GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 5, 2025

Timothy Van Dyk
Residential Opportunities, Inc.
1100 South Rose Street
Kalamazoo, MI 49001

RE: License #: AS390293416
Investigation #: 2026A0581001
D Avenue

Dear Timothy Van Dyk:

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 (517) 335-5985.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390293416
Investigation #:	2026A0581001
Complaint Receipt Date:	10/01/2025
Investigation Initiation Date:	10/01/2025
Report Due Date:	11/30/2025
Licensee Name:	Residential Opportunities, Inc.
LicenseeAddress:	1100 South Rose Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-3731
Administrator:	Nick Cahill
Licensee Designee:	Timothy Van Dyk
Name of Facility:	D Avenue
Facility Address:	2951 East D Avenue Kalamazoo, MI 49004
Facility Telephone #:	(269) 488-3933
Original Issuance Date:	01/18/2008
License Status:	REGULAR
Effective Date:	09/10/2024
Expiration Date:	09/09/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION

	Violation Established?
Three tablets of Resident A's Klonopin prescription went missing from the facility on or around 09/29/2025.	Yes

III. METHODOLOGY

10/01/2025	Special Investigation Intake - 2026A0581001
10/01/2025	Contact - Telephone call received - Interview with Complainant
10/01/2025	Contact - Telephone call made - Interview with ISK Suzie Suchyta
10/01/2025	Contact - Document Received - Email from Suzie Suchyta.
10/01/2025	Special Investigation Initiated – Letter - Reviewed IR, medication sheet counts, and the medication administration record (MAR).
10/03/2025	Contact – Telephone call made – Interview with Administrator, Nick Cahill, staff, David McNinch and Josh Bongers.
10/07/2025	Contact – Telephone call made – Interview with staff, Sara Roberts.
10/15/2025	Inspection Completed On-site - Observed Resident A and staff. Reviewed medication.
10/30/2025	Inspection Completed-BCAL Sub. Compliance
11/04/2025	APS Referral not required as no allegation of abuse or neglect.
11/04/2025	Exit conference with the licensee designee, Timothy Van Dyk.

ALLEGATION: Three tablets of Resident A's Klonopin prescription went missing from the facility on or around 09/29/2025.

INVESTIGATION: On 10/01/2025, Complainant contacted me via telephone to report Resident A had three tablets of 0.5 mg Klonopin medication go missing from the facility on or around 09/29/2025. Complainant confirmed Integrated Services of

Kalamazoo (ISK) Recipient Rights Office (RRO) received the allegations and were investigating.

On 10/01/2025, I interviewed ISK Recipient Rights Officer, Suzie Suchyta, who confirmed she was investigating the allegations. She emailed me copies of Resident A's September Medication Administration Record (MAR), the physician's order for Resident A's Klonopin, the facility's Incident Report (IR), dated 09/29/2025 and a licensee document titled "D AVENUE NARCOTIC COUNT SHEET" tracking Resident A's Klonopin 0.5 mg tablets, dated September 2025.

Upon review of Resident A's September MAR, I determined Resident A received three tablets of Klonopin 0.5 mg, twice daily, throughout September, including 09/28 and 09/29. Review of the physician's order for Resident A's Klonopin confirmed the prescription and dosage information.

The facility's IR, dated 09/29/2025, was completed by administrator, Nick Cahill. According to the IR, at approximately 12 pm, direct care staff Sara Roberts reviewed Resident A's narcotic count sheet and noticed three tablets of 0.5 mg Klonopin were "unaccounted for" as the medication count was actually 144 tablets when it should have been 147 tablets. The IR documented Nick Cahill also completed a count and determined three Klonopin tablets were missing. The IR documented staff searched the medication cabinet for "misplacement", but did not find the missing medication. The IR also documented the "AM" staff were contacted who reported no "abnormalities".

Upon reviewing the D Avenue Narcotic Count Sheet (count sheet), I determined two staff are expected to sign at each shift to confirm the number of Klonopin tablets passed that shift matches the number of Klonopin tablets left at the end of that shift. For first shift on 09/28, the count sheet documented three Klonopin tablets were administered leaving 153 tablets. For second shift on 09/28, the count sheet documented three Klonopin tablets were administered leaving 150 tablets. For third shift on 09/28, the count sheet documented zero Klonopin were administered leaving 150 tablets. For first shift on 09/29, the count sheet documented three Klonopin were administered leaving 147 tablets; however, the facility's Administrator, Nick Cahill, documented 144 tablets were actually accounted for at the end of the first shift, which is consistent with the allegations of three tablets missing. For second shift on 09/29, the count sheet documented three Klonopin tablets were administered leaving 141 tablets. The count sheet documented only one staff initialed the medication count sheet at shift change starting first shift on 09/28 until two staff initialed at first shift on 09/29.

