GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 13, 2026

Tamisha Kaplan
A Caring Home of Michigan, LLC
P.O. Box 81
Walled Lake, MI 48390

RE: License #: AS630418269
Investigation #: 2026A0602011
Chateau of Bloomfield-Lasher Home

Dear Tamisha Kaplan:

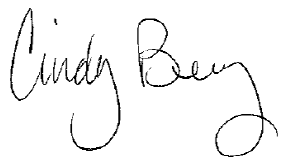
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 972-9136.

Sincerely,



Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3044 West Grand Blvd
2nd Floor Annex, Suite 2-730
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630418269
Investigation #:	2026A0602011
Complaint Receipt Date:	05/07/2026
Investigation Initiation Date:	05/08/2026
Report Due Date:	07/06/2026
Licensee Name:	A Caring Home of Michigan, LLC
Licensee Address:	45750 Eleven Mile Novi, MI 48374
Licensee Telephone #:	(248) 380-4663
Licensee Designee/Administrator:	Tamisha Kaplan
Name of Facility:	Chateau of Bloomfield-Lasher Home
Facility Address:	2563 Lasher Road Bloomfield Hills, MI 48304
Facility Telephone #:	(248) 380-4663
Original Issuance Date:	12/16/2024
License Status:	REGULAR
Effective Date:	06/16/2025
Expiration Date:	06/15/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A walked away from the home with no shirt or shoes on and his pants falling down. Resident A walked into an urgent care and passed out. The group home never called to report him missing or request assistance in locating him. Resident A is supposed to have a caretaker with him due to his diagnoses, but he regularly walks away from the home. Police pick him up and take him back to the group home.	Yes

III. METHODOLOGY

05/07/2026	Special Investigation Intake 2026A0602011
05/08/2026	Special Investigation Initiated - Telephone Message left for the complainant.
05/13/2026	Inspection Completed On-site No response.
05/19/2026	Inspection Completed On-site No response.
06/09/2026	Inspection Completed On-site No response.
06/09/2026	Contact - Telephone call made Call made to the home, no answer.
06/16/2026	Contact - Telephone call made Message left for the complainant.
07/10/2026	Inspection Completed On-site No response.
07/21/2026	Contact - Document Sent Email sent to the complainant.
07/21/2026	Contact - Telephone call received Spoke with Sgt. Joseph Monti of the Bloomfield Township Police Department.
07/21/2026	Contact - Document Received

	Received copies of police reports from Sgt. Monti.
07/21/2026	Contact – Telephone call made Spoke with staff member Khamya Young.
07/21/2026	Contact – Telephone call made Call made to staff member Akeia Williams – number no longer in service.
07/29/2026	Contact – Telephone call made Message left for the licensee designee, Tamisha Kaplan
07/30/2026	Contact – Telephone call received Spoke with Ms. Kaplan.
07/31/2026	Inspection Completed On-site Interviewed the home manager Thomas Bates, Resident A, Resident B, Resident C, Resident D, staff members Crystal Cooper, and Charles Lee.
08/03/2026	Contact – Telephone call made Message left for Mr. Bates requesting staff schedules for the month of May 2026.
08/03/2026	Contact – Telephone call made Spoke with the new home manager, Chenille Dearman.
08/03/2026	Exit Conference Message left for the licensee designee, Tamisha Kaplan requesting a return call.
08/03/2026	APS referral Adult protective services referral made.
08/11/2026	Contact – Document sent Referral made to recipient rights.
08/11/2026	Contact – Telephone call made Message left for Chenile Dearman.
08/11/2026	Contact – Telephone call made Message left for Thomas Bates.
08/11/2026	Contact – Telephone call made Call made to Ms. Kaplan - voicemail full, unable to leave a message

08/11/2026	Contact – Document sent Email sent to Ms. Kaplan requesting staff schedules and incident reports.
08/12/2026	Contact – Document received Received requested documents.
08/13/2026	Exit Conference Call made to the licensee designee, Tamisha Kaplan, mailbox full.

ALLEGATION:

Resident A walked away from the home with no shirt or shoes on and his pants falling down. Resident A walked into an urgent care and passed out. The group home never called to report him missing or request assistance in locating him. Resident A is supposed to have a caretaker with him due to his diagnoses, but he regularly walks away from the home. Police pick him up and take him back to the group home.

