the special investigation report would be mailed once approved. I also requested that she contact me with any questions.

APPLICABLE RULE	
R 400.685	Resident admission; resident assessment plan; resident care agreement; health care appraisal.
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	On 07/06/2026, I completed an unannounced onsite investigation. The licensee provided me with a copy of Resident A's assessment plan dated 03/25/2026. Resident A's assessment plan was not signed by the resident or resident's designated representative.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.691	Resident Records.
	(4) A licensee shall complete and maintain a separate record for each resident that includes all of the following: (g) Admission and monthly weight record.

ANALYSIS:	On 08/03/2026 and 09/08/2026 requests were sent for Resident A's weight record. As of 09/10/2026, a copy of his weight record has not been received.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Kristine Cilluffo

09/10/2026

Kristine Cilluffo
Licensing Consultant

Date

Approved By:

Denise Y. Nunn

09/17/2026

Denise Y. Nunn
Area Manager

Date