GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 25, 2024

Janet McCarver
Creative Images Inc
PO Box 253
Southfield, MI 48037

RE: License #: AS820399426
Investigation #: 2024A0121047
Bringard Home

Dear Ms. McCarver:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On November 15, 2024, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

K. Robinson

K. Robinson, MSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820399426
Investigation #:	2024A0121047
Complaint Receipt Date:	09/09/2024
Investigation Initiation Date:	09/10/2024
Report Due Date:	11/08/2024
Licensee Name:	Creative Images Inc
Licensee Address:	28125 7 Mile Rd Livonia, MI 48152
Licensee Telephone #:	(313) 527-1098
Administrator:	Shannon McCormick
Licensee Designee:	Janet McCarver
Name of Facility:	Bringard Home
Facility Address:	16132 Ryland Redford, MI 48239
Facility Telephone #:	(313) 766-4308
Original Issuance Date:	09/27/2019
License **Status:**	REGULAR
Effective Date:	03/27/2024
Expiration Date:	03/26/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident was burned by staff from receiving a perm hair relaxer.	Yes

III. METHODOLOGY

09/09/2024	Special Investigation Intake 2024A0121047
09/09/2024	APS Referral
09/09/2024	Referral - Recipient Rights
09/10/2024	Special Investigation Initiated - Telephone Shannon McCormick
09/11/2024	Inspection Completed On-site Interviewed home manager, Darlene Stewart, direct care staff (DCS) Febie Nichols, and Resident A.
09/13/2024	Contact - Telephone call received Laticia Sharp with Adult Protective Services (APS)
09/13/2024	Contact - Document Sent Email to APS and Recipient Rights Investigator (RRI), Krystal Copeland
09/20/2024	Contact - Telephone call made Home manager, Darlene Stewart
09/24/2024	Contact - Telephone call made Left message for Dr. Innocent Agbassi; no response.
09/24/2024	Contact - Telephone call made Left message for Guardian A
09/24/2024	Contact - Telephone call made Left message for Krystal Copeland; no response.
09/24/2024	Contact - Telephone call made Follow up call to Ms. Sharp

09/25/2024	Contact - Telephone call received Return call from Guardian A.
10/11/2024	Contact - Telephone call made Left 2nd message for Dr. Agbassi; no response.
10/11/2024	Contact - Telephone call made Left 2nd message for Krystal Copeland, RRI; no response.
10/11/2024	Contact - Telephone call made Ms. Sharp with APS
10/16/2024	Contact - Telephone call made Attempted call to (DCS) Martha Harrison; voicemail unavailable.
10/16/2024	Contact - Telephone call made DCS Fidel Nelson
10/21/2024	Contact - Telephone call made Attempted call to DCS Martha Harrison; voicemail unavailable.
11/07/2024	Exit Conference Janet McCarver
11/15/2024	Corrective Action Plan Received/Approved.
11/20/2024	Contact - Telephone call made Follow up with Ms. McCormick

ALLEGATION: Resident was burned by staff from receiving a perm hair relaxer.

INVESTIGATION: On 9/10/24, I initiated the complaint with a phone call to administrator, Shannon McCormick. Ms. McCormick acknowledged Resident A sustained injuries to her neck area. According to Ms. McCormick, the incident report related to the injury was written incorrectly. Although the incident reported stated Resident A was observed by staff picking her scalp, Ms. McCormick explained the writer intended to report that Resident A was “picking at a scab, not scalp.”

On 9/11/24, I completed an unannounced onsite inspection at the facility. Home manager, Darlene Stewart and direct care staff (DCS) Febie Nichols were present on the day of inspection. Resident A was also present. However, it should be noted that Resident A has limited communication skills especially as it relates to talking to

