



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 17, 2026

Leah Ann Beltran
Love & Harmony Senior Living LLC
32163 Linderman Ave.
Warren, MI 48093

RE: License #: AS500411952
Investigation #: 2026A0604023
Love & Harmony Senior Living LLC

Dear Ms. Beltran:

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 #:	AS500411952
Investigation #:	2026A0604023
Complaint Receipt Date:	07/10/2026
Investigation Initiation Date:	07/13/2026
Report Due Date:	09/08/2026
Licensee Name:	Love & Harmony Senior Living LLC
Licensee Address:	32163 Linderman Ave. Warren, MI 48093
Licensee Telephone #:	(586) 393-9578
Administrator:	Leah Ann Beltran
Licensee Designee:	Leah Ann Beltran
Name of Facility:	Love & Harmony Senior Living LLC
Facility Address:	3611 Alderdale Drive Sterling Heights, MI 48310
Facility Telephone #:	(586) 393-9578
Original Issuance Date:	10/12/2022
License Status:	REGULAR
Effective Date:	04/12/2025
Expiration Date:	04/11/2027
Capacity:	6
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was left sitting on commode for over eight hours. Staff have refused to take him to restroom or clean him afterwards.	No
Staff refuse to transfer Resident A in a timely manner. The transporter does not care if they run him into walls.	No
Resident A has been told if he asks for help, he will have to stay in room.	No
Additional Findings	Yes

III. METHODOLOGY

07/10/2026	Special Investigation Intake 2026A0604023
07/13/2026	APS Referral Referral sent to licensing by Adult Protective Services (APS). No APS referral needed.
07/13/2026	Special Investigation Initiated - Letter Email to APS Worker, Debra Johns
07/14/2026	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed licensee designee Leah Ann Beltran, Staff Liezl Corsane, and Resident A. APS Worker, Debra Johns, also present
07/28/2026	Contact - Document Sent Email to licensee, Leah Ann Beltran, requesting resident records
07/28/2026	Contact - Document Received Email from APS Worker, Debra Johns. Sent return email.
07/28/2026	Contact - Document Received Email to and from APS Worker, Debra Johns. APS will be substantiating case. Resident A no longer placed at home.
07/29/2026	Contact - Document Received Received resident records by email from Leah Beltran
07/30/2026	Contact - Document Sent Email to and from Leah Ann Beltran

09/16/2026	Exit Conference Completed exit conference with Licensee Designee, Leah Ann Beltran.
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ALLEGATION:

- **Resident A was left sitting on commode for over eight hours. Staff have refused to take him to restroom or clean him afterwards.**
- **Staff refuse to transfer Resident A in a timely manner. The transporter does not care if they run him into walls.**
- **Resident A has been told if he asks for help, he will have to stay in room.**

INVESTIGATION:

I received a licensing complaint regarding Love & Harmony Senior Living on 07/10/2026. The Complainant alleged that Resident A is unable to complete his activities of daily living independently. Resident A lives in an adult group home. There has been multiple times when he needs to use the restroom and staff would not take him out the chair or clean him afterwards. Group home staff have left Resident A sitting on the commode for over eight hours. They refuse to transfer him in a timely manner. He was told if he continues to ask for help he would have to stay in his room. When being transferred to the main hall or dining area staff do not care if the transporter runs into walls with the wheelchair. The transporter does not care if residents hit their body during transport. There is a chair Resident A wants to sit in and the staff will not assist in transferring him into the chair. There is a concern for neglect.

I completed an unannounced onsite investigation on 07/14/2026. I interviewed licensee designee, Leah Ann Beltran, Staff Liezl Corsane, and Resident A. APS Worker, Debra Johns, was also present when I arrived at the home.

On 07/14/2026, I interviewed Licensee Designee, Leah Ann Beltran. They currently have four residents; however, one resident is in hospital. Ms. Beltran stated that Resident A moved into the home on 03/07/2026. He recently returned from hospital where he went for a routine bag change. She denied that staff have run residents into walls while transporting them. Staff always assist residents with transfers. Ms. Beltran indicated that Resident A does not sit on toilet. He wears briefs that are changed in bed. Ms. Beltran denied that Resident A has been told that he has to stay in room if he asks for help. Ms. Beltran indicated that they always have staff available to assist residents. Ms. Beltran provided copies of house rules during the onsite investigation which indicates bedtime starts at the home at 7:00 pm and residents start getting out of bed at 7:00 am.

On 07/14/2026, I interviewed Staff, Liezl Corsane. She stated that she has worked at the home for one year in August. She indicated that she assists residents with changing briefs, changing clothes and making food. She stated that residents start going to bed in

rooms at 6:30 pm. She indicated that they can stay in living room if they ask. She stated that she has never ran a resident into the wall or door when transporting them. She stated that she will check on Resident A and ask if he wants to get up. Staff help him when he needs assistance. Ms. Corsane stated that Resident A does not sit on toilet.

On 07/14/2026, I interviewed Resident A. He stated that living here is “ok”. He does not like going to bed at 6:00 pm. They have to go to bedroom between 6:00 pm- 6:30 pm and do not get up until 8:00 am or later. They are not allowed to stay and watch tv in living room. He also stated that he has to eat what they make. Resident A stated that staff need Hoyer lift to transfer him. He might have to wait 15-20 minutes to be transferred if staff are busy. Staff assist him with changing briefs. They change him in the morning. He indicated that staff do not do regular checks but would assist if he asked for help. Resident A denied that he was ever left sitting on commode for hours. He stated that he has not used commode in months. He stated that he did hit his elbow on wall while being transferred and indicated he had a mark on his arm. APS Worker, Debra Johns, indicated that Resident A is supposed to be referred to a homecare nurse for additional assistance. He is his own guardian. Resident A is no longer residing at the home.

