GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 21, 2025

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

RE: License #: AS820399426
Investigation #: 2025A0121020
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 May 21, 2025, 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) 456-0439.

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 #:	2025A0121020
Complaint Receipt Date:	03/19/2025
Investigation Initiation Date:	03/26/2025
Report Due Date:	05/18/2025
Licensee Name:	Creative Images Inc
Licensee Address:	28125 7 Mile Rd Livonia, MI 48152
Licensee Telephone #:	(313) 527-1098
Administrator:	Janet McCarver
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?
On 3/17/25, direct care staff Mariama failed to administer resident medication at 8:00 a.m.	Yes

III. METHODOLOGY

03/19/2025	Special Investigation Intake 2025A0121020
03/19/2025	APS Referral
03/19/2025	Referral - Recipient Rights
03/26/2025	Special Investigation Initiated - Telephone DWIHN; spoke with Recipient Rights Investigator, Sherry Underwood
03/26/2025	Contact - Document Received Email from Ms. Underwood (Incident Report)
04/03/2025	Inspection Completed-BCAL Sub. Compliance Interviewed direct care staff, Victoria Nwosu-Buti. Observed Resident A.
04/04/2025	Contact - Document Received Received copies of MARs via fax.
05/14/2025	Contact - Telephone call made Left message for licensee.
05/16/2025	Exit Conference Gretchen Craft
05/21/2025	Corrective Action Plan Received/Approved

ALLEGATION: On 3/17/25, direct care staff Mariama failed to administer resident medication at 8:00 a.m.

INVESTIGATION: On 3/26/25, I initiated the complaint with a phone call to Recipient Rights Investigator (RRI), Sherry Underwood. Ms. Underwood reported that Resident A-D didn't receive their morning medications on 3/17/25. Ms. Underwood forwarded copies of the incident report to document the medication error. According to the incident report, direct care staff Mariama Sowe failed to administer resident medication at 8:00 a.m. On 4/3/25, I conducted an unannounced onsite inspection at the facility. I reviewed 4 of 4 resident medication records. It appears resident medication is normally administered as prescribed. Therefore, the incident appears isolative in nature. Victoria Nwosu-Buti was on duty. Mrs. Nwosu-Buti identified herself as the medication coordinator for the home. Mrs. Nwosu-Buti acknowledged the medication error did occur as written. Mrs. Nwosu-Buti reported that direct care staff, Erika Henderson noticed the morning medication hadn't been administered later that evening around 6:00 p.m. The incident was reported to home manager, Annetta Martin for investigation. On 5/16/25, I completed an exit conference with co-licensee designee, Gretchen Craft. Ms. Craft agrees with the department's findings and recommendation. On 5/21/25, I received an approved corrective action plan signed by co-licensee designee, Janet McCarver. Ms. McCarver implemented medication refresher training for the staff involved.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the incident report, medication administration records for March 2025, and staff interviews, I determined the licensee did not ensure that resident medication was given, taken, and applied pursuant to label instructions on 3/17/25.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/21/25

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Kara Robinson — Date
Licensing Consultant

Approved By:

05/21/25

_____

Ardra Hunter — Date
Area Manager