GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 5, 2025

Marlene Burgess
Homes of Opportunity Inc
P.O. Box 190179
Burton, MI 48519

RE: License #: AS630294018
Investigation #: 2025A0612017
Christian Hills

Dear Ms. Burgess:

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,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(248) 302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630294018
Investigation #:	2025A0612017
Complaint Receipt Date:	04/25/2025
Investigation Initiation Date:	04/28/2025
Report Due Date:	06/24/2025
Licensee Name:	Homes of Opportunity Inc
Licensee Address:	Suite C 1110 Eldon Baker Drive Flint, MI 48507
Licensee Telephone #:	(248) 505-1987
Administrator:	Marlene Burgess
Licensee Designee:	Marlene Burgess
Name of Facility:	Christian Hills
Facility Address:	1788 Crooks Rochester Hills, MI 48309
Facility Telephone #:	(248) 505-1987
Original Issuance Date:	05/19/2009
License Status:	REGULAR
Effective Date:	05/15/2024
Expiration Date:	05/14/2026
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was observed with significant bruises on her lower back and side. On an unknown date, Resident A fell out of a moving van. The group home did not write an incident report or seek medical attention for her.	Yes

III. METHODOLOGY

04/25/2025	Special Investigation Intake 2025A0612017
04/28/2025	Special Investigation Initiated - Telephone Telephone call to reporting source. There was no answer. I left a voicemail requesting a return call.
04/28/2025	APS Referral Referral received from Adult Protective Services (APS). Emails exchanged with assigned APS worker Kanati-Owl Davenport.
04/28/2025	Inspection Completed On-site I completed an unscheduled onsite inspection. There was no one onsite at the time of my inspection. I was unable to conduct interviews.
04/29/2025	Contact - Telephone call made Telephone call to former direct care staff Tita Cowart. There was no answer. I was unable to leave a voicemail as the voicemailbox was not set up. I followed up with a text message requesting a return call.
04/29/2025	Contact - Telephone call received Telephone interview completed with former direct care staff Tita Cowart.
04/29/2025	Contact - Document Received One photo of Resident A received via text message from former direct care staff Tita Cowart.
04/30/2025	Contact - Telephone call made

	Telephone call to Macomb County Community Mental Health Office of Recipient Rights Specialist Amber Sultes. There was no answer. I left a voicemail requesting a return call.
04/30/2025	Inspection Completed On-site I completed a second unscheduled onsite inspection. I interviewed Home Manager Queen Lotsu, direct care staff Dreaunna Harrison, Resident A, and Resident B.
05/01/2025	Contact - Telephone call made Telephone interviews completed with direct care staff Marvin Hunter and Johnny Anderson. Telephone call to direct care staff Marques. There was no answer. I left a voicemail requesting a return call.
05/05/2025	Contact - Telephone call made Telephone call to Macomb County Community Mental Health Office of Recipient Rights Specialist Amber Sultes. There was no answer. I left a voicemail requesting a return call.
05/05/2025	Exit Conference I placed a telephone call to licensee designee Marlene Burgess to conduct an exit conference.
05/06/2025	Contact - Document Received I received a copy of Resident A's Easter Seals MORC Individual Plan of Service sent via email from licensee designee Marlene Burgess.
05/15/2025	Contact - Telephone call received Interview completed with Macomb County Community Mental Health Office of Recipient Rights Specialist Amber Sultes.

ALLEGATION:

Resident A was observed with significant bruises on her lower back and side. On an unknown date, Resident A fell out of a moving van. The group home did not write an incident report or seek medical attention for her.

INVESTIGATION:

On 04/28/25, I received a referral from Adult Protective Services (APS) and Macomb County Community Mental Health (MCCMH) Office of Recipient Rights. In summary, the referrals indicate Resident A is diagnosed with an intellectual disability, schizoaffective disorder and adjustment disorder. Resident A resides at Christian Hills.

Resident A has a legal guardian. On an unknown date in February 2025, Resident A fell out of a moving van. Resident A sustained significant bruising to her lower back and side. Photographs were taken by former direct care staff, Tita Cowart, who discovered this while assisting Resident A in the shower. This staff did not report this to any entity. The group home did not write an incident report or seek medical attention for Resident A. It is unknown how Resident A fell out of the van or how fast the van was going.

On 04/28/25, I initiated my investigation by making a call to MCCMH Office of Recipient Rights Specialist Amber Sultes. There was no answer. I left a voicemail requesting a return call.

On 04/28/25, I emailed the assigned APS worker Kanati-Owl Davenport to coordinate. Ms. Davenport indicated that she completed an onsite investigation on 04/25/25. Ms. Davenport is not substantiating her investigation as Resident A reported that the car was parked in front of the house, she was not paying attention and slid off the seat and out of the vehicle. Ms. Davenport spoke to Resident A's guardian who expressed no concern regarding the care that Resident A receives.

