GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 4, 2026

LaToshia Baruti
Vintage Specialized Services LLC
P.O. Box 541
Leslie, MI 49251

RE: License #: AS380390596
Investigation #: 2026A0007027
Creekside Residential Care

Dear Ms. Baruti:

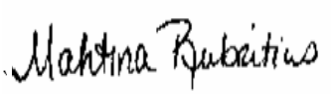
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 335-5985.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380390596
Investigation #:	2026A0007027
Complaint Receipt Date:	04/09/2026
Investigation Initiation Date:	04/09/2026
Report Due Date:	06/08/2026
Licensee Name:	Vintage Specialized Services LLC
Licensee Address:	207 E. Bellevue St. Leslie, MI 49521
Licensee Telephone #:	(313) 567-0709
Administrator:	LaToshia Baruti
Licensee Designee:	LaToshia Baruti
Name of Facility:	Creekside Residential Care
Facility Address:	2055 Perrine Road Rives Junction, MI 49277
Facility Telephone #:	(517) 574-2401
Original Issuance Date:	03/05/2018
License Status:	REGULAR
Effective Date:	03/05/2025
Expiration Date:	03/04/2027
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
An unlicensed employee who is also the manager/HR with no experience, is allowed to administer injections, while having tremors.	No
The home in Rives Junction is very unorganized. All documentation is lost or unorganized, several medication errors take place.	Yes

III. METHODOLOGY

04/09/2026	Special Investigation Intake - 2026A0007027
04/09/2026	Special Investigation Initiated – Letter - APS Referral Made.
04/09/2026	APS Referral made.
04/09/2026	Referral - Recipient Rights made.
04/09/2026	Contact - Telephone call received from LaShanda Walker, ORR. She has a contract and will be conducting a cite visit next week.
04/09/2026	Contact - Document Received - APS Referral Denied.
04/21/2026	Inspection Completed On-site - Unannounced- Face to face contact with Aaliyah Goodlow, DCW, Ashanti Hulburt, DCW, Resident A, Resident B, Resident C, Resident D, and Brenda Knowles, Home Manager.
04/24/2026	Contact - Telephone call made to LaToshia Baruti, Licensee Designee. Discussion.
06/01/2026	Contact - Document Sent - Email to LaShanda Walker, ORR. Status update requested.
06/01/2026	Contact - Telephone call received from LaShanda Walker, ORR. Status update provided.
06/02/2026	Contact - Telephone call made to Brenda Knowles, Home Manager. Follow up.

06/02/2026	Contact - Telephone call made to Gina Fox, DCW. Message left.
06/02/2026	Contact - Telephone call made to Althea Fox, DCW. Interview.
06/02/2026	Document – Received – March 2026 Fire drill record.
06/04/2026	Exit Conference conducted with LaToshia Baruti, Licensee Designee, and Ernest Flagg, Director of Clinical Services and Staff Training.

ALLEGATIONS:

- **An unlicensed employee who is also the manager/HR with no experience, is allowed to administer injections, while having tremors.**

- **The home in Rives Junction is very unorganized. All documentation is lost or unorganized. Several medication errors take place in the facility.**

INVESTIGATION:

As a part of this investigation, I reviewed the written complaint, and summary of the following additional information was noted:

The facility does not have a lot of employees, and when there are no staff available, they will have family come in and work. The family members do not complete the documentation, and they have other employees commit fraudulent documentation (including resident medications and employee information), as a result.

All documentation is lost or unorganized, several medication errors take place. Audits are not completed throughout the year, but quickly at the end, including fraudulent paperwork. No drills or meetings take place but are documented for.

On April 21, 2026, an unannounced on-site investigation was conducted, and I made face to face contact with Aaliyah Goodlow, (direct care worker) DCW, Ashanti Hulburt, DCW, Resident A, Resident B, Resident C, Resident D, and Brenda Knowles, who has the role of Home Manager.

When I arrived that afternoon, I observed the facility to be neat and clean. I did not observe the home to be unorganized. I did not observe stacks of random papers or other clutter in the facility. The medication records were maintained in binders. The residents were in the living room and dining areas of the home. They appeared to be doing well, as they were chatting with each other. The staff were preparing lunch. The direct care staff informed me that there were three staff on duty that day.

