GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 5, 2025

James Palmer
Covenant to Care, Inc.
44997 Coachman Ct.
Canton, MI 48187

RE: License #: AS820316698
Investigation #: 2025A0992019
Jacquelyn Street

Dear James Palmer:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 456-0439.

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 #:	AS820316698
Investigation #:	2025A0992019
Complaint Receipt Date:	03/17/2025
Investigation Initiation Date:	03/18/2025
Report Due Date:	05/16/2025
Licensee Name:	Covenant to Care, Inc.
Licensee Address:	181 Dogwood Ct Canton, MI 48187
Licensee Telephone #:	(734) 228-6933
Administrator:	James Palmer
Licensee Designee:	James Palmer
Name of Facility:	Jacquelyn Street
Facility Address:	28646 Jacquelyn Livonia, MI 48154
Facility Telephone #:	(734) 524-0159
Original Issuance Date:	03/13/2012
License Status:	REGULAR
Effective Date:	10/03/2024
Expiration Date:	10/02/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 3/7/2025, Resident A sustained a second degree burn while direct care staff, Aleayah Lynum, was asleep on shift.	Yes

III. METHODOLOGY

03/17/2025	Special Investigation Intake 2025A0992019
03/18/2025	Special Investigation Initiated - On Site Home manager, Latia Wilson and Resident A.
03/26/2025	Referral - Recipient Rights
03/26/2025	Contact - Telephone call made Office of Recipient Rights, Lexus Davis
04/08/2025	Contact - Face to Face Licensee designee, James Palmer.
04/10/2025	Contact - Telephone call made Resident A's guardian, Relative A, was not available. Message left.
04/10/2025	Contact - Telephone call made Direct care staff, Carmen Adams.
04/10/2025	Contact - Telephone call made Direct care staff, Michelle Clemons.
04/15/2025	Contact - Telephone call made Relative A was not available. Message left.
04/18/2025	Contact - Telephone call made Relative A was not available. Message left.
04/18/2025	Contact - Telephone call made Mr. Palmer.
04/24/2025	Contact - Telephone call received Relative A.

04/28/2025	Contact - Telephone call made Ms. Davis
04/28/2025	Contact - Telephone call made Former direct care staff, Aleayah Lynum

ALLEGATION: On 3/7/2025, Resident A sustained a second degree burn while direct care staff, Aleayah Lynum, was asleep on shift.

INVESTIGATION: On 03/18/2025, I completed an unannounced onsite inspection and interviewed, home manager, Latia Wilson and Resident A. Ms. Wilson stated she was not on shift when the incident occurred, but stated she was notified on 03/03/2025 by direct care staff, Carmen Adams. She stated Ms. Adams made her aware that Resident A approached her and direct care staff, Michelle Clemons, and showed them a mark on her chest. Ms. Wilson stated Resident A told Ms. Adams and Ms. Clemons that she burned herself while using the curling iron. Ms. Wilson stated Resident A stated direct care staff, Aleayah Lynum, was on shift at the time and she was asleep on the couch in the living room. Ms. Wilson stated, according to Ms. Adams, the mark appeared to be old, and it looked like a burn. She stated there was a scab on it and it seemed to be healing. Ms. Wilson stated, according to Ms. Adams Resident A, was not in any pain, so she applied some ointment and monitored her. Ms. Wilson said on or about 03/07/2025, Resident A must have picked at the scab and irritated the area. Ms. Wilson stated Ms. Adams and Ms. Clemons transported Resident A to urgent care, and she was examined. She stated Resident A was diagnosed with a second degree burn and provided burn cream. Ms. Wilson stated she believes the curling irons belonged to Ms. Lynum.

I interviewed Resident A, she confirmed she burned herself with a curling iron. She stated she could not remember if she was in the bathroom or her bedroom when it happened. She said she screamed when it happened, but no one heard her. I asked if there was staff in the home when it happened, and she said yes. She stated Aleayah was on the couch sleeping in the living room. Resident A was uncertain if the other residents were in the home at the time. Resident A could not recall the actual day the incident occurred. She stated she was examined by the doctor at urgent care and prescribed medication. Resident A stated she is fine and denied having any concerns.

On 03/26/2025, I contacted the Office of Recipient Rights, Lexus Davis regarding the allegation. Ms. Davis stated she is actively investigating the allegation and will keep me updated.

On 04/08/2025, I made face-to-face contact with licensee designee, James Palmer. I interviewed Mr. Palmer regarding the allegation. He stated the incident was brought to his attention on 3/07/2025 by Ms. Wilson. He stated he instructed Ms. Wilson to

take Resident A to urgent care. He stated Resident A was examined and diagnosed with a low-level second-degree burn. Mr. Palmer stated he conducted an internal investigation regarding the incident and interviewed Resident A and the direct care staff. Mr. Palmer stated he asked Resident A about the curling iron and understands Resident A got the curling iron from the counter in the dining room. He stated he asked her who was on shift when the incident occurred, and she stated she did not know. Mr. Palmer stated it was further determined that during Resident A's visit with her supports coordinator, Kendra Williams, she disclosed Ms. Lynum was on shift and she was sleeping on the couch, snoring loud. He stated Ms. Clemons and Ms. Adams denied observing Ms. Lynum sleeping, but Ms. Clemons stated Ms. Lynum was lying on the couch. He stated Ms. Adams stated she did see a curling iron in the home and there was red hair tangled in the curling iron, which was consistent with Ms. Lynum's hair. Mr. Palmer stated he interviewed Ms. Lynum, and she stated the curling iron is not hers, but she used them in the past on Resident A's hair. Mr. Palmer stated Ms. Lynum was initially removed from the schedule, pending the investigation. He stated she has since been terminated due to sleeping on shift and lack of supervision.

