GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 5, 2026

LaToshia Baruti
Vintage Specialized Services LLC
P.O. Box 541
Leslie, MI 49251

RE: License #: AS380417986
Investigation #: 2026A0007028
Creekside Residential Care - Metro

Dear Ms. Baruti:

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 (517) 335-5985.

Sincerely,

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380417986
Investigation #:	2026A0007028
Complaint Receipt Date:	04/09/2026
Investigation Initiation Date:	04/09/2026
Report Due Date:	06/08/2026
Licensee Name:	Vintage Specialized Services LLC
Licensee Address:	207 E. Bellevue St. Leslie, MI 49521
Licensee Telephone #:	(313) 567-0709
Administrator:	LaToshia Baruti
Licensee Designee:	LaToshia Baruti
Name of Facility:	Creekside Residential Care - Metro
Facility Address:	219 Second Street Jackson, MI 49201
Facility Telephone #:	(517) 795-8731
Original Issuance Date:	05/13/2025
License Status:	REGULAR
Effective Date:	11/13/2025
Expiration Date:	11/12/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The medications are kept out in the open and the residents could get into them. The keys are left in the med cart. The staff forges signatures and documentation. All documentation is lost or unorganized, several medication errors take place.	Yes
Audits are not completed throughout the year, but quickly at the end, including fraudulent paperwork. No drills or meetings take place but are documented for.	No
The facility has another family member (name unknown) who strips clients of their rights and disrespects them, due to their connection in the business.	No
Additional Findings	Yes

III. METHODOLOGY

04/09/2026	Special Investigation Intake- 2026A0007028
04/09/2026	Special Investigation Initiated – Letter - APS Referral
04/09/2026	APS Referral Made.
04/09/2026	Contact - Document Received - APS referral denied.
04/09/2026	Contact - Telephone call received from LaShanda Walker, ORR. Discussion.
04/14/2026	Inspection Completed On-site - Unannounced - Face to face contact with Imani Love, DCW, Shaina Johnson, DCW, Resident A, Resident B, and Resident D.
04/14/2026	Contact - Telephone call received from and to Brenda Knowles, Home Manager. Message received and message left.
04/14/2026	Contact - Telephone call received from Brenda Knowles, Home Manager. Discussion.
04/21/2026	Contact - Face to Face with Brenda Knowles, Home Manager during (SIR# 2026A0007027).

04/23/2026	Contact - Telephone call received from LaToshia Baruti, Licensee Designee. Message left.
04/24/2026	Contact - Telephone call made to LaToshia Baruti, Licensee Designee. Discussion.
06/01/2026	Contact - Document Sent - Email to LaShanda Walker, ORR. Status update requested.
06/01/2026	Contact - Telephone call received from LaShanda Walker, ORR. Status update provided.
06/02/2026	Contact - Telephone call made to Brenda Knowles, Home Manager. Follow up.
06/03/2026	Inspection Completed On-site - Unannounced- Face to face contact with Imani Love, DCW, Hailee Reul, DCW, Resident A, Resident C, Resident D, and Brenda Knowles, Home Manager.
06/03/2026	Contact - Telephone call received from Ms. Baruti, Licensee Designee. Discussion.
06/03/2026	Contact - Document Received- Email from Ms. Baruti, Licensee Designee.
06/04/2026	Exit conference conducted with LaToshia Baruti, Licensee Designee, and Ernest Flagg, Director of Clinical Services and Staff Training.

ALLEGATIONS: The medications are kept out in the open and the residents could get into them. The keys are left in the med cart. The staff forges signatures and documentation. All documentation is lost or unorganized, several medication errors take place.

INVESTIGATION:

On April 14, 2026, I conducted an unannounced on-site investigation and made face to face contact with Imani Love, direct care worker (DCW), who also has the role of assistant home manager, Shaina Johnson, DCW, Resident A, Resident B, and Resident D. Staff informed me that Resident C was at school. While at the facility, I noticed that the staff office had been transformed into a bedroom. Imani Love informed me that Resident D had moved into the facility due to a physical plant issue at the facility on Dixon Rd. I did not observe any medications out in the open or not kept in a locked cabinet. Regarding the keys to the medication, I asked if they were kept on an assigned staff person, and Imani Love informed me they were kept in the drawer. It was noted that the keys were in the kitchen, in a drawer, next to the

refrigerator. No keys were observed to be left in the medication cart. I inquired if there were any residents who received medications at noon and she stated there were not. I reviewed the medications and medication logs. Imani Love confirmed that she had been trained to pass medications. We discussed medications and how they were administered. Imani Love arrived to work that day at 8:00 a.m. She informed me that Resident C, who attends school at 8:00 a.m., had a morning medication. Imani Love described that she would pass the medication and then wait to initial the medication log until after the resident takes the medication. It was noted that it was 1:00 p.m. and the medication log had not been initialed for the 8:00 a.m. medication.

