GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 11, 2024

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

RE: License #: AS820399426
Investigation #: 2024A0992036
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 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 #:	AS820399426
Investigation #:	2024A0992036
Complaint Receipt Date:	06/04/2024
Investigation Initiation Date:	06/06/2024
Report Due Date:	08/03/2024
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 A was hit with a shoe by direct care staff Denise Cannon.	Yes

III. METHODOLOGY

06/04/2024	Special Investigation Intake 2024A0992036
06/06/2024	Special Investigation Initiated - Face to Face Darlene Stewart, home manager and Resident A.
06/12/2024	Contact - Telephone call made Janet McCarver, licensee designee was not available. Message left and email sent.
06/12/2024	Contact - Telephone call made Shannon McCormick, administrator was not avaiable. Message left and email sent.
06/12/2024	Contact - Telephone call made Guardian A1 Resident A's guardian was not available. Message left.
06/12/2024	Contact - Telephone call made LaTicia Sharp, adult protective services (APS).
06/12/2024	Contact - Telephone call made Sharon Moore, direct care staff (DCS) was not available. Message left.
06/12/2024	Contact - Telephone call made Denise Cannon, former DCS was not available. Message left.
06/12/2024	Contact - Telephone call received Ms. McCarver
06/13/2024	Contact - Document Received Ms. McCormick via email
06/14/2024	Contact - Telephone call received

	Guardian A1
06/14/2024	Contact - Telephone call made Ms. Cannon was not available. Message left.
06/17/2024	Contact - Document Received Ms. McCormick provided a copy of Resident A's individual plan of service (IPOS) via email
06/17/2024	Contact - Telephone call received Ms. Cannon
06/24/2024	Contact - Telephone call made Ms. Moore was not available. Message left.
07/02/2024	Contact - Telephone call made Ms. Moore was not available. Message left.
07/02/2024	Contact - Telephone call made Ms. Stewart and Ms. Moore
07/02/2024	Exit Conference Ms. McCarver
07/09/2024	Contact - Telephone call made Zachary Flynn, Office of Recipient Rights (ORR).

ALLEGATION: Resident A was hit with a shoe by direct care staff Denise Cannon.

INVESTIGATION: On 06/06/2024, I completed an unannounced onsite inspection and interviewed home manager, Darlene Stewart, and observed Resident A. Ms. Stewart stated the incident occurred on 05/11/2024 and she was notified on 05/13/2024 by DCS Sharon Moore. Ms. Stewart stated she contacted former DCS Denise Cannon and addressed the allegation. Ms. Stewart said Ms. Cannon denied hitting Resident A. She further stated Ms. Cannon was very defensive and rude during the call. Ms. Stewart stated Resident A requires 1:1 staffing, and Ms. Cannon was assigned as her 1:1 staff at the time the incident occurred. Ms. Stewart stated Ms. Cannon was immediately removed from the schedule and she will not be returning to the home. Ms. Stewart stated Resident A does have a history of aggression including biting and hitting. However, she said the DCS should not retaliate against the residents. Ms. Stewart stated Resident A cannot be interviewed due to her cognitive impairment and limited verbal skills.

I observed Resident A she appeared to be clean and adequately dressed. No unusual marks or bruises were observed on her. Resident A is very active. I observed her saying words such as clothes, food and yes but due to her limited verbal skills, she was unable to be interviewed.

On 06/12/2024, I contacted APS LaTicia Sharp and discussed the allegation. Ms. Sharp confirmed she is investigated the allegation. She stated she spoke with Ms. Cannon, and she denied hitting Resident A but stated she did threaten to hit her with her shoe. She stated Resident A was hitting at another resident and she attempted to verbally redirect her, and she was not responding. She stated Ms. Cannon said she threatened to hit her with the shoe to stop her from misbehaving. Ms. Sharp stated she is substantiating due to Ms. Cannon threatening Resident A.

On 06/12/2024, I received a call from Janet McCarver, licensee designee, and I interviewed her. Ms. McCarver stated she was previously made aware of the allegation and Ms. Cannon has been removed from the schedule. I made her aware of the investigative process and agreed to follow-up with her to conduct an exit conference once the investigation is complete.

