GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 11, 2025

Clifford Brown
Care Assistant Living Home Inc.
430 Franklin Lake Circle
Oxford, MI 48371

RE: License #: AS630301800
Investigation #: 2025A0605016
Care Assistant Living

Dear Clifford Brown:

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,

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630301800
Investigation #:	2025A0605016
Complaint Receipt Date:	07/30/2025
Investigation Initiation Date:	07/30/2025
Report Due Date:	09/28/2025
Licensee Name:	Care Assistant Living Home Inc.
Licensee Address:	430 Franklin Lake Circle Oxford, MI 48371
Licensee Telephone #:	(248) 722-7171
Administrator:	Ebony Goree
Licensee Designee:	Clifford Brown
Name of Facility:	Care Assistant Living
Facility Address:	31521 W. Stonewood Ct. Farmington, MI 48334
Facility Telephone #:	(248) 254-3195
Original Issuance Date:	08/18/2009
License Status:	REGULAR
Effective Date:	02/22/2024
Expiration Date:	02/21/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
An unknown female night shift worker at Care Assistant Living is reportedly drinking alcohol and playing loud music in the driveway, raising concerns about resident safety and supervision.	No
Additional Findings	Yes

III. METHODOLOGY

07/30/2025	Special Investigation Intake 2025A0605016
07/30/2025	APS Referral Adult Protective Services (APS) made a referral but will not be investigating these allegations
07/30/2025	Special Investigation Initiated - Letter Email to APS requesting the reporting sources contact information. Received an email stating that APS is no longer allowed to release this information.
07/31/2025	Contact - Document Sent Email sent to Farmington Hills Police Department (FHPD) records (records@fhgov.com)division requesting any contact at this group home within the last six months
07/31/2025	Contact - Document Received Email received from FHPD records
07/31/2025	Inspection Completed On-site Conducted unannounced on-site investigation
08/19/2025	Contact - Telephone call made Discussed allegations with Chandra Grant, Resident F, Resident F's legal guardian and DCS Left messages for DCS and Wayne County APS worker Monique King
08/20/2025	Contact - Telephone call made Discussed allegations with Resident C's medical care decision maker and left messages for Resident A and Resident D's family

08/26/2025	Exit Conference I conducted the exit conference via telephone with licensee designee Clifford Brown with my findings

ALLEGATION:

An unknown female night shift worker at Care Assistant Living is reportedly drinking alcohol and playing loud music in the driveway, raising concerns about resident safety and supervision.

INVESTIGATION:

On 07/30/2025, intake #206668 was referred by Adult Protective Services (APS) regarding a nightshift female working sitting in her car in the driveway playing music and drinking alcohol. APS denied their referral.

On 07/30/2025, I initiated the special investigation by sending an email to APS requesting the information of the reporting person. The reporting person was anonymous.

On 07/31/2025, I conducted an unannounced on-site investigation at Care Assistant Living. I interviewed the administrator, Ebony Goree, regarding the allegations. There are three direct care staff that work at this home: Camilla Parsons, Marcia McDonald and Ebony Leonard who is in training. Ms. Goree worked about two months ago the midnight shift and has never sat in the driveway with the radio blaring and denied drinking alcohol. Ms. Goree has never smelled alcohol from any of the DCS and has not received any complaints from staff regarding anyone drinking alcohol or music blaring outside. Ms. Goree has not received any complaints from residents' families or residents regarding staff.

I interviewed DCS Ebony Leonard regarding the allegations. Ms. Leonard is in training and stated she has not smelled alcohol on any DCS she has worked with and has not received any complaints from residents or their families. She had no other information to provide.

I interviewed Resident A regarding the allegations. Resident A denied smelling alcohol on any of the staff and does not know about any staff sitting outside in their car at night with the music blaring. She reported no concerns.

I interviewed Resident B regarding the allegations. Resident B moved in yesterday and is her own guardian. She has not smelled alcohol on any of the DCS and does not know any staff that sits outside in their car with the music blaring. She stated, "I like it here and all the staff are caring and compassionate." She had no concerns.

I interviewed Resident C regarding the allegations. Resident C has not smelled alcohol on any of the staff, and she does not know anything about DCS sitting outside in their car with the music blaring. She had no concerns.

