



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

December 4, 2025

Charlotte Coleman-White  
Lewisite Inc  
424 Saint Johns  
Wyandotte, MI 48192

RE: License #: AS820014306  
Investigation #: 2026A0992001  
Lewisite II

Dear Ms. Coleman-White:

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,

A handwritten signature in black ink, appearing to read 'Denasha Walker', with a stylized, cursive script.

Denasha Walker, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Pl. Ste 9-100  
3026 W. Grand Blvd  
Detroit, MI 48202  
(313) 300-9922

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS820014306
<b>Investigation #:</b>	2026A0992001
<b>Complaint Receipt Date:</b>	09/29/2025
<b>Investigation Initiation Date:</b>	10/01/2025
<b>Report Due Date:</b>	11/28/2025
<b>LicenseeName:</b>	Lewisite Inc
<b>Licensee Address:</b>	424 Saint Johns Wyandotte, MI 48192
<b>Licensee Telephone #:</b>	(734) 285-6864
<b>Administrator:</b>	Charlotte Coleman-White
<b>Licensee Designee:</b>	Charlotte Coleman-White
<b>Name of Facility:</b>	Lewisite II
<b>Facility Address:</b>	424 Saint Johns Wyandotte, MI 48192
<b>Facility Telephone #:</b>	(734) 285-6864
<b>Original Issuance Date:</b>	07/22/1985
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	07/16/2024
<b>Expiration Date:</b>	07/15/2026
<b>Capacity:</b>	6
<b>Program Type:</b>	MENTALLY ILL

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
On 09/13/2025, Resident A (66), a resident at Lewisite II AFC home with multiple health conditions, was denied her essential medications by direct care staff, Debra Clark.	No
Additional Findings	Yes

**III. METHODOLOGY**

09/29/2025	Special Investigation Intake 2026A0992001
10/01/2025	Special Investigation Initiated - On Site Home manager, Bernice James and Resident A.
10/08/2025	Contact - Telephone call made Licensee designee, Charlotte White was not available. Message left.
10/10/2025	Contact - Telephone call received Ms. White
10/10/2025	Contact - Telephone call made Resident A's guardian, Shavonne Rippy was not available. Message left.
11/19/2025	Contact - Telephone call made Ms. Rippy was not available. Message left.
11/24/2025	Contact - Telephone call made Ms. Rippy was not available. Message left.
11/25/2025	Contact - Telephone call received Ms. Rippy
12/02/2025	Contact - Telephone call made Direct care staff, Dionne Stamps
12/02/2025	Contact - Telephone call made Direct care staff, Deborah Clark

12/02/2025	Exit Conference Ms. White was not available. Message left.
12/02/2025	Contact - Telephone call received Ms. White

**ALLEGATION: On 09/13/2025, Resident A (66), a resident at Lewisite II AFC home with multiple health conditions, was denied her essential medications by direct care staff, Debra Clark.**

**INVESTIGATION:** On 10/01/2025, I completed an unannounced onsite inspection and interviewed home manager, Bernice James and Resident A regarding the allegation. Ms. James denied the allegation. She stated Resident A receives her medication as prescribed. However, she stated Resident A can be very uncooperative and she complains about everything. She stated Resident A gives the direct care staff a very hard time and she has threatened to have direct care staff, Deborah Clark fired. Ms. James said it seems as though Resident A targets Ms. Clark. Ms. James provided me with a copy of a letter written by Ms. Clark. In summary the letter stated Resident A is very rude and disrespectful towards staff. Resident A cannot be redirected. She lies on staff and states she can do whatever she wants to do because she pays the staff. Resident A threatened to call recipient rights on staff. Resident A is very demanding and wants to control the home. Ms. James stated Resident A alleges she does not receive her medication, but the staff states and documents otherwise. She stated the medication administration records (MARs) are initialed by the staff at the time the medication is given. Ms. James stated Resident A refuses services from Team Wellness (her mental health provider), her guardian, Guardian Care, case management and psychiatric services. She stated Resident A will not allow the staff to be involved in her medical appointments or needs. She stated she schedules her own appointments and retrieves her medications. Ms. James reiterated that Resident A is very uncooperative.

I reviewed Resident A's MARs from September 2025 to date. The following medications were not initialed in September:

- Metformin HCL 500mg, take one tablet twice daily was not initialed on 9/01/2025 at 5:00p.m.
- Erythromycin 0.5% eye ointment, apply to lower eyelid three times daily was not initialed on 9/30/2025 at 5:00p.m. and 8:00p.m.

