



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 18, 2025

Jennifer Bhaskaran
Alternative Services Inc.
Suite 10
32625 W Seven Mile Rd
Livonia, MI 48152

RE: License #: AS330311852
Investigation #: 2026A0577008
Willoughby Home

Dear Ms. Bhaskaran:

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,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330311852
Investigation #:	2026A0577008
Complaint Receipt Date:	12/05/2025
Investigation Initiation Date:	12/05/2025
Report Due Date:	02/03/2026
LicenseeName:	Alternative Services Inc.
Licensee Address:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Jeremy Hagerman
Licensee Designee:	Jennifer Bhaskaran
Name of Facility:	Willoughby Home
Facility Address:	5343 Willoughby Road Lansing, MI 48911
Facility Telephone #:	(517) 394-9699
Original Issuance Date:	07/01/2011
License Status:	REGULAR
Effective Date:	01/21/2024
Expiration Date:	01/20/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Residents are not being administered their medications as prescribed.	Yes
The passing of residents' medications are not being correctly documented on MAR's.	Yes

III. METHODOLOGY

12/05/2025	Special Investigation Intake 2026A0577008
12/05/2025	Special Investigation Initiated – Letter- Email to CEI.
12/05/2025	Referral - Recipient Rights
12/05/2025	APS Referral
12/08/2025	Contact - Telephone call made to Kayla Spitzley, CM with CMHCEI, TX and Email.
12/09/2025	Contact - Document Received from Ashlee Bailey, CEI-ORR, received IR's.
12/15/2025	Inspection Completed On-site
12/15/2025	Inspection Completed-BCAL Sub. Compliance
12/15/2025	Exit Conference with licensee designee Jennifer Bhaskaran.

ALLEGATION:

- **Residents are not being administered their medications as prescribed.**
- **The passing of residents' medications is not being correctly documented on MARs.**

INVESTIGATION:

On December 05,2025, a complaint was received alleging that direct care worker Tasia Churchill, whose role is home manager, ripped up Resident A's medication administration record (MAR) and created a new handwritten MAR when it was discovered Resident A was not administered prescribed medication for a month. The complaint reported the original MAR was provided to Resident A's case manager, Kayla Spitzley.

On December 05, 2025, I contacted Drew Kersjes, Director of Community Services with Community Mental Health of Clinton, Eaton, Ingham Counties (CMHCEI) who provided me contact information for Kayla Spitzley, Case manager with CMHCEI.

On December 08, 2025, I interviewed Staff Member 1 and Staff Member 2 together via telephone. Staff Member 1 reported Resident A has a medication that starts with the letter 'M' that was not administered for about a week, and Resident A's Nitro-Bid ran out and was not filled so could not be administered. Staff Member 1 reported they cannot remember the dates when Resident A's medications were not administered as prescribed. Staff Member 1 reported these concerns were brought to the attention of direct care worker Tasia Churchill. Staff Member 1 reported there was a time when Ms. Churchill was shredding a form that resembled a MAR, but when Ms. Churchill was asked about this, she reported it was a MAR that was incorrect. Staff Member 1 reported not being aware of a MAR being ripped but was aware of a MAR that was shredded but did not know any specifics about whose MAR it was. Staff Member 1 reported the only handwritten MAR they knew about was a MAR from Resident B's previous placement. Staff Member 2 did not have any information about Resident A not being administered medication as prescribed or any information pertaining to a MAR being ripped and handwritten. Staff Member 2 reported she only documented medication administrations on the MAR's sent from the pharmacy and is not familiar with Resident A having a handwritten MAR.

On December 08, 2025, I interviewed Kayla Spitzley, Case manager with CMHCEI, who reported she is not usually sent copies of resident MARs. Ms. Spitzley stated she reviewed files for October 2025 and November 2025 and did not find any copies of Resident A's MARs. Ms. Spitzley reported she typically reviews resident MARs when she is onsite at the facility. Ms. Spitzley reported she reviewed resident MARs during a site visit on November 14, 2025, and observed a few dates/times that were missing staff initials verifying a medication was administered. Ms. Spitzley clarified that she observed direct care staff initials on the medication bubble packs verifying the medication was administered but staff initials were not on each resident MAR. Ms. Spitzley reported she addressed these concerns with Tasia Churchill during the onsite visit. Ms. Spitzley reported Ms. Churchill confirmed she would address this with direct care staff immediately. Ms. Spitzley reported she observed two medication *Incident Reports* in the CEICMH system for October 18 and 19, 2025, regarding MARs signing errors for Resident A's Erythromycin ointment.

