GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 10, 2025

Felicia Evans
Community Living Options
626 Reed Street
Kalamazoo, MI 49001

RE: License #: AS390366234
Investigation #: 2025A1024005
Misty Creek

Dear Felicia Evans:

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 (616) 356-0183.

Sincerely,

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390366234
Investigation #:	2025A1024005
Complaint Receipt Date:	11/20/2024
Investigation Initiation Date:	11/20/2024
Report Due Date:	01/19/2025
Licensee Name:	Community Living Options
Licensee Address:	626 Reed Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-6355
Administrator:	Fiorella Spalvieri
Licensee Designee:	Felicia Evans
Name of Facility:	Misty Creek
Facility Address:	5452 Misty Creek Kalamazoo, MI 49009
Facility Telephone #:	(269) 349-2305
Original Issuance Date:	11/05/2014
License Status:	REGULAR
Effective Date:	08/21/2024
Expiration Date:	08/20/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has been mistreated because staff yells at her, has grabbed her by the arms and has raped her.	No
Resident B was not given her medication in a timely manner.	Yes

III. METHODOLOGY

11/20/2024	Special Investigation Intake 2025A1024005
11/20/2024	APS Referral is complaint source
11/20/2024	Special Investigation Initiated – Telephone with Resident A, direct care staff members Moony Williams, Brandy Franklin
11/25/24	Contact - Document Received-additional allegations regarding Resident B from Intake #203416
12/02/2024	Contact - Document Received-additional allegations from Intake 203457 regarding Resident A
12/02/2024	Inspection Completed On-site with direct care staff members Bernard Hall, Moony Williams, Resident A, Resident B, Relative A1
12/02/2024	Contact - Telephone call made Relative B1
12/03/2024	Contact - Face to Face with Felicia Evans, Robyn Hill and Sarah Gue
12/03/2024	Contact - Document Received- *AFC Licensing Division-Incident/Accident Reports*
01/07/2025	Contact-Telephone call with Resident A's case manager Zach Mousseus
01/07/2025	Exit Conference with licensee designee Felicia Evans and administrator Fiorella Spalvieri
01/07/2025	Inspection Completed-BCAL Sub. Compliance
01/07/2025	Corrective Action Plan Requested and Due on 01/07/2025

ALLEGATION: Resident A has been mistreated because staff yells at her, has grabbed her by the arms and has raped her.

INVESTIGATION:

On 11/20/2024, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged Resident A has been mistreated because staff yells at her and has grabbed her by the arm. On 12/02/2024, I received additional allegations stating that staff raped Resident A.

On 11/20/2024, I conducted interviews with direct care staff members Moony Williams, Brandy Franklin and Resident A. Moony Williams and Brandy Franklin both stated they have no knowledge of any staff member mistreating Resident A in any way and stated that Resident A has a history of making false accusations against others for no apparent reason. Moony Williams and Brandy Franklin also both stated they have witnessed Resident A yell out “rape” while just sitting quietly in a chair or will randomly call 911 and say that someone has raped her which has repeatedly been false statements. Brandy Franklin stated Resident A’s case manager has been notified and they are working on solutions for this behavior.

Resident A stated she is getting verbally and physically abused everyday by all the staff members and everyone knows about it. Resident A stated she is going to be moving out of the facility because of the constant abuse she receives. It should be noted Resident A was not able to provide any examples or incidents of the alleged abuse she has been subjected to.

On 12/02/2024, I conducted an onsite investigation at the facility with direct care staff member Bernard Hall, Moony Williams, Resident A, Resident B, and Relative A1. Bernard Hall stated he has not seen Resident A be mistreated in any way and believes this complaint was made from Resident A who repeatedly makes false complaints against staff members. Bernard Hall stated in the last two weeks Resident A has randomly yelled out “rape” while sitting in the living room or has called the police to make this claim. Bernard Hall stated Resident A was recently sent to the hospital after she made the claim of being rape and examined with no findings determined. Bernard Hall stated due to Resident A’s abuse of calling 911 to make false claims, whenever she calls 911 a dispatch person calls the facility phone number to talk with staff instead of coming out to the home.

