



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

January 6, 2026

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

RE: License #: AS390011445  
Investigation #: 2026A1024010  
Oak Creek Home

Dear Ms. Evans:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care violations identified in the report, a six-month provisional license is recommended as well as 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing, and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (616) 356-0183.

Sincerely,

A handwritten signature in cursive script that reads "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**

<b>License #:</b>	AS390011445
<b>Investigation #:</b>	2026A1024010
<b>Complaint Receipt Date:</b>	12/12/2025
<b>Investigation Initiation Date:</b>	12/12/2025
<b>Report Due Date:</b>	02/10/2026
<b>Licensee Name:</b>	Community Living Options
<b>Licensee Address:</b>	626 Reed Street Kalamazoo, MI 49001
<b>Licensee Telephone #:</b>	(269) 343-6355
<b>Administrator:</b>	Fiorella Spalvieri
<b>Licensee Designee:</b>	Felicia Evans
<b>Name of Facility:</b>	Oak Creek Home
<b>Facility Address:</b>	2416 Oakcreek Drive Kalamazoo, MI 49004
<b>Facility Telephone #:</b>	(269) 383-0747
<b>Original Issuance Date:</b>	09/14/1990
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	10/22/2025
<b>Expiration Date:</b>	10/21/2027
<b>Capacity:</b>	6
<b>Program Type:</b>	MENTALLY ILL

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident B assaulted Resident A for about two minutes while staff members Melissa Lockett and Darnell Boyd watched this incident without providing any intervention.	Yes
ADDITIONAL FINDINGS:	Yes

## III. METHODOLOGY

12/12/2025	Special Investigation Intake 2026A1024010
12/12/2025	APS Referral-already involved
12/12/2025	Special Investigation Initiated – Telephone with Recipient Rights Officer (RRO) Suzie Suchyta
12/15/2025	Contact - Face to Face at Community Living Options (CLO) Office with Suzie Suchta and staff member Sarah Gue
12/15/2025	Contact - Document Received Mandt Training Verification and photo of Resident A's injury to face.
12/19/2025	Contact - Telephone call made with direct care staff member Deanna Miller and Darnell Boyd
12/19/2025	Contact - Document Received <i>AFC Licensing Division-Incident/Accident Report</i>
12/23/2025	Contact-Face to Face-with staff member Douglass Schroeder
12/23/2025	Contact - Document Received-email correspondence from APS Specialist Allyson Wright to AFC Licensing Supervisor Dawn Timm
12/23/2025	Contact - Telephone call made with Adult Protective Services (APS) Specialist Allyson Wright
12/23/2025	Contact - Telephone call made with Integrated Services of Kalamazoo (ISK) Supervisor Carla Springer
12/23/2025	Contact - Telephone call made by mental health provider Michael Dwyer
12/23/2025	Inspection Completed On-site-with direct care staff members Talia Williams, James Gainey, Fatima Snell, Resident C, Resident D, Resident E
12/23/2025	Contact - Telephone call made with Guardian A1
12/23/2025	Contact - Telephone call made with staff member Sarah Gue and licensee designee Felicia Evans
12/23/2025	Contact - Telephone call received from staff member Sara Gue, administrator Fiorella Spalvieri, licensee designee Felicia Evans, ISK staff member Kathy Lentz, ISK Supervisor Carla Springer
12/23/2025	Exit Conference with staff member Sarah Gue, licensee designee Felicia Evans, and administrator Fiorella Spalvieri
12/23/2025	Inspection Completed-BCAL Sub. Non-Compliance

**ALLEGATION: Resident B assaulted Resident A for about two minutes while staff members Melissa Lockett and Darnell Boyd watched this incident without providing any intervention.**

**INVESTIGATION:**

On 12/12/2025, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged Resident B assaulted Resident A for about two minutes while direct care staff members Melissa Lockett and Darnell Boyd watched this incident without providing any intervention.

