GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 29, 2025

Sheila Leadbetter
Barrett Regency, Inc.
1318 Maple
Rochester, MI 48307

RE: License #: AS630377781
Investigation #: 2025A0602017
Barrett Regency Inc

Dear Ms. Leadbetter:

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 (248) 972-9136.

Sincerely,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630377781
Investigation #:	2025A0602017
Complaint Receipt Date:	06/09/2025
Investigation Initiation Date:	06/10/2025
Report Due Date:	08/08/2025
Licensee Name:	Barrett Regency, Inc.
Licensee Address:	5101 N. Rochester Rochester, MI 48306
Licensee Telephone #:	(248) 494-6719
Administrator:	Sheila Leadbetter
Licensee Designee:	Sheila Leadbetter
Name of Facility:	Barrett Regency Inc
Facility Address:	5101 N. Rochester Rochester, MI 48306
Facility Telephone #:	(248) 494-6719
Original Issuance Date:	05/10/2016
License Status:	REGULAR
Effective Date:	06/07/2025
Expiration Date:	06/06/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED ALZHEIMERS, AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A suffers from a brain injury and was intimidated by staff.	No
Resident A was sent to the emergency room twice with untreated urinary tract infections.	No
Resident A was not provided with all of her medication upon discharge.	No
Resident A's weights were not documented.	Yes
Resident A's responsible person was not given a copy of the resident care agreement.	No

III. METHODOLOGY

06/09/2025	Special Investigation Intake 2025A0602017
06/10/2025	Special Investigation Initiated - Telephone Call made to the complainant.
06/17/2025	Contact - Document Received Received email from complainant.
06/23/2025	Inspection Completed On-site I interviewed staff member, Taryn Aguayo and the licensee designee, Sheila Leadbetter.
07/07/2025	Contact – Telephone call made Message left for Oakland County Sheriff Dept.
07/07/2025	Contact – Document Received Received email from Resident A's Family Member 1.
07/10/2025	Contact – Document Received Received fax from Ms. Leadbetter.
07/11/2025	Contact – Telephone call received Spoke with Resident A's Family Member 1.
07/14/2025	Contact – Document Received Received email from Resident A's Family Member 2.

08/27/2025	Contact – Telephone call made Spoke with staff member Tyanna Peoples.
08/27/2025	Contact – Telephone call made Call made to Resident A's new placement, Tendercare.
08/27/2025	Contact – Telephone call made Message left for Dr. Stamatine.
08/28/2025	Exit conference I held the exit conference with the licensee designee, Sheila Leadbetter by telephone.

ALLEGATION:

- **Resident A suffers from a brain injury and was intimidated by staff.**
- **Resident A was sent to the emergency room twice with untreated urinary tract infections.**
- **Resident A was not provided with all of her medication upon discharge.**
- **Resident A's weights were not documented.**
- **Resident A's responsible person was not given a copy of the resident care agreement.**

INVESTIGATION:

On 6/09/2025, a complaint was received and assigned for investigation alleging that Resident A suffers from a brain injury, was intimidated by staff, was sent to the emergency room twice with untreated urinary tract infections, not provided with all of her medication upon discharge, weight was not documented, and responsible person was not given a copy of the resident care agreement.

On 6/23/2025, I conducted an unannounced on-site investigation at which time I interviewed the licensee designee, Sheila Leadbetter and staff member, Taryn Aguayo. Ms. Leadbetter stated Resident A moved into the home on 2/26/2025 and moved out on 5/28/2025. She had a very difficult time adjusting to the home as she lived in her own home with her daughter prior to her admittance to the facility. On 5/22/2025 Family Member 2 picked up Resident A to take her for a hair appointment. Shortly after leaving the facility, Family Member 2 called Ms. Leadbetter and informed her that Resident A had refused to get out of the car when they arrived at the salon. Family Member 2 returned to the facility with Resident A and she continued to refuse to get out of the car. Family Member 2 exited the vehicle while Resident A remained in the vehicle. Staff members Cathy Rohl and Tywanna Peoples attempted to convince Resident A to exit the vehicle but she refused. When Ms. Rohl attempted to get Resident A out of the car by placing her hands on her shoulders, Resident A swung at Ms. Rohl. Ms. Rohl told her not to do that. Ms. Leadbetter said she instructed Family Member 2 to have

