GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 23, 2025

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

RE: License #: AS390291227
Investigation #: 2025A1024029
Alamo

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 was required. On June 6, 2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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

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 #:	AS390291227
Investigation #:	2025A1024029
Complaint Receipt Date:	04/28/2025
Investigation Initiation Date:	04/28/2025
Report Due Date:	06/27/2025
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:	Alamo
Facility Address:	2725 Alamo Ave. Kalamazoo, MI 49006
Facility Telephone #:	(269) 343-6355
Original Issuance Date:	07/11/2007
License Status:	REGULAR
Effective Date:	01/18/2024
Expiration Date:	01/17/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff did not follow Resident A's treatment plan and allowed Resident A access to food in the kitchen.	Yes
Staff left residents unattended without any staff members present at the facility.	Yes

III. METHODOLOGY

04/28/2025	Special Investigation Intake 2025A1024029
04/28/2025	Contact-Document Received-Additional allegations from Intake #205318 regarding no staff supervision.
4/28/2025	APS Referral-not warranted
04/28/2025	Special Investigation Initiated – Telephone with Recipient Rights Officer (RRO) Kate Koyak
04/29/2025	Contact - Document Received-Resident A's *Assessment Plan for AFC Residents*, *Behavior Treatment Plan*, *AFC Licensing Division Incident/Accident Report, Physician Order*
05/01/2025	Contact - Document Received-*Termination Letter* for direct care staff member Matthew Jackson
05/09/2025	Contact - Telephone call made with licensee designee Felicia Evans
05/09/2025	Inspection Completed On-site-with direct care staff member Gweneth Perry, Chancalor Hughes and Resident A
05/12/2025	Contact - Telephone call made with Resident A's case worker Emily Musculan
06/02/2025	Contact - Telephone call made with direct care staff member Kelvin Singleton
06/02/2025	Exit Conference with licensee designee Felicia Evans
06/02/2025	Inspection Completed-BCAL Sub. Compliance
06/02/2025	Corrective Action Plan Requested and Due on 06/17//2025

06/06/2025	Corrective Action Plan Received
06/06/2025	Corrective Action Plan Approved

ALLEGATION: Staff did not follow Resident A's behavior treatment plan and allowed Resident A access to food in the kitchen.

INVESTIGATION:

On 4/28/2025, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged staff did not follow Resident A's behavior treatment plan and allowed Resident A access to food in the kitchen. This complaint further stated the facility has a kitchen gate that is supposed to be closed due to Resident A's risk of choking and history of stealing food.

On 4/28/2025, I conducted an interview with Recipient Rights Officer (RRO) Kate Koyak who stated that she is also investigating this allegation and found that a staff member left a baby gate opened which was installed in the kitchen to prevent Resident A from having access to food. Kate Koyak also stated keeping the gate closed is part of his behavior treatment plan and Resident A's case manager had to intervene to prevent Resident A from obtaining food.

On 4/29/2025, I reviewed Resident A's *Assessment Plan for AFC Residents* dated 10/24/2024 which stated that Resident A requires staff assistance with eating meals/snacks and consumption monitoring. The *Assessment Plan for AFC Residents* documented that Resident A's foods are pureed and he uses a sippy cup and straw to drink. Resident A can only eat soft items and can feed himself. This *Assessment Plan for AFC Residents* further stated Resident A has been known to get into the kitchen and take foods that aren't pureed. Resident A has a physician order to lock the kitchen for Resident A's safety and this restriction is in Resident A's behavior plan.

I also reviewed Resident A's *Behavior Treatment Plan* (BTP) dated 12/3/2024. According to the BTP, Resident A requires a Dysphagia diet and his food must be pureed in a blender. The BTP further stated, Resident A has a history of stealing food which is a choking hazard to him as Resident A is on a mechanical soft food diet therefore there is a need to maintain a locked kitchen to avoid this choking hazard. This BTP stated restrictive strategies for Resident A including a locked gate for the kitchen which should be at the entry points of the kitchen so Resident A will not have access to the kitchen.