strangers, so I was not able to interview the Resident A. I observed Resident A was very busy and easily agitated. I observed Resident A would not sit still unless staff rewarded her with treats. When asked to see Resident A's wound, Ms. Stewart prompted Resident A to sit, but Resident A would run in another direction. I was able to catch a quick glimpse of Resident A's wounds. The wounds are located on her nape area, and the marks are linear shaped. Ms. Stewart explained fast pacing, refusing to sit still, and not following directions is Resident A's normal behavior. Ms. Stewart reported Resident A has a 1:1 staffing assignment 12 hours per day, 7:00 a.m. – 7:00 p.m. Ms. Stewert reported Resident A's hair was chemically treated with a perm relaxer by DCS Martha Harrison on 8/3/24; however, the injuries weren't noticed by staff until 8/30/24. Resident A was transported to Henry Ford Go Health Urgent Care for evaluation and treatment the same day. Resident A was diagnosed with a "chemical burn that is healing." According to Ms. Stewart, the doctor did not note any sores or burns on the resident's scalp. Ms. Stewart also acknowledged Resident A requires assistance with bathing and showering, but Resident A "does not like being touched." Ms. Nichols reported she didn't notice the marks on Resident A's skin while assisting her with bathing. Both Ms. Nichols and Ms. Stewart reported they did assist Resident A with performing her activities for daily living, including bathing, since the perm was given. Neither Ms. Nichols nor Ms. Stewart were able to offer an explanation why it took so long for them to notice the burn marks for weeks after Mrs. Harrison gave her the perm.

On 9/25/24, I interviewed Guardian A by phone. Guardian A indicated that she goes to the home to visit Resident A 2-3 times monthly. Guardian A reported she does not believe Resident A is being abused by staff; however, Guardian A did express concern about Resident A's injuries going unnoticed for weeks especially during bathtime. Guardian A reported Resident A will "strike back" if someone tries to hit her. Guardian A also expressed extreme confidence that Resident A would disclose any abuse to her should it happen to occur. Guardian A stated she is "satisfied" with how the burn is healing thus far.

On 10/16/24 and 10/21/24, I made attempts to interview Mrs. Harrison by phone to no avail. The outgoing message on Mrs. Harrison's phone indicated that voicemail hadn't been setup, so I couldn't leave a message asking for a return call. On 10/16/24, I contacted Ms. McCormick to verify Mrs. Harrison's phone number. Ms. McCormick confirmed I had the correct number for Mrs. Harrison; she also reported Mrs. Harrison quit on 9/22/24 following a written reprimand. Before quitting, Mrs. Harrison provided a written statement detailing the events surrounding Resident A's hair treatment. Mrs. Harrison's letter acknowledges that she permed Resident A's hair on 8/3/24 because the hair was "very nappy and I desired to make her look pretty." The letter also states that Resident A was "moving around", so some perm "dropped on he neck area." Mrs. Harrison wrote, "Immediately I washed it off with African shampoo." Mrs. Harrison apologized for the accident.

On 9/24/24 and 10/11/24, I left messages for Resident A's primary care physician, Dr. Innocent Agbassi. To date, Dr. Agbassi has not returned my calls.

On 9/13/24, 9/24/24, and 10/11/24, I conferenced the case with APS investigator, Laticia Sharp. Ms. Sharp reported she had no success contacting Dr. Agbassi or the urgent care doctor who treated Resident A on 8/30/24. Nevertheless, Ms. Sharp did find substantial evidence to determine the home was negligent in providing for Resident A's care. On 11/18/24, I received a confirmation email from Krystal Copeland with the Office of Recipient Rights stating she will be substantiating as well.

On 11/7/24, I completed an exit conference with licensee designee, Janet McCarver. I informed Ms. McCarver that based on the appearance and location of the burn marks, Resident A's injury does not appear consistent with the explanation. Ms. McCarver could not provide a reasonable explanation why Resident A's injuries were not discovered until 3 weeks after her hair was permed. Ms. McCarver shared the home's policy on hair services for residents. The policy is dated 4/22/13 and it prohibits staff from using "any chemicals" without the permission of the Program Manager. The policy has since been updated to prohibit chemical use outside the scope of basic hygiene care. Perming, relaxing, and hair dying is now required by a licensed cosmetologist in a salon setting. On 11/15/24, Ms. McCarver submitted an acceptable corrective action plan outlining the steps that were taken to achieve compliance with the rule requirements.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Mrs. Harrison chemically treated Resident A's hair on 8/3/24, yet the burn marks weren't discovered by staff until 8/30/24. Mrs. Harrison provided a written statement which states she washed the perm out immediately after a portion fell onto the resident's neck. Therefore, there is sufficient evidence that the explanation is inconsistent with the injury. Resident A cannot communicate well enough to report what happened and Mrs. Harrison no longer works at the facility. Nevertheless, Mrs. Harrison violated policy by chemically treating Resident A's hair without prior approval. Resident A was not treated with dignity and her personal needs, including protection and safety was not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain unchanged.

11/22/24

Kara Robinson — Date
Licensing Consultant

Approved By:

11/25/24

Ardra Hunter — Date
Area Manager