On 07/14/2026, I received copy of house rules signed by Resident A. The house rules state, “Staff must assist resident in getting out of bed starting @ 7 am and at bedtime starting @ 7 pm. However resident’s bedtime preference will also be considered.”

On 07/28/2026, I received email from APS Worker, Debra Johns. She indicated that she found that Resident A was put to bed daily at 6:30 pm and up between 8:30- 9:00 am and was not changed by staff during this period of almost 14 hours. It was also reported that Resident A’s rent was raised by \$500.00 after onsite investigation and he moved out of home. It was reported that Resident A always had food and medication while at Love & Harmony Senior Living. She will be substantiating for neglect regarding Resident A not being changed/checked during the midnight shift and medications not being locked up.

On 07/29/2026, I received copy of Resident A’s resident information record, health care appraisal and assessment plan from licensee designee, Leah Ann Beltran by email. Resident information record indicates that Resident A was admitted to home on 03/07/2026 and discharged on 07/19/2026. His assessment plan dated 03/07/2026 indicates that he required a two-person assist for toileting, bathing and personal hygiene. The plan also indicates that he uses a Hoyer lift. Resident A has a regular diet. Resident A had a health care appraisal completed on 03/09/2026.

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 no information to determine that staff have left Resident A sitting on the commode for over eight hours. Licensee designee, staff and Resident A all reported that he does not use commode. There is also not enough information to determine that staff have run Resident A into wall while transporting him and do not care. Resident A indicated that he had hit his elbow on wall while being transferred, however, it does not appear that this was a regular occurrence. Resident A also reported that staff would assist him if he asks for help. On 07/28/2026, I received email from APS Worker, Debra Johns. She indicated that she found that Resident A was put to bed daily at 6:30 pm and up between 8:30- 9:00 am and was not changed by staff during this period of almost 14 hours. APS will be substantiating case. On 07/14/2026, I interviewed Resident A. He stated that he does not like going to bed at 6:00 pm. They have to go to bedroom between 6:00 pm- 6:30 pm and do not get up until 8:00 am or later. He also indicated that staff assist him with changing brief in morning.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/14/2026, I interviewed Resident A at Love and Harmony Senior Living. He stated that he does not like going to bed at 6:00 pm. Resident A indicated that they have to go to bedroom between 6:00 pm- 6:30 pm and do not get up until 8:00 am or later. They are not allowed to stay and watch tv in living room. On 07/14/2026, I received copy of house rules from licensee designee, Leah Ann Beltran. The house rules were signed by Resident A. The house rules state, "Staff must assist resident in getting out of bed starting @ 7 am and at bedtime starting @ 7 pm. However resident's bedtime preference will also be considered."

On 07/14/2026, I completed an unannounced onsite investigation. During the onsite investigation, I observed medications that were not in a locked location. I observed medications on desk in the living room. I requested the licensee to put medications in a locked location.

I completed an exit conference with licensee designee, Leah Ann Beltran, on 09/16/2026. I left message for Ms. Beltran informing her that special investigation report

has been completed and I would be requesting a corrective action plan. I informed her that a copy of special investigation report would be mailed once approved and requested that she contact me if she had any questions. I also sent Ms. Beltran an email with findings and recommendation and again requested she contact me with any questions. On 09/16/2026, I received return email from Ms. Beltran indicating that she would submit a corrective action plan.

APPLICABLE RULE	
R 400.651	Living space.
	(1) Common use areas of the facility must be accessible to all residents unless a resident has restrictions imposed in the resident's assessment plan or individual plan of service.
ANALYSIS:	On 07/14/2026, I interviewed Resident A at Love and Harmony Senior Living. He stated that he does not like going to bed at 6:00 pm. Resident A indicated that they have to go to bedroom between 6:00 pm- 6:30 pm and do not get up until 8:00 am or later. They are not allowed to stay and watch tv in living room. Common areas such as living room must be accessible to residents. Resident A had no restrictions in regard to common area use listed in his assessment plan.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: (q) Access their bedroom at their own discretion.
ANALYSIS:	On 07/14/2026, I interviewed Resident A at Love and Harmony Senior Living. He stated that he does not like going to bed at 6:00 pm. Resident A indicated that they have to go to bedroom between 6:00 pm- 6:30 pm and do not get up until 8:00 am or later. They are not allowed to stay and watch tv in living room. On 07/14/2026, I received copy of house rules signed by Resident A. The house rules state, "Staff must assist resident in getting out of bed starting @ 7 am and at bedtime starting @ 7 pm. However resident's bedtime preference will also be considered." Based on Resident A's interview he was not given discretion as to when he entered his room at night and his bedtime preference was not considered per house rules.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.675	Resident medications.
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	On 07/14/2026, I completed an unannounced onsite investigation. During the onsite investigation, I observed medications that were not in a locked location. Medications were on desk in the living room.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Kristine Cilluffo

09/16/2026

Kristine Cilluffo
Licensing Consultant

Date

Approved By:

Denise Y. Nunn

09/17/2026

Denise Y. Nunn
Area Manager

Date