GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 11, 2025

Shelly Sibert
The Noble Home Inc
19620 Cherrylawn
Detroit, MI 48221

RE: License #: AL820068121
Investigation #: 2025A0901034
Noble Home II

Dear Shelly Sibert:

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,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AL820068121
Investigation #:	2025A0901034
Complaint Receipt Date:	06/10/2025
Investigation Initiation Date:	06/10/2025
Report Due Date:	08/09/2025
Licensee Name:	The Noble Home Inc
Licensee Address:	19620 Cherrylawn Detroit, MI 48221
Licensee Telephone #:	(313) 477-0461
Administrator:	Shelly Sibert
Licensee Designee:	Shelly Sibert
Name of Facility:	Noble Home II
Facility Address:	327 E Grand Blvd Detroit, MI 48207
Facility Telephone #:	(313) 922-4164
Original Issuance Date:	03/01/1996
License Status:	REGULAR
Effective Date:	12/20/2024
Expiration Date:	12/19/2026
Capacity:	17
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was pushed away from the medications by staff, Irene McRunels.	Yes

III. METHODOLOGY

06/10/2025	Special Investigation Intake 2025A0901034
06/10/2025	Referral - Recipient Rights
06/10/2025	Special Investigation Initiated - Telephone Recipient Rights
06/10/2025	Adult Protective Services Referral
06/12/2025	Contact - Telephone call received Recipient Rights
06/16/2025	Inspection Completed On-site
06/17/2025	Contact - Telephone call made Licensee designee, Shelly Sibert
06/17/2025	Contact - Telephone call made Recipient Rights
06/17/2025	Contact - Telephone call made Staff, Irene McRunels
07/10/2025	Contact - Telephone call made Resident A’s Case Manager
08/05/2025	Exit Conference Licensee designee, Shelly Sibert
08/05/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A was pushed away from the medications by staff, Irene McRunels.

INVESTIGATION:

On 06/10/2025, I made a telephone call to Dominique Moore, from Recipient Rights. I left a voice message, and the call was returned on 06/12/2025. Dominique stated she already talked to everyone. She explained that the incident was witnessed by Resident B and that Resident A and Resident B's account of what happened were consistent. Both described a disagreement Resident A had with staff, Irene McRunels, regarding her medications and that Irene pushed Resident A.

On 06/16/2025, I conducted an onsite inspection at the facility and interviewed Resident A. She stated that Irene was passing the medications and gave her three pills to take. She tried to explain to her that her psychiatrist recently discharged two of the medications and that she was only supposed to take one. Resident A said this caused a big disagreement because Irene thought she did not know what she was talking about and insisted she was supposed to take all three. She said Irene was yelling at her and using profanity. To keep down the confusion, Resident A said she reached to grab the medication cup and Irene pushed her. She stumbled backwards, but did not fall. She further stated Resident B was the only person present that witnessed the incident.

During the onsite inspection on 06/16/2025, I interviewed Resident B. She said Resident A was trying to tell Irene that there was a change with her medications, but Irene was not listening and was argumentative. Resident A stopped going back and forth with her about it and decided to just take the medications. When she reached to grab the cup, Irene pushed her into the table. Resident A went backwards but balanced herself with the table and did not fall. Resident B said Irene stated to Resident A, "I'm a grown motherfucker. I'm in my 70's and I'll whip your ass. You do not touch the medications."

During the onsite inspection 06/16/2025, I interviewed staff, Shirly McKing. She stated she was not present during the incident, but since the incident, they contacted Resident A's psychiatrist for clarity. She explained that Resident A sees her psychiatrist alone and that she recently had an appointment. The psychiatrist verified changing the medications but forgot to notify them. Therefore, they could not implement the change until they received the order. Since then, they received it, which she showed me.

On 06/17/2025, I made a telephone call to the licensee designee, Shelly Sibert. She stated Resident A told her two different accounts of what happened. She first said They had a disagreement about her medications and Irene pushed her. The story changed and she said Irene hit her face and put her nails in her arm. Shelly also explained that a few days before the incident, Resident A saw her psychiatrist.

There was a change in her medications, but the psychiatrist never gave them an order. The psychiatrist told Resident A about the changes that her being made but they were not made aware. She said when Resident A called her after the incident, she explained to her that they could not implement the changes until they received the order.

On 06/17/2025, I made a telephone call to Dominique. I informed her that Resident A and Resident B details of what happened where consistent and were the same as reported to her. She stated she was substantiating her complaint.

On 06/17/2025, I made a telephone call to Irene. She denied pushing Resident A. She said Resident A was being argumentative about taking her medications. She explained to her that they did not have a discharge notice from her doctor regarding any changes, therefore, she had to give her the medications as they were prescribed. Irene stated Resident A attempted to grab the medications and she only pushed her hands away but did not physically push her body.

On 07/10/2025, I made a telephone call to Resident A's case manager, Lanita McCotteritat, from the Guidance Center. She stated Resident A told her about the incident. Resident A said she tried to tell Irene she was off the medication, but Irene would not listen to her. According to Resident A, Irene was making it seem like she was refusing her medications. She felt Irene was manipulating the situation in an attempt to send her back to the hospital. Resident A said when she tried to take the medication, Irene pushed her backwards. Lanita indicated when she spoke with Irene regarding the situation, Irene admitted to pushing Resident A because she had water in her hands and threatened to throw it at her.

On 08/05/2025, I made a telephone call to Shelly and conducted an exit conference. She stated she was aware that it would be substantiated because Recipient Rights already substantiated their complaint. She also stated she already implemented a corrective action plan and would send it when she receives the report.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on the information obtained during this investigation, there is sufficient evidence to confirm that Resident A was not treated with dignity and her protection and safety was not attended to at all times. Resident A reported being pushed by Irene and spoken to inappropriately. This was observed by Resident B, who confirmed what was reported by Resident A. Furthermore, according to Resident A's case manager, Irene admitted to her that she pushed Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/05/2025

Regina Buchanan
Licensing Consultant

Date

Approved By:

08/11/2025

Ardra Hunter
Area Manager

Date