GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 28, 2026

Zattie Young
Northrop Loving Care Inc
17777 Northrop
Detroit, MI 48219

RE: License #: AS820068138
Investigation #: 2026A0121010
Northrop Loving Care

Dear Ms. Young:

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 20, 2026, 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) 456-0380.

Sincerely,

K. Robinson

K. Robinson, MSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, 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 #:	AS820068138
Investigation #:	2026A0121010
Complaint Receipt Date:	03/31/2026
Investigation Initiation Date:	04/01/2026
Report Due Date:	05/30/2026
Licensee Name:	Northrop Loving Care Inc
Licensee Address:	17777 Northrop, Detroit, MI 48219
Licensee Telephone #:	(313) 727-3239
Administrator:	Zattie Young
Licensee Designee:	Zattie Young
Name of Facility:	Northrop Loving Care
Facility Address:	17777 Northrop, Detroit, MI 48219
Facility Telephone #:	(313) 727-3239
Original Issuance Date:	03/11/1996
License **Status:**	REGULAR
Effective Date:	05/21/2025
Expiration Date:	05/20/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 3/26/26, home manager, Marvin Bassett pushed Resident A causing the resident to fall. Resident A has unexplainable scratches on his neck.	Yes

III. METHODOLOGY

03/31/2026	Special Investigation Intake 2026A0121010
03/31/2026	Referral - Recipient Rights
03/31/2026	APS Referral
04/01/2026	Special Investigation Initiated - Letter Email to Alexus Horton, Recipient Rights Investigator (RRI)
04/02/2026	Contact - Document Received Email from Alexus Horton, RRI
04/02/2026	Inspection Completed On-site No answer at the door.
04/03/2026	Contact - Telephone call made Licensee, Zattie Young
04/03/2026	Contact - Telephone call made Left message for Ms. Horton
04/06/2026	Contact - Telephone call received Return call from Ms. Horton
04/13/2026	Contact - Telephone call made Guardian 1A
04/14/2026	Inspection Completed-BCAL Sub. Compliance Interviewed Resident B, home manager, Marvin Bassett, and Ms. Young.
04/14/2026	Inspection Completed On-site Interviewed Resident A at new placement.

05/12/2026	Contact - Telephone call made Left message for Ms. Horton
05/12/2026	Contact - Telephone call made Attempted exit conference with licensee
05/13/2026	Contact - Telephone call received Message from Ms. Horton
05/13/2026	Exit Conference Ms. Young
05/14/2026	Contact - Telephone call received Ms. Horton
05/20/2026	Corrective Action Plan Received/Approved

ALLEGATION: On 3/26/26, home manager, Marvin Bassett pushed Resident A causing the resident to fall. Resident A has unexplainable scratches on his neck.

INVESTIGATION: On 4/2/26, I conducted an unannounced onsite inspection at the facility; however, no one was present. On 4/3/26, I spoke with licensee designee, Zattie Young by phone. Ms. Young reported Resident A was discharged from the facility on 3/26/26 after residing there for 15 years. Ms. Young stated Resident A could not return to the facility due to his combative behavior, like "taking his hand smearing feces on the wall … urinating on himself on a regular basis."

On 4/6/26 and 5/14/26, I spoke with Recipient Rights Investigator (RRI), Amber Walker-Hubbard by phone. On 4/6/26, Mrs. Walker-Hubbard shared photos of Resident A's injuries via text. I saw multiple scratches on Resident A's neck; the scratches appeared to be fresh. On 5/14/26, Mrs. Walker-Hubbard reported she completed her investigation and substantiated the abuse.

On 4/13/26, I interviewed Guardian 1A. Guardian 1A shared Resident A's new location with me. Guardian 1A described Resident A as "quiet, very gentle". I asked Guardian 1A if Resident A was known to fabricate stories and Guardian 1A replied a resounding, "No way", emphasizing that Resident A is a very honest person.

On 4/14/26, I completed an onsite inspection at the facility. I interviewed Resident B, home manager Marvin Bassett, and Ms. Young. I also reviewed the incident report related to the complaint allegation. According to Mr. Bassett, on 3/26/26,

Resident B started a fire in one of the upstairs bedrooms. In an effort to evacuate everyone from the home, Mr. Bassett reported he tried to help Resident A get dressed, but Resident A "lounged at me." Mr. Bassett said he responded to Resident A's attack by holding the resident's shoulders to "keep him from grabbing my neck again." During this contact, Mr. Bassett reported Resident A "stepped on a loose boot" that was on the floor, causing the resident to trip and fall. Mr. Bassett denied that he "pushed" Resident A causing the fall. I showed Mr. Bassett digital images of Resident A's injury, and Mr. Bassett could not explain the scratches. Mr. Bassett stated, "I didn't do that … I don't have no fingernails to do that." However, Mr. Bassett's interview statements do not align with the incident report he wrote on the day of the incident. On 3/26/26, Mr. Bassett wrote, "… Staff went to try to help him get dressed, {Resident A} grabbed staff by head and neck. Staff told {Resident A} to let go, no response staff push {Resident A} off, {Resident A} fell on bed and slide into clothing basket on floor." In addition, Resident B reported seeing Mr. Bassett "push" Resident A because Mr. Bassett was trying to take Resident A's shirt.

On 4/14/26, I interviewed Resident A in-person at this new placement. Resident A reported Mr. Bassett caused the scratches on his neck. Resident A stated Mr. Bassett "told me to hurry up" and get dressed, but Resident A insisted that he does not require assistance with dressing. Resident A also stated he does not feel safe at the facility and does not wish to return.

On 5/13/26, I completed an exit conference with Ms. Young. Ms. Young could not explain the discrepancy between Mr. Bassett's interview statement versus what he wrote on the incident report. Based on physical evidence as well as Mr. Bassett's inconsistent statements, I determined it is more likely than not, Mr. Bassett did push Resident A causing harm. On 5/20/26, Ms. Young submitted an approved corrective action plan.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	Based on Resident A and B's statements and the physical evidence, it is more likely than not, Staff Marvin Bassett exposed Resident A to serious risk, physical or emotional harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/28/26

Kara Robinson — Date
Licensing Consultant

Approved By:

05/28/26

Ardra Hunter — Date
Area Manager