GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 05, 2026

Tamisha Kaplan
A Caring Home of Michigan, LLC
P.O. Box 81
Walled Lake, MI 48390

RE: License #: AS630418269
Investigation #: 2026A0602019
Chateau of Bloomfield-Lasher Home

Dear Ms. Kaplan:

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 (248) 972-9136.

Sincerely,



Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3044 West Grand Blvd
2nd Floor Annex, Suite 2-730
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630418269
Investigation #:	2026A0602019
Complaint Receipt Date:	07/23/2026
Investigation Initiation Date:	07/23/2026
Report Due Date:	09/21/2026
Licensee Name:	A Caring Home of Michigan, LLC
Licensee Address:	45750 Eleven Mile Novi, MI 48374
Licensee Telephone #:	(248) 380-4663
Administrator:	Tamisha Kaplan
Licensee Designee:	Tamisha Kaplan
Name of Facility:	Chateau of Bloomfield-Lasher Home
Facility Address:	2563 Lasher Road Bloomfield Hills, MI 48304
Facility Telephone #:	(248) 380-4663
Original Issuance Date:	12/16/2024
License Status:	REGULAR
Effective Date:	06/16/2025
Expiration Date:	06/15/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 07/23/2026, unidentified group home staff members yelled at Resident C and tried to break his phone in an unspecified manner. Unidentified group home staff members yelled at Resident C in the past attempting to get him out of bed.	Yes
Staff refused to transport Resident C to summer camp, and he was sent to camp in an Uber by himself.	Yes
There was no food in the home for two days and staff did not provide Resident C with lunch on 7/27/2026 and 7/28/2026.	No
Staff members punched and dragged Resident A by his shirt leaving bruises.	No

III. METHODOLOGY

07/23/2026	Special Investigation Intake 2026A0602019
07/23/2026	Special Investigation Initiated - Telephone
07/23/2026	APS Referral Adult Protective Services (APS) referral denied.
07/30/2026	Comment Additional allegations received.
07/30/2026	APS referral Adult Protective Services referral received.
07/31/2026	Inspection Completed On-site Interviewed Resident B, Resident C, Resident D, staff members Thomas Bates, Crystal Cooper, Khamya Young, and Charles Lee.
08/03/2026	Contact – Telephone call made Message left for staff member Ashley Wilkens.
08/03/2026	Contact – Telephone call made Spoke with staff member Chenille Dearman.

08/04/2026	Contact – Telephone call received Spoke with office of recipient rights worker, Hailey Milner. She confirmed she has an open investigation.
09/03/2026	Contact – Telephone call received Spoke with assigned APS worker, Tanisha Tipton.
09/17/2026	Contact – Telephone call made Spoke with Resident C's father.
09/17/2026	Contact – Telephone call made Message left for Resident C's care coordinator.
09/30/2026	Exit Conference Held with the licensee designee, Tamisha Kaplan by telephone.

ALLEGATION:

- **On 07/23/2026, unidentified group home staff members yelled at Resident C and tried to break his phone in an unspecified manner. Unidentified group home staff members yelled at Resident C in the past attempting to get him out of bed.**
- **Staff refused to transport Resident C to summer camp, and he was sent to camp in an Uber by himself.**
- **There was no food in the home for two days and staff did not provide Resident C with lunch on 7/27/2026 and 7/28/2026.**
- **Staff members punched and dragged Resident A by his shirt leaving bruises.**

INVESTIGATION:

On 7/23/2026, a complaint was received and assigned for investigation alleging that unidentified group home staff members yelled at Resident C and tried to break his phone in an unspecified manner, unidentified group home staff members yelled at Resident C in the past attempting to get him out of bed and staff refused to transport Resident C to summer camp and he was sent to camp in an Uber by himself.

On 7/30/2026, additional allegations were received alleging that there was no food in the home for two days, staff did not provide Resident C with lunch on 7/27/2026 and 7/28/2026 and staff members punched and dragged Resident A by his shirt leaving bruises.