I also reviewed Resident A's *Physician Order* dated 7/25/2024 which stated that due to Resident A being vulnerable to non-pureed food items, it is suggested that the AFC home has the refrigerator locked. This is deemed the safest for Resident A's health and safety as Resident A is on a puree/dysphasia diet.

On 5/9/2025, I conducted an interview with licensee designee Felicia Evans who stated that one of the direct care staff members was misinformed and did not follow Resident A's BTP after not closing the kitchen gate. Felicia Evans reiterated that the gate is installed to keep Resident A from accessing food due to the potential severe consequences if he chokes on food that is not pureed. Felicia Evans stated all direct care staff members have been reinformed and understand that Resident A's BTP requires the kitchen gate to be closed at all times to restrict Resident A's access to foods.

On 5/9/2025, I conducted an onsite investigation at the facility and interviewed direct care staff members Gweneth Perry and Chancalor Hughes who both stated that they are familiar with Resident A's BTP and understand that Resident A is restricted from going into the kitchen unsupervised. Both stated that recently direct care staff members Kelvin Singleton and Matthew Jackson both left Resident A unattended in the kitchen with the gate open giving Resident A unsupervised access to food. Gweneth Perry stated since that incident, staff members have been notified to always follow Resident A's BTP which includes keeping the kitchen gate closed for his safety.

While at the facility, I also observed Resident A in his wheelchair in the common area. Resident A was not able to be interviewed due to his cognitive impairment.

While at the facility, I also observed a soft fabric baby gate installed at the kitchen entry way with a one motion lock to open the gate.

On 5/12/2025, I conducted an interview with Resident A's case manager Emily Musculan who stated that she was recently at the facility visiting with Resident A and had to intervene and block Resident A from getting food left on the counter because a direct care staff member had left the kitchen gate open which is not in compliance with Resident A"s behavior treatment plan. Emily Musculan stated she implemented these kitchen restrictions for Resident A because he is at risk of choking when he eats whole foods and has a history of stealing food out of the kitchen. Emily Musculan stated the gate should be kept closed at all times and Resident A is only allowed in the kitchen with staff supervision. Emily Musculan stated she is concerned because while the food was being prepared in the kitchen, direct care staff members left the kitchen area to perform other staff duties leaving the gate opened and food accessible. Emily Musculan stated if she had she not been present, Resident A would have been able to take food off the counter. Emily Musculan stated Resident A attempted to take some food but she prevented him from doing so.

On 6/2/2025, I conducted an interview with direct care staff member Kelvin Singleton who stated that he works regularly with Resident A and usually ensures that the kitchen gate is shut to prevent Resident A from entering the kitchen. Kelvin Singleton stated he understand this is part of Resident A's BTP, however a couple of days prior to Resident A's case manager visiting, Kelvin Singleton was informed by an administrative staff member that the gate did not have to be closed shut. Kelvin Singleton while Resident

A's case manager was recently visiting with Resident A, Kelvin Singleton stated he left the gate open to attend to another resident and when he returned to the kitchen, he found Resident A in the kitchen with Emily Musculan attempting to stop Resident A from obtaining food from the kitchen counter. Kelvin Singleton stated he immediately intervened and assisted with getting Resident A out of the kitchen and was reminded by Emily Musculan to follow Resident A's BTP by keeping the gate shut due for Resident A's safety.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on my investigation which included interviews with direct care staff members Gweneth Perry, Chancalor Hughes, and Kelvin Singleton, RRO Kate Koyak, licensee designee Felicia Evans, Resident A's case manager, Emily Musculan, along with my review of Resident A's assessment plan, BTP, and physician order there is evidence direct care staff did not follow Resident A's behavior treatment plan and allowed Resident A access to food in the kitchen. According to Felicia Evans and Gweneth Perry, direct care staff members Kelvin Singleton and Matthew Jackson failed to follow Resident A's BTP and left the kitchen gate opened allowing Resident A access to food that was in the kitchen. Emily Musculan stated she was visiting with Resident A and had to provide behavioral intervention to stop Resident A from accessing food after direct care staff members left the kitchen gate open without staff supervision leaving Resident A access to the kitchen and refrigerator. According to Resident A's BTP, Resident A requires a Dysphagia diet and his food must be pureed in a blender as Resident A has a history of stealing food which is a choking hazard for him. Consequently, the facility kitchen must have a gate at all areas of entry so Resident A cannot access the kitchen without direct care staff supervision. I also reviewed a physician order which stated that due to Resident A being vulnerable to non-pureed food items, it is suggested that the AFC home has the refrigerator locked. Kelvin Singleton stated that he did not follow Resident A's BTP like he normally does and left the gate open to attend to another resident and when he returned to the kitchen, he found Resident A in the kitchen with Emily Musculan attempting to stop Resident A from obtaining food from the kitchen counter. Therefore, Resident A's protection and safety needs were not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff left residents unattended without any staff members present at the facility.