It also was noted that the medication log for Resident B was missing staff initials on April 8, 2026, and April 9, 2026, for the Sodium Fluor 5000 CRE: (Brush /pea sized strip twice a day). The 8:00 a.m. and 8:00 p.m. initials were missing for both days. However, the other medications were initialed for on those dates. It was also noted that several of the 8:00 a.m. medications had not been initialed for that day (April 14, 2026).

The medication logs for Resident D reflected that four of the 8:00 a.m. medications had not been initialed for on April 12, 2026, and April 14, 2026.

I spoke with Imani Love and explained the importance of documenting all medications at the time of medication administration.

After reviewing the medications and interviewing Resident A, it was noted that Amani Love was getting ready to take a resident to an outing. She pulled me aside and informed that there was a situation over the weekend where a staff member came to the facility and took paperwork. They were unsure exactly what was missing as that was being investigated, however, Brenda Knowles, Home Manager, would have some additional information. In addition, they had recently let staff go.

On April 16, 2026, I spoke with Brenda Knowles, Home Manager. We discussed the investigation, and she informed that there may have been some confusion about the medication keys and where they were to be kept. We also discussed the issues with the medication logs. Brenda Knowles informed me that there were no medication errors that she was aware of, and that all staff were fully trained to pass medications.

On April 21, 2026, Brenda Knowles informed me that they were not sure which documentation was missing as everything was being reviewed.

On April 24, 2026, I spoke with Ms. Baruti, Licensee Designee, regarding the investigation. We discussed the discrepancies with the medication logs. She stated she spoke with Imani Love about the medications and they’re going to start auditing files every Friday.

Ms. Baruti also informed me that she had to terminate staff on or about April 19, 2026, as they were doing things such as eating out of the pan (instead of getting a

plate). The individual who was terminated came to the home to pick up groceries and they later discovered that paperwork was missing. The individual also worked at this facility (Creekside Residential Care – Metro – AS380417986). The individual then was a no call, no show.

Ms. Baruti also confirmed that she is related to Imani Love (daughter) and Brandon Love (son), and both are fully trained. We also discussed her hiring or contracting with a registered nurse to assist with medication procedures, as Ms. Baruti has a certain way that she would like things to be done. She wanted processes in place to adequately address any issues with medications/documentation.

On June 2, 2026, I interviewed Althea Fox, DCW. She stated that she has been employed for Creekside Resident Care since 2023, and she works as a direct care worker on third shift. She stated she usually works alone. She also stated that no one has asked her to sign for work that she did not complete or falsify any documents.

On June 3, 2026, I conducted an unannounced on-site investigation and made face to face contact with Imani Love, DCW, Hailee Reul, DCW, Resident A, Resident C, Resident D, and Brenda Knowles, Home Manager. I informed staff that I was following up on the pending investigation. While at the facility, I noted that Imani Love had the medication keys on her person, and the medication cart was observed to be locked. I randomly selected and reviewed the medication logs and medications for Resident B and Resident C, and no errors were noted.

I interviewed Hailee Reul, DCW. She informed me that she has worked for the licensee since October of 2025, and she was helping to cover at this home. She reported that she did not pass medications. She also informed me that she has not been asked to falsify documents and she has not falsified records.

I interviewed Resident C and Resident A. Both reported receiving their prescribed medications and had no concerns.

While at the facility on June 3, 2026, I did not observe any medications left out or the medication cabinet to be unsecured.

On June 4, 2026, I conducted the exit conference with LaToshia Baruti, Licensee Designee, and Ernest Flagg, Director of Clinical Services and Staff Training. We discussed the investigation, the conclusion, and my recommendations. They agreed to submit a written corrective action plan to address the established violations.

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:	Based upon my investigation, which consisted of unannounced on-site investigations, observations, interviews with staff and administration, it's concluded that there is not a preponderance of the evidence to support the allegations that medications are left out and accessible to the residents. While the keys were not observed to be left in the medication cart, on April 14, 2026, it was noted that the keys to the medication cart were not kept with staff but instead in a drawer next to the refrigerator, making them accessible to the residents. Based upon that information, it's concluded that there is a preponderance of the evidence to support the allegations that the keys to the medication cart were not safeguarded.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(b) Complete an individual medication log that contains all of the following:** **(i) Medication name.** **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) Initials of the individual who administered the medication at the time given.** **(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.**

ANALYSIS:	Based upon my investigation, which consisted of unannounced on-site investigations, observations, interviews with staff and administration, and review of relevant documents, it's concluded that while it was not confirmed that staff falsified documentation and the records were unorganized, there is a preponderance of the evidence to support the allegations that staff did not promptly initial the medication logs for Resident B, Resident C, and Resident D, at the time of medication administration.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS: Audits are not completed throughout the year, but quickly at the end, including fraudulent paperwork. No drills or meetings take place but are documented for.

