GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 21, 2026

James Palmer
Covenant to Care, Inc.
44997 Coachman Ct.
Canton, MI 48187

RE: License #: AS820316698
Investigation #: 2026A0993021
Jacquelyn Street

Dear Mr. Palmer:

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) 456-0380.

Sincerely,

DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS820316698
Investigation #:	2026A0993021
Complaint Receipt Date:	07/02/2026
Investigation Initiation Date:	07/02/2026
Report Due Date:	08/31/2026
Licensee Name:	Covenant to Care, Inc.
Licensee Address:	181 Dogwood Ct Canton, MI 48187
Licensee Telephone #:	(734) 228-6933
Administrator:	James Palmer
Licensee Designee:	James Palmer
Name of Facility:	Jacquelyn Street
Facility Address:	28646 Jacquelyn Livonia, MI 48154
Facility Telephone #:	(734) 228-6933
Original Issuance Date:	03/13/2012
License Status:	REGULAR
Effective Date:	10/03/2024
Expiration Date:	10/02/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff, Deborah Royal, threatened to punch Resident A in her face.	Yes

III. METHODOLOGY

07/02/2026	Special Investigation Intake 2026A0993021
07/02/2026	APS Referral Allegations received from adult protective services (APS). APS denied the intake.
07/02/2026	Special Investigation Initiated - Telephone Telephone call made to Trinity Health Livonia. Resident A was already discharged from the hospital. No additional information provided.
07/06/2026	Inspection Completed On-site Conducted an unannounced onsite investigation with no success. Left a business card in the front door.
07/06/2026	Referral - Recipient Rights Forwarded allegations to Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights
07/07/2026	Contact - Telephone call received Telephone call received from licensee designee, James Palmer
07/09/2026	Contact - Telephone call made Telephone call made to home manager, Timika Adams
07/09/2026	Contact - Telephone call made Telephone call made to staff, Laketa King
07/09/2026	Contact - Telephone call made Telephone call made to staff, Deborah Royal. Left a message.
07/13/2026	Inspection Completed On-site Conducted an unannounced onsite investigation. I interviewed Resident A.
07/14/2026	Contact - Telephone call made

	Telephone call made to staff, Deborah Royal
07/14/2026	Contact - Telephone call made Telephone call made to supports coordinator, Sabrin Mohamed
07/14/2026	Contact - Telephone call made Telephone call made to Guardian A1
07/14/2026	Contact - Telephone call made Telephone call made to DWIHN recipient rights officer, Dwight Snodgrass
07/14/2026	Exit Conference Held with licensee designee James Palmer

ALLEGATION:

Staff, Deborah Royal, threatened to punch Resident A in her face.

INVESTIGATION:

On 07/02/2026, I received allegations from adult protective services (APS). APS denied the intake.

On 07/02/2026, I contacted a telephone call to Trinity Health Livonia and was informed Resident A was already discharged from the hospital. No additional information provided.

On 07/06/2026, I forwarded allegations to Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights.

On 07/07/2026, I conducted a telephone interview with licensee designee, James Palmer. Mr. Palmer stated he was not present in the facility when the alleged incident occurred. However, he was informed staff, Deborah Royal, was feeding the residents. Resident A got up from the table and threw away her food. Ms. Royal asked Resident A if she threw her broccoli away. Resident A replied, “No,” but that question must have upset her. Resident A went into her bedroom and locked the bedroom door as well as the bathroom door that leads into her bedroom. Ms. Royal banged on the door and told Resident A to “open the f*cking door.” Staff contacted the home manager to tell her about what was occurring. It was either Ms. Royal or staff, Laketa King, the other staff working at the time of the incident. The home manager informed staff where the keys were located to unlock the door. Ms. Royal entered Resident A’s bedroom to talk to her. Resident A gathered her belongings and left the facility. Ms. King followed her. Resident A went to the park. Police were contacted. Resident A stated she did not want to return to the facility. Resident A was transported to the hospital.

Mr. Palmer stated Ms. Royal was removed from the schedule and will be terminated.

