GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 8, 2022

Loretta Marshall
Blithesome Home Inc.
P.O. Box 2409
Southfield, MI 48037

RE: License #: AG820000046
Investigation #: 2022A0901012
Hillcrest Residence

Dear Mrs. Marshall:

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) 456-0380.

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

I. IDENTIFYING INFORMATION

License #:	AG820000046
Investigation #:	2022A0901012
Complaint Receipt Date:	01/07/2022
Investigation Initiation Date:	01/10/2022
Report Due Date:	03/08/2022
Licensee Name:	Blithesome Home Inc.
Licensee Address:	P.O.Box 2409 Southfield, MI 48037
Licensee Telephone #:	(313) 613-1227
Administrator:	Loretta Marshall
Licensee Designee:	Loretta Marshall
Name of Facility:	Hillcrest Residence
Facility Address:	2008 W. Grand Boulevard Detroit, MI 48208
Facility Telephone #:	(313) 898-3928
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	04/02/2020
Expiration Date:	04/01/2022
Capacity:	35

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was verbally abused and threatened by staff, Lorenzo. Lorenzo entered Resident A's room and when asked to leave, called Resident A a derogatory name and threatened to fight him.	Yes

III. METHODOLOGY

01/07/2022	Special Investigation Intake 2022A0901012
01/07/2022	APS Referral
01/07/2022	Referral - Recipient Rights
01/10/2022	Special Investigation Initiated - Telephone Administrator, Venessa Campbell
01/10/2022	Contact - Telephone call made Resident A and B
01/12/2022	Contact - Telephone call made Staff, Lorenzo Young
01/12/2022	Contact - Telephone call made Staff, Michael Nunn
01/19/2022	Exit Conference Licensee Designee, Loretta Marshall

01/19/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A was verbally abused and threatened by staff, Lorenzo. Lorenzo entered Resident A's room and when asked to leave, called Resident A a derogatory name and threatened to fight him.

INVESTIGATION:

On 01/10/2022, I made a telephone call to Vanessa Campbell, the administrator. She stated the alleged incident happened 12/21/2022. She was not working that day but Resident A informed her about it. She identified the staff involved as, Lorenzo Young, and stated he denied the allegations. She also indicated Resident A did not have a guardian.

On 01/10/2022, I made a telephone call to the facility and spoke with Resident A. He stated Mr. Young came into his room with no cause. He explained usually when staff come in their room they state why. On this day, Mr. Young did not say anything. When Resident A questioned Mr. Young about being in his room, he was called a derogatory word and Mr. Young threatened to fight him by saying "we can take it outside." He also stated his roommate, Resident B, was present and witnessed it.

On 01/10/2022, I interviewed Resident B. He admitted to being present during the alleged incident. He stated Mr. Young came into their room demanding something, but he could not remember what it was. When Resident A questioned him about being in the room, there was an exchange of words. He said they both were calling each other bad names and using a lot of inappropriate words. Resident B did not want to repeat anything that was said.

On 01/12/2022, I made a telephone call to Mr. Young. He denied the allegations. He stated he was mopping the floors and asked Resident A not to come out his room until he was done, which he had a problem with. Resident A later came out while Mr. Young was passing medication and was recording him with his phone. Due to being defiant, his co-worker, Michael Nunn, had a talk with Resident A and gave him his medication. Mr. Young denied going in Resident A's room or having a verbal exchange with him.

On 01/12/2022, I made a telephone call to the facility and interviewed Mr. Nunn. He stated while Mr. Young was administering medication, Resident A came to the

medication cart and words were exchanged between the two of them. He said Resident A also got made when Mr. Young came in his room. He explained that Mr. Young was checking the radiators in the bedrooms, making sure they were all clear and working properly. Resident A got mad about him coming into his room and they started arguing. Mr. Nunn stated both men said some inappropriate things to each other and was calling each other foul names. He indicated things got ugly fast and should not have gone that far. Mr. Nunn did not want to repeat anything that was said and stated he did not remember word for word. He also denied hearing any threats to fight.

APPLICABLE RULE	
R 400.2412	**Care of residents.**
	(4) A resident shall be treated with dignity, and his personal needs, including protection and safety, shall be attended to at all times.
ANALYSIS:	Based on the information obtained during this investigation, Resident A was not treated with dignity. He reported being verbally abused by staff, Lorenzo Young, and this was confirmed by Resident B and staff, Michael Nunn.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend the status of the license remain unchanged

_______________________________ 02/07/2022
Regina Buchanan Date
Licensing Consultant

Approved By:

_______________________________ 02/08/2022
Ardra Hunter Date
Area Manager