GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 4, 2025

Zattie Young
Northrop Loving Care Inc
17777 Northrop
Detroit, MI 48219

RE: License #: AS820068138
Investigation #: 2025A0101019
Northrop Loving Care

Dear Ms. Young:

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) 456-0439.

Sincerely,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820068138
Investigation #:	2025A0101019
Complaint Receipt Date:	03/25/2025
Investigation Initiation Date:	03/27/2025
Report Due Date:	04/24/2025
Licensee Name:	Northrop Loving Care Inc
Licensee Address:	17777 Northrop Detroit, MI 48219
Licensee Telephone #:	(313) 727-3239
Administrator:	Zattie Young
Licensee Designee:	Zattie Young
Name of Facility:	Northrop Loving Care
Facility Address:	17777 Northrop Detroit, MI 48219
Facility Telephone #:	(313) 727-3239
Original Issuance Date:	03/11/1996
License **Status:**	REGULAR
Effective Date:	05/21/2025
Expiration Date:	05/20/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive a proper discharge.	No
Staff are verbally abusive.	No
On 04/05/2025, Resident B was brought to his dialysis, and he had feces all over him. According to Resident B he had a bowel movement early that morning and the staff did not change him. Furthermore, Resident B appears dirty.	No
Resident A's personal belonging smelled.	No
Resident A's wallet is missing. Ms. Young should have given it to Guardian A1.	No
Additional Finding	Yes

III. METHODOLOGY

03/25/2025	Special Investigation Intake 2025A0101019
03/27/2025	Special Investigation Initiated - Telephone Guardian A1
03/27/2025	APS Referral
04/04/2025	Inspection Completed On-site Interviewed the home manager Marvin Bassett
04/10/2025	Inspection Completed On-site Interviewed direct care staff Mr. Bassett Interviewed Resident C
04/30/2025	Contact – Telephone call made Licensee designee Zattie Young
04/30/2025	Contact – Document received Resident A's discharge notices

05/20/2025	Contact – Telephone call made Guardian B1
05/20/2025	Contact – Telephone call made Resident A's former case manager supervisor Watisha Sims, Lincoln Behavioral
05/21/2025	Inspection Completed On-site Interviewed Residents B, D and E
05/22/2025	Contact - Documents received Resident A's and B's assessment plan Resident A's resident care agreement
05/22/2025	Contact – Telephone call made Guardian A1
05/22/2025	Exit conference with Ms. Young

ALLEGATION: Resident A did not receive a proper discharge.

INVESTIGATION: On 03/27/2025, I spoke with Guardian A1. Guardian A1 is Resident A's sister. Guardian A1 stated Ms. Young caused Resident A to have a "mental breakdown". Guardian A1 stated when Resident A received two discharge notices, he had a "mental breakdown".

On 04/30/2025, I spoke with the licensee designee, Zattie Young. Ms. Young stated she gave Guardian A1 and the case worker a 30-days discharge notice on 01/22/2025. Ms. Young stated the discharge notice was sent to Detroit Wayne Integrated Network on 02/05/2025 and the discharge was approved. Ms. Young stated that Guardian A1 has a history of harassing and threatening the group home staff, which leads to Resident A being discharged from his placements. Ms. Young stated that Resident A didn't want to move, however Guardian A1 would not cooperate with staff and was disrupting the household. Ms. Young stated Resident A begged Guardian A1 to apologize to the staff but Guardian A1 would not honor his request. Ms. Young stated Guardian A1 has a bad attitude and was often confrontational. Ms. Young further stated that Resident A had been decompensating and on 02/07/2025, she took him to Corewell Health Farmington Hils Hospital. Ms. Young stated when Resident A was in the hospital, she received a telephone call from Guardian A1. According to Ms. Young, Guardian A1 told her to pack up Resident A's belongings because he would not be returning to the Northrop Group Home.

On 04/30/2025, I review copies of the 30-day written notices that were given to

Guardian A1 and to Resident A. They were the same notice. One of the notices was on Northrop Loving Care LLC's letterhead and the other notice was notification to Detroit Wayne Integrated Health Network of the proposed discharge on their required form. The Northrop Loving Care notice was dated 01/20/2025, and the Detroit Wayne Integrated Health Network form was dated 02/05/2025.