Resident A transported to the hospital as she seemed to be presenting with an altered mental state. Family Member 2 transported Resident A to Macomb Henry Ford Hospital and Resident A again refused to exit the vehicle. Resident A was returned to the home and Family Member 3 was contacted. When Family Member 3 arrived, Resident A was still in the car and Family Member 2 was standing outside of the car. Family Member 3 grabbed Resident A by her shoulders, removed her from the car, placed her in a wheelchair and left the home. Ms. Leadbetter said she received a call from Ms. Aguayo later on in the evening stating Resident A was up all night and would not go to sleep. She could hear Resident A yelling in the background during the telephone call. Ms. Leadbetter advised that Resident A be transported to the hospital for an altered mental state. Ms. Leadbetter contacted Family Member 3 to report that Resident A was being transported to the hospital. A couple of days later, Ms. Leadbetter received a call from Family Member 3 asking if she would contact Resident A's doctor and ask that Resident A not be discharged from the hospital because she needs to be placed in a locked facility. Ms. Leadbetter said this was the first she had heard of Resident A needing to be in a locked facility and would not be returning to her facility. On 5/28/2025 Resident A was discharged from the hospital and placed in another group home.

On 6/4/2025, an Oakland County Sheriff arrived at the home and stated they received a report that staff put her finger in Resident A's face. On 6/4/2025, Ms. Leadbetter received a text from Family Member 2 requesting that Resident A's file be emailed to her within 24 hours. Ms. Leadbetter was advised by her attorney not to respond to the email as she had filed a lawsuit through a small claims court for non-payment of rent as a result of Family Member 2 failing to provide a 30-day notice prior to moving Resident A out of the facility. Ms. Leadbetter said on 5/28/2025 Resident A's medication was delivered to the home in anticipation of her return upon discharge from the hospital. When she was notified that Resident A would not be returning, the family requested to pick up her medication. Ms. Leadbetter contacted the pharmacy and was informed that the family called the pharmacy as well. The pharmacy sent the delivery driver back to the home to pick up the medication and delivered them to Resident A's new group home. Ms. Leadbetter stated that all of Resident A's medication that was not administered because she was hospitalized was discarded at the Rochester Police Department. Ms. Leadbetter stated that Resident A's weight was taken and documented each month she resided in the home. She went on to state that Family Member 2 was given a copy of the resident care agreement at the time she signed it. I requested to review Resident A's resident file and was informed that it was with her attorney as she had filed a lawsuit against Family Member 2. She agreed to retrieve the file and fax the requested documents to me.

On 6/23/2025, I interviewed Ms. Aguayo. Ms. Aguayo stated on 5/22/2025 she worked the evening shift and was at the home when Resident A returned with Family Member 2 from the hospital. Resident A refused to get out of the car. Family Member 3 was contacted and when he arrived he said several times, "We're not doing this." Family Member 2 unlocked the car, he grabbed Resident A up with her shoulders, put her in her wheelchair and drove off. Family Member 2 left the home as well. Resident A said, "I don't want to be here. Family Member 2 has my car, my home and they think I'm

crazy.” Later that evening, Ms. Aguayo said she called Ms. Leadbetter and reported that Resident A would not sleep and was up most of the night yelling that she wanted to go home. Ms. Leadbetter called Family Member 3 and reported that Resident A was being transported to the hospital for an altered mental state. Ms. Aguayo went with Resident A to the hospital and remained there until Family Member 3 arrived. Resident A was admitted to the hospital and has not returned to the facility. This was all the information Ms. Aguayo had regarding the incident.