Ashanti Hulbert informed me that Resident B had received his medication at noon. I reviewed the medication log and noted that staff had initialed the log, documenting that the Antacid 500 mg had been administered.

Brenda Knowles arrived at the facility shortly after me. I inquired if there had been any recent medication errors and Brenda Knowles informed me there had not been any. I reviewed the medication logs for Resident B, and it was noted that the medication logs were not initialed on 4/20/2026, for the Ditropan XL. Third shift (8:00 p.m. to 8:30 a.m.) staff did not initial the medication logs. It was also noted that the staff initials were missing for Resident B's Tylenol administration on 4/19/26 at 8:00 p.m. Brenda Knowles informed me that they were holding Resident B's Polyethylene glycol, due to him having diarrhea; however, there was no documentation noting that they were holding the medication on 4/19/2026, 4/20/2026, and 4/21/2026.

I reviewed the medications and medication logs for Resident C. It was noted that the medication count for the Lorazepam 1mg Tab (generic for Ativan) PRN, and the medication logs were inconsistent; as the medication log had only been initialed on April 17, 2026 (but there were more medications gone from the bubble pack). Brenda Knowles informed me that she was the only one who administered that medication, and that it was usually chaotic when the medication was being administered. I inquired if there were any incidents reports that would coincide with the medication administrations; she checked the file, noting that there were no documented incident reports in the month of April.

Regarding the staffing, Brenda Knowles informed me that they have two shifts, 8:00 a.m. to 8:30 p.m. and 8:00 p.m. to 8:30 a.m., and there are usually one to two staff on each shift. I reviewed the staff schedule and noted that during the week of 4/12/2026 to 4/18/2026, there was one staff on each shift on April 12, 2026. For the reminder of the week, there were two staff listed each day on the first shift, with the exception of April 16, 2026, as there were three staff listed on first shift. There was one staff on duty for the second shift every day that week.

I inquired about any of the residents receiving injections in the facility and Brenda Knowles informed me that Resident B was receiving them in the facility, but they were now being administered at Lifeways. Resident B changed providers, and the new provider, Doctor # 1, prescribed the injections for once per month; and his next injection was due on April 23, 2026. She stated that Ms. Baruti was giving the injections, but it had been a few months since she administered them. Brenda Knowles also informed me that she was not aware of family members coming in and working there.

During the on-site investigation, Brenda Knowles informed me that they had a staff member, who showed up at the facility to pick up some groceries they left in the pantry, and the staff on duty went to retrieve the items. On the following Monday (specific date not given), Brenda Knowles noted missing documents. They were not sure which documentation was missing as everything was being reviewed. I inquired

about reviewing the fire drill records and she stated that Ms. Baruti, Licensee Designee, was reviewing the documents. While at the facility it was also noted that a ramp was being built. Brenda Knowles informed me that there was a guy building the ramp incorrectly, so that contract was terminated and they would be working with a different contractor. I agreed that it was not correct. I also informed her that the licensee needed to submit a modification request, and that per the rules, the ramp would need to be inspected by either state or local building authorities.

On April 24, 2026, I spoke with Ms. Baruti, Licensee Designee, regarding the investigation. We discussed the discrepancies with the medications. She stated she conducted an internal review, went back and questioned the staff and residents, documented the information and made corrections. Ms. Baruti stated the staff give a report at the end of every shift. She also informed me that they usually audit the files at the end of the month; however, now the files will be audited weekly.

Regarding Resident B's injections, she stated he first received the injections from Agency #1 in Wayne County; however, he now receives them in Jackson at Lifeways (the location is closer). Resident B receives the injections every three weeks. According to Ms. Baruti, there was a period of time when they allowed her to administer the injections. Ms. Baruti reported that she was the only person administering the injections. During this conversation, we discussed the allegations as it was alleged that the home manager (Brenda Knowles) administered injections while having tremors. Ms. Baruti informed me that she (Ms. Baruti) was the only person administering injections; however, the home manager was prescribed medications to treat her tremors. It should be noted that Ms. Baruti has adequate work experience in this field and has previously provided documentation to satisfy the qualifications and training requirements identified in the group home administrative rules. She has also been trained in First Aid and CPR.