INVESTIGATION:
On April 14, 2026, Imani Love informed me that there was a situation over the weekend where a staff member came to the facility and took paperwork. They were unsure exactly what was missing as that was being looked into, however, Brenda Knowles, Home Manager, would have some additional information.

On April 16, 2026, I spoke with Brenda Knowles, Home Manager and she informed me that they were dealing with a disgruntled worker.

On April 24, 2026, I spoke with Ms. Baruti, Licensee Designee, regarding the investigation, and she reported that they're going to start auditing files every Friday.

On June 2, 2026, I spoke with Brenda Knowles, Home Manager, as I had some follow up questions. I requested that she submit the fire drill records for the first quarter of 2026. It was noted that I only received a fire drill record for March of 2026. The fire drill was conducted during the daytime hours on 3/18/2026. Brenda Knowles informed me that the residents did not move into the facility until March 17, 2026; therefore, there were no fire drills conducted prior to that.

On June 2, 2026, I interviewed Althea Fox, DCW. She reported that the meeting place for residents during a fire drill was at the end of the driveway.

On June 3, 2026, I interviewed Imani Love and she informed me that she does not falsify any documents and keeps up with her documentation daily.

During the interview with Hailee Reul, she informed me that she has not been asked to falsify documents and she has not falsified records. Regarding the fire drills, she informed me that she participated in fire drills and stated the meeting place was at the corner.

I interviewed Resident C and Resident A and they both reported participating in the fire drills and knew the meeting place.

During the interview with Resident A, she confirmed that they have house meetings and the residents can voice their concerns; including any concerns about staff. Resident A informed me that she found the meetings to be helpful.

On June 3, 2026, I reviewed the fire drill logs and noted that fire drills were conducted in April and May as required. The documents were maintained in the fire book, which was a labeled binder, with dividers and plastic covers for each document.

APPLICABLE RULE	
R 400.617	**Records.**
	(1) A licensee shall maintain the following records: **(k) Fire drill records.**
ANALYSIS:	Based upon my investigation, which consisted of unannounced on-site investigations, observations, interviews with staff and administration, and review of relevant documents, it's concluded that there is not a preponderance of the evidence to support the allegations that the staff are falsifying the records and they're not being maintained.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility has another family member (name unknown) who strips clients of their rights and disrespects them, due to their connection in the business.

INVESTIGATION:
On April 14, 2026, I interviewed Resident A and she informed me that she liked living in this facility, as there was better phone service. Resident A reported having access to the community, her room, phone etc. Regarding how she got along with the other residents, Resident A stated that she did not get along with Resident D. Regarding how she was treated by the staff, she stated she was treated okay. She also stated that some staff were stricter than others, but it was more about their tone. In the past, a staff member cursed but they no longer work there. Resident A talked about wanting to live on her own and having a lemonade stand.

While I was at the facility, it was noted that Resident B just smiled when I spoke to her, Resident C was at school, and Resident D was resting in his bed.

On June 1, 2026, I spoke with LaShanda Walker, ORR. She informed me that she completed an on-site visit on April 14, 2026. There was one resident in the home at

the time of her visit, and there were no concerns reported. She stated that it appeared that there was a disgruntled employee who was making the allegations, after the licensee tried to recoup money for overpayment.

On June 3, 2026, I interviewed Hailee Reul and she informed me that the staff interact well with the residents. The residents have access to their rooms, the community and cell phones. She also stated that Resident C's phone is taken away at 6:00 p.m.; however, she was not sure why, as she was just covering in the home.

While at the facility, I also observed a posted note/reminder regarding Resident C's phone restrictions.

I interviewed Resident C. She reported having access to her cell phone for six hours a day, per her guardian. Resident A reported that the staff at the facility treat her good and much better than her parents treated her. Resident C informed me that she did not have any concerns about the facility or how she was treated by staff.

During the interview with Resident A, she did not report any concerns about how staff treated her, and she informed me that there were avenues available for residents to voice their concerns.

I spoke with Imani Love and inquired about the phone restrictions for Resident C. She stated that they were following the recommendations of the guardian and case manager. I inquired if the restrictions were outlined in her *Assessment Plan* or *Individual Plan of Service*. Imani Love reviewed the most recent IPOS and was not able to locate the information. She also contacted administrative staff, including Ms. Baruti, as she stated they discussed this at the meeting on April 1, 2026, and was not sure why the information was not included in the plan. I also spoke with Ms. Baruti on the telephone, and she stated that the information regarding the phone restrictions were not in her IPOS; however, she had always had phone restrictions, as Resident C would tell men where the group home is located, she has phone contact with several men and gives out information that could be a safety risk. Ms. Baruti stated they would call the case manager and guardian and get something in writing until the information could be included in the IPOS. She also stated she would review her emails to determine if she had any written documentation regarding this matter.