On 05/15/25, I spoke to Macomb County Community Mental Health Office of Recipient Rights Specialist Amber Sultes. Ms. Sultes stated she is substantiating her investigation. Ms. Sultes further indicated that during the course of her investigation she was informed that Resident A was out of workshop from 02/25/25 – 03/06/25 for "illness."

On 04/28/25, I completed an unscheduled onsite investigation. There was no one onsite at the time of my investigation. I was unable to conduct interviews.

On 04/29/25, I completed a telephone interview with former direct care staff, Tita Cowart. Ms. Cowart's employment was terminated effective 04/22/25, as a result of SIR # 2025A0612013. Ms. Cowart stated on 03/04/25, she worked the night shift from 4:00 pm – 12:00 am with direct care staff Marvin Hunter. While she was showering Resident A, Resident A asked her to check out the bruising on her lower back and tell her how it was healing. Ms. Cowart stated she observed significant bruising to Resident A's lower back. Ms. Cowart took a picture and informed Mr. Hunter about the bruises she observed. Ms. Cowart stated Resident A told her that while she was stepping out of the van onto the ramp to go inside of the house she fell. Home Manager Queen Lotsu was present when this occurred. Resident A said she did not receive medical attention. Ms. Cowart stated she did not notify anyone other than Mr. Hunter about the bruises and she is unaware if an incident report was written. Ms. Cowart stated she did not complete any documentation regarding what Resident A reported to her or the bruises that she observed. Ms. Cowart stated she assumed that Ms. Lotsu documented the incident when it occurred as she is the home manager, and she was present when it happened.

On 04/29/25, I observed one photo of Resident A sent via text message from former direct care staff, Tita Cowart. The photo is time stamped; it was taken on 03/04/25 at

5:02 pm. The photo is the back of Resident A's body. I observed significant black and blue bruising to Resident A's lower back, buttock, side, and left shoulder.

On 04/30/25, I completed a second unscheduled onsite investigation. I interviewed Home Manager Queen Lotsu, direct care staff Dreaunna Harrison, Resident A, and Resident B. Resident C was on site at the time of the investigation. However, due to Resident C's intellectual disability he was unable to be interviewed. While onsite, I reviewed Resident A's health care appraisal dated 03/06/25. The health care appraisal indicates Resident A had bruising to her right buttock.

On 04/30/25, I interviewed Home Manager Queen Lotsu. Ms. Lotsu stated Resident A has an unsteady gait therefore, she always walks behind her. One morning while the residents were getting into the van to go to workshop there was ice on the ground. Resident A slipped, Ms. Lotsu caught her, and she fell backwards into Ms. Lotsu's chest. Ms. Lotsu stated she pushed Resident A up back into her seat in the van. Resident A did not fall onto the ground, there was no accident or injury. Resident A was not hurt, she did not require medical attention, and no documentation was completed as no incident occurred. Ms. Lotsu stated Resident A requires assistance with showering and toileting. Due to incontinence Resident A often showers twice daily. Ms. Lotsu stated none of the staff reported to her that they observed bruises on Resident A's body while they were assisting her with showering or toileting. Ms. Lotsu stated she did not observe bruises on Resident A when she assisted her with personal care. Ms. Lotsu further stated there was no written documentation completed by any staff regarding bruises on Resident A. Ms. Lotsu denied that Resident A fell out of the van while it was moving. Ms. Lotsu denied that she caused the bruises on Resident A. Ms. Lotsu stated Resident A completed a physical with her primary care doctor on 03/06/25. Ms. Lotsu stated that she was in the room with Resident A during the appointment. Resident A was required to get undressed for the physical examination. Ms. Lotsu stated during the appointment she did not observe any bruises on Resident A. When asked about Resident A's health care appraisal, indicating that Resident A had bruises on her right buttock Ms. Lotsu remarked Resident A bruises easily and the doctor stated it was nothing to worry about.

On 04/30/25, I interviewed Resident A. Resident A stated one morning on an unknown date she and her housemates were going outside to get into the van to go to work. The van was parked in front of the garage. There was ice on the ground. Resident A stated she slipped and fell on the ground. Home Manager Queen Lotsu was behind her and tried to catch her while she was falling. Resident A stated it did not hurt when she fell and at the time she did not have any bruising. Resident A stated following the incident she went to workshop. She did not require medical attention. Resident A denied that she fell out of the van while it was moving. Resident A denied that anyone harmed her causing the bruises.

On 04/30/25, I interviewed Resident B. Resident B stated on an unknown date she and her housemates were walking out to the van to go to workshop. The van was parked in front of the garage. Resident A slipped on ice and “slid down.” Home Manager Queen Lotsu was walking behind Resident A, and she caught her. Resident B stated that Resident A did not fall onto the ground. Following the incident they all went to workshop. Resident A did not require medical attention.

On 04/30/25, I interviewed direct care staff Dreaunna Harrison. Ms. Harrison stated she has worked at this home for three years. Ms. Harrison works the morning shift from 8:00 am – 4:00 pm. Ms. Harrison stated Resident A requires assistance with showering. She also wears a brief, and the staff assist her with brief changes. Ms. Harrison stated she assists Resident A with showers during the morning shift. Ms. Harrison did not observe any bruises on Resident A while assisting her with activities of daily living (ADL’s). Ms. Harrison denied any knowledge of Resident A having any accidents or falls. Ms. Harrison denied any knowledge of Resident A falling out of a moving van.

