GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 19, 2026

Charles Mckay III
Samaritan Homes, Inc.
2521 Oakwood Blvd
Melvindale, MI 48122

RE: License #: AS820068075
Investigation #: 2026A0116039
Vreeland Home

Dear Mr. Mckay III:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820068075
Investigation #:	2026A0116039
Complaint Receipt Date:	07/02/2026
Investigation Initiation Date:	07/06/2026
Report Due Date:	08/31/2026
Licensee Name:	Samaritan Homes, Inc.
Licensee Address:	2521 Oakwood Blvd Melvindale, MI 48122
Licensee Telephone #:	(248) 399-8115
Administrator:	Charles Mckay III
Licensee Designee:	Charles Mckay III
Name of Facility:	Vreeland Home
Facility Address:	17090 Ray Riverview, MI 48194
Facility Telephone #:	(248) 399-8115
Original Issuance Date:	10/01/1995
License Status:	REGULAR
Effective Date:	04/12/2026
Expiration Date:	04/11/2028
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 06/29/2026, a staff member walked off shift leaving one staff member. There are 6 residents and two residents that require 1:1 staffing. There was no report of harm to any of the residents.	Yes

III. METHODOLOGY

07/02/2026	Special Investigation Intake 2026A0116039
07/02/2026	APS Referral Received.
07/06/2026	Special Investigation Initiated - On Site Staff, Alana Fails, Bianca Wilson, Tiffany Stoutermire, Resident A, attempted interview with Resident C. Reviewed Resident's A and B individual plans of service (IPOS).
07/06/2026	Contact - Telephone call received Interviewed home manager, Tameika Lashore while onsite.
07/06/2026	Contact - Telephone call received Licensee designee, Charles McKay.
07/20/2026	Contact - Document Received July 2026 staff schedules.
08/12/2026	Contact - Telephone call made Guardian D1.
08/12/2026	Contact - Telephone call made Guardian B1.
08/12/2026	Inspection Completed-BCAL Sub. Compliance
08/12/2026	Contact - Document Sent Email sent to ORR requesting contact information for assigned investigator.
08/12/2026	Exit Conference Licensee designee, Charles McKay.

08/13/2026	Contact-Telephone call made Recipient rights investigator, Nia Creighton.

ALLEGATION:

On 06/29/2026, a staff member walked off shift leaving one staff member. There are 6 residents and two residents that require 1:1 staffing. There was no report of harm to any of the residents.

INVESTIGATION:

On 07/06/2026, I conducted an unscheduled onsite inspection and interviewed staff, Alana Fails, Bianca Wilson, Tiffany Stouter, Resident A, attempted interview with Resident C and reviewed Resident's A and B individual plans of service (IPOS).

Ms. Fails reported that the incident occurred on 07/01/26 and not 06/29/26. She reported that she was scheduled off but was called in to cover a no call no show. Ms. Fails reported she arrived at the home at about 7:20 p.m. and worked until 12:00 a.m. Ms. Fails reported when she arrived staff, Christina McFall, was the only staff present and was upset because the other staff who was scheduled to work from 4:00 p.m. to 12:00 a.m. never came. Ms. Fails reported that Ms. McFall gathered her belongings and left, leaving her alone until home manager, Tameika Lashore, arrived around 8:30 p.m. Ms. Fails reported that she and Ms. Lashore finished the shift and left at midnight when the three midnight staff arrived.

I interviewed staff Bianca Wilson, and she reported that she worked 12:00 a.m. until 4:50 p.m. on 07/01/26. She reported that she stayed the extra 50 minutes to help Ms. McFall out and to see if the other staff, Ziesha Johnson, was going to show up. Ms. Wilson reported she worked 16 hours and was not able to stay any longer.

I interviewed staff, Tiffany Stoutermire, and she reported that she worked from 8:00 a.m. to 4:00 p.m. on 07/01/26. Ms. Stoutermire reported she also stayed over to help Ms. McFall while waiting for Ms. Johnson to arrive. Ms. Stoutermire reported she had to leave about 5:00 p.m. and at that time Ms. Johnson had still not arrived.