On 7/31/2026, I conducted an on-site investigation at which time I separately interviewed Resident A, Resident B, Resident C, Resident D and staff members Khamya Young, Crystal Cooper, and Charles Lee. Resident A stated he did not hear staff yell at Resident C or try and break his phone. Resident B stated he moved into the

home about two months ago and has never witnessed staff yell at Resident C or try and break his phone.

Resident A stated he had no knowledge of staff yelling at Resident C, trying to break his phone or refusing to take him to camp. Resident A denied that there was no food in the home for two days and had no knowledge of Resident C not receiving lunch on 7/27/2026 and 7/28/2026. Resident A also denied that staff members, Derick, Ashley and Felisha punched and dragged him by his shirt. I observed Resident A's stomach, back, legs, and arms and did not observe any marks or bruises.

Resident B stated he had no knowledge of staff trying to break Resident C's phone, refused to take him to camp or sent him in an Uber by himself. Resident B said he has heard staff yell at Resident C (exact date unknown). Resident B denied that there was no food in the home for two days and had no knowledge if Resident C was not provided lunch on 7/27/2026 and 7/28/2026. Resident B did not witness any staff member abusing Resident A.

Resident C stated staff yelled at him to get in the car and said, "If you don't get in the car, I'm going to break your phone." He went on to state that he got into the car, and staff did not break his phone. Resident C said staff member Khamya Young would not take him to his summer camp (exact unknown date) and yelled at him. He had to take an Uber to the main office, and someone from the main office dropped him off at his camp. Resident C stated Ms. Young did not make his lunch for camp, and he had to make it himself (exact date unknown). He then said, "I called my dad to bring me a lunch, and he did." Resident C denied that there was no food in the home for two days and said he did not witness any staff member abusing Resident A.

Resident D stated he has lived in the home about a year now and has not heard staff yell at Resident C, try and break his phone or refuse to take him to camp. Resident D denied that there was no food in the home for two days and said there is always food in the home. He said he had no knowledge if Resident C was not provided lunch on 7/27/2026 and 7/28/2020 as he goes to camp or school every day. He went on to state that there is always food in the home.

Ms. Young stated she has raised her voice at Resident C in the past during episodes of his aggressive behavior. She said she understands this is not acceptable and agreed not to do it again. She had no knowledge of any staff member breaking or threatening to break Resident C's cell phone. Ms. Young said she recalled an incident (exact date unknown) when she was sitting in the staff office and Resident C knocked on the door. Resident C was upset and yelled at her, "Why didn't you make my lunch? You're supposed to make it!" Ms. Young told Resident C that she did not know as she had just arrived for her shift and staff on the previous shift were supposed to make his lunch. Resident C walked away very agitated, yelling and screaming. Ms. Young called the manager and stated she did not feel comfortable transporting Resident C to his camp due to his behavior and that a staff member did not show up for their shift. Ms. Kaplan sent an Uber to pick Resident C up and had him transported to the main office and

someone at the main office transported him to his camp. Ms. Young stated Resident C was provided with lunch, but he is a picky eater and if he does not like what is packed in his lunch, he will not eat it and say he did not get lunch. She denied that there was no food in the home for two days as there was always food in the home. Ms. Young said she never witnessed any staff member abuse any of the residents.

Ms. Cooper stated she began working for the company in July 2026 and only works on Saturdays and Sundays. She had no knowledge of staff yelling at Resident C, attempting to break his phone and refusing to take him to camp. She said there is always food in the home, and she has never witnessed any staff member punch or hit Resident A.

Mr. Lee stated he began working for the company in January 2026 and usually works the day shift between the hours of 7:00 am – 3:00 pm or the afternoon shift between the hours of 3:00 pm – 7:00 am. Mr. Lee said sometimes staff will call out Resident C's name loudly in the morning to get him up for school but he has never witnessed any staff member yelling at Resident C in a mean or inappropriate manner. Mr. Lee had no knowledge of staff attempting to break Resident C's phone or refused to take him to camp. Mr. Lee said there is always food in the home. He went on to state that he has no knowledge of any staff member punching or dragging Resident A.