On 12/12/2025, I conducted an interview with Recipient Rights Officer (RRO) Suzie Suchyta who stated that she received a complaint that Resident A was physically assaulted by Resident B on 12/03/2025. However after watching a video that captured the incident from a camera installed in the medication room, Suzie Suchyta stated she became concerned due to the neglect and lack of actions that she observed by direct care staff members who stood nearby while Resident B assaulted Resident A. Suzie Suchyta stated neither direct care staff member attempted to physically intervene while Resident A was repeatedly punched for about two minutes. This assault left Resident A with a visible cut under his eye and other minor abrasions. Suzie Suchyta further stated this video recording was observed by other direct care staff members in the facility who did not report this neglect by staff members to administration or to any other investigatory body (Adult Protective Services, AFC Licensing, or local police) which Suzie Suchyta stated was also alarming. Suzie Suchyta stated direct care staff members Melissa Lockett and Darnell Boyd were both working during the incident and are both trained in Mandt, which is a behavioral physical intervention training. Suzie Suchyta state they should have been able to effectively intervene in some way to de-escalate the incident. Suzie Suchyta stated that she is planning to watch the full video of this incident on 12/15/2025 with direct care staff member Sarah Gue at the Community Living Options (CLO) office.

On 12/15/2025, I reviewed a video prepared by staff member Sarah Gue who confirmed that a video shows the entire incident that took place on 12/03/2025 involving Resident B assaulting Resident A. Sarah Gue stated the video was recorded by a camera installed in the facility medication room at Oak Creek AFC. The video recording showed Resident A talking on the telephone while in the medication room with no direct care staff present and Resident B in the medication room looking around in drawers and cabinets with no direct care staff present. The video then shows Resident B rushing out of the medication room and holding the door closed while Resident A attempted to open the door. The video documents Resident A yelling for direct care staff members to let him out of the medication room. Resident B can be heard yelling from the other side of the door at Resident A. The video continues to document Resident A saying, "let me out" and calling for direct care staff Darnell Boyd and Melissa Lockett to help him while pacing back and forth in the medication room in visible frustration. Direct care staff member Darnell Boyd, confirmed by Sarah Gue, can also be heard yelling from the other side of the door, however the door remained closed with Resident A inside for

approximately 10 minutes. After 10 minutes of Resident A being blocked in the medication room, with both Resident A and Resident B yelling at each other through the door, the video showed Resident B then opened the medication room door, ran in and started attacking Resident A by punching him repeatedly. Resident A can be heard screaming. Direct care staff members Melissa Lockett and Darnell Boyd are observed both standing in the medication room doorway while Resident B continues to repeatedly punch Resident A in the face, head, and upper body areas. While Darnell Boyd and Melissa Lockett watched Resident B repeatedly punch Resident A, direct care staff member Melissa Lockett can be heard saying “stop” in a passive, nonchalant manner on two occasions during the two-minute duration of Resident B punching Resident A. Direct care staff member Darnell Boyd can be seen holding up his cell phone while watching Resident B assault Resident A looking like he was taking pictures or recording the incident. Towards the end of the two minutes of Resident B assaulting Resident A, Resident B grabbed Resident A by the neck and stood over him yelling “I will kill you.” Per the video, direct care staff Melissa Lockett and Darnell Boyd continued to watch at the door. It should be noted, at no time during the approximate 20-minute-long video recording of this incident, did either direct care staff Melissa Lockett or Darnell Boyd attempt to physically intervene to break up this assault. Resident B eventually kicked Resident A and left the room at which time Melissa Lockett asked Resident A to sit down, take off his sweater while asking Resident A, “what happened?”. During this time, Melissa also wiped Resident A’s face. Resident A was observed to have blood on his face and Resident B was observed to have blood on his fist.