Moony Williams stated recently Resident A has been making false “rape” accusations every day and has called the police. Moony Williams further stated she has noticed that when Resident A is upset with her parents or can’t get in touch with them, Resident A will dial 911 and say that she has been raped. Moony Williams stated staff members are never alone with Resident A due to her constantly making false accusations and she has not seen any inappropriate behaviors conducted by staff.

Resident A stated she was raped last week three different times and was raped today three different times. Resident A stated she knows she was raped by a man but cannot describe anything else about the man. Resident A also stated she does not remember where she was at when the alleged incident occurred.

Relative A1 stated he is aware that Resident A constantly makes false abuse claims such as being raped, and he believes this is due to her mental illness. Relative A1 stated Resident A has been to the hospital for these claims to be examined and no findings have ever been present. Relative A1 stated he does not believe Resident A has been mistreated in any way and he is trying to get Resident A the helps she needs for her mental illness which causes her to make false accusations against others.

On 12/03/2024, I conducted interviews with licensee designee Felicia Evans and staff members Robyn Hill and Sarah Gue who all stated that Resident A has a history of making excessive calls to law enforcement claiming rape and other accusations which has been founded to be untrue. They both stated they met with Resident A's mental health provider to discuss solutions and if the facility is the proper setting for Resident A. Felicia Evans stated since no solutions has been presented to assist with Resident A's behaviors a 30-discharge notice has been issued. Felicia Evans, Robyn Hill and Sarah Gue all stated they have no knowledge of any staff member ever mistreating Resident A in any way.

On 12/3/2024, I reviewed the facility's *AFC Licensing Division-Incident/Accident Reports* dated 9/9/24, 10/15/24, 11/20/24, 11/27/24, 11/28/24 that all stated Resident A called the police and reported that she was raped which was found to be untrue in all instances. I also reviewed incident reports dated 9/9/24, 11/5/24, 11/6/24, 11/27/24, 12/6/24 which all stated that Resident A called the police stating that she fell and was taken to the hospital however no injuries were founded.

On 01/07/2025, I conducted an interview with Resident A's case manager Zach Mousseus who stated that Resident A has documented history of falsely reporting accusations including rape, abuse, and neglect, while residing in an AFC setting. Zach Mousseus stated these accusations have not been found to be creditable and he has no concerns for the facility.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or

	physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on my investigation which included interviews with licensee designee Felica Evans, staff members Robyn Hill, Sarah Gue, Moony Williams, Bernhard Hall, Brandy Franklin, Resident A, Relative A1, and A's case manager Zach Mousseus and review of incident reports there was no evidence to support the allegation Resident A has been mistreated because staff yells at her, has grabbed her by the arm and/or has raped her. All staff members interviewed reported they have no knowledge of any staff member mistreating Resident A in any way and stated that Resident A has a history of making false accusations, including being raped, for no apparent reason and that has not been substantiated. Relative A1 and Zach Mousseus also both stated that Resident A tends to make false complaints against others, and they have no concerns for the facility. Resident A has not been mistreated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident B was not given her medication in a timely manner.

INVESTIGATION:

On 11/25/2024, I received additional allegations which stated that Resident B was not given her medication in a timely manner.

On 12/02/2024, I conducted an onsite investigation at the facility with direct care staff members Bernard Hall and Moony Williams. Bernard Hall stated staff took Resident A for a routine psychiatric appointment on 11/06/24 and was notified on 11/8/2024 that Resident B had an UTI infection which was found in her blood drawn at her routine appointment. Bernard Hall stated he wasn't notified until 11/13/24 by another staff member that Resident B had an antibiotic dropped off by the pharmacy to the facility on 11/11/24 however the staff member neglected to enter this antibiotic in the system to notify other staff members that the medication was dropped off which is the facility's protocol. Bernard Hall stated when he was notified of the antibiotic, he immediately made sure to request the physician script and entered the antibiotic on the medication administration record (MAR) so staff can administer the medication to Resident B. Bernard Hall stated unfortunately the medication was supposed to start on 11/11/24 however did not start until 11/13/24.