On 07/19/2026, I conducted a telephone interview with home manager, Timika Adams. Ms. Adams stated she was not present in the facility when the alleged incident occurred. Ms. Royal and Ms. King were working that day. Resident A became upset. Ms. Adams stated staff asked Resident A to take her medication, and she refused. She went into her bedroom and locked the door. Staff contacted Ms. Adams, and she instructed staff to allow Resident A time to cool off and to give her space. Resident A left the facility. Staff followed her and called the police. Resident A told police she did not want to return to the facility, and she was transported to the hospital. Ms. Adams stated when she picked up Resident A from the hospital, he asked her if she wanted to talk about what had occurred at the facility. Resident A said, “No.” Ms. Adams stated she later found out that Resident A stated Ms. Royal informed her she would punch her in the face.

Ms. Adams stated this is the first time a resident had accused her of threatening to punch them in the face and/or hitting them. In addition, Ms. Adams stated Resident A has a history of reporting false allegations against staff. Ms. Adams did not provide any details about the false allegations.

On 07/09/2026, I conducted a telephone interview with staff, Laketa King. She confirmed she was working in the facility with Ms. Royal when Resident A became upset and left the facility. Per Ms. King, Resident A went into her bedroom and locked the door. Ms. Royal banged on the door while asking Resident A to open the door. Ms. Royal unlocked the door and went into Resident A’s bedroom. Ms. King stated she did not hear what was said while Ms. Royal was in Resident A’s bedroom. Resident A packed up her belongings and left the facility. Ms. King stated she followed Resident A and called the police. The police arrived while they were at the park. The police transported Resident A to the hospital.

On 07/13/2026, I conducted an unannounced onsite investigation. I interviewed Resident A. Resident A confirmed she locked her bedroom door and the bathroom door that leans to her bedroom. She stated Ms. Royal yelled at her and told her to open the “got d@mn door.” Resident A stated Ms. Royal used a key, entered her bedroom, and told her she was going to punch her in the face. Resident A packed her belongings and left the facility. Ms. King followed her. The police picked her up and took her to the hospital.

On 07/14/2026, I conducted a telephone interview with staff, Deborah Royal. Ms. Royal denied telling Resident A that she was going to punch her in the face. Ms. Royal stated she was trying to give Resident A her medication and she refused. Resident A had locked her bedroom door. Ms. Royal stated she knocked on the door and asked her to take her medication. When she unlocked the door, Resident A stormed off. The police were called, and Resident A was taken to the hospital.

On 07/14/2026, I conducted a telephone interview with supports coordinator, Sabrin Mohamed. Ms. Mohamed stated she did not have knowledge of Ms. Royal telling Resident A that she was going to punch her in the face. Ms. Mohamed stated she met with Resident A in the facility on 07/08/2026, and Resident A did not say anything about it or report any concerns. Ms. Mohamed denied any concerns with the care Resident A receives in the facility. Ms. Mohamed stated Resident A has a history of making things up such as having siblings or reporting a fake injury, but she has never reported false allegations against staff.

On 07/14/2026, I conducted a telephone interview with Guardian A1. She stated she did not have knowledge of Ms. Royal telling Resident A that she was going to punch her in the face. She stated Resident A does not have a history of making false allegations.

On 07/14/2026, I conducted a telephone interview with DWIHN recipient rights officer, Dwight Snodgrass. He stated his investigation is pending.

On 07/14/2026, I contacted licensee designee, James Palmer and conducted an exit conference. I informed him of the findings. He agreed with the findings. He stated Ms. Royal was terminated because of the incident.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Resident A locked her bedroom door and the bathroom door leading to her bedroom. Ms. King and Resident A both stated that Ms. Royal banged on the door to get Resident A to open it. Resident A stated Ms. Royal yelled at her and told her to open the “got d@mn door.” Resident A stated Ms. Royal used a key, entered her bedroom, and told her she was going to punch her in the face. Resident A left the facility and was eventually taken to the hospital. Evidence supports Resident A was not treated with dignity and respect.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/20/2026

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DaShawnda Lindsey Date
Licensing Consultant

Approved By:

07/21/2026

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Ardra Hunter Date
Area Manager