GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 9, 2025

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

RE: License #: AS820399426
Investigation #: 2025A0992032
Bringard Home

Dear Janet 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 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.

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 #:	AS820399426
Investigation #:	2025A0992032
Complaint Receipt Date:	06/17/2025
Investigation Initiation Date:	06/18/2025
Report Due Date:	08/16/2025
Licensee Name:	Creative Images Inc
Licensee Address:	28125 7 Mile Rd Livonia, MI 48152
Licensee Telephone #:	(313) 527-1098
Administrator:	Shannon McCormick
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?
There was an altercation between Residents A and B. Manager, Annette Martin was the only staff onsite. Resident A requires 1:1 staffing and did not have 1:1 staffing at the time of the altercation.	Yes

III. METHODOLOGY

06/17/2025	Special Investigation Intake 2025A0992032
06/18/2025	Special Investigation Initiated - Telephone Office of Recipient Rights (ORR), Edna Green was not available. Message left.
06/18/2025	Contact - Telephone call received Ms. Green
06/18/2025	Contact - Telephone call made ORR Investigator, Ann Alexander
06/20/2025	Contact - Telephone call made Home manager, Annetta Martin
06/24/2025	Contact - Face to Face Direct care staff, Sharon Moore; direct care staff, Mariama Sowe, Resident A and B.
06/24/2025	Contact - Telephone call made Manager, Karlton Flowers
07/09/2025	Contact - Telephone call made Ms. Alexander
07/10/2025	Contact - Telephone call made Administrator, Shannon McCormick and Program Director, Gretchen Craft.
07/11/2025	Contact - Document Received Resident A's individual plan of service (IPOS), incident reports, 1:1 staffing schedule and progress notes.
07/25/2025	Contact - Telephone call made

	Resident A's supports coordinator, Janice Gonzalex with Wayne Center.
07/25/2025	Contact - Telephone call made Ms. Alexander, ORR.
09/03/2025	Exit Conference Licensee designee, Janice McCarver was not available. Message left.
09/04/2025	Contact - Telephone call made Ms. Alexander, ORR was not available. Message left.
09/04/2025	Contact - Telephone call made Ms. McCormick and Ms. Craft.
09/04/2025	Contact - Telephone call received Ms. Alexander
09/05/2025	Contact - Telephone call made Resident A’s guardian, Relative A, was not available. Message left
09/05/2025	Exit Conference Ms. McCarver
09/09/2025	Contact - Telephone call received Relative A

ALLEGATION: There was an altercation between Residents A and B. Manager, Annette Martin was the only staff onsite. Resident A requires 1:1 staffing and did not have 1:1 staffing at the time of the altercation.

INVESTIGATION: On 06/18/2025, I received a return call from Office of Recipient Rights (ORR), Edna Green. Ms. Green stated the investigation was assigned to ORR investigator, Ann Alexander.

On 06/18/2025, I contacted Ms. Alexander regarding the allegation. Ms. Alexander stated she is actively investigating the complaint but based on preliminary information she received, there was an altercation between Residents A and B while home manager, Arnetta Martin was on shift alone. She stated Ms. Martin completed an incident report and but was advised by another staff not to file the report because it would reveal that there was insufficient staffing at the time the altercation occurred. Ms. Alexander agreed to keep me abreast of her findings.

On 06/20/2025, I contacted Ms. Martin and interviewed her regarding the allegation, which she confirmed. She stated on 06/04/2025, she arrived at work at 7:00 a.m. and the midnight DCS shift was ending, and they left. She stated DCS, Victoria Nwosu was scheduled to work with her, but she was running late. Ms. Martin stated there are typically two staff per shift, but in this instance, she was left to supervise four residents by herself. She stated Resident A requires 1:1. Ms. Martin stated Ms. Nwosu arrived at approximately 8:30 a.m., but prior to her arrival there was an altercation between Residents A and B. Ms. Martin stated she completed an incident report (IR) but manager, Karlton Flowers advised her to send the IR to him, and he would submit it to the office and other responsible agencies. Ms. Martin stated she has experience working in adult foster care and is familiar with completing an IR. Ms. Martin stated the real issue was management did not agree with all of the information that she included on the IR because it would reveal that there was insufficient staffing at the time the altercation occurred, which would pose a problem with the placing agencies. Ms. Martin made me aware that she no longer works for the company. She stated DCS and management made the work environment very uncomfortable and questioned everything she was doing as a manager.

