GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 11, 2024

Zad White
Blithesome Home Inc.
P.O.Box 2409
Southfield, MI 48037

RE: License #: AS820067541
Investigation #: 2025A0992003
Chalmers Home

Dear Mr. White:

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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820067541
Investigation #:	2025A0992003
Complaint Receipt Date:	10/16/2024
Investigation Initiation Date:	10/16/2024
Report Due Date:	12/15/2024
Licensee Name:	Blithesome Home Inc.
Licensee Address:	P.O. Box 2409 Southfield, MI 48037
Licensee Telephone #:	(313) 613-1227
Administrator:	Zad White
Licensee Designee:	Zad White
Name of Facility:	Chalmers Home
Facility Address:	5945 Chalmers Detroit, MI 48213
Facility Telephone #:	(313) 822-7142
Original Issuance Date:	03/15/1996
License Status:	REGULAR
Effective Date:	07/29/2023
Expiration Date:	07/28/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff, Lisa Tait pulled a machete on Resident A. Resident A is drugged at the home and was dumped at the hospital.	No
Additional Findings.	Yes

III. METHODOLOGY

10/16/2024	Special Investigation Intake 2025A0992003
10/16/2024	Special Investigation Initiated - Telephone Adult Protective Services (APS), Monique King
10/16/2024	Contact - Telephone call made Resident A's guardian, Shavonne Rippy with Guardian Care was not available. Message left.
10/17/2024	Contact - Face to Face Resident A
10/18/2024	Contact - Telephone call made Ms. Rippy was not available. Message left.
10/18/2024	Contact - Telephone call made Licensee designee, Zad White
10/18/2024	Contact - Telephone call made Home manager, Vanessa Campbell
10/25/2024	Contact - Telephone call made Direct care staff, Lisa Tait
10/28/2024	Inspection Completed On-site Direct care staff, Tameka Craig
11/21/2024	Contact - Face to Face Resident B
11/25/2024	Contact - Telephone call made Ms. Rippy was not available. Message left.

11/26/2024	Contact - Telephone call made Ms. Rippy was not available. Message left.
12/10/2024	Exit Conference Mr. White

ALLEGATION: Staff, Lisa Tait pulled a machete on Resident A. Resident A is drugged at the home and was dumped at the hospital.

INVESTIGATION: On 10/16/2024, I contacted Adult Protective Services (APS), Monique King regarding the allegation. Ms. King stated she recently inherited this complaint and discovered Resident A no longer resides at the reported facility. She provided me with Resident A's current whereabouts. Ms. King stated she interviewed Resident A, and he stated the staff chased him with a machete. Ms. King stated Resident A specifically stated "machete." She stated she is not sure if he was exaggerating or if the staff actually had a machete. However, Ms. King stated Resident A appeared lucid and descriptive. She stated he was not injured, and she did not observe any marks or bruises.

On 10/17/2024, I made face-to-face contact with Resident A and interviewed him regarding the allegation. Resident A stated the staff came after him with a silver machete. Resident A was unable to provide me with staff's name. He stated the staff picked up a chair and swung it at him, so he picked up a chair to block her. He stated the staff called the police and they came to the home. Resident A stated the police told him to behave and take his medicine. Resident A stated when the police returned, they took him to the hospital, and he never returned to that facility. I asked if anyone observed the staff with the machete and he said no. He said there were residents there, but they did not come out their bedroom. He stated the staff did not hit him. I asked if there were any other staff on shift, and he said no. Resident A has a slight speech impediment which made it somewhat difficult to understand him. I did not observe any marks or bruises on Resident A. Throughout the interview Resident A continuously jumped around dancing to show me that he is in perfect shape. Resident A was very animated.

On 10/18/2024, I contacted licensee designee, Zad White regarding the allegation. He stated that he was made aware of the allegation by home manager, Vanessa Campbell. Mr. White suggested I contact Ms. Campbell for specifics. He stated he is aware that the direct care staff involved was Lisa Tait.

On 10/18/2024, I contacted Ms. Campbell and interviewed her regarding the allegation. Ms. Campbell stated she was not on shift when the incident occurred. However, she stated during the day shift Resident A was agitated because he had an appointment for a medication review, and he does not like taking medication. Ms.

Campbell said apparently Resident A's agitation carried over to the evening because during the evening shift, she received a telephone call from Ms. Tait stating Resident A refused to take his medication. Ms. Campbell stated she suggested Ms. Tait tell Resident A step outside and get some fresh air. She stated according to Ms. Tait when Resident A came back in the house, he was aggressive. She stated he followed her around the house, threw a chair at her and swung his cane and knocked the television off the stand. Ms. Campbell stated Ms. Tait called the police twice and the second time they transported Resident A to the hospital. She stated once Resident A was discharged from the hospital, he was discharged from Chalmer's Home and admitted into Hilcrest Residence. Ms. Campbell stated Resident A is relatively new to the home and she has never experienced any behaviors from him.