I was unable to interview Resident D and Resident E as both have dementia and are unable to carry a conversation.

On 07/31/2025, after I left, I observed a neighbor getting into their vehicle, so I approached them regarding the allegations. The neighbor stated that there is a red car that “rolls up to the driveway with their music loud.” The female sits in the driveway for 20 minutes in the morning around 7AM-9AM and again in the evening around 5PM-6PM playing their music. The neighbor denied seeing the female driver drinking any alcohol. The neighbor has not called the police regarding the music but stated that the police have been seen at the home.

On 07/31/2025, I emailed Farmington Hills Police Department Records Bureau requesting all police contact at this home within the last six months. I received the following police reports:

- I did not receive any police reports regarding loud music or anyone drinking alcohol in their vehicle.

On 07/31/2025, I contacted via telephone Chandra Grant regarding the allegations. Ms. Grant denied any DCS drinking alcohol during their shift. She too has not received any complaints from DCS, residents, or families regarding DCS drinking or playing music too loud outside. Ms. Grant has not received any complaints from neighbors regarding staff’s music blaring outside. Ms. Grant stated that Camilia Parsons drives a red car, but that Ms. Parsons would not be blaring her music, however, she will have a conversation with Ms. Parsons.

On 08/20/2025, I contacted DCS Camilla Parsons via telephone regarding the allegations. Ms. Parsons works the midnight shift from 5PM-8AM. She owns a red car but denied sitting in her car in the driveway with the music blaring. Once she arrives at the group home, she goes inside and does not stay in her car. She also denied drinking alcohol and denied any other DCS smell of alcohol.

On 08/19/2025, I interviewed via telephone DCS Marcia McDonald regarding the allegations. She has been working at this group home on/off since 2010 but returned only two weeks ago. Ms. McDonald denied sitting in her car with the music blaring. She also denied drinking alcohol or smelling alcohol on any other DCS. She has not worked with Camilla Parsons but does communicate with her during shift change and has not smelled alcohol on her. Ms. McDonald also denied hearing blaring music outside when Ms. Parsons arrives on her shift.

On 08/20/2025, I received a return call from DCS Michelle John regarding the allegations. Ms. John was working at this group home but due to medical reasons she is

no longer. She worked the midnight shift and during shift change, she has never heard Camilla Parsons playing her music loud outside and has never smelled alcohol on Ms. Parsons. She had no other information to provide.

On 08/20/2025, I interviewed Resident C's durable power of attorney (DPOA-C) for medical regarding the allegations. DPOA-C visits but not frequently. The last time she visited Resident C was last month. She has never observed any staff under the influence of alcohol or smell of alcohol. DPOA-C has never seen any staff sitting in a red car or any other car with the music blaring. DPOA-C stated, "I have no concerns. I'm happy with the care and Resident C is always clean. The staff always communicate with me via phone, and I've recommended this home to others."

On 08/20/2025, I interviewed Resident D's granddaughter regarding the allegations. The granddaughter has no concerns about staff. She visits monthly on Sundays and has never seen staff sit in their cars with the music blaring and has never seen any DCS drink alcohol or smell of alcohol when she is at the group home. The granddaughter is happy with the care Resident D receives and reported no concerns.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on my investigation and information gathered DCS at Care Assistant Living denied sitting in their cars with the music blaring and denied drinking alcohol. The neighbor reported seeing a female in a red car playing music loud but never called police and denied observing the female drinking alcohol. The DCS driving a red car was identified as Camilla Parsons. Ms. Parsons denied playing her music too loud and denied drinking alcohol. Residents A, B, and C denied observing staff drinking alcohol and denied smelling alcohol on staff. I interviewed Resident C's DPOA and Resident D's granddaughter who also denied the allegations. Therefore, all DCS including Camilla Parsons are suitable to meet the physical, emotional, intellectual, and social needs of Residents A, B, C, D, and E.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/31/2025, I emailed Farmington Hills Police Department Records Bureau requesting all police contact at this home within the last six months. I received the following police reports:

- Report date: 05/23/2025, missing persons call regarding Resident F was not observed in her bed after direct care staff (DCS) Michelle John woke up and made her rounds. Resident F was found.