I reviewed Resident A's MARs for October 2025. The following morning medications were not initialed on 10/01/2025:

- Levothyroxine 88mcg, take one table daily was not initialed at 7:00a.m.

- Amlodipine Besylate 10mg, take one tab daily was not initialed at 8:00a.m.
- Atorvastatin 10mg, take one tab daily was not initialed at 8:00a.m.
- Metformin HCL take one table twice daily was not initialed at 8:00a.m.
- Erythromycin 0.5% eye ointment, apply to lower eyelid three times daily was not initialed at 8:00a.m.

I brought this to Ms. James' attention, she stated the midnight staff, Dionne Stamps, was responsible for administering medication and that is unlike her. Ms. James contacted Ms. Stamps. Ms. Stamps stated Resident A did receive her medications. She stated there was an argument between residents and she got distracted after giving Resident A her medication and forgot to initial. She reiterated that Resident A did receive her medication.

I interviewed Resident A. As I introduced myself, Resident A was dismissive. She stated she did not want to be interviewed. I explained that I was there to address concerns regarding her medication. She stated she can handle her medication issues, and she does not need to discuss it with me. She stated, "I can talk to the state about it." I explained that I am from "the state," and that I am an adult foster care licensing consultant. Resident A's demeanor changed and she was welcoming. Resident A stated she is not receiving her medication as prescribed from one staff specifically, Deborah Clark. She stated Ms. Clark skipped her eyedrops and she told Ms. James, but nothing was done about it. Resident A stated now she has her eyedrops in her possession and she can take it as prescribed. Resident A grabbed her prescribed eyedrops out of her bedroom and showed me. I observed the Erythromycin 0.5% eye ointment, apply to lower eyelid three times daily was not initialed at 8:00a.m. I explained that all her medication should be handled by the staff and locked in the cabinet/drawer. Resident A stated she can handle her own medication. She stated she picks up her medication from the pharmacy. Resident A stated she did receive her morning medications this morning. She went on to state that the home is dirty and she does not need to be there. She stated she does not need a guardian, and she is capable of living on her own. Resident A stated she does not need mental health services and does not require 24-hr supervision or adult foster care services.

On 10/10/2025, I received a return call from licensee designee, Charlotte White. I interviewed her regarding the allegation. Ms. White stated sometimes Resident A is uncooperative and she refuses her medication. She stated the staff attempt to administer her medications as prescribed, but they cannot make her take her medication. She stated there are times when Resident A will take her medication without a problem, it depends on her mood. She stated Resident A is not prescribed any psychotropic medication. She stated Resident A refuses services from Team Wellness, her guardian, Guardian Care, case management and psychiatric services. I referenced the fact that Resident A is not actively involved with Team Wellness or any other psychiatric services and asked Ms. White how she can properly service Resident A, when she has not been properly assessed. Ms. White stated Resident A is combative, but she is not violent. I made Ms. White aware that Resident A has her

eyedrop medication in her possession. Ms. White stated she is aware and that Resident A is not willing to give that medication to the staff. She stated Resident A makes her own doctor appointments and picks up her own medication. Ms. White stated she feels as though her hand is forced because she does not want to violate the residents' rights and does not feel the need to discharge her. I made Ms. White aware that I am going to interview all parties involved as a part of the investigation and I will conduct an exit conference with her once the investigation is complete. She denied having any questions at this time.

On 11/25/2025, I received a return call from Resident A's guardian, Shavonne Rippy. I made Ms. Rippy aware of the allegation and proceeded to interview her. Ms. Rippy stated Resident A is very uncooperative. She stated when she calls to speak with her, she hangs up on her. She stated Resident A does not want services and she refuses all service providers that try to engage her. Ms. Rippy stated she does not have any concerns regarding the services Resident A is receiving. She stated Resident A has a history of being combative and non-compliant.

On 12/02/2025, I contacted direct care staff, Dionne Stamps, regarding the allegation. Ms. Stamps stated Resident A receives her medication as prescribed. She stated Resident A can be uncooperative at times, but it is mainly with the other staff. She stated there are times she refuses her medication. Ms. Stamps explained that Resident A's medications come from CVS, they do not come from United Specialty like the other residents. She stated Resident A's medications are administered based on the label instructions on the medication that she provides. Ms. Stamps stated Resident A does not allow the staff to be involved in her medical needs, appointments or medications.