Moony Williams stated Resident B did not start her antibiotic Nitrofurantoin 100mg medication in a timely manner on 11/11/2024. Moony Williams stated this medication was dropped off on 11/11/2024 but the staff member failed to enter this medication in the facility's computer system to alert other staff members that Resident B had a new medication to administer. Moony Williams stated she wasn't notified until 11/13/2024

that Resident B had an antibiotic that she needed to take at which time it was administered to Resident B without incident.

I observed Resident B sitting at the dining room table, but Resident B was not able to be interviewed due to her cognitive impairment.

While at the facility, I reviewed the facility's *Medical Visit Form* dated 11/06/2024 which stated that Resident B was seen by her physician for a medical review.

I also reviewed the facility's *Medication Administration Record* (MAR) for the Month of November 2024. According to this MAR, Resident B was administered medication Nitrofurantoin 100mg beginning on 11/13/2024 and ending on 11/19/2024.

I also reviewed a physician script for medication Nitrofurantoin 100 mg which stated that Resident B should take 1 capsule by mouth twice daily for seven days written on 11/11/2024.

I also reviewed the facility's *Medication Delivery Form* which stated on 11/11/24 the medication Nitrofurantoin 100mg was delivered to the facility.

On 12/02/2024, I conducted an interview with Relative B1 who stated that Resident B was taken to the doctor for a routine appointment on 11/06/24 and was diagnosed with having a UTI infection two days later after her test results came back. Relative B1 stated she was notified by staff members that her antibiotic for this infection was dropped by the pharmacy on 11/11/2024 however the staff members did not administer this medication to Resident B until 11/13/2024. Relative B1 stated the staff members could not give an explanation why Resident B did not receive her mediation on time.

On 12/03/2024, I conducted interviews with licensee designee Felicia Evans who stated she was notified that Resident B did not take her medications according to the start date because when the pharmacy dropped off Resident B's antibiotic for her UTI infection the physician did not send over the script until the next day. Felicia Evans stated staff should have immediately called the on-call person when the medication was dropped off to get the script however this was not done until days later, which caused Resident B to have a delay in getting her medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as

	amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on my investigation which included interviews with licensee designee Felica Evans, staff members Moony Williams, Bernhard Hall, Relative B1, review of the facility's MAR, *Medication Delivery Form,* physician script and *Medical Visit Form,* there is evidence to support the allegation Resident B was not given her medication in a timely manner. According to Moony Williams and Bernard Hall Resident B had an antibiotic delivered to the facility on 11/11/24 however this medication was not administered to Resident B until 11/13/2024 because staff failed to follow the facility's medication delivery protocol to alert other staff members that this medication was stored at the facility to administer to Resident B. Felicia Evans also stated Resident B missed taking this antibiotic on time because when the medication was delivered, staff failed to call on-call staff to receive further instructions which is also the facility's protocol. According to facility records, medication Nitrofurantoin 100 mg was delivered to the facility on 11/11/24 and was not administered to Resident B until 11/13/2024. Therefore, this prescription medication was not administered as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/7/2025, I conducted an exit conference with licensee designee Felicia Evans and administrator Fiorella Spalvieri. I informed Felicia Evans and Fiorella Spalvieri of my findings and allowed them an opportunity to ask questions or make comments.

IV. RECOMMENDATION

Upon an acceptable corrective action plan, I recommend the current license status remain unchanged.

Ondrea Johnson 01/07/2025

Ondrea Johnson Date
Licensing Consultant

Approved By:

Dawn Timm 01/10/2025

Dawn N. Timm Date
Area Manager