GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 2, 2026

Nichole Taylor
CMHB Of CEI Counties
Suite 115
812 E Jolly Road
Lansing, MI 48910

RE: License #: AM230249421
Investigation #: 2026A0581012
MLK Road Home

Dear Nichole Taylor:

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 #:	AM230249421
Investigation #:	2026A0581012
Complaint Receipt Date:	01/12/2026
Investigation Initiation Date:	01/12/2026
Report Due Date:	03/13/2026
Licensee Name:	CMHB Of CEI Counties
Licensee Address:	Suite 115 812 E Jolly Road Lansing, MI 48910
Licensee Telephone #:	(517) 346-8200
Administrator:	Melissa Doss
Licensee Designee:	Nichole Taylor
Name of Facility:	MLK Road Home
Facility Address:	300 North Michigan Eaton Rapids, MI 48827
Facility Telephone #:	(517) 663-2374
Original Issuance Date:	04/09/2003
License Status:	REGULAR
Effective Date:	05/21/2025
Expiration Date:	05/20/2027
Capacity:	12
Program Type:	MENTALLY ILL

II. ALLEGATIONS

	Violation Established?
The facility is in poor condition.	No
Resident A did not receive her medication two days in January 2026.	Yes
The licensee is illegally taking Resident A's Michigan Bridge Card and accessing Supplemental Nutrition Assistance Program (SNAP) benefits.	No
The facility does not follow proper visitor procedures.	No

III. METHODOLOGY

01/12/2026	Special Investigation Intake - 2026A0581012
01/12/2026	Special Investigation Initiated – Telephone - Interview with Complainant.
01/21/2026	Contact - Document Received - Additional allegations.
01/21/2026	APS Referral - APS received the allegations; no referral necessary.
01/21/2026	Contact - Document Sent - Email to Shelly Stratz, Eaton County APS specialist.
01/26/2026	Contact - Telephone call received - Interview with Shelly Stratz
01/26/2026	Contact - Document Received - Email from Shelly Stratz.
02/04/2026	Inspection Completed On-site - Interview with Resident A and staff.
02/04/2026	Contact - Document Received - Email from Jason Smith, facility's home manager.
02/04/2026	Contact - Telephone call made - Interview with licensee designee, Nichole Taylor.
02/04/2026	Contact - Document Received - Email from Nichole Taylor
02/26/2026	Contact – Telephone call made – Interviews with direct care staff, Isis Fugon and Taqua Friday. Follow up interview with Jason Smith.

03/02/2026	Exit conference with licensee designee, Nichole Taylor.

ALLEGATION: T**he facility is in poor condition.**

INVESTIGATION: On 01/12/2026, I received this complaint through the Bureau of Community Health (BCHS) online complaint system pertaining to allegations other than the condition of the facility. On 01/21/2026, additional allegations were received alleging cigarette butts were present throughout the entryway and vomit was observed in a sink and not been cleaned up.

On 01/21/2026, I interviewed Eaton County Adult Protective Services (APS) specialist, Shelly Stratz. Shelly Stratz stated she conducted two unannounced visits at the facility on 01/13/2026 and 01/23/2026. She stated the facility was clean during each of these visits. She stated she did not observe any cigarette butts in the facility, but observed some cigarette butts on the ground outside of the facility that were not in the designated cigarette butt container. Shelly Stratz stated she did not observe any vomit in any of the facility's sinks during her inspections. She stated she interviewed Resident A who reported to her that residents had thrown up outside of the facility and in the shower; however, Resident A reported to Shelly Stratz the vomit was cleaned up by staff.

On 02/04/2026, I conducted an unannounced inspection at the facility. A designated smoking area was observed away from the facility. Additionally, a pile of cigarette butts was observed on the concrete walkway near the front entrance; however, none appeared lit or smoldering. The facility's home manager, Jason Smith, stated that some of the residents may rummage through the cigarette butt disposal container in search of cigarette butts containing leftover, unburnt tobacco. He further stated that staff clean up cigarette butts daily, despite the cigarette butts being on the ground at the start of my inspection. I did not observe any cigarette butts inside the facility's entryway.

Jason Smith also stated he was not aware of any facility sinks containing vomit that had not been cleaned by staff. He stated that residents frequently dispose of instant coffee grounds in the sinks, which may resemble vomit. He further stated that staff check the bathrooms at least once per shift and clean up any concerns observed.

Jason Smith stated that staff have assigned morning and evening duties documented on the licensee's "AM Duty Checklist", "PM Duty Checklist", and "Overnight Cleaning Checklist". I reviewed these checklists, which included various cleaning tasks required to be completed by staff throughout the facility.

I interviewed direct care staff, Julian Johnson, whose statement was consistent with Jason Smith's statement to me.

I interviewed Resident A whose statement regarding residents vomiting in the facility was consistent with her statement to Shelly Stratz. Resident A also stated both staff and residents clean up cigarette butts from outside.

A walk through the facility was completed, and no vomit was observed in any sinks.

At the conclusion of the inspection, the cigarette butts observed on the exterior of the facility had been cleaned up and disposed of properly.

On 02/26/2026, I interviewed direct care staff, Isis Fugon, whose statement was consistent with Jason Smith's and Julian Johnson's statements to me.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.
