GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 25, 2026

Jenice Choate
Coventry Home, LLC
14901 Coventry
Southgate, MI 48195

RE: License #: AS820395902
Investigation #: 2026A0575031
The Retreat At Meadowbrook

Dear Ms. Choate:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 284-9720.

Sincerely,

Jeffrey J. Bozsik, Licensing Consultant
Bureau of Community and Health Systems
(734) 417-4277

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

I. IDENTIFYING INFORMATION

License #:	AS820395902
Investigation #:	2026A0575031
Complaint Receipt Date:	06/08/2026
Investigation Initiation Date:	06/08/2026
Report Due Date:	07/08/2026
Licensee Name:	Coventry Home, LLC
Licensee Address:	14901 Coventry Southgate, MI 48195
Licensee Telephone #:	(734) 234-8900
Administrator:	Jenice Choate
Licensee Designee:	Jenice Choate
Name of Facility:	The Retreat At Meadowbrook
Facility Address:	19772 Meadowbrook Northville, MI 48167
Facility Telephone #:	(248) 308-3399
Original Issuance Date:	10/21/2019
License **Status:**	REGULAR
Effective Date:	04/21/2026
Expiration Date:	04/20/2028
Capacity:	6
Program Type:	ALZHEIMERS; AGED

II. ALLEGATION(S)

	Violation Established?
Resident A mistreated by former direct care staff Capri Summers.	No
Primary means of egress door locked with a key.	No
Primary means of egress not ramped/not ramped correctly.	Yes

III. METHODOLOGY

06/08/2026	Special Investigation Intake-2026A0575031
06/08/2026	APS Referral received
06/08/2026	Special Investigation Initiated -On Site-(a) interview with Resident A and review of her assessment plan; (b) Residents B, C, and D; (c) Laura Hamey-home manager
06/09/2026	Contact - Telephone call made-(a) Guardian A1; (b) Jenice Choate, licensee designee; (c) former direct care staff Capri Summers
06/09/2026	Contact - Document Received-video dated 4/26/2026 of alleged assault
06/10/2026	Contact - Telephone call made-interviews with Guardians B1, C1, and D1
06/12/2026	Inspection Completed On-site- interview with Jenice Choate, licensee designee
06/12/2026	Inspection Completed-BCAL Sub. Compliance
06/12/2026	Contact - Document Received-Northville Township Police department-police report #26-17385
06/12/2026 06/24/2026	Exit Conference- with Jenice Choate, licensee designee Contact- Telephone call made- (a) Jenice Choate, licensee designee; (b) Shavonn Larry-direct care staff

ALLEGATION:

Resident A mistreated by former direct care staff Capri Summers

INVESTIGATION:

On 6/8/2026, I interviewed Resident A. Due to her dementia she was unable to remember any details to the 4/26/2026 video that allegedly depicted her of being mistreated by former staff Capri Summers.

On 6/8/2026, Resident B was unavailable for an interview as she was out and in the process of moving to another facility. Residents C and D also have dementia which resulted in them not having any recollection of being mistreated or of witnessing any other residents being mistreated by anyone.

On 6/8/2026, I interviewed Laura Hamey, home manager. She stated that she was not employed when the alleged mistreatment took place, but that she had no knowledge of any current staff mistreating any of the residents.

On 6/9/2026, I contacted Guardian A1. She said that the incident only involved one staff member and she was satisfied that the alleged perpetrator Capri Summers was no longer employed at the facility. She stated that she was satisfied with the facility placement and services.

On 6/9/2026, I interviewed Jenice Choate, licensee designee. She provided me with a copy of the 4/26/2026 video of former staff Capri Summers allegedly mistreating Resident A. She gave me Capri Summers' telephone number and stated that she was no longer employed by Coventry Home LLC.

On 6/9/2026, I reviewed the video of Capri Summers allegedly mistreating Resident A. I observed Capri Summers assisting Resident A out of her wheelchair by her arm and on to the sofa. Resident A appears to awkwardly sit on the sofa at an angle with Capri Summers then attempting to straight her out on the sofa. They appear to talk but there is no audio accompanying the video to know what was spoken. I did not see any evidence of Capri Summers mistreating Resident A.