On 06/24/2025, I completed an unannounced onsite inspection. At the time of my arrival there were three DCS onsite, Sharon Moore, Mariama Sowe and Martha Chambers. I interviewed Ms. Moore and Ms. Sowe; Ms. Chambers shift was over, and she left, I did not interview Ms. Chambers. I conducted separate face-to-face interviews with DCS Moore and Sowe regarding the allegation. Ms. Moore stated she was not on shift on 06/04/2025. She confirmed Resident A does require 1:1 staffing from 9:00 a.m. to 9:00 pm. She stated there are four residents and there are always two DCS on shift. Ms. Moore stated there are four shifts including a swing shift. She stated the shifts are from 7:00 a.m. to 3:00 p.m., 1:00 p.m. to 9:00 p.m. (swing shift), 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. Ms. Moore stated all the residents except Resident A attend program throughout the week. She stated when the residents go to program, there is only one DCS on shift as Resident A’s 1:1. She stated the swing shift DCS shift starts at 1:00 p.m. and is assigned as Resident A's 1:1 and the DCS that was on shift does transportation to pick up the other residents. She stated once all the residents return to the home, the DCS that provided transportation remains on shift, which leaves two DCS until 9:00 p.m.; by that time Resident A is asleep. Ms. Moore stated Resident A always has 1:1 staffing.

Ms. Sowe also known as “MiMi,” stated she works both afternoon and midnight shifts and there is always adequate staffing. Ms. Sowe statements were consistent with Ms. Moore as it pertains to the staffing and scheduling, stating there is always two DCS on shift when all the residents are in the home. She stated to her knowledge there has never been a time when Resident A did not have 1:1 staffing.

I observed Residents A and B. Resident B is non-verbal and unable to be interviewed. Resident A is very active and frequently moves about the home. Resident B is verbal but has limited verbal skills. Both Residents A and B appeared to be adequately dressed, and no marks or bruises were observed.

On 06/24/2025, I contacted manager, Karlton Flowers, and interviewed him regarding the allegation. Mr. Flowers stated he is the home manager of another Creative Images facility and was assigned to train Ms. Martin. He stated on 06/04/2025 he received a call from Ms. Martin at approximately 7:15 a.m. stating that the two midnight DCS left before waiting for relief, leaving her by herself. Mr. Flowers stated he is not sure what time the other staff arrived. He stated Ms. Martin made him aware that there was an altercation between residents while she was on shift alone. He stated all DCS are trained on completing IRs and the IR is reviewed by the supervisor to make sure it is thoroughly completed, and all the required fields contain pertinent and accurate information. He stated the only reason he requested to review the IR is because Ms. Martin was new to the cooperation and he wanted to make sure she completed the IR correctly since he was training her.

On 07/09/2025, I made follow-up contact with ORR investigator Alexander. She stated she is still investigating but she did interview Ms. Craft regarding the allegation. She stated Ms. Craft did not seem to think there was a staffing issue. She stated it appears that she feels Ms. Martin was not competent and not grasping the material that she was being trained on as it pertains to her role as a manager. Ms. Alexander agreed to follow up with me once the investigation is completed.

On 07/10/2025, I contacted administrator, Shannon McCormick to interview her regarding the allegation. Ms. McCormick added program director, Gretchen Craft, to the call and I proceeded to address the allegation. Ms. Craft stated she was not present and was off when the incident occurred. Both Ms. McCormick and Ms. Craft stated Resident A does require 1:1 staffing and that staffing is in place from 9:00 a.m. to 9:00 p.m. Ms. Craft and Ms. McCormick stated Resident A is allotted 12 hours of 1:1 staffing. Ms. McCormick stated on the day in question Ms. Martin let the midnight staff leave before Ms. Nwosu arrived; she stated she was running late. She stated there was not an altercation. She stated Resident A hit Resident B while Ms. Martin was on shift by herself. I reference that Ms. Martin was on shift by herself when Resident A hit Resident B. I explained whether it was an altercation or not 1:1 staffing is assigned to residents to provide direct supervision and help decrease behaviors and if her 1:1 was present this situation could have possibly been prevented. Ms. McCormick and Ms. Craft explained that Resident A's 1:1 is from 9:00 a.m. to 9:00 p.m. because Resident A has a routine and although she might wake up at 8:00 a.m. or so, she will remain in her bedroom making her bed or changing her clothes multiple times. I asked what would happen if she decided to come out of her bedroom before 9:00 a.m. as it appears she did on the day in question; Ms. McCormick and Ms. Craft stated they were not sure what happened on this particular day. Ms. McCormick and Ms. Craft stated they are not sure things happened as it was reported because Ms. Martin made several different reports. Ms. McCormick stated all the DCS are orientated on Resident A's triggers and when she says, "I wanna," that means she is about to hit someone. She also stated Resident A does not like anyone sitting close to her which is a trigger. I explained that the issue is not whether the staff was properly trained, the issue is there was not sufficient

staffing on shit when Resident A was triggered. I requested a copy of Resident A's IPOS and contact information for her support coordinator, who was identified as Janice Gonzalez.

On 07/11/2025, I received and reviewed Resident A's individual plan of service (IPOS). According to Resident A's IPOS states she requires 1:1 staffing 12 hours a day during waking hours and 2:1 staff during all transport to ensure she stays seated and buckled.