On 05/01/25, I interviewed direct care staff Marvin Hunter via telephone. Mr. Hunter stated he has worked for this company since 2016, he works the afternoon and midnight shift on Mondays, Tuesdays, and Wednesdays. Mr. Hunter stated he is always scheduled to work with a women staff. The women provide personal care to the women residents therefore, he does not assist Resident A with ADL’s. Mr. Hunter denied any knowledge of Resident A having any injuries, accidents, or falls. Mr. Hunter denied any knowledge of Resident A falling out of a moving van. Mr. Hunter stated Resident A did not tell him that she was in pain or that she had any bruises. Mr. Hunter denied that former direct care staff Ms. Cowart informed him about observing bruises on Resident A.

On 05/01/25, I interviewed direct care staff Johnny Anderson via telephone. Mr. Anderson stated he was not aware that Resident A had any bruises on her body. He was not informed that Resident A had any injuries, accidents, or falls. Mr. Anderson denied any knowledge of Resident A falling out of a moving van. Mr. Anderson stated that Resident A gets bruised easily and if she was to have had an accident that no one witnessed she would likely not tell staff about it. Mr. Anderson stated because he is a male he does not assist Resident A with her ADL’s.

On 05/06/2025, I reviewed Resident A’s Easter Seals MORC Individual Plan of Service (IPOS) sent via email from licensee designee Marlene Burgess. In summary, Resident A’s IPOS indicates Resident A relies on caregivers to recognize any medical emergencies. Caregivers are to monitor any signs and symptoms of illness and injury and document it in the health care chronological (HCC). Resident A requires verbal prompts and assistance from caregivers to complete ADL’s.

On 05/05/25, I placed a telephone call to licensee designee Marlene Burgess to conduct an exit conference and review my findings. Ms. Burgess stated that she was aware of the allegation and that she had seen a photo of the bruises on Resident A. Ms. Burgess was advised that a corrective action plan (CAP) was required, she acknowledged and agreed to submit a CAP upon receipt of the report.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the information gathered during this investigation there is sufficient information to conclude that on 03/04/25, at 5:02 pm former direct care staff Tita Cowart observed significant black and blue bruising to Resident A's lower back, buttock, side, and left shoulder. Ms. Cowart stated that she did not complete any documentation regarding the bruises or seek medical attention for Resident A. Resident A requires assistance with activities of daily living (ADL's). It was reported that Resident A often takes two showers a day. All staff interviewed denied observing any bruises on Resident A while assisting her with ADL's including showering and/or toileting. On 03/06/25, two days after Ms. Cowart observed the bruises on Resident A, Resident A completed a physical with her physician. The health care appraisal indicates that there was bruising on Resident A's right buttock. Home Manager Queen Lotsu stated she was in the exam room while Resident A completed her physical, however she denied observing the bruises. Ms. Lotsu, Resident A, and Resident B consistently reported that on an unknown date Resident A slipped on ice while walking to the van to go to workshop one morning. Ms. Lotsu stated she caught Resident A; Resident A did not fall to the ground or sustain any injuries. Resident A said that she slipped and fell on the ground. Ms. Lotsu was behind her and tried to catch her while she was falling. Resident B said that Resident A slipped on ice and "slid down" Ms. Lotsu caught her. When interviewed by APS worker Ms. Davenport, Resident A stated that while the van was parked, she slid off the seat and out of the vehicle. It was consistently reported that Resident A did not require immediate medical attention following this incident.

	However, when there was a change to her physical condition (she developed significant bruises) immediate medical attention was not obtained and there was no written documentation about what occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(3) An incident must be recorded on a department-approved form and kept in the home for a period of not less than 2 years.
ANALYSIS:	Based on the information gathered during this investigation there is sufficient information to conclude that former direct care staff Tita Cowart worked on 03/04/25, and while showering Resident A Ms. Cowart observed significant bruises on Resident A's body. Resident A told her that while she was stepping out of the van onto the ramp to go inside of the house she fell. Ms. Cowart stated she did not complete any written documentation regarding what Resident A reported to her or the bruises that she observed. Further, Ms. Lotsu, Resident A, and Resident B consistently reported that on an unknown date Resident A slipped on ice while walking to the van to go to workshop one morning. Although, Ms. Lotsu stated she caught Resident A; Resident A did not fall to the ground or sustain any injuries. Resident A said that she slipped and fell on the ground. Ms. Lotsu was behind her and tried to catch her while she was falling. Resident B said that Resident A slipped on ice and "slid down" Ms. Lotsu caught her. There was no incident report written regarding any variation of what occurred that morning.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/15/2025

_____

Johnna Cade Date
Licensing Consultant

Approved By:

For 06/05/2025

_____

Denise Y. Nunn Date
Area Manager