On 7/07/2025, I received and reviewed (from Ms. Leadbetter) a copy of Resident A’s resident identification record, weight record (dated 2/2025, 3/2025, 4/2025, 5/2025), financial agreement (signed and dated 2/26/2025), refund policy (signed and dated 2/26/2025), fee and rate policy (sign and dated 3/6/2025), resident funds part I (dated 2/26/2025), resident funds part II (dated 2/2025, 3/2025, 4/2025, 5/2025), health care appraisal (dated 2/26/2025), resident care agreement (signed and dated 2/26/2025), assessment plan (dated 2/26/2025) According to the resident information identification record, Resident A was admitted to the facility on 2/26/2025. The weight record documents that Resident A weighed 157 pounds at admission. The record further documented that on 2/26/2025 Resident A weighed 150 pounds, on 3/1/2025 149 pounds, on 4/1/2025 147 pounds, on 5/1/2025 142 pounds and on 5/12/2025 145 pounds. The health care appraisal documents Resident A’s diagnosis as CVA and dementia with an unsteady gait.

On 7/07/2025, I received an email from Family Member 1 stating Resident A was intimidated by staff, was sent to the hospital for an altered mental state but was admitted for an untreated urinary tract infection and upon discharge from the group home Resident A was not given the unused medication during the times she was hospitalized. According to Family Member 1, Resident A spent a total of 21 days in the hospital between April 2025 and May 2025 and all of her unused medications should have been returned to the family but it was not. Family Member 1 also reported that they were informed that a copy of the signed resident care agreement would be emailed but they never received a copy.

On 7/11/2025, I spoke with Family Member 1 by telephone. Family Member 1 stated Resident A was living at home with her daughter and able to do things for herself prior to moving into the facility. She fell while in her own home and sustained a hematoma to her face. She lost 85% of her vision from the fall and sustained traumatic brain injury. It was as if she obtained dementia overnight and was hospitalized for several days. She returned to her home after three weeks and it was realized that she needed more care than what could be provided in her own home. Family Member 1 said prior to Resident A moving into the facility a tour was taken and Ms. Leadbetter informed the family that they would work to make sure Resident A was engaged and received physical therapy. Resident A moved into the facility in February 2025 and would constantly say she wanted to go back home. She complained about the food so Family Member 2 would bring her some of the foods she liked. Resident A reported to the family that she was being tied down at night but this was never observed.

Family Member 1 went on to report that Resident A's roommate was observed with blow up mittens on both hands and her hands were tied to the sides of her bed. During a visit, Family Member 1 observed Resident A sitting alone on the couch in the front room with a camera watching her. There was another incident when Resident A refused to do physical therapy and the therapist was okay with her refusal and did not try and persuade her to do it. Resident A had her own physical therapist she wanted to work with but Ms. Leadbetter gave them a hard time and would not allow the therapist into the home. Family Member 1 also reported that Ms. Leadbetter informed the family that she could test for urinary tract infections but never did. She went on to say that Ms. Leadbetter did not pay for Resident A's prescriptions for three months and left a balance of $170. Resident A complained of stomach pain for two weeks back in April 2025. She was taken to the hospital where she remained for about a week. There was another incident where Resident A was receiving physical therapy in the home and experienced an episode of syncope. She was transported to the hospital (exact date unknown) and fell while in the hospital. There were no scans taken at that time. When Resident A returned to the facility she was very agitated. On 5/22/2025, Family Member 2 arrived at the home to take her for a hair appointment. Resident A stated she did not want to return to the group home because she hated it there and they were awful to her. When they arrived back home, Resident A refused to get out of the car. Ms. Rohl yelled at Resident A, told her to get out of the car and pointed her finger at her face. Family Member 2 called Ms. Leadbetter and was instructed to take Resident A to the hospital due to an altered mental state. Family Member 2 transported Resident A to the hospital where she was interviewed and determined not to be a threat to herself or others and was not admitted. Family Member 2 transported Resident A back to the facility where she again refused to exit the car. Family Member 3 was notified, arrived at the facility, calmed Resident A down and was able to get her into the home. Later that evening, Family Member 3 received a text message from Ms. Leadbetter stating Resident A was being transported to the hospital for an altered mental state. She was admitted and it was determined that she had a severe urinary tract infection. Upon discharge, Resident A was placed in another adult foster care home on hospice with stage three kidney failure but seems to be doing well.

On 7/14/2025, I received and reviewed nursing notes from Family Member 2 documenting Resident A's treatment at Ascension Providence Rochester Hospital on 1/15/2025. According to the document, Resident A weighed 158 pounds on 1/15/2025.