On 08/19/2025, I contacted Chandra Grant regarding the allegations. Resident F was admitted into this group home by Wayne County APS worker Monique King on an emergency basis as Resident F was in the hospital and had nowhere to go. Resident F was a temporary placement until a permanent one was found. Ms. King nor the hospital informed Ms. Grant that Resident F was an elopement risk. On 05/23/2025, DCS Michelle John informed Ms. Grant that Ms. John was in the back changing another resident and when she finished, she returned to check on Resident F and realized she eloped. The windows in all the bedrooms have alarms as do the doors but Ms. John believes that Resident F left through the sliding door that was observed open. Police were contacted and Resident F contacted her brother who then called the police advising them that Resident F was found and safe. Resident F was then transported the hospital to be checked out but then she was discharged the same day back to this group home. Resident F began to exhibit aggressive behaviors and was a sundowner. Due to her requiring a higher level of supervision, she was discharged from the home. Ms. Grant did not know that the police report stated that Ms. John told the police she was sleeping and then woke up to find Resident F had eloped. Ms. John is no longer a member of staff at this group home for medical reasons. Ms. Grant stated that when she arrived the morning of 05/23/2025, DCS Camilla Parsons was present because she was “staying downstairs.”

On 08/19/2025 and 08/20/2025, I left messages for Wayne County APS worker Monique King but received no return calls.

On 08/19/2025, I contacted Resident F’s legal guardian via telephone. Resident F’s legal guardian was driving with Resident F, so he put the phone on the speaker so I could speak to both. Resident F stated that she left through her bedroom window, not the sliding or front door. She stated, “I climbed out with my pillowcase and my belongings. It was a short jump.” She waited for a bus but then a cab picked her up and at some point, I called my brother who called the police.” Resident F was then transported to Detroit Receiving Hospital and then discharged back to this group home. Resident F’s legal guardian stated that the group home was informed that Resident F was an elopement risk because she was placed here due to it being a 24/7 locked facility. Resident F worked with Wayne County APS to get this placement and now has located another placement for Resident F.

On 08/19/2025, I interviewed DCS Marcia McDonald regarding the allegations. Ms. McDonald had not returned from her leave of absence; therefore, she had no information to provide.

On 08/20/2025, I interviewed DCS Camilla Parsons regarding the allegations. Ms. Parsons was contacted by DCS Michelle John informing her that Resident F left the home. Ms. Parsons arrived at the group home around 4:30AM-5AM, but then later during the interview Ms. Parsons stated that she was sleeping in the basement as she had been living at the group home for several months. Chandra Grant approved her moving downstairs because she had nowhere else to live. Ms. Parsons was asleep downstairs and does not know if Ms. John was sleeping during her shift resulting in Resident F leaving the group home. Ms. Parsons stated she nor the other DCS were informed about Resident F being an elopement risk. After Resident F was found and returned to the group home, supervision was increased, but then Resident F was discharged from the group home. She had no other information to provide.

On 08/20/2025, I interviewed DCS Michelle John regarding the allegations. Ms. John worked on 05/23/2025. Resident F was an emergency placement directly from Detroit Receiving Hospital by APS. No one knew Resident F was a “flight risk.” Resident F is highly functioning and independent with minor memory loss. Ms. John stated, “She seemed normal, but with her short stay she displayed minor agitation, anxiousness, then sundowning symptoms.” Ms. John cannot recall what time she checked on Resident F but when she did, Resident F was lying in bed awake. Ms. John cracked open the sliding door because “it was stuffy inside,” then went to the desk to complete paperwork. She stated, “I nodded off at the desk, probably for about 40-45 minutes.” After she woke up, she went to check on all the residents and discovered that Resident F was no longer in her bedroom. Ms. John found a letter written by Resident F on the nightstand. It was a “Thank you, note.” Ms. John checked the bathroom and the entire house but was unable to locate her. Ms. John immediately called police, Chandra Grant, and Ebony Goree. The police arrived at the home and then police dispatched other local law enforcement to help conduct a search. About four hours later, Resident F called her brother who in turn called the group home, advising them that Resident F was found. The police went where Resident F was (unknown where) and then transported Resident F to the hospital and then she was discharged back to this group home. As protective measures, supervision was increased for Resident F where one-hour bed checks were conducted during the shifts. Ms. John stated this was an isolated incident. Ms. John stated that there is a bed in the basement for staff when staff do not want to drive home in bad weather, but that Camilla Parsons has been “staying,” in the basement. She does not know anything else about Ms. Parsons staying in the basement. Ms. John quit because of personal medical reasons.