After watching the video, direct care staff Sarah Gue stated that both direct care staff Melissa Lockett and Darnell Boyd are fully trained and should have used Mandt behavior intervention techniques to keep both residents safe. Sarah Gue stated that Melissa Lockett and Darnell Boyd could have provided more intensive verbal prompting or redirection, could have used a “body escort” to guide Resident B out of the room, or could have called either the police or the on-call staff person. Sarah Gue stated that she was very disappointed in her staff and stated that they did not follow CLO policies and procedures. Sarah Gue also stated that no facility staff member who watched the video reported any concerns to her, and she was not made aware of this incident until Suzie Suchyta contacted her. Sarah Gue stated after hearing from Suzie Suchyta she contacted APS once she observed the video showing staff failing to provide any type of intervention.

On 12/15/2025, I reviewed Mandt Training verification for Melissa Lockett dated 3/8/2025 and 3/9/2025 and Darnell Boyd dated 9/12/2025.

On 12/15/2025, I also reviewed a photo of Resident A’s face that showed blood under Resident A’s left eye sent by staff member Sarah Gue who stated that the photo was taken on 12/03/2025 after the incident.

On 12/19/2025, I conducted interviews with Deanna Miller and Darnell Boyd. Deanna Miller stated that she was contacted on 12/3/2025 by staff member Darnell Boyd and notified that Resident B had assaulted Resident A therefore, she went to the facility to

check on all the residents around 7:30pm. Deanna Miller stated she observed prominent scratches on Resident A's neck and under his eye. Deanna Miller stated talked with Resident A who told her that he wanted to "lock [Resident B] up." Deanna Miller stated she advised Resident A to keep away from Resident B to avoid any further fighting. Deanna Miller stated she discussed the incident with Darnell Boyd who stated to her that he did not intervene while Resident B physically assaulted Resident A because he was afraid that he would get in trouble. Deanna Miller stated she advised Darnell Boyd that he should have used behavioral intervention techniques from the Mandt system to safely intervene. Deanna Miller stated she was notified of the video that captured the incident and watched the video on 12/4/2025. Deanna Miller stated she observed that both staff members Melissa Luckett and Darnell Boyd stood by and watched Resident B keep Resident A shut into the medication room and then physically assault Resident A. Deanna Miller stated she did not report the neglect by staff members that she observed on the video because she assumed someone else had already reported the situation to administration. Deanna Miller stated she determined that Melissa Luckett and Darnell Boyd did not follow company protocol and should have at the very minimum, contacted law enforcement or an on-call staff person.

Darnell Boyd stated that Resident B often physically assaults all the residents in the facility, and it is a normal response for staff members to only watch when physical altercations occur between residents. Darnell Boyd stated that he was trained to use the Mandt behavioral intervention techniques, however he does not believe he was provided the tools in the training to safely break up fights between two residents. Darnell Boyd stated that this was why he chose not to intervene when Resident B physically assaulted Resident A on 12/3/2025. Darnell Boyd stated on 12/3/2025 while he was preparing food in the kitchen, he heard yelling on the lower level of the facility. Darnell Boyd stated he went to the top of the stairs and observed Resident B blocking the medication room door while Resident A was trapped inside the room yelling for help. Darnell Boyd stated he did not believe he could intervene during this time because "there was no physical aggression or fighting demonstrated which is the only time Mandt techniques are supposed to be used." Darnell Boyd then stated he and Melissa Luckett observed Resident B attack and repeatedly punch Resident A however, neither of them felt comfortable physically intervening. Darnell Boyd again stated this is how direct care staff regularly respond when residents are physically fighting. Darnell Boyd stated direct care staff do not physically intervene to avoid staff from getting hurt. Darnell Boyd stated after the incident staff observed an injury to Resident A's face which was bleeding. Darnell Boyd stated Melissa Luckett cleaned Resident A's face but Resident A was not taken to a physician for evaluation. Darnell Boyd stated he reported the incident to house manager James Gainey who then advised him to write an incident report. Darnell Boyd stated he realized that he did not keep Resident A safe during the incident but did not think calling law enforcement was warranted since residents fighting at the facility is a normal occurrence.

