



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 4, 2025

Zad White
Blithesome Home Inc.
P.O.Box 2409
Southfield, MI 48037

RE: License #: AS820067541
Investigation #: 2025A0901049
Chalmers Home

Dear Zad White:

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) 456-0439.

Sincerely,

A handwritten signature in black ink that reads "Regina Buchanan". The signature is written in a cursive, flowing style.

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820067541
Investigation #:	2025A0901049
Complaint Receipt Date:	08/14/2025
Investigation Initiation Date:	08/18/2025
Report Due Date:	10/13/2025
Licensee Name:	Blithesome Home Inc.
Licensee Address:	P.O. Box 2409 Southfield, MI 48037
Licensee Telephone #:	(248) 670-9787
Administrator:	Zad White
Licensee Designee:	Zad White
Name of Facility:	Chalmers Home
Facility Address:	5945 Chalmers Detroit, MI 48213
Facility Telephone #:	(313) 822-7142
Original Issuance Date:	03/15/1996
License Status:	REGULAR
Effective Date:	07/29/2025
Expiration Date:	07/28/2027
Capacity:	6

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED
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II. ALLEGATION(S)

	Violation Established?
Staff, Janinie Simmons, kicked Resident A twice on purpose. There was another incident in which she slammed a cup of water on the table causing it to splash in his face.	Yes

III. METHODOLOGY

08/14/2025	Special Investigation Intake 2025A0901049
08/14/2025	Referral - Recipient Rights
08/14/2025	APS Referral
08/18/2025	Special Investigation Initiated - Telephone Case Manager, Rosalyn Cross
08/19/2025	Inspection Completed On-site
08/20/2025	Contact - Telephone call made Licensee Designee, Zad White
08/25/2025	Inspection Completed On-site Resident A Resident C
08/25/2025	Contact - Telephone call made Resident B
08/25/2025	Contact - Telephone call made Staff, Janinie Simmons
08/25/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Staff, Janine Simmons, kicked Resident A twice on purpose. There was another incident in which she slammed a cup of water on the table causing it to splash in his face.

INVESTIGATION:

On 08/18/2025, I made a telephone call to Resident A's case manager, Rosalyn Cross, from All Wellbeing Services. She stated she heard about the allegations but had not spoken with Resident A about them yet. She indicated Resident A tends to make a lot of complaints and they normally are not valid. Rosalyn also said for some reason he seems fixated with staff, Janine Simmons, and complains about her a lot. She stated she would have the home manger to keep Resident A back from his day program tomorrow and would meet me at the facility.

On 08/19/2025, I conducted an onsite inspection at the facility, but Resident A was not there. He was mistakenly sent to his day program.

On 08/20/2025, I made a telephone call to the licensee designee, Zad White. I informed him that a complaint was received and requested that he have staff to keep Resident A home from his program the morning of 08/25/2025, so I could meet with him. Zad said Recipient Rights made him aware of the allegations and that they substantiated the water incident. He said they also suggested that either Resident A or Janine be moved, so he moved Janine to another facility.

On 08/25/2025, I conducted another onsite inspected at the facility and interviewed Resident A. He explained that he was sitting on the porch when Janine kicked him twice on purpose. She kicked the bottom of his right leg. Resident A said he did not know why and that he was not in her way. He could not recall when it happened but said Resident B witnessed it. Resident A also reported that on another occasion, he was sitting at the dining room table and Janine was passing the medications. She was mad at him so when she gave him water to take with his medications, she slammed the cup down in front of him and it splashed in his face. Resident A said his roommate, Resident C, was present and saw everything.

During the onsite inspection on 08/25/2025, I interviewed Resident C. He said Resident A was "mouthing off" to Janine. He explained that both were mad at each other and were saying mean things back and forth. As she was passing Resident A his medications, Janine slammed his cup of water down hard on the table and the

water splashed on Resident A. Resident C stated Janine and Resident A do not get along and do not like each other.

On 08/25/2025 I made a telephone call to the facility and interviewed Resident B. She stated she never saw anyone kick Resident A.

On 08/25/2025, I made a telephone call to Janine. She denied the allegations and said she did not recall any of that ever happening. She further said she no longer worked at the facility.

On 08/29/2025, I made a telephone call to Zad and informed him of my investigative findings. He stated Janine remains at the other facility and Recipient Rights had her take a class, which she completed. I requested that he forward the information along with his corrective action plan.

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 I obtained during this investigation, Resident A was not treated with dignity. Although I was not able to corroborate that he was kicked by Janine, Resident C confirmed and witnessed the incident in which Janine slammed Resident A's cup of water down causing it to splash on him. Resident A and C were interviewed separately and gave consistent accounts of what happened.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains



Regina Buchanan
Licensing Consultant

08/29/2025
Date

Approved By:



Ardra Hunter
Area Manager

09/04/2025
Date