INVESTIGATION:

On 4/28/2025, I received additional allegations which stated that direct care staff left residents unattended without any staff members present at the facility.

On 4/28/2025, I conducted an interview with RRO Kate Koyak who stated that she is also investigating this allegation and found that direct care staff member Matthew Jackson left his shift early with no direct care staff members present leaving residents unattended until the next shift staff person arrived. Kate Koyak stated she is very

concerned given that the home consists of a very vulnerable population due to their high needs and require 24/7 supervision at all times.

On 4/29/2025, I reviewed the facility's *AFC Licensing Division Incident/Accident Report* dated 4/19/2025 at 12am which stated that when direct care staff member Scott Bessie arrived to work there were no direct care staff members present.

On 5/1/2025, I reviewed direct care staff member's Matthew Jackson's *Termination Letter* dated 4/23/2024, which stated that Matthew Jackson's employment with Community Living Options was terminated effective 4/22/2025 for multiple performance issues including on 4/18/2024-4/19/2025 Matthew Jackson left the work site prior to relief coverage arriving, resulting in vulnerable consumers, who require medical care and supervision, unattended and alone.

On 5/9/2025, I conducted an interview with licensee designee Felicia Evans who stated that direct care staff member Matthew Jackson left his shift prior to the next staff member arriving leaving the residents without adequate staffing for less than three minutes.

On 5/9/2025, I conducted an onsite investigation at the facility with Gweneth Perry who stated that she is the home manager and was notified by direct care staff member Scott Bessie that when he arrived to work at midnight for the beginning of this shift, there was no direct care staff members present at the facility care for the residents who were sleeping. Gweneth Perry stated Matthew Perry reported to her when she followed up regarding this incident, that Matthew Perry was under the impression that it was okay to leave without a direct care staff present since all the residents were asleep.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.

ANALYSIS:	Based on my investigation which included interviews with direct care staff members Gweneth Perry, RRO Kate Koyak, licensee designee Felicia Evans, review of facility's incident report and employee termination letter, there is evidence direct care staff member Matthew Jackson left residents unattended for an unknown length of time during the late night hours on 04/18/2025. According to the facility's incident report, direct care staff member Scott Bessie arrived at the facility at midnight on 4/19/2025 and found no staff members present at the facility. Gweneth Perry stated that she was contacted by Scott Bessie and was advised that Matthew Jackson left his shift early prior to Scott Bessie arriving leaving the residents unattended. I reviewed a termination letter which stated that Matthew Jackson employment was terminated on 4/22/2025 due to Matthew Jackson leaving his work site prior to relief coverage arriving resulting in vulnerable residents who require medical care and supervision, alone and unattended. Therefore, the ratio of direct care staff to residents was not adequate to carry out staff responsibilities.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/2/2025, I conducted an exit conference with licensee designee Felicia Evans. I informed Felicia Evans of my findings and allowed her an opportunity to ask questions or make comments. On 6/6/2025, I received and approved an acceptable correction action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was approved therefore I recommend the current license status remain unchanged.

Ondrea Johnson 6/17/2025

Ondrea Johnson Date
Licensing Consultant

Approved By:

Dawn Timm 06/23/2025

Dawn N. Timm Date
Area Manager