On 12/19/2025, I reviewed the facility's *AFC Licensing Division Accident/Incident Report* (incident report) dated 12/03/2025 written by Melissa Luckett and recorded, in part, the following: staff heard yelling from the basement and went to see what was happening.

Staff observed Resident B holding the staff office door yelling “he is the evil batman.” Staff asked Resident B to open the door multiple times and when Resident A stepped out, Resident B rushed him and proceeded to punch him in the face and his body repeatedly. Resident B began to claw him and tried to choke him and as this was happening Resident B was cursing and yelling at Resident A. Resident B then got Resident A on the ground and continued to punch him while Resident A was yelling for him to stop. Resident B finally stopped and moved away. The incident lasted for about two minutes, and staff cleaned the wounds on Resident A’s face. The incident report stated that staff repeatedly asked Resident B to stop and tried to step in between them to get Resident A to move away without success. It should be noted this statement is not consistent with the video footage that captured the incident.

On 12/23/2025, I conducted an interview with staff member Douglass Schroeder who stated that he is a certified trainer in Mandt, a program that focuses on de-escalating and safely intervening in behavioral crisis situations. Douglass Schroeder stated direct care staff members Darnell Boyd and Melissa Luckett should have intervened and used Mandt behavior intervention tools like body positioning as a way to escort Resident B away from Resident A, a side body hold restraint technique, or firm verbal redirection. Douglass Schroeder stated that both Darnell Boyd and Melissa Luckett were trained in the Mandt System and completed a test at the end of their training to ensure that they were competent in the material. Douglass Schroeder stated he believes they were capable and equipped with the tools necessary to safely intervene to keep the residents safe during a physical altercation.

On 12/23/2025, I reviewed email correspondence from APS Specialist Allyson Wright to AFC Licensing supervisor Dawn Timm. Allyson Wright stated that another complaint was made involving Resident B assaulting Resident A and she is highly concerned for Resident A’s safety at the facility. Allyson Wright further stated that she is going to contact Guardian A1 to discuss finding alternate placement for Resident A.

On 12/23/2025, I conducted an interview with APS Specialist Allyson Wright who stated that she believes staff members have been very neglectful and are not able to keep residents safe in their home. Allyson Wright stated that Resident A’s case manager contacted APS because Resident B physically assaulted Resident A again on 12/22/2025 and the staff members have no effective safety plan in place to keep Resident A safe therefore Allyson Wright has requested Guardian A1 to keep Resident A away from the facility until a safety plan is able to be established to ensure Resident A’s safety. Allyson Wright stated she has been trying to contact the home manager James Gainey who has not returned her phone calls and at this time the only plan in place is that the “the staff will try to keep residents separated” which Allyson Wright stated is not sufficient.

On 12/23/2025, I conducted an interview with ISK Supervisor Carla Springer who stated that she received an incident report that documented that Resident A was physically assaulted by Resident B on 12/22/2025 at 4:20pm while Resident A was visiting his case manager Michael Dwyer. Carla Springer stated according to the incident report

direct care staff effectively intervened with the use of physical behavior management and was able to get Resident A out of the home safely. Carla Springer stated that the incident report noted that Resident A was observed with scratches on his neck.

On 12/23/2025, I conducted an interview with Resident A's mental health case manager Michael Dwyer who stated that he went to the facility on 12/22/2025. During this time, Michael Dwyer stated he observed Resident B in Resident A's bedroom at which time Resident A asked Resident B to leave so he could visit privately with Michael Dwyer. Michael Dwyer stated Resident B refused to leave leading to Resident A calling Resident B a derogatory name. Michael Dwyer stated that Resident B then stood up and started punching Resident A. Michael Dwyer stated that staff member Scott Mead came right away and used physical management to stop the assault. Michael Dwyer took Resident A out of the facility and eventually took him to Guardian A1's house for the holidays. Michael Dwyer stated that Resident A and Resident B are friends and usually get along, however Resident B has physically assaulted Resident A in the past on more than one occasion.