On 7/31/2026, I observed adequate food in the home. There was milk, juice, eggs, bread etc. in the refrigerator, meat and frozen meals in the freezer and canned goods in the pantry.

While conducting the on-site investigation, I reviewed a copy of Resident C's individual plan of service (IPOS) dated 6/10/2026. According to the plan, Resident C has a diagnosis of autism and requires 1-1 staffing.

On 8/03/2026, I spoke with staff member Chenille Dearman by telephone. Ms. Dearman stated she began working for the company in April 2026 as a direct care worker and was appointed as the home manager on 8/01/2026. Ms. Dearman had no knowledge of staff yelling at Resident C, attempting to break his phone or refusing to take him to camp. She said there is always food in the home and to her knowledge Resident C receives lunch every day. Ms. Dearman stated to her understanding, Resident C is allowed to use an Uber if it is monitored.

On 9/03/2026, I spoke with the assigned APS worker Tanisha Tipton by telephone. Ms. Tipton stated she interviewed each resident, multiple staff members, Resident C's father, observed plenty of food in the home and will not be substantiating any allegations of abuse or neglect. Ms. Tipton said her case will be closed.

On 9/17/2026, I spoke with Resident C's father by telephone. Resident C's father stated he is active in his son's life and does not have any issues to report regarding the care his son receives. The staff at the home keep him informed of any issues that arise. He was informed that a staff member was disciplined due to yelling at his son. Resident

C's father stated there was an incident when he gave Ms. Kaplan permission to have his son transported from the group home to the main office by Uber (unknown date). He was informed that there was a staffing issue and Resident C could not be transported to camp by the group home staff. Resident C's father said he is aware that his son should have 1-1 staffing but felt it would be okay for him to go to the office by Uber. Resident C's father stated his son is always provided with lunch to take to school or camp, and he has never known the home to be without t food. Resident C is a very picky eater and has a small palate. If he does not like what is being served or packed for lunch, he will call him and say he did not eat or he did not have lunch.

On 9/30/2026, I conducted an exit conference with the license designee, Tamisha Kaplan by telephone. Ms. Kaplan stated Ms. Young was suspended for yelling at Resident C and will no longer work with him. She said Resident C was transported alone by Uber from the group home to the main office as there was a staffing issue and he could not be transported to camp by the group home staff. Ms. Kaplan stated she obtained approval from Resident C's father/guardian and his care coordinator. She was able to monitor the Uber from the home in Bloomfield Hills to the main office in Farmington Hills. Ms. Kaplan denied that the home has gone without food and said Resident C will call his father to bring him food if he does not like what is being served. She went on to state that she had no knowledge of Resident A being punched or dragged by any staff member. Ms. Kaplan agreed to submit a corrective action plan upon receipt of this report.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse. (iii) Derogatory remarks. (iv) Threats.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with facility staff members and Residents A, B, C, and D, there is sufficient evidence to substantiate the allegation that staff member Khamya Young yelled at Resident C on an unknown date.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Resident C's Individual Plan of Services (dated 6/10/2026) specifies that he is to have 1:1 staffing. Based upon my investigation, it has been established that Resident C was transported in an Uber alone without staff being present. Although Resident C's father/guardian gave Ms. Kaplan permission for the transport, this approval is not documented in the IPOS.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with facility staff members, Resident C's father, Residents A, B, C, and D and my own observations, there is no evidence to substantiate the allegation that Resident C did not receive lunch on 7/27/2026 and 7/28/2026 or that there was no food in the home for two days.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	During my investigation, Resident A reported the allegation of him being punched and dragged by staff members was not true. Based upon interviews with multiple facility staff members, Residents B, C, and D there is no evidence to substantiate the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

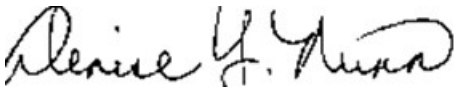
Contingent upon an acceptable corrective action plan, I recommend no change to the status of the license.



10/01/2026

Cindy Berry — Date
Licensing Consultant

Approved By:



10/05/2026

Denise Y. Nunn — Date
Area Manager