On 05/20/2025, I spoke with Resident A's former case manager supervisor Watisha Sims. Ms. Sims stated Guardian A 1 is very demanding and her demands can be overwhelming. Ms. Sims stated Guardian A1 is the contributing variable in Resident A being discharged from his placements.

On 05/22/2025, I conducted an exit conference with Ms. Young. Ms. Young agreed with my findings.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for the discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	The discharge was not improper. Ms. Young provided Resident A and Guardian A1 with a 30-day written notice before discharge from the home. The Northrop written discharge notice was dated 01/20/2025. He was hospitalized on 02/07/2025. Upon discharge from the hospital Resident A could have returned to the group home. However, during his hospitalization Guardian A1 called Ms. Young and told her to pack up Resident A's belongings because he would not be returning to the Northrop Group Home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Staff are verbally abusive.

INVESTIGATION: On 04/10/2025, I interviewed Resident C and on 05/21/2025, I interviewed Residents B, D and E. They all stated that staff treat them well.

On 05/22/2025, I spoke with Guardian B1. Guardian B1 stated Resident B has been in this home for decades and she has never heard staff being verbally abusive.

On 05/22/2025, I conducted an exit conference with Ms. Young. Ms. Young agreed with my findings.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (a) Use any form of punishment. (b) Use any form of physical force other than physical restraint as defined in these rules. (c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident. (d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner. (e) Withhold food, water, clothing, rest, or toilet use. (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse. (iii) Derogatory remarks about the resident or members of his or her family. (iv) Threats. (g) Refuse the resident entrance to the home. (h) Isolation of a resident as defined in R 400.14102(1)(m). (i) Any electrical shock device.

ANALYSIS:	Based upon the preponderance of evidence staff are not subjecting the residents to verbal abuse. On 04/10/2025, I interviewed Resident C and on 05/21/2025, I interviewed Residents B, D and E. They all stated that staff treat them well. Guardian B1 stated Resident B has been in this home for decades and she has never heard staff being verbally abusive.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On 04/05/2025, Resident B was brought to his dialysis, and he had feces all over him. According to Resident B he had a bowel movement early that morning and the staff did not change him. Furthermore, Resident B appears dirty.

INVESTIGATION: On 04/10/2025, I interviewed the home manager, Marvin Bassett. Mr. Bassett stated Resident B had the bowel movement in the van on the way to dialysis. According to Mr. Bassett, when they arrived at dialysis Resident B was cleaned up and given scrubs to wear. Mr. Bassett stated he believes Resident B's smearing feces behavior is reemerging. Mr. Bassett stated Resident B will be lying in bed watching television and he will have a bowel movement. Mr. Bassett also stated Resident B refuses to bathe and it is a challenge to get him to take a bath. Mr. Bassett stated to get him to take a bath Guardian B1, Relative 1 or Ms. Young must come to the home and put him in the tub.

On 04/10/2025, I interviewed Resident C. Resident C stated Resident B had a bowel movement in the van on the way to dialysis. Resident C stated Resident B is old and needs to go to a nursing home.

On 04/30/2025, I spoke with Ms. Young. Ms. Young stated Resident B is not incontinent. Ms. Young stated if you asked him why he is using the bathroom in his pants he will say "that is why staff is paid." Ms. Young stated it is one of his behaviors. Ms. Young stated when Resident B goes to dialysis she gives him a bath. Ms. Young further stated that she has purchased a hygiene bag for Resident B. Ms. Young stated the hygiene bag has wipes and a change of clothing for Resident B to take with him when he goes to dialysis. Ms. Young stated Resident B's psychiatrist suggested moving Resident B to a nursing home. However, Guardian B1 does not want him to be moved.

On 05/22/2025, I spoke with Guardian B1. Guardian B1 acknowledged that Resident B does not like bathing. Guardian B1 stated that Resident B is doing well at his current placement, and she will not be moving him to a nursing home. Guardian

B1 stated you can get Resident B to bathe by offering him cigarettes.