On 12/23/2025, I conducted an onsite investigation at the facility with direct care staff members Talia Williams, James Gainey, and Fatima Snell as well as Resident C, Resident D, and Resident E. Talia Williams stated that she regularly works with Resident A and Resident B and they are usually able to hang out with one another with no issues however there was one incident, date unknown, where Talia Williams had to get in between the two residents because Resident B hit Resident A during an argument. Talia Williams stated she has not seen any other physical altercations involving Resident B however she has heard that Resident B has gotten physically aggressive with other residents including Resident A in the past. Talia Williams stated when she works with Resident B, he is very easy to work with and can be easily redirected. Talia Williams denied observing any challenging behaviors from Resident B. Talia Williams stated she believes all staff members are trained in the Mandt system which teaches staff tools to effectively redirect residents and safely intervene when necessary to keep residents safe. Talia Williams stated that Resident B is usually able to demonstrate when he is getting upset or agitated, which is when staff should be proactive and redirect him before he gets escalated.

James Gainey stated that both Resident A and Resident B have been living in the home for many years and get along well with one another most times. James Gainey stated to his knowledge he does not believe Resident B is aggressive towards other residents often in the home and believes Resident B has gotten aggressive with other residents maybe once a quarter. James Gainey stated to his knowledge, Resident B has only been physically aggressive with Resident A twice this month however Resident B has physically assaulted Resident A in the past. James Gainey stated he has not been directly involved in these incidents. James Gainey stated he saw Resident A's injury on 12/4/2025 when he worked on shift and believes that staff members should have intervened much sooner to keep Resident A safe from getting harmed. James Gainey stated on 12/22/2025, he received a phone call from Michael Dwyer who stated that while he was visiting with Resident A, Resident B became upset with Resident A and

started punching him. James Gainey stated that due to Resident B's most recent behaviors of aggression, an appointment has been scheduled with his psychiatric doctor. Meanwhile, James Gainey stated direct care staff members will attempt to keep Resident A and Resident B separated. James Gainey stated that to his knowledge, Resident A will be returning to the facility on 12/29/2025.

Fatima Snell stated she works regularly with Resident A and Resident B and has not had any issues involving Resident A and Resident B fighting with one another. Fatima Snell stated she has heard of incidents where Resident B physically hit other residents including Resident A in the past. Fatima Snell stated she has also seen Resident B hit other residents however it has never been to the extent of the aggression he has been currently exhibiting. Fatima Snell stated most of Resident B's incidents of physical aggression occur during the second shift when she doesn't work. Fatima Snell stated she believes Resident B will hit other residents when staff members are not around or paying attention. Fatima Snell stated she believes Resident B targets Resident A because he is jealous of him.

Resident C stated he has been living in the home for many years and has not had any issues with Resident B. Resident C stated that he shares a bedroom with Resident A and observed Resident B hit Resident A multiple times on 12/22/2024. Resident C stated direct care staff Scott Mead came to the bedroom and stopped the fight. Resident C stated that Scott Mead was able to get Resident B to sit down and calm down. Resident C stated that he has seen Resident A cry a lot in the past because Resident B hurt Resident A by hitting him.

Resident D stated he has been living in the facility for about two months and gets along with all the residents in the home. Resident D stated he heard that Resident A and Resident B have gotten into physical fights as recently as on 12/22/2025 however he has not directly seen any altercations between the two residents.

Resident E stated that he has been living in the facility for a while and believes that Resident A and Resident B do not get along well because they have gotten into fights many times in the past.