On 12/02/2025, I contact Ms. Clark regarding the allegation. Ms. Clark stated Resident A receives her medication as prescribed. Ms. Clark began to recite Resident A's medications and the times she receives them. She stated she has been employed at that home for over 29 years, and this is the first time it seems as though a resident is targeting her. She stated Resident A has threatened to get her fired and she is very rude towards her. Ms. Clark stated Resident A has threatened to call recipient rights on her multiple times, until she gets fired. Ms. Clark denied the allegation and stated Resident A receives her medication as prescribed.

On 12/02/2025, I conducted an exit conference with Ms. White. I made Ms. White aware that based on the information received there is insufficient evidence to support the allegation that Resident A is not receiving her medications as prescribed. I made her aware that based on my interview and interaction with Resident A she is combative, and it seems as though she is controlling the situation and not allowing the direct care staff to do their job. I explained that Resident A does not allow the staff to be involved in her medical needs, appointments or medications, which is concerning because how do you know when medication has been discontinued or changed. I expressed concerns that Resident A is not receiving proper services and suggested Ms. White address the situation, which she agreed.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.</b>
<b>ANALYSIS:</b>	<p>During this investigation, I interviewed licensee designee, Charlotte Coleman-White; home manager, Bernice James; direct care staff, Dionne Stamps and Deborah Clark; Resident A's guardian, Shavon Rippey with Guardian Care regarding the allegation. All of which denied the allegation, except Resident A.</p> <p>Resident A refuses to allow the staff to be involved in her medical needs, appointments or medications which hinders the direct care staffs ability to do their job. Resident A refuses services from Team Wellness, Guardian Care, case management and psychiatric services. She has a history of being combative and non-compliant.</p> <p>Based on the information received, I am unable to determine there is evidence to support the allegation that Resident A's medications are not given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional. The allegation is unsubstantiated.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:** I reviewed Resident A's MARs from September 2025 to date. The following medications were not initialed:

- Metformin HCL 500mg, take one tablet twice daily was not initialed on 9/01/2025 at 5:00p.m.
- Erythromycin 0.5% eye ointment, apply to lower eyelid three times daily was not initialed on 9/30/2025 at 5:00p.m. and 8:00p.m.

I reviewed Resident A's MARs for October 2025. The following morning medications were not initialed on 10/01/2025:

- Levothyroxine 88mcg, take one table daily was not initialed at 7:00a.m.
- Amlodipine Besylate 10mg, take one tab daily was not initialed at 8:00a.m.
- Atorvastatin 10mg, take one tab daily was not initialed at 8:00a.m.
- Metformin HCL take one table twice daily was not initialed at 8:00a.m.
- Erythromycin 0.5% eye ointment, apply to lower eyelid three times daily was not initialed at 8:00a.m.

On 12/02/2025, I contacted direct care staff, Dionne Stamps, regarding the MARs not being initialed on 10/1/2025. allegation. Ms. Stamps stated Ms. James previously brought this to her attention. She stated Resident A did receive her medication on that day. She stated there was an argument between residents and she got distracted after giving Resident A her medication and forgot to initial. She reiterated that Resident A did receive her medication.

On 12/02/2025, I conducted an exit conference with Ms. White. I made Ms. White aware during the course of the investigation I reviewed Resident A's MARs, and initials were missing, I referenced the dates and times. Ms. White stated she is aware and has implemented a corrective action. I explained that based on the violation, a written corrective action plan is required, which Ms. White agreed. She denied having any questions.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<p><b>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:</b></p> <p><b>(b) Complete an individual medication log that contains all of the following:</b></p> <ul style="list-style-type: none"> <li><b>(i) Medication name.</b></li> <li><b>(ii) Dosage.</b></li> <li><b>(iii) Label instructions for use.</b></li> <li><b>(iv) Time to be administered.</b></li> <li><b>(v) Initials of the individual who administered the medication at the time given.</b></li> <li><b>(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.</b></li> </ul>

<b>ANALYSIS:</b>	At the time of inspection, Resident A's medication log did not contain the initials of the individual who administered the medication at the time given.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same



12/2/2025

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Denasha Walker  
Licensing Consultant

Date

Approved By:



12/4/2025

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Ardra Hunter  
Area Manager

Date