On 6/9/2026, I interviewed former direct care staff Capri Summers. She denied mistreating Resident A and stated that she quit her employment to pursue her college education.

On 6/10/2026, I interviewed Guardians B1, C1, and D1. Guardian B1 stated that Resident B is moving out of the facility, and she had no knowledge of any staff

mistreating any residents. Guardians C1 and D1 stated that they were satisfied with the placement and had no knowledge of any staff mistreating residents.

On 6/12/2026, I visited the Northville Township police department, and they provided me with copies of the police reports #26-17385 and #26-15997 submitted by officers Urbano and Bachand, respectively, and dated 6/5/2026 and 5/23/2026. In Officer Bachand's report dated 5/23/2026, he viewed the video from 4/26/2026, interviewed Resident A, spoke by text to Guardian A1 and with Resident A's grandson, and concluded that he did not find any evidence of a crime in this case. In officer Urbano's police report, dated 6/5/2026, he responded to an APS referral for possible elder abuse of Resident A. He conducted a welfare check at the facility on 6/5/2026 and found Resident A to be in good care.

On 6/24/2026, I interviewed direct care staff Shavonn Larry. She stated that Resident A may request to go to the bathroom every 15-30 minutes per day. She stated that she takes her to the bathroom and she uses the toilet about 50% of the time. Also, she stated she has never seen or heard of any staff denying Resident A proper eating utensils.

On 6/24/2026, I interviewed Jenice Choate, licensee designee. She stated that when Resident A was placed at the facility, she had a UTI and would frequently request to us the bathroom. She stated that even though Resident A's UTI has been treated when she recently worked the overnight shift, Resident A frequently requested to use the bathroom. However, when she walked into her room to assist her to the bathroom, she was asleep. Also, she stated she has never seen or heard of any staff denying Resident A proper eating utensils.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	The preponderance of evidence is that Resident A was not mistreated by former direct care staff Capri Summers.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Primary means of egress door locked with a key

INVESTIGATION:

On 6/12/2026, I conducted an onsite inspection and found the back door of the facility which leads out to a deck to have a key lock. This means of egress is not one of the two required means of egress for this facility.

APPLICABLE RULE	
R 400.725	**Means of egress.**
	(3) Doors that form a part of a required means of egress must be equipped with positive-latching, non-locking-against-egress hardware and have a width to allow for residents requiring wheelchairs or other devices to easily navigate through doorways.
ANALYSIS:	Since this door is not a required means of egress then it can have a key lock.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Primary means of egress not ramped/not ramped correctly

INVESTIGATION:

On 6/12/2026, as part of my onsite inspection, I measured the 2 primary means of egress used by this facility. One of the egresses exits had no ramp and there were 2 steps, each 7-8 inches, out of the front door to ground level. The other exit had a ramp, but with the step being 7-8 inches high and the ramp being 3 feet long, it doesn't meet the 1 foot of run for each inch of rise requirement.

On 6/12/2026, I conducted an exit conference with Jenice Choate, licensee designee. She stated that she agreed with my findings.

APPLICABLE RULE	
R 400.725	**Means of egress.**
	(5) Facilities that accommodate residents who regularly require wheelchairs must be equipped with ramps located at 2 approved means of egress from the first floor. Ramps constructed before the effective date of these rules must not exceed 1 foot of rise in 12 feet of run. Ramps

	constructed on or after the effective date of these rules must comply with R 400.647(10).
ANALYSIS:	Since these 2 exits are the approved means of egress for this facility, the ramps, which were constructed before the effective date of these rules, exceeded the 1 foot of rise in 12 feet of run requirement. Therefore, this facility that accommodates residents who regularly require wheelchairs is not equipped with ramps located at 2 approved means of egress from the first floor that do not exceed 1 foot of rise in 12 feet of run.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes in the license status.

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Jeffrey J. Bozsik
Licensing Consultant

Date: 6/24/2026

Approved By:

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Ardra Hunter
Area Manager

Date: 6/25/2026