On 05/22/2025, I conducted an exit conference with Ms. Young. Ms. Young agreed with my findings.

APPLICABLE RULE	
R 400.14314	**Resident hygiene**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	The licensee is affording Resident B the opportunity and instructions, when necessary, for daily bathing. However, while on the way to dialysis, Resident B had a bowel movement in the van. Ms. Young stated when Resident B goes to dialysis she gives him a bath.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A's personal belonging smelled.

INVESTIGATION: On 04/04/2025, I interviewed the home manager, Marvin Bassett. Mr. Bassett stated that prior to packing up Resident A's belongings he washed all of his clothing.

According to the complainant, the licensee at Resident A's new placement stated when Resident A arrived at her home his clothing smelled bad. On 05/22/2025, I spoke to Guardian A1. I asked Guardian A1 for Resident A's new placement name and telephone number. Guardian A1 refused to give me the new placement information.

On 05/22/2025, I conducted an exit conference with Ms. Young. Ms. Young agreed with my findings.

APPLICABLE RULE	
R 400.14314	**Resident hygiene**
	(5) A licensee shall afford a resident with opportunities, and instructions when necessary, to routinely launder clothing. Clean

	clothing shall be available at all times.
ANALYSIS:	The licensee afforded Resident A with opportunities, and instructions when necessary to routinely launder clothing. Mr. Bassett stated that prior to packing up Resident A's belongings he washed all of his clothing. I could not contact the new placement to determine if Resident A's clothing smelled bad when he arrived because Guardian A1 refused to disclose information regarding his new placement.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A's wallet is missing. Ms. Young should have given it to Guardian A1.

INVESTIGATION: On 05/22/2025, I spoke with Ms. Young. Ms. Young stated that the only funds and valuables she accepted from Resident A and Guardian A1 was the payment for Resident A's cost of care. Ms. Young stated that Resident A kept his own wallet and Guardian A1 was the representative payee. Ms. Young stated that Guardian A1 gave Resident A a debit card and the guardian would load his allowance onto that card.

On 05/22/2025, I reviewed Resident A's assessment plan dated 01/01/2025. According to the assessment plan Resident A knows how to count and he can manage his own money.

On 05/22/2025, I conducted an exit conference with Ms. Young. Ms. Young agreed with my findings.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(1) Upon a request from a resident or the resident's designated representative, a licensee may accept a resident's funds and valuables to be held in trust with the licensee.

ANALYSIS:	Neither resident A nor Guardian A1 requested that the licensee accept Resident A's funds and valuables. According to Ms. Young the only funds and valuables she accepted from Resident A and Guardian A1 was the cost of care payment.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

INVESTIGATION: On 05/25/2025, I reviewed Resident A's and Resident B's 2025 assessment plan dated 01/01/2025. I observed that the assessment plans were incomplete because their guardian did not sign it.

On 05/22/2025, I conducted an exit conference with Ms. Young. Ms. Young agreed with my finding.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, and the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	The licensee did not complete the 2025 annual written assessment plan with the resident or the resident's designated representative. On 05/25/2025, I reviewed Resident A's and Resident B's written assessment plan. I observed that Resident A's and Resident B' written assessment plan for 2025 were incomplete. I deemed them incomplete because their guardian did not sign it.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 05/25/2025, I reviewed Resident A's resident care agreement, dated 01/01/2025. I observed that the resident care agreement was incomplete because the guardian did not sign it.

On 05/22/2025, I conducted an exit conference with Ms. Young. Ms. Young agreed with my finding.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party.
ANALYSIS:	The licensee did not complete Resident A's 2025 annual resident care agreement with the resident or the resident's designated representative. On 05/25/2025, I reviewed Resident A's resident care agreement, dated 01/01/2025. I observed that Resident A's resident care agreement for 2025 was incomplete. I deemed it incomplete because his guardian did not sign it.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/28/2025

Edith Richardson — Date
Licensing Consultant

Approved By:

For 06/04/2025

Ardra Hunter — Date
Area Manager