On 8/27/2025, I interviewed staff member, Tywanna Peoples by telephone. Ms. Peoples stated she was working the day (exact date unknown) Resident A refused to get out of the car. She said when Family Member 2 arrived (around 1:50 pm) to pick Resident A up for a hair appointment, Resident A was already agitated because she was expecting to be picked up earlier in the day. When they returned home, they were sitting in the car in the driveway and appeared to be arguing. Family Member 2 came into the home crying and informed her that Resident A was refusing to get out of the car. Ms. Peoples went out to the car in an attempt to convince Resident A to come into the home. Resident A had locked the car door, Family Member 2 entered the car through the trunk, unlocked it and stood at the back of the vehicle. Ms. Peoples went into the home

to call Ms. Leadbetter and inform her of the situation. She was instructed to tell Family Member 2 that if Resident A continues to refuse to exit the vehicle, emergency medical services (EMS) would be notified. When Ms. Peoples went back outside, staff member Cathy Rohl was standing near the car talking to Resident A trying to convince her to come into the home. Resident A continued to refuse and attempted to hit Ms. Rohl. Ms. Rohl put her finger up and told Resident A not to do that and that she needed to come inside. Ms. Peoples informed Family Member 2 that she was instructed to call EMS they were unable to get Resident A to exit the vehicle. Family Member 2 stated she did not want Resident A to go to the hospital and told Ms. Rohl she was not going to treat Resident A that way. Family Member 2 got back in the car and drove away with Resident A. When Family Member 2 and Resident A returned to the home, Family Member 3 was already there waiting on them. Family Member 3 told Resident A, “We’re not doing this”, lifted Resident A out of the car, put her in a wheelchair and drove away. Family Member 2 then drove away as Ms. Rohl and Ms. Peoples took Resident A into the home. Ms. Peoples went on to state that Resident A was a very sweet lady but her behavior changed when Family Member 2 came for visits. They would argue and Resident A would tell her staff did nothing for her and she wanted to go back home.

On 8/27/2025, I spoke with Marshal Bajpai, the licensee designee for the group home where Resident A currently resides. According to Ms. Bajpai, when Resident A first arrived at the facility she was extremely angry with her family and would have several outbursts. She is currently on hospice and has been prescribed a mood stabilizer to help with the outbursts. This has calmed her down a great deal and she seems to be doing much better. Ms. Bajpai stated that the pharmacy did deliver her medication and she went through it in the presence of the family.

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 on the information obtained during the investigation, there is insufficient information to determine whether Resident A was not treated with dignity or that her personal needs were not attended to at all time. According to Ms. Peoples, Ms. Rohl did not put her finger near Resident A’s face. She raised her finger when Resident A attempted to hit her and told her not to do that.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	Based on the information obtained during the investigation, there is sufficient information to determine that weights were recorded for Resident A each month. However, according to the record there were two weights documented on 2/26/2025 for Resident A; 157 pounds and 150 pounds. It is unclear what Resident A's actual weight was at time of admission.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(8) A copy of the signed resident care agreement shall be provided to the resident or the resident's designated representative. A copy of the resident care agreement shall be maintained in the resident's record.
ANALYSIS:	Based on the information obtained during the investigation, there is insufficient information to determine if Resident A's designated representative was provided with a copy of the resident care agreement. According to Ms. Leadbetter, Family Member 2 was given a copy of the care agreement the day it was signed (2/26/2025). However, Family Member 1 stated a copy was supposed to be emailed but never was. On 7/07/2025 I reviewed a copy of the care agreement that was signed by Ms. Leadbetter and Family Member 2 on 2/26/2025.
CONCLUSION:	VIOLATION NOT ESTABLISHED

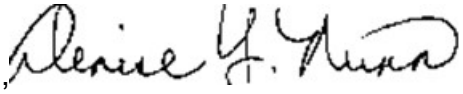
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

8/28/2025

Cindy Berry Date
Licensing Consultant

Approved By:



08/29/2025

Denise Y. Nunn Date
Area Manager