INVESTIGATION:

On 5/07/2026, a complaint was received and assigned for investigation alleging that Resident A walked away from the group home with no shirt or shoes on and his pants falling down. Resident A walked into an urgent care at Woodward and Square Lake Road and passed out. The group home staff never called to report him missing or request assistance in locating him. Resident A is supposed to have a caretaker with him due to his diagnoses, but he regularly walks away from the home and police pick him up and take him back to the group home.

On 5/13/2026, 5/19/2026, 6/09/2026, and 7/10/2026 I attempted to conduct unannounced on-site investigations, but there was no one at the home.

On 7/21/2026, I spoke with Sergeant (Sgt) Joseph Monti of the Bloomfield Township Police Department by telephone. Sgt Monti stated the detective assigned to this case, Detective Marisa Miller, is out on extended leave and he did not know when she would return. He said there have been at least 12, if not more, visits to the home regarding Resident A. Sgt Monti agreed to provide a copy of the report written regarding the allegations listed in this investigation.

On 7/21/2026, I received and reviewed two police reports from the Bloomfield Township Police Department dated 5/06/2026 and 6/04/2026. According to the report dated 5/06/2026, a well-being call was made to the Bloomfield Township Police Department reporting that a male in his late 20s to early 30s (later identified as Resident A) was

observed walking around Smokey's Cigar Lounge with no shirt or shoes on with his pants falling off. Resident A walked into an urgent care where he passed out. Upon arrival, Resident A was observed inside the urgent care and was transported to the hospital by the fire department. This is all the information documented in the report.

According to the report dated 6/04/2026, Detective Miller and Officer Borro were dispatched to Hickory Grove Road and Colonial Trail for a male (later identified as Resident A) laying on his stomach on the side of the road. Upon arrival, Resident A appeared to be unconscious but breathing and unable to answer any questions. It was suspected that he had a seizure, and he was transported to Trinity Health Oakland for further care. Contact was made to the group home and staff members, Akeia Williams and Khamya Young, were interviewed. Ms. Williams reported that Resident A was supposed to go with her to drop the other residents off at school, but he left out the back of the home and over the bricks around 0745 hours. Ms. Williams stated she looked for Resident A for 30-45 minutes, checking the area of Woodward Ave. and Square Lake Road at local gas stations and plazas, but she could not locate him. Detective Miller asked Ms. Williams if there had been a plan put in place to keep Resident A from running away from the home. Ms. Williams stated if Resident A runs out of the home, they are not allowed to grab him because it would be considered a recipient rights violation. The report goes on to document that Resident A has had numerous contacts with law enforcement and the fire department. He is known to run away from home, run into traffic, and has been found nude in public areas. This is all the information documented in the report.

On 7/21/2026, I spoke with staff member Khamya Young by telephone. Ms. Young stated she began working for the company in May 2026 and was not working the day Resident A left the home and passed out at the urgent care. Ms. Young said on 6/04/2026, she arrived for her shift around 8:00 am. Staff and the residents were in the van getting ready to transport Resident C to school when Resident A said he had to use the bathroom. The home manager at the time, Akeia Williams, was in the home with Resident A. After a few minutes, she called his name, but he did not answer. She went to the bathroom and realized he had left out the back door. Ms. Williams instructed the other staff to transport Resident C to school, while she drove around looking for Resident A, and Ms. Young remained at the home. When Ms. Williams returned to the home, she said she could not locate Resident A. Ms. Young then proceeded to leave the home to drive around and look for Resident A. As she was leaving, the Bloomfield Township Police arrived and informed them that Resident A was found on the side of the road and was transported to the hospital. Ms. Young said she went to Trinity Health Oakland Hospital and sat with Resident A for the remainder of her shift. Resident A was kept for observation for several hours before being released.

On 7/30/2026, I spoke with the licensee designee, Tamisha Kaplan, by telephone. I informed Ms. Kaplan that I had made several unsuccessful visits to the home to interview staff and residents. She stated the residents attend programs or go on outings during the day. Ms. Kaplan agreed to have staff and the residents at the home on 7/31/2026 at 9:30 am.

On 7/31/2026, I conducted an on-site investigation at which time I interviewed the home manager, Thomas Bates, Resident A, Resident B, Resident C, Resident D, and staff members, Crystal Cooper and Charles Lee. Mr. Bates stated he has worked for the company since 2021 and became the home manager in 2022 of another home operated by Ms. Kaplan. Most recently, Mr. Bates has been training Chenille Dearman to become the home manager of this home. He said he did not recall an incident where Resident A left the home, went to urgent care, and passed out. Mr. Bates said Resident A has a history of running away from the home and staff are to follow him in the van or on foot and attempt to get him to return home. There have been times when Resident A refused to return home and the police were notified. He stated there was an incident in June 2026 (exact date unknown) when Resident A got mad about something and left the home on foot with staff following behind him. Resident A initially attempted to go into the nearby CVS, but it was closed. He then tried to run across Square Lake Road but fell before he could cross the street. Staff remained with him until the police arrived.