While at the facility, I reviewed *AFC Licensing Division-Incident/Accident Report* (incident report) dated 12/22/2025 written by direct care staff member Scott Mead. According to this incident report, staff Scott Mead was in the medication room looking for gift cards for residents to take on an outing when he heard loud noises in Resident A's bedroom. The incident report stated Scott Mead rushed over to find Resident B assaulting Resident A. The incident report stated that Scott Mead then used Mandt restraint to hold Resident B while Resident A was escorted out by his case manager. The incident report stated that Scott Mead de-escalated the situation while Resident A was taken on an outing by his case worker.

On 12/23/2025, I conducted an interview with Guardian A1 who stated that on 12/22/2025 he was talking on the phone with Resident A and heard Resident A ask

Resident B to leave his bedroom. Guardian A1 stated he then heard Resident B physically attack Resident A because they started to argue. Guardian A1 stated due to this most recent assault to Resident A, he allowed Resident A to come home right away because he does not trust that the staff members will have a plan in place to keep Resident A safe. Guardian A1 stated he did not have an exact return date when Resident A will be back to the facility. Guardian A1 stated that he is very upset that Resident A continues to get assaulted by Resident B. Guardian A1 stated these assaults have happened about five times and direct care staff do not seem to be able to prevent these assaults. Guardian A1 stated he was told direct care staff planned to keep Resident A and Resident B separated from one another. Guardian A1 further stated he does not understand why Resident B will not be discharged from the facility since he continues to physically assault residents in the facility due to staff not being able to manage his behaviors.

On 12/23/2025, I conducted an interview with staff member Sarah Gue and licensee designee Felicia Evans who both stated that at this time direct care staff will try to keep Resident A and Resident B separated from one another. Both stated they are not able to prevent Resident B from entering Resident A's bedroom due to Resident B's rights even though they are not roommates and despite Resident B assaulting Resident A. Felicia Evans stated that Resident A and Resident B are good friends and were hanging out in Resident A's bedroom the very next day after Resident B physically assaulted Resident A on 12/3/2025. I advised that the current safety plan is not effective due to another assault occurring on 12/22/2025 after Resident B assaulted Resident A. Sarah Gue and licensee designee Felicia Evans will submit the new plan prior to Resident A returning to the facility. Felicia Evans and Sarah Gue both stated that discharge will be explored for Resident B as part of an effective safety plan that could be put in place.

On 12/23/2025, I conducted a conference call with staff member Sara Gue, administrator Fiorella Spalvieri, licensee designee Felicia Evans, ISK Executive Kathy Lentz, and ISK Supervisor Carla Springer regarding the implementation of a safety plan. They all reported that they would like to implement a safety plan that would allow both Resident A and Resident B to remain in the facility. I advised that the current safety plan was not sufficient since Resident A has been physically assaulted by Resident B twice this month and on multiple other occasions in past. Members on this conference call all stated that they were only made aware of Resident A being physically assaulted twice this month and had no knowledge of any other incidents involving Resident B assaulting Resident A. The members stated additional safety measures will be put in place such as 1:1 staffing for Resident B, extra case management for both Resident A and Resident B and a referral to behavioral services for Resident B. This will allow a behavior treatment plan to be considered for Resident B. I informed the individuals on this call that this safety plan will need to be put into place prior to Resident A returning to the facility.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.</b>