On 04/10/2025, I interviewed direct care staff, Carmen Adams, regarding the allegation. Ms. Adams stated she is not sure when the incident actually occurred or who was on shift. She stated she works midnights. She stated on 3/2/2025, Resident A walked up to her and said this hurt, pointing to a mark on her upper chest area. Ms. Adams stated the mark looked like an old burn. She stated there was a scab on it and it seemed to be healing. She stated she asked Resident A what happened, and she said, "I did not know." Ms. Adams stated the following morning on 3/03/2025, she made Ms. Wilson aware of the mark on Resident A's chest. Ms. Adams said fast-forward to 3/07/2025, during her shift Resident A walked up to her and Ms. Clemons pointed to the mark and said it is hurting worse. Ms. Adams stated the mark looked irritated and the scab was gone. She stated she asked Resident A what happened, and she said, "I did not know." Ms. Adams made me aware that Resident A often says, "I don't know," when she is hiding something or afraid she did something wrong. Ms. Adams stated she assured Resident A she was not in any kind of trouble and asked her again what happened. Ms. Adams stated Resident A stated she burned herself with a curling iron. Ms. Adams stated she asked Resident A what curling iron, and Resident A retrieved the curling iron from her bedroom. Ms. Adams stated the curling iron had red hair tangled in it, which was consistent with Ms. Lynum's hair. Ms. Adams stated Resident A does not own curling irons and she does not know how or why they were in her possession. She stated Resident A does not have the mental capacity to use curling irons safely. Ms. Adams confirmed she has worked with Ms. Lynum in the past, she denied she has observed Ms. Lynum sleeping.

On 04/10/2025, I interviewed direct care staff, Michelle Clemons, regarding the allegation. Ms. Clemons provided statements consistent with the statements Ms. Adams provided to me during my telephone interview with her. Ms. Clemons stated Resident A is not supposed to have curling irons in her possession. She stated

Resident A is very inquisitive but does not have the mental capacity to use curling irons safely. As far as Ms. Lynum sleeping, she stated she does not typically work at that home and was filling in for another staff on the above-mentioned day. She denied having any knowledge of Ms. Lynum sleeping.

On 04/18/2025, I contacted Mr. Palmer. I made him aware that all parties were interviewed except for Relative A and my attempts to contact her were unsuccessful. I requested Mr. Palmer have Relative A contact me if he happens to speak with her, which he agreed. However, I made Mr. Palmer aware that based on the information received, there is sufficient evidence that Resident A's personal needs, including protection and safety, were not attended to at all times, and as a result she burned herself with a curling iron. Mr. Palmer agreed, and he stated that Ms. Lynum was terminated due to sleeping on shift and not supervising the residents, which is not tolerated.

On 04/24/2025, I received a telephone call from Relative A. I interviewed her regarding the allegation. Relative A stated she is uncertain if she was made aware of the incident at the time it occurred. She stated it is possible the staff notified her, but she could not remember. Relative A stated Mr. Palmer has always considered Resident A's best interest, and she is certain that he made the best decision as it pertains to making sure Resident A is safe. Relative A denied having any concerns regarding Resident A's quality of care.

On 04/28/2025, I made follow-up contact with Ms. Davis. Ms. Davis stated that based on her findings, she substantiated for lack of supervision.

On 04/28/2025, I contacted former direct care staff, Aleayah Lynum and interviewed her regarding the allegation. Ms. Lynum denied the allegation. She stated she could not remember the exact date but recalled working a double when the incident was brought to her attention. She stated during her shift, Resident A walked up to her and asked her to look at a mark on her chest, Ms. Lynum stated the mark looked like a burn. She stated she asked her what happened, and Resident A said she did not know. Ms. Lynum stated the mark looked old, but she asked Resident A if it hurt, and she said no. Ms. Lynum stated she sent a picture of the mark to Ms. Wilson and applied some aloe vera gel on it. Ms. Lynum stated she was later made aware by Ms. Wilson and Mr. Palmer that Resident A burned herself with a curling iron. Ms. Lynum stated the curling iron was not hers and that she had braids in her hair at the time. She stated the curling iron was in Resident A's bedroom. She stated as far as the curling iron having red hair tangled in it, Resident A has red braiding hair in her bedroom. Ms. Lynum denied sleeping on shift and stated it is uncertain when Resident A burned herself. Ms. Lynum stated she was initially suspended pending the investigation but was later terminated.

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:	During my investigation, which consisted of multiple interviews with licensee designee, James Palmer; home manager, LaTia Wilson; direct care staff Carmen Adams and Michelle Clemons; Relative A and Resident A which all confirmed Resident A burned herself with a curling iron. Resident A received medical treatment and was diagnosed with a low-level second-degree burn. Based on the investigative findings, there is evidence that Resident A's personal needs, including protection and safety, were not attended to at all times, and as a result she burned herself with a curling iron. 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.

4/28/2025

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Denasha Walker Date
Licensing Consultant

Approved By:

5/5/2025

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Ardra Hunter Date
Area Manager