On 7/31/2026, I interviewed Resident A in his bedroom while he was lying in bed. He said he did not remember going to urgent care and passing out but admitted that he does walk away from the home without staff. He stated he has fallen when he goes to the store or the gas station. This is all the information Resident A provided. He said he was upset that he was not going to be able to go to the movies to see the new Spiderman movie and refused to answer any further questions.

Resident B stated he did not recall an incident where Resident A left the home with no shoes or shirt on and went to urgent care and passed out. Nor did he have any knowledge about Resident A being found on the side of the road. Resident B said Resident A does leave the home without staff all the time and staff will follow him. He has witnessed Resident A drop to the ground if he does not get his way and refuses to get up. Resident B said the police come to the home often to talk about Resident A or bring him back to the home.

Resident C stated the only thing he had to say about Resident A was that he runs away from the home a lot and the police will bring him back.

Resident D stated he had no information about Resident A leaving the home with no shoes or shirt on and going to urgent care and passing out. Nor did he have any knowledge of Resident A being found on the side of the road and transported to the hospital. He said Resident A has a history of running away often but staff go after him.

Ms. Cooper stated she began working for the company three weeks ago and had no knowledge regarding the allegations listed above or about Resident A being found on the side of the road. Ms. Cooper said she only works on Saturdays and Sundays and has not experienced Resident A running away from home during any of her shifts.

Mr. Lee stated he began working for the company in January 2026 and usually works the day shift between the hours of 7:00 am – 3:00 pm or the afternoon shift between the

hours of 3:00 pm – 7:00 am. Mr. Lee stated he did not recall an incident where Resident A left the home with no shoes or shirt on and went to urgent care or being found on the side of the road. Mr. Lee said Resident A does not elope from the home during his shifts. He stated he talks to Resident A to calm him down when he becomes upset and that usually works.

On 7/31/2026, I reviewed Resident A's individual plan of service (IPOS). According to the plan, Resident A has a diagnosis of mild neurocognitive disorder, impulse disorder, adjustment disorder, epilepsy, West Nile virus with encephalitis, and morbid obesity. Resident A has 2:1 staffing during awake hours and 1:1 staffing during sleeping hours. Staff should always know his whereabouts due to possible elopement or seizure activity. When not in the common areas of the home, staff should provide visual checks every 15 minutes.

On 7/31/2026, I reviewed Resident C's IPOS. According to the plan, Resident C has a diagnosis of autism spectrum disorder, mild intellectual disability, mood disorder, and attention-deficit hyperactivity disorder. Resident C has 1:1 staffing 24 hours a day due to behaviors and elopement risk.

On 8/3/2026, I interviewed the home manager, Chenille Dearman, by telephone. Ms. Dearman stated she began working for the company in April 2026 as a direct care worker. She was the home manager in training during the month of July 2026 and is now the home manager as of 8/1/2026. She said Resident A has a history of eloping from the home, but she had no knowledge of him leaving the home with no shoes or shirt on and going to urgent care and passing out. Ms. Dearman stated although Resident A has 2:1 staffing during awake hours and 1:1 staffing during sleeping hours, he is very sneaky when eloping from home. He will say he has to go to the bathroom but will run out of the back door. He is very impulsive and will randomly jump up and leave the home. If he becomes upset about something he will drop to the ground, refuse to get up and ignore staff talking to him. He has a history of faking seizures so that he can go to the hospital. Ms. Dearman stated that when she is assigned to Resident A, she will stay with him all the time. If he goes to the bathroom, she is right there with him. If he goes into his room, she is right there with him. I requested that Ms. Dearman provide copies of the staff schedule for the month of May 2026. Ms. Dearman stated she was not scheduled to return to work until 8/5/2026 and she would obtain and provide a copy of the May 2026 staff schedule.