<p><b>ANALYSIS:</b></p>	<p>Based on my investigation which included interviews with APS Specialist Allyson Wright, direct care staff members Sarah Gue, Douglass Schroeder, Deanna Miller, Darnell Boyd, Talia Williams, James Gainey, and Fatima Snell, Resident C, Resident D, and Resident E, ISK Staff Carla Springer, Michael Dwyer and Kathy Lentz, administrator Fiorella Spalvieri, and licensee designee Felicia Evans, along with my review of facility incident reports and facility video footage, there is sufficient evidence that Resident B assaulted Resident A for about two minutes while staff members Melissa Luckett and Darnell Boyd watched without physically intervening. The physical assault included Resident B grabbing Resident A by the neck and threatening to kill him. Staff members Darnell Boyd and Melissa Luckett were observed standing by and watching while asking both residents to “stop” in a nonchalant manner during the entire two minutes of Resident B hitting Resident A. At no time did either Melissa Luckett or Darnell Boyd utilize their Mandt training to stop this assault and keep Resident A safe. Resident A sustained prominent scratches to his neck and face and was choked during this assault which could have been prevented if direct care staff members had intervened and utilized their Mandt behavior intervention techniques training. Prior to this physical assault, Resident B blocked Resident A in the medication room for at least ten minutes before physically assaulting Resident A. Direct care staff were aware of this too but did not take any definitive action to get Resident A out. Darnell Boyd is heard on the video threatening Resident B while telling Resident B to let Resident A out of the medication room. At no time did Darnell Boyd or Melissa Luckett take any action to get Resident A out of the medication room.</p> <p>Shortly after the 12/3/2025 incident, APS Specialist Allyson Wright reported Resident B assaulted Resident A again on 12/22/2025 resulting in scratches to Resident A’s neck. Direct care staff physically intervened with assistance from Resident A’s case manager Michael Dwyer who then took Resident A out of the facility.</p> <p>James Gainey, Fatima Snell, Talia Williams, Darnell Boyd, Guardian A1 and Michael Dwyer all stated that Resident B has a history of physically assaulting Resident A and no safety plan was ever implemented to keep Resident A safe from harm even after he was physically assaulted with visible injuries on 12/03/2025 and again on 12/22/2025. Consequently, Resident A was not provided with protection and safety.</p>
<p><b>CONCLUSION:</b></p>	<p><b>VIOLATION ESTABLISHED</b></p>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

I reviewed a facility video with staff member Sarah Gue that showed Resident A calling for help while he was trapped in the medication room for at least ten minutes. On the other side of the door Resident B and staff members were heard yelling. Specifically staff member Darnell Boyd can be heard yelling to Resident B, “move your ass out the way” and “if I come down there, I’m going to throw your ass out the window.” Melissa Luckett could be heard yelling “leave him alone.” Sara Gue confirms that the voices that were heard yelling at Resident B were Darnell Boyd and Melissa Luckett.

<b>APPLICABLE RULE</b>	
<b>R 400.641</b>	<b>Resident behavior interventions.</b>
	<b>(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.</b>
<b>ANALYSIS:</b>	Per my review of a video involving Resident A and Resident B, direct care staff Melissa Luckett and Darnell Boyd did not act to get Resident A out of the medication room despite his calls for help. Resident A remained blocked in the medication room for at least 10 minutes. Further, direct care staff Darnell Boyd was heard yelling threats and using profane language toward Resident B as he directed him to open the door so Resident A could leave the room. Melissa Luckett could be heard yelling at Resident B to “leave him alone.” Consequently, Resident A and Resident B were mistreated after direct care staff did not take action to get Resident A out of the medication room and also because direct care staff used threats and profane language toward Resident B.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

While at the facility, I interviewed three residents and three direct care staff members and during this time I observed the medication room door left open and unattended by direct care staff with multiple medications on the counters for about 20 minutes. Direct care staff Talia Williams reported that she was unsure why the medication room door was left open and unattended while medications were on the counter. She reported that the medication room door is usually closed.

James Gainey stated that he was in the medication room logging medications upon my arrival and wanted to give this consultant privacy therefore he left the medication room to go into his office and close the door. James Gainey stated that he forgot to close the medication room door during this time.