On 07/25/2025, I contacted Resident A's supports coordinator, Janice Gonzalez with Wayne Center regarding the allegation. Ms. Gonzalez stated she is very familiar with Resident A. She confirmed Resident A requires 1:1 staffing. I asked about the specifics as far as the timing of Resident A's 1:1 staffing. She stated Resident A's 1:1 is during wake hours and to her knowledge Resident A gets up at 5:00 a.m. and she is a wanderer. I made Ms. Gonzalez aware that according to Ms. McCormick and Ms. Craft Resident A's 1:1 is from 9:00 a.m. to 9:00 p.m. Ms. Gonzalez asked a rhetorical question and said are you saying Resident A remains in her bedroom for four hours every day. Ms. Gonzalez stated there is no way Resident A remains in her bedroom for four hours. She stated it appears someone is not being forthcoming. She stated 1:1 staffing should be in place when Resident A wakes up. She stated the IPOS does not state specific hours; it states wake hours for 12 hours.

On 07/25/2025, I contacted Ms. Alexander, ORR and made her aware of the information received from Ms. Gonzalez. I also made her aware that according to Resident A's IPOS states she requires 1:1 staffing 12 hours a day during waking hours and 2:1 staff during all transport to ensure she stays seated and buckled.

On 09/04/2025, I contacted Ms. McCormick and Ms. Craft and made them aware of my findings. I explained that based on Resident A's IPOS she requires 1:1 staffing 12 hours a day during waking hours and 2:1 staff during all transport to ensure she stays seated and buckled. Ms. McCormick and Ms. Craft stated routinely, Resident A wakes up at 8:00 a.m. and remains in her bedroom making her bed or changing her clothes multiple times and that is why her 1:1 staffing is in place from 9:00 a.m. to 9:00 p.m. I referenced the reported incident and stated apparently there are times that she does not follow her routine and comes out of her bedroom before 9:00 a.m. I made Ms. McCormick aware of my efforts to contact licensee designee, Janet McCarver and left a message requesting Ms. McCarver call me.

On 09/04/2025, I contacted Ms. Alexander regarding her findings. She explained that she substantiated and is waiting on a plan of action.

On 09/05/2025, I contacted an exit conference with licensee designee, Janice McCarver. I explained that based on the investigative findings, there is evidence to support the allegation. I stated according to Resident A's IPOS she requires 1:1 staffing 12 hours a day during waking hours and 2:1 staff during all transport to ensure she stays seated and buckled. Although Ms. McCormick and Ms. Craft stated

routinely, Resident A wakes up at 8:00 a.m. and remains in her bedroom making her bed or changing her clothes multiple times and that is why her 1:1 staffing is in place from 9:00 a.m. to 9:00 p.m., that may not be the case every day and she has to make sure Resident A has 1:1 staffing during wake hours at all times. Ms. McCarver stated she understands and will make sure Resident A has 1:1 staffing as needed and speaks with Wayne Center to make adjustments.

On 09/09/2025, I received a return call from Resident A's guardian, Relative A. I interviewed Relative A regarding the allegation. Relatives visited with Resident A this past Sunday and everything appeared to be going well. Relative A stated all the old DCS have been replaced and there is completely new staffing. As far as Resident A's 1:1 staffing, she stated she is aware that Resident A receives 12 hours of 1:1 staffing. She stated Resident A wakes up at 7:00 a.m., receives her medication and goes back to sleep. She stated when Resident A wakes back up, she receives 1:1 staffing. I explained that there was an isolated incident when a DCS was running late, leaving one DCS on shift and there was an incident between Residents A and B. Relative A stated she is aware of the incident and stated she spoke to the DCS about making adjustments to ensure there is coverage at all times. Relative A stated there should never be a lapse in coverage. Relative A stated she is very active in Resident A's quality of care and will make sure her 1:1 staffing is in place because Resident A is very active and needs to be supervised.

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 upon my investigation, which consisted of multiple interviews with licensee designee, Janice McCarver; administrator, Shannon McCormick and program director, Gretchen Craft; manager, Karlton Flowers; direct care staff Sharon Moore, Mariama Sowe; Resident A's guardian, Relative A; and Resident A's supports coordinator with Wayne Center, Janice Gonzalez. I observed Residents A and B. Resident B is non-verbal and unable to be interviewed. Resident B is verbal but has limited verbal skills. Both Residents A and B appeared to be adequately dressed, and no marks or bruises were observed. I reviewed Residents A's IPOS, which states she requires 1:1 staffing 12 hours a day during waking hours and 2:1 staff during all transport to ensure she stays seated and buckled. There is sufficient evidence to substantiate the allegation that Janet McCarver did not have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents as specified in the resident's assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same.

09/04/2025

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Denasha Walker Date
Licensing Consultant

Approved By:

09/09/2025

_____

Ardra Hunter Date
Area Manager