On 06/12/2024, I received a call from Guardian A1, I interviewed her regarding the allegation. Relative A confirmed she was contacted by Ms. Stewart and made aware of what happened. She said based on what she was told, Ms. Cannon was Resident A's 1:1 staff and she became frustrated with Resident A's behaviors and hit her with a shoe. Relative A said she was not contacted immediately and there was somewhat of delay, maybe a day or so. I made Relative A aware that the staff has 48 hours to contact the designated representative such as herself; Relative A said she was not aware of the timeframe. She stated she was a little concern because Resident A was hit in the same leg she fractured a couple months ago. However, she stated she was contacted by both Ms. Stewart and Creative Images licensee Gretchen Craft and reassured Resident A was doing well and the staff was removed from the home. Relative A stated she understands Resident A can be aggressive, confrontational and she will hit. However, she said her 1:1 staffing must be able to exercise

patience, know how to deescalate and/or redirect Resident A. Relative A stated Resident A has been in Creative Images care for 23 years and she does well there. She denied having any concerns.

On 06/13/2024, I received an email from administrator, Shannon McCormick, responding to my attempt to contact her. Ms. McCormick stated Ms. Cannon was removed from the schedule and terminated. I responded, requesting a copy of Resident A's IPOS.

On 06/17/2024, I received a copy of Resident A's IPOS. According to her IPOS she requires 1:1 staff during waking hours due to impulsive behaviors which put her and others at risk for health and safety.

On 06/17/2024, I contacted Ms. Cannon and interviewed her regarding the allegation. Ms. Cannon denied hitting Resident A. However, she did admit to threatening her with her shoe. She stated she was in the living room with Resident A and Resident B. She stated Resident A kept asking for her medication and she had just had her medication two hours prior, so she told her it was not time. Ms. Cannon said Resident A kept asking for her medication and she became agitated. Ms. Cannon stated Resident A started swinging at Resident B, but she did not hit her. Ms. Cannon stated she told her to stop, and she did not. Ms. Cannon said she took off her shoe and told her to stop. Ms. Cannon stated hindsight she should not have taken off her shoe, that was not the right thing to do. However, she stated she did not hit Resident A. Ms. Cannon said it was reported to her that Ms. Moore observed her hit Resident A and that is not true. Ms. Cannon stated Ms. Moore was in the kitchen area and did not observe her hit Resident A. She further stated Resident A has hit Ms. Moore in the past, so Ms. Moore stays away from her. Ms. Cannon said Resident A asked to go to her bedroom and the situation deescalated. Ms. Cannon said Resident A has a behavior every day and she has a history of aggression.

On 07/2/2024, I interviewed Ms. Moore regarding the allegation. Ms. Moore stated she was sitting at the kitchen table, and she heard a hitting/slapping noise. Ms. Moore stated that she heard Ms. Cannon say, “Every time you hit me, I am going to hit you.” Ms. Moore stated she went into the living room area and observed Ms. Cannon hit Resident A on the leg with her shoe. Ms. Moore stated she told Resident A to come here, and Ms. Cannon was standing in front of her blocking her from passing by. Ms. Moore stated she told Ms. Cannon to let her by so she can go to her bedroom and calm down. Ms. Moore stated Resident A went to her bedroom and calmed down. She stated Resident A was not injured.

On 07/02/2024, I conducted an exit conference with Ms. McCarver. I made her aware based on my investigation there is evidence to support the allegation. Ms. McCarver stated Ms. Cannon was terminated. I made Ms. McCarver aware that based on the findings, a written corrective action plan is required. She denied having any questions and agreed to review the report and submit the corrective action plan.

On 07/09/2024, I contacted ORR Zachary Flynn, regarding the allegation. Ms. Flynn confirmed he investigated the allegation and substantiated due to Ms. Cannon threatening Resident A.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means. **(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:** **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.** **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.** **(e) Withhold food, water, clothing, rest, or toilet use.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.** **(g) Refuse the resident entrance to the home.** **(h) Isolation of a resident as defined in R 400.14102(1)(m).** **(i) Any electrical shock device.**

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with Janet McCarver, licensee designee and facility DCS Darlene Stewart, Sharoon Moore, and former staff Denise Cannon; Relative A, Resident A's guardian; APS LaTicia Sharp; ORR Zachary Flynn, there is evidence to support the allegation. On 05/11/2024, Resident A was threatened by DCS Denise Cannon. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same.

07/10/2024

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Denasha Walker Date
Licensing Consultant

Approved By:

07/11/2024

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Ardra Hunter Date
Area Manager