On 10/25/2024, I contacted direct care staff, Lisa Tait and interviewed her regarding the allegation. Ms. Tait denied chasing Resident A with a knife of any kind. She stated on the day the incident occurred everyone had finish eating and it was time for medications, so she was getting things ready. She stated Resident A wanted some more fries and she asked him to give her a minute to finish administering medication and she would give him more fries. She stated Resident A refused to take his medication. Ms. Tait stated once she finished with medications, she tried to give Resident A more fries and he stated he didn't want any. Ms. Tait stated she called Ms. Campbell and made her aware that Resident A refused his medication. She stated Ms. Cambell suggested Resident A go on the porch and get some fresh air any maybe offer him a snack and try to administer his medications again. Ms. Tait stated when she started talking to Resident A, he took his cane and hit table hard, she stated she was startled. Ms. Tait stated due to Resident A's behaviors, she called the police. She stated the police arrived and suggested Resident A behave and take his medication as prescribed. Ms. Tait stated soon as the police left, Resident A jumped up and knocked the television off the stand and came towards her. Ms. Tait stated she ran out of the house, got in her car and called the police again. Ms. Tait stated she remained in her car until the police arrived. She further stated that residents were in the home when she ran out. Ms. Tait stated when the police arrived, they transported him to the hospital. She stated direct care staff Tameka Craig and LeAndre Mitchell arrived at the home to supervise the other residents while she went to petition Resident A. She stated she is not familiar with Resident A and/or his behaviors. Ms. Tait stated she was covering a shift at that facility at the time the incident occurred and that she does not typically work at that facility. I asked if the residents in the home witnessed the incident and Ms. Tait stated Resident B possibly observed the incident and he is capable of being interviewed.

On 10/28/2024, I completed an unannounced onsite inspection in attempt to interview Resident B. Ms. Craig made me aware that Resident B attends workshop daily. She stated he returns to the facility by 2:30 p.m. I interviewed Ms. Crag about the allegation. She stated she was not present when the incident occurred but later arrived to cover Ms. Taits shift while she went to petition Resident A. I asked Ms.

Craig if she ever experienced any behaviors from Resident A, and she said no. She stated Resident A was relatively new to the facility.

On 11/21/2024, I completed an unannounced onsite inspection and interviewed Resident B about the allegation. Resident B stated he did not witness any staff chase Resident A with a knife/machete. He stated he was sitting on the couch and Resident A wanted to go to the store and the staff said no. He stated Resident A got upset and caused an issue. Resident B stated he got a long well with Resident A, but that day Resident A was upset. Resident B stated he gets along well with the staff, and he feels safe.

On 12/10/2024, I contacted Mr. White and conducted an exit conference. I made Mr. White aware that I had an opportunity to interview all involved parties and based on the findings there is insufficient evidence to support the allegations, that Resident A was not treated with dignity and his personal needs, including protection and safety, was not attended to at all times. I made Mr. White aware that during the investigation it was determined that Ms. Tait ran out the house during the incident and sat in her car until the police arrived, leaving the residents without proper supervision. I further explained that due to Ms. Taits inability to handle the emergency situation, the violations identified requires a written corrective action plan. Mr. White agreed to review the report and respond accordingly.

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:	Based upon my investigation, which consisted of interviews with licensee designee, Zad White; home manager, Vanessa Campbell; direct care staff Lisa Tait and Tamika Criag; APS, Monique King and Residents A and B regarding the allegation. All parties denied the allegations except for Resident A. Although Residents A appeared lucid; his statements were not consistent with the statements provided by others involved. I am unable to determine that Resident A was not treated with dignity, including protection and safety at all times. The allegation is unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 10/25/2024, I contacted direct care staff, Lisa Tait and interviewed her regarding the allegation. Ms. Tait stated Resident A took his cane

and hit table hard, she stated she was startled. Ms. Tait said due to Resident A's behaviors, she called the police. She stated the police arrived and suggested Resident A behave and take his medication as prescribed. Ms. Tait said soon as the police left, Resident A jumped up and knocked the television off the stand and came towards her. Ms. Tait stated she ran out of the house, got in her car and called the police. Ms. Tait stated she remained in her car until the police arrived. She further stated that residents were in the home when she ran out. She stated when the police arrived, they transported him to the hospital.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	On 10/25/2024, Lisa Tait stated Resident A jumped up and knocked the television off the stand and came towards her. Ms. Tait stated she ran out of the house, got in her car and called the police. Ms. Tait stated she remained in her car until the police arrived. Ms. Tait did not appropriately handle the emergency situation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the status of the license remain unchanged.

12/09/2024

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Denasha Walker Date
Licensing Consultant

Approved By:

12/11/2024

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Ardra Hunter Date
Area Manager