On 8/12/2026 I received and reviewed staff schedules dated May 2026 and June 2026, as well as incident reports written regarding Resident A for the months of May 2026 and June 2026. On 5/06/2026 the staff schedule reads as follows: 7 am - 7 pm – Chanel, 7 am – 3 pm – Cherish, 3 pm – 11 pm – Shataara, and 7 pm – 7 am- Nickidta. On 6/04/2026 the staff schedule reads as follows: 7 am – 7 pm – Akeia, 7 am – 3 pm – Khamya, 3 pm – 11 pm – Shataara and 7 pm – 7 am Nickidta.

I reviewed the incident report dated 5/7/2026, written and signed by staff member Akeia Williams (previous home manager) regarding an incident that occurred on 5/6/2026

involving Resident A, and staff members Cherish Love and Chanell Purdy. It notes at 8:40 am Resident A ran out of the home and staff followed attempting to redirect him. Resident A went into the urgent care. The urgent care staff called 911 and Resident A was taken to Trinity Health Hospital.

I reviewed the incident report dated 6/4/2026, written and signed by staff member Akeia Williams. It notes at 7:40 am Resident A ran out the back door and staff ran after him. Resident A laid on the sidewalk, 911 was called, and Resident A was taken to Trinity Health Hospital, evaluated and discharged with no injuries.

I attempted to conduct an exit conference with the licensee designee on 08/03/26 and 08/13/26 by phone. I did not receive a return call on 08/03/26 and her voicemail box was full on 08/13/26.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.
ANALYSIS:	Based on the information obtained during the investigation, there is sufficient information to determine that there was insufficient staffing during the months of May 2026 and June 2026. There are four residents residing in the home. As documented in their individual plans of service, Resident A requires 2:1 staffing during daytime hours and 1:1 staffing at night, while Resident C requires 1:1 staffing 24 hours/day. The home should have a minimum of four staff on shift during daytime hours and three staff on shift during nighttime hours to meet the staffing requirements of Resident A, Resident C, and the other residents in the home. According to the staff schedules reviewed, each shift had one staff member scheduled for 7 am – 7 pm, 7 am – 3 pm, 3 pm- 11 pm and 7 pm – 7 am.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based on the information obtained during the investigation, there is sufficient information to determine that Resident A is not safe and protected in the home, as he has a history of eloping. On at least two occasions, Resident A was located by the police without staff knowing his whereabouts or reporting him missing, despite Resident A having 2:1 staffing during awake hours per his IPOS. On 5/06/2026, the Bloomfield Twp Police Department located Resident A walking around Smokey's Cigar Lounge with no shirt or shoes on with his pants falling down. Resident A walked into urgent care where he passed out. Staff did not call to report Resident A's elopement from the home. On 6/04/2026, Resident A eloped from the home and was found by the Bloomfield Twp Police Department lying on his stomach on the side of the road, appearing to be unconscious but breathing and unable to answer any questions. Mr. Bates, Ms. Young, Ms. Cooper, Mr. Lee and Ms. Dearman all report no recollection of Resident A leaving the home and passing out at a nearby urgent care. Each staff member indicated that Resident A has a history of running away from home, but staff will follow him in the van or on foot.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #: 2025A0605021; CAP Dated: 12/04/2025**

APPLICABLE RULE	
R 400.693	**Incident notification, incident records.**
	(2) If an elopement occurs, facility staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the initiation of the search, staff shall contact law enforcement.

ANALYSIS:	Based on the information obtained during the investigation, there is sufficient information to determine that staff did not contact law enforcement when Resident A eloped from the home on 5/06/2026. According to the Bloomfield Twp Police, on 5/06/2026 Resident A was observed walking around Smokey's Cigar Lounge with no shirt or shoes on with his pants falling down. Resident A walked into urgent care where he passed out. Staff did not contact the police to report him missing. There was no mention of staff being on-site at the urgent care when emergency medical staff arrived. According to the incident report dated 5/6/2026, staff members Cherish Love and Chanel Purdy were working when Resident A eloped from the home. Cherish Love was not listed on the staff schedule as working on this date. Mr. Bates, Ms. Young, Ms. Cooper, Mr. Lee and Ms. Dearman all report no recollection of Resident A leaving the home and passing out at a nearby urgent care.
CONCLUSION:	**VIOLATION ESTABLISHED**

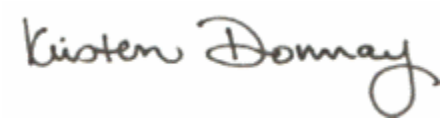
IV. RECOMMENDATION

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

8/13/2026

Cindy Berry — Date
Licensing Consultant

Approved By:



WOC Area Manager for 08/13/2026

Denise Y. Nunn — Date
Area Manager