It should be noted I observed multiple residents walking back and forth near the medication room while the medication room door was open and unattended with multiple medications left out on the counters. It should also be noted that when I reviewed the facility video that captured the assault involving Resident A and Resident B, and observed the medication room door wide open with no staff members present at that time as well. Resident B was observed going through the drawers and cabinets while Resident A was on the phone talking in the medication room with no staff supervision.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(2) Prescribed medication must be kept in the original \ pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.</b>

<b>ANALYSIS:</b>	<p>While I was at the facility interviewing multiple residents and direct care staff, the medication room door was left open and unattended with multiple medications on the counters for about 20 minutes. The medication room door was also observed left open and unattended on the video from the 12/03/25 assault. During both incidents, residents walked past the open medication room multiple times and on 12/03/25 Resident B was observed opening drawers and cabinets in the medication room.</p> <p>James Gainey stated that he was in the medication room logging medications upon my arrival and wanted to give this licensing consultant privacy but forgot to close the medication room door during this time.</p> <p>Consequently, medications were not kept in a locked cabinet or drawer after direct care staff left the medication room open and unattended and accessible to residents.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

I reviewed video footage that showed Resident A trapped in the medication room for at least 10 minutes due to Resident B blocking the door. Although Resident A yelled for help by calling out Darnell Boyd and Melissa Lockett’s names, neither staff member opened the door to let Resident A out of the medication room.

Darnell Boyd stated that he observed Resident B blocking the medication room door while Resident A was trapped inside the room yelling for help however, he did not believe he could intervene during this time because “there was no physical aggression or fighting demonstrated which is the only time Mandt techniques are supposed to be used.”

According to the facility incident report, Melissa Lockett also confirmed that she was aware that Resident A was trapped in the medication room due to hearing yelling from the lower level of the facility, however, did not provide a specific timeframe on how long Resident A was trapped in the medication room which the video footage captured at least 10 minutes with no staff member ever intervening to assist Resident A.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(3) A licensee and staff shall respect and safeguard all of the following resident rights to: (b) Exercise individual constitutional rights including right to vote, right to practice religion of choice, freedom of movement, and freedom of association.</b>
<b>ANALYSIS:</b>	<p>I reviewed video footage that showed Resident A trapped in the medication room for at least 10 minutes due to Resident B blocking the door. Although Resident A yelled for help by calling out for direct care staff Darnell Boyd and Melissa Lockett's, neither staff member opened the door to let Resident A out of the medication room.</p> <p>Darnell Boyd stated that he observed Resident B blocking the medication room door while Resident A was trapped inside the room yelling for help however, he did not believe he could intervene during this time because "there was no physical aggression or fighting demonstrated which is the only time Mandt techniques are supposed to be used."</p> <p>According to the facility incident report, Melissa Lockett also confirmed she was aware that Resident A was trapped in the medication room due to hearing yelling from the lower level of the facility. Melissa Lockett did not intervene to get Resident A out of the medication room.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

I also reviewed video footage and a photo of Resident A having blood on his face after he was assaulted on 12/3/2025. Darnell Boyd and Deanna Miller both stated that they observed injury to Resident A's face and neck however neither of them offered Resident A the option to seek medical treatment with a provider to be further evaluated since he was repeatedly punched and kicked by Resident B.

<b>APPLICABLE RULE</b>	
<b>R 400.689</b>	<b>Resident health care.</b>
	<b>(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.</b>

<b>ANALYSIS:</b>	I also reviewed video footage and a photo of Resident A having blood on his face after he was assaulted on 12/3/2025. Darnell Boyd and Deanna Miller both stated that they observed injury to Resident A's face and neck however neither of them offered Resident A to seek treatment with a medical provider to be further evaluated since he was repeatedly punched and kicked by Resident B.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 12/23/2025, I conducted an exit conference with licensee designee Felicia Evans and administrator Fiorella Spalvieri. I informed them of my findings and allowed them to answer questions and make comments.

#### IV. RECOMMENDATION

I recommend the current license is changed to provisional status.

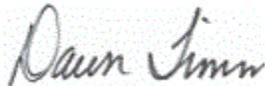


12/23/2025

\_\_\_\_\_  
Ondrea Johnson  
Licensing Consultant

Date

Approved By:



01/06/2026

\_\_\_\_\_  
Dawn N. Timm  
Area Manager

Date