On 08/20/2025, I interviewed Administrator Ebony Goree regarding the allegations. Resident F was admitted into this group home on 05/21/2025 on an emergency basis by Wayne County APS. APS worker never informed Chandra Grant nor the group home that Resident F was a flight risk or had tried to leave the hospital when she was there.

Within the days of her admission, staff learned that Resident A was a “sundowner,” and “a different person,” at night. On 05/23/2025, Ms. Goree received a call from DCS Michelle John around 5:30AM-6AM in a panic saying, “Resident F is not in the house.” The police were at the group home, so Ms. Goree drove around the neighborhood looking for Resident F. Resident F was later found after Resident F called her brother. The police then transported Resident F to the hospital to get medically cleared and then returned to this group home. Resident F’s supervision was increased and there were no other incidents. Resident F was discharged on 06/19/2025. Ms. Goree stated that all DCS are aware that they cannot sleep during their shifts. In addition, all residents have a two-hour bed check that needs to be completed during the midnight shifts. Ms. Goree has never had any issues with DCS Michelle John when she worked for this corporation. This was an isolated incident. Ms. John left because of medical reasons.

On 08/26/2025, I conducted the exit conference with licensee designee Clifford Brown via telephone with my findings. Mr. Brown stated that DCS Camilla Parsons was homeless and had nowhere to go, so sometime in April 2025, he allowed her to move into the basement. He did not know that he needed to inform me of this change. Ms. Parsons was only to stay for about a week but then it became one month for her to save money, but she is still living at the group home. He will have a conversation with Ms. Parsons regarding this living arrangement. Mr. Brown never received a complaint from neighbors or anyone else regarding Ms. Parsons playing her music loud outside or drinking alcohol. Mr. Brown asked Ms. Parsons about her playing loud music and Ms. Parsons told him “it may have been up but not that loud.” Ms. Parsons denied drinking alcohol. Mr. Brown stated that when he found out about Resident F being missing and DCS Michelle John was sleeping during her shift, he was extremely upset. He conducted an in-service with Ms. John regarding all staff must remain awake during their shifts. Mr. Brown stated this was an isolated incident and that Ms. John is no longer working at this group home for personal medical reasons. He agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(5) An applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for a license, including any changes in the household and in personnel-related information, within 5 business days after the change occurs.

ANALYSIS:	Based on my investigation, licensee designee Clifford Brown did not give written notice to the department when DCS Camilla Parsons moved into this group home in April 2025. Ms. Parsons has been living in the basement of this group home because she was homeless.
CONCLUSION:	**VIOLATION ESTABLISHED**

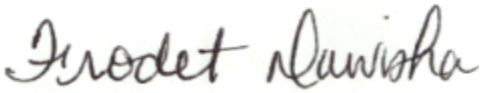
APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on my investigation and information gathered, there were insufficient DCS on shift on 05/23/2025. DCS Michelle John was working the midnight shift alone. She stated she “nodded off,” for about 40-45 minutes and then when she woke up, she discovered that Resident F was not in the house. Ms. John contacted the police immediately and Resident F was found. However, due to Ms. John sleeping during her shift, Residents A, B, C, D, E, and F’s supervision, personal care, and protection were not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 my investigation and information gathered, DCS Michelle John did not attend to Residents A, B, C, D, E, and F supervision, protection, and personal care at all times on 05/23/2025. Ms. John was working the midnight shift alone. She stated she “nodded off,” for about 40-45 minutes and when she woke up, she discovered that Resident F was not in the house. Police were contacted and Resident F was later found. Ms. John placed all the residents at risk of harm when she “nodded off” during her shift leaving all the all the residents unattended.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

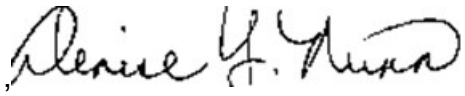
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



09/08/2025

Frodet Dawisha — Date
Licensing Consultant

Approved By:



09/11/2025

Denise Y. Nunn — Date
Area Manager