Ms. Baruti also informed me that she had to terminate staff on or about April 19, 2026, as they were doing things such as eating out of the pan (instead of getting a plate). The individual who was terminated came to the home to pick up groceries and they later discovered that paperwork was missing. She also worked at the facility on Second Street (Creekside Residential Care – Metro – AS380417986). The individual then was a no call, no show. We also discussed the ramp at the facility, and she informed me that would be a walking ramp, not a wheelchair ramp.

Ms. Baruti also confirmed that she is related to Imani Love (daughter) and Brandon Love (son), and both are fully trained. We also discussed her hiring or contracting with a registered nurse to assist with medication procedures, as Ms. Baruti has a certain way that she would like things to be done. She wanted processes in place to adequately address any issues with medications/documentation.

On June 1, 2026, I spoke with LaShanda Walker, ORR. She informed me that she completed an on-site visit on April 14, 2026. The home was not disorganized, the facility was set up appropriately for the resident population, and there were no

concerns. She stated that it appears there was a disgruntled employee who was making the allegations, after the licensee tried to recoup money for overpayment.

On June 2, 2026, I spoke with Brenda Knowles as I had some follow up questions. She informed me that she has been a care provider for twenty plus years and she is fully trained. She stated that a no time did she administer injections to the residents. We discussed the supervision levels of the residents. She informed me that while they provide increased supervision for all the residents as a general rule, for safety, there were no residents in the facility (based on their Behavior Treatment Plans), that required 1:1 supervision. She also confirmed that Imani Love and Brandon Love were related to Ms. Baruti, Licensee Designee, that they were fully trained, and that they did not work in the facility very often. It should be noted that the employee file for Imani Love was previously reviewed during licensing renewal inspection.

On June 2, 2026, I interviewed Althea Fox, DCW. She stated that she has been employed for Creekside Resident Care since 2023, and she works as a direct care worker. She also stated that she does not work in the facility very often (as she assigned to a different facility), but she has covered shifts in the facility. She stated that no one has asked her to sign for work that she did not complete or falsify any documents.

As a part of this investigation, I reviewed the facility maintenance and fire drill records, residential meetings, staff meetings, and emergency bag checks for the months of January and February of 2026. Staff documented monthly checks, such as the temperatures for the refrigerator and freezer, completed adaptive equipment safety checks, had meetings with the residents and staff, and conducted emergency preparedness and fire drills. Fire drills were completed during the first quarter of 2026, as required by the rule.

On June 4, 2026, I conducted the exit conference with LaToshia Baruti, Licensee Designee, and Ernest Flagg, Director of Clinical Services and Staff Training. We discussed the investigation, the conclusion, and my recommendations. They agreed to submit a written corrective action plan to address the established violations.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	Based upon my investigation, which consisted of an on-site investigation, interviews with staff, and a review of pertinent documents, it's concluded that there is not a 51% preponderance of the evidence, at this time, to support the allegations that Brenda Knowles administered injections to the residents in the facility or staff are falsifying documentation. There is a preponderance of the evidence to support the allegations that staff did not follow the rules for medication administration and documentation; as the medication count was inaccurate for Resident C's medication, Lorazepam.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(b) Complete an individual medication log that contains all of the following:** **(v) Initials of the individual who administered the medication at the time given.**
ANALYSIS:	Based upon my investigation, which consisted of an on-site investigation, interviews with staff, and a review of pertinent documents, it's concluded that there is a preponderance of the evidence to support the allegations that staff did not follow the rules for medication administration and documentation; as the medication logs were not initialed (for Resident B & Resident C), as outlined and required by the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.

ANALYSIS:	Based upon my investigation, which consisted of an unannounced on-site investigation and observations, it's concluded that there is not a preponderance of the evidence to support the allegations that the facility was unorganized.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.619	**Emergency preparedness plan.**
	(8) A licensee shall practice the emergency preparedness plan, including the fire safety plan, at least once a quarter per calendar year during each shift, 7 a.m. to 3 p.m., 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. A record of the practices must be maintained for 2 years.
ANALYSIS:	Based upon my investigation, which consisted of an on-site investigation, interviews with staff, and a review of pertinent documents, it's concluded that there is not a preponderance of the evidence to support the allegations that emergency preparedness drills were not completed as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable written corrective action plan, it's recommended that the status of the license remains the same.

Mahtina Rubritius

6/03/2026

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Mahtina Rubritius Date
Licensing Consultant

Approved By:

Dawn Timm

06/04/2026

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Dawn N. Timm Date
Area Manager