It should be noted that while I was at the facility, I noticed that Resident C was on her cell phone, and she was telling the individual her plans for the day. She also told the person on the phone that she would not cheat on them. Resident C was in the line of sight while speaking on her phone in the living room.

On this same day, Ms. Baruti forwarded me an email from Resident C's guardian, and the following was noted:

> "[Resident C] may have a cell phone for two hours a week, one hour of usage at a time, with staff monitoring of the phone usage. [Resident C] is to remain in

sight of staff persons so they can monitor phone usage, including seeing the phone screen, per guardian request. Staff will set a 60-minute alarm, and [Resident C] will end her cell phone usage when her 60 minutes are up.

The phone is to be returned to staff and kept in a safe place. Cell phone usage is to be logged as to when she made calls, the date-time-minutes, and [Resident C's] cooperation in following the guidelines without complaint.

We do not feel that it is in her best interest to be on social media, Whatsap, or other video platforms at this time.

These are baby steps; but if she chooses not to adhere to these guidelines, we will step back and ask that her phone be shut off until we can re-evaluate her cell phone privileges."

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based upon my investigation, which consisted of unannounced on-site investigations, observations, interviews with staff, administration, residents and ORR, it's concluded that there is not a preponderance of the evidence to support the allegations that the residents are not treated with dignity and respect.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation (June 3, 2026), it was discovered that Resident C's phone hours were restricted. Imani Love reviewed the IPOS for Resident C and noted that the phone restrictions and guidelines were not included. Ms. Baruti informed me that the information was not included in the IPOS, but she would get something in writing until the IPOS could be updated. Ms. Baruti provided me with an email from the guardian which outlined the phone usage guidelines.

During the exit conference, I informed Ms. Baruti and Mr. Flagg that it was important to have the information documented and outlined in the plan, as there were some inconsistencies on the time frames that were reported (for when Resident C could use her phone etc.). Having a clear plan will help to ensure that staff are following the programmatic guidelines, while also ensuring that the residents' rights are

protected. We also discussed other challenges with Resident C's case management. They agreed to submit a written corrective action plan to address the established violation.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(2) Interventions must be specified in the resident's assessment plan and performed in accordance with that plan. Interventions must ensure that the safety, welfare, and rights of the resident are adequately protected. If an intervention is needed to address the unique programmatic needs of a resident, the intervention must be developed in consultation with, or obtained from, a professional or professionals licensed, certified, or registered in that scope of practice.
ANALYSIS:	Based upon my investigation, which consisted of unannounced on-site investigations, interviews with the staff, the licensee designee, and Resident C, it's concluded that there is a preponderance of the evidence to support the allegations that the phone interventions and restrictions were not specified in Resident C's IPOS.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

As a part of this investigation, I reviewed the Original Licensing Study Report. It was noted that room to the left of the dining room was licensed as the staff office. On April 14, 2026, during the on-site investigation, it was noted that the staff office was changed and arranged into a bedroom for Resident D.

On April 24, 2026, Ms. Baruti stated that the facility was licensed for six residents. On March 17, 2026, they received approvals to move Resident A, Resident B, and Resident C into the facility (from another facility). Ms. Baruti also stated that the oil boiler had gone out at Creekside Residential Care – West (AS380410974), it was a big ordeal as they didn't know what was going on; therefore, they evacuated. She stated that Resident D was moved over to this facility (Creekside Residential Care – Metro (AS380417986) that day, otherwise she would have utilized the hotel until the problem was fixed. The three female residents were on the second floor, and Resident D, who is a male was placed on the first floor. I informed Ms. Baruti that licensing must be notified of these changes within ten business days after the change occurs.

On June 3, 2026, I observed Resident D resting in his bed. Imani Love informed me that the renovations were almost completed and he would be moving in two weeks.

During the exit conference, I clarified situations in which licensing should be notified of changes. Ms. Baruti and Mr. Flagg agreed to submit a written corrective action plan.

APPLICABLE RULE	
R 400.611	**Required information; fee; posting of license; change of information.**
	(4) An applicant or licensee shall give written notice to the department within 10 business days after a change occurs in information that was previously submitted in or with an application for a license.
ANALYSIS:	While it's noted that the licensed capacity for the facility is six, and the licensee did not exceed the licensed capacity; and the staff office was transformed into a bedroom for Resident D because the other bedrooms were occupied by female residents, the licensee did not notify licensing within ten business days after the change occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.

6/4/2026

_____

Mahtina Rubritius Date
Licensing Consultant

Approved By:

06/04/2026

_____

Dawn N. Timm Date
Area Manager