On 10/03/2025, Suzie Suchyta and I interviewed the facility's home manager and Administrator, Nick Cahill, via Microsoft Teams. Nick Cahill stated it was the expectation direct care staff count narcotic medications three times per day at each shift change and believed staff were completing these medication counts. Nick Cahill stated all staff have access to the facility's medication room and subsequently would

have access to the narcotics. Nick Cahill identified both Josh Bongers and Dave McNinch as the two staff working from 3 pm on 09/28 through 8 am on 09/29. He stated both staff worked a double shift and despite working a double shift they should have still completed the narcotic counts at all shift changes.

Nick Cahill stated he and newly hired staff, Alayziah Pratt, arrived to work at approximately 8 am on 09/29; however, he stated neither he nor she were present for any narcotic counts with either Dave McNinch or Josh Bongers. He stated the facility's assistant home manager, Sara Roberts, came into work around 9:30 am; however, she was not able to review the narcotic count sheet until approximately 12:30 pm. He stated upon Sara Roberts reviewing and counting the narcotic medications she discovered three of Resident A's Klonopin were missing and only one staff, Josh Bongers, initialed the narcotic count sheet for the previous shifts. Nick Cahill stated he and Sara Roberts looked throughout the medication room and in other resident medication bins, but could not locate the missing medication.

Nick Cahill stated as a result of the incident, he conducted a staff meeting on or around 10/02/2025. He stated he updated the instructions on the narcotic count sheets so each staff had a specific spot to sign or initial after the narcotic counts were completed.

Nick Cahill stated Resident A's three tablets of Klonopin are still unaccounted for and missing.

On 10/03/2025, Suzie Suchyta and I interviewed direct care staff, David McNinch, via Microsoft Teams. He stated he has worked for the licensee for approximately 20 years and has been at the facility for approximately 10 years. He stated he primarily works the overnight shift, which he stated begins at 10 pm. David McNinch stated his duties upon arriving to work are debriefing with outgoing staff, reviewing their notes, and counting narcotics. David McNinch confirmed he came into work at 3 pm on 09/28 and worked a double shift until approximately 8 am on 09/29. He stated he did not count any narcotic medications throughout his double shift, which included Resident A's Klonopin tablets. He stated he had "no excuse" as to why he did not count or witness the counting of narcotic medication at shift changes.

David McNinch stated he did not know what happened to Resident A's missing Klonopin medication. He also denied taking the medication. He stated he did not believe the medication was administered incorrectly to any of the other residents as none of the residents acted differently throughout his double shift. He also stated he was not aware of any staff taking the medication.

On 10/03/2025, I reviewed the licensee's "Medication Supply and Ordering" policy, dated 02/14/2020, which was provided by Nick Cahill. According to this policy, each of the licensee's programs must have a "…double signature count system for all narcotics".

On 10/06/2025, Suzie Suchyta and I interviewed direct care staff, Josh Bongers, via Microsoft Teams. He stated he has worked for the licensee for approximately 17 years and primarily works the overnight or 3rd shift. His statement was consistent with David McNinch's statement. Josh Bongers stated he administered medication to residents while working his double shift with Dave McNinch from 3 pm on 09/28 through 8 am on 09/29. He stated there were no issues with preparing or administering any of the medications and stated, "it was a normal day". He stated when he arrived at work he counted all the narcotic medication, as required, and documented his counts on the narcotic count sheets. He stated he counted the medications by himself and had no additional staff to witness the counts despite acknowledging an additional staff was expected to count with him. He stated when he left at approximately 8 am on 09/29 there was no incoming 1st shift staff to count with him. Josh Bongers stated he initialed on the narcotic count sheet that the medications had been counted; however, he stated he did not actually count the medications prior to leaving at approximately 8 am on 09/29. Josh Bongers also stated he did not take Resident A's Klonopin medication tablets and did not know what happened to them.

On 10/07/2025, Suzie Suchyta and I interviewed direct care staff and identified "assistant coordinator", Sara Roberts, via Microsoft Teams. Sara Roberts stated she has worked for the licensee for 14 years and primarily works the day shifts. Her statement to us was consistent with Nick Cahill's, David McNinch's and Josh Bonger's statements.

On 10/15/2025, I conducted an unannounced inspection at the facility. I was unable to interview Resident A due to his diminished cognitive capacity; however, he appeared well cared for. I reviewed Resident A's Klonopin narcotic count sheet and I determined the sheet was updated to reflect a designated spot for each staff to sign identifying if the staff was the "AM Staff", "PM Staff", or "ON Staff". My review of the medication count sheet also determined inconsistencies with two staff initialing they were present when the medication counts were completed.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.

ANALYSIS:	On 09/29/2025, the facility's staff discovered three tablets of Resident A's 0.5 mg Klonopin medication missing from the facility. Though the circumstances surrounding Resident A's missing Klonopin tablets cannot be determined, staff failed to adhere to the licensee's established narcotic medication policy, which resulted in the medication being unaccounted for and allowed an opportunity for the medication to be used by another person.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/04/2025, I conducted my exit conference with the licensee designee, Tim Van Dyk, informing him of my findings. He did not have any questions and stated he would confer with the facility's Administrator to ensure adequate corrective action.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

11/05/2025

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Cathy Cushman Date
Licensing Consultant

Approved By:

11/05/2025

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Dawn N. Timm Date
Area Manager