While onsite, area manager, Tamekia Lashore, called and requested to speak with me. Ms. Lashore confirmed what was previously reported by Ms. Fails, Ms. Wilson and Ms. Stoutermire. She reported that once Ms. Fails notified her that Ms. McFall walked off shift, she began calling around to try to find staff coverage. Ms. Lashore reported at the time of the incident, Resident B, who is one of the residents who require 1:1 staffing, was out with his family, so they were only in need of two staff, until he returned. Ms. Lashore reported that she was unsuccessful in securing coverage, so she went to the home and covered the shift. Ms. Lashore reported she arrived to the home about 8:30 p.m. and worked until 12:00 a.m. with Ms. Fails. Ms.

Lashore reported that shortly after arriving to the home, Resident B returned to the home, however she was still unsuccessful in securing an additional staff.

Ms. Lashore reported that Ms. McFall is no longer employed with the company.

I reviewed Resident A's IPOS effective 05/28/26 and confirmed that she requires 1:1 staffing 24 hours per day. I also reviewed Resident B's IPOS effective 09/15/25 and confirmed he requires 1:1 staffing 24 hours per day. There are also four other residents who reside in the home.

I interviewed Resident A and she reported that she likes living in the home and the staff treat her well. Resident A reported that there is always staff in the home and reported she has never been left in the home alone. Resident A was not able to provide any details regarding the incident on 07/01/26 when Ms. McFall walked off shift.

I attempted to interview Resident C. Resident C would repeat the questions asked and when he spoke it was difficult to understand him, so I concluded the interview. Resident C was neatly dressed and groomed.

Resident B and D-F were not in the home at the time of my onsite inspection as they were in school or at their workshop program.

On 07/06/2026, I interviewed licensee designee, Charles McKay. Mr. McKay reported that this incident occurred because he terminated Ms. McFall's close friend who worked in the home. He reported that once Ms. McFall became aware of this, she was upset and decided she would walk off shift and self-terminate. Mr. McKay reported that he is fully aware that the home requires 3 staff per shift, due to Resident A and B requiring 1:1 staffing 24 hours per day. Mr. McKay reported the home is being properly staffed, but when staff no call no show, it's difficult to plan for those things. He reported that they are continuing to hire and have been making decisions about the future of existing staff who are not a good fit or who are causing problems in the home with other staff.

On 07/20/26, I received and reviewed the July 2026 staff scheduled. I confirmed that on 07/01/26 there were three staff scheduled for each shift.

On 08/12/26, I interviewed Guadian D1 and she reported that she was aware of the incident but could not recall who notified her. She reported that she was glad there was at least one staff in the home and that no harm came to any of the residents. Guardian D1 reported that she has no concerns at all and reported that Resident D is well cared for. Guardian D1 reported that two of the staff have worked with Resident D for years and reported that they are angels.

On 08/12/26, I interviewed Guardian B1 and he reported that he was aware of the incident but could not recall if the staff notified him or recipient rights. Guardian B1

reported that he is glad the matter is being addressed and hopes that this doesn't happen again. Guadian B1 reported that he did not have any concerns to report.

On 08/12/26, I conducted the exit conference with licensee designee, Charles McKay, and informed him of the findings of the investigation and the rule cited. Mr. McKay reported an understanding. Mr. McKay reported that he had to "clean house" at this home and terminate some of the staff who were causing problems and no longer a good fit. He reported his hope of being able to maintain good staff in the home.

On 08/13/26, I interviewed, recipient rights investigator, Nia Creighton. Ms. Creighton reported that the investigation will be substantiated and that she will be requesting the licensee designee complete a policy update to address what they plan to do when they have staff call offs and/or no call no shows. Ms. Creighton reported it took entirely too long for management to get another staff to the home, leaving one person on shift. She reported the current plan is not feasible.

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 findings of the investigation, which included interviews of staff, Alana Fails, Bianca Wilson, Tiffany Stoutermire, home manager, Tamekia Lashore, licensee designee, Charles McKay, and my review of Resident's A and B IPOSs, there is a preponderance of evidence to substantiate the allegations that on 07/01/26, that there was only 1 staff on shift from about 5:00 p.m. until 8:30 p.m. and then two staff on shift from 8:30 p.m. until 12:00 a.m. The home requires a minimum of three staff per shift as Resident A and B require 1:1 staffing 24 hours per day and there are four other residents who reside in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/14/26

_____

Pandrea Robinson — Date
Licensing Consultant

Approved By:

08/19/26

_____

Ardra Hunter — Date
Area Manager