On December 09, 2025, Ashlee Bailey, Office of Recipient Rights with CMHCEI contacted me to report that upon Ms. Bailey reviewing Resident A's medical records she found two Incident Reports documenting staff signing errors on October 18 and 19, 2025. These errors were documented as direct care staff not initialing the MAR upon administration of Resident A's medications on those dates. Ms. Bailey provided me with a copy of the IRs which confirmed what was reported by Ms. Bailey and Ms. Spitzley.

On December 15, 2025, I completed an unannounced onsite investigation and reviewed the facility's *Resident Register* which documented that there are currently six residents admitted to the facility. I interviewed Tasia Churchill who reported that all six residents are prescribed medications and require medications to be administered by direct care staff. Ms. Churchill completed a mock medication administration to show me the facility medication administration process. Ms. Churchill reported direct care staff are required to pass one resident's medication at a time and compare the bubble packed medication to the MAR to assure the medication is being given to the right person, right time, right medication, right dose, and right route. Ms. Churchill reported once this has been completed per medication the medication is popped into a cup, direct care staff initial and date the bubble pack, pass the medication to the resident, and then initial the MAR after the medication has been passed. Ms. Churchill reported there is a second direct care staff who is supposed to watch and sign off that medications were correctly passed. Ms. Churchill reported she is not aware of Resident A or any other residents who did not receive their medications for more than a week in November 2025 for any reason including medications not being refilled timely. Ms. Churchill reported Resident B was hospitalized from November 21-November 25, 2025, and was not administered his medication while being hospitalized. Ms. Churchill reported that all residents' MARs are sent directly from the pharmacy and none of the residents' MARs are handwritten. Ms. Churchill denied that resident medications are not being administered as prescribed or documented as administered on each resident MAR. Per my review of Resident B's MAR, it reflected Resident B's medications were not administered during his hospitalization from November 21-25, 2025. Ms. Churchill reported the two IR's from October 18 and 19, 2025 were completed due to staffing signature errors, meaning the direct care staff did not sign the MAR upon administering the medications but did initial and date the medication bubble packs upon administering the medications. Ms. Churchill acknowledged that direct care staff are not following the facility medication administration policy and procedures, by not initialing and dating the bubble packs or initialing the MAR when medications are being administered.

During the onsite investigation on 12/15/2025, I reviewed the resident MARs, corresponding bubble packed prescribed medications, and physician's orders for Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F for November 2025 and December 2025 through December 15, 2025, found the following:

- Resident A is prescribed Loratadine, 10mg tablet; take 1 tablet by mouth once daily. Per Resident A's MAR, Resident A's Loratadine was not administered on November 30, 2025.
- Resident B was prescribed Atorvastatin, 40mg tablet; take 1 tablet by mouth once daily. Per Resident B's MAR, Resident B's Atorvastatin was not administered on December 02, 2025.

Per my review and receipt of a photos of the medication bubble packs and MARs, the MAR for Resident A's Loratadine on November 30, 2025, and Resident B's Atorvastatin on December 02, 2025, were initialed by direct care staff on the MAR to verify the medications were administered. But upon review of Resident A's bubble pack of Loratadine, the bubble pack was not initialed and dated by direct care staff to verify the

medication was administered on November 30, 2025. The bubble pack also did not reflect the Loratadine being popped out and administered. Upon review of Resident B's MAR, the Atorvastatin was initialed on December 02, 2025, as administered, however the bubble pack did not reflect the Atorvastatin being popped, initialed, and dated for December 02, 2025.

Per my review, all resident MAR's for the months of November 2025 and December 2025 were from pharmacy printed. I did not observe any handwritten MARs during my review.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based on the information gathered during the investigation and my review of Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F MARs for November and December 2025, Resident A's Loratadine was not administered as prescribed on November 30, 2025, and Resident B's Atorvastatin was not administered as prescribed on December 02, 2025.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.675	Resident medications.
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: (b) Complete an individual medication log that contains all of the following: <ul style="list-style-type: none"> (i) Medication name. (ii) Dosage. (iii) Label instructions for use. (iv) Time to be administered. (v) Initials of the individual who administered the medication at the time given. (vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.

ANALYSIS:	<p>During the investigation there was no evidence found that direct care worker Tasia Churchill falsified Resident A's MAR for November 2025. I reviewed and received a copy of Resident A's MAR which is the original typed MAR from the pharmacy.</p> <p>During the investigation, I reviewed two incident reports which documented that on October 18 and 19, 2025, direct care staff did not initial the MARs upon the administration of resident's medications. I also determined via a medication audit that Resident A's Loratadine was not administered as prescribed on November 30, 2025, and Resident B's Atorvastatin was not administered as prescribed on December 02, 2025. These medications remained in the bubble packs despite being initialed in the MAR as administered.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Bridget Vermeesch

12/17/2025

Bridget Vermeesch
Licensing Consultant

Date

Approved By:

Dawn Timm

12/18/2025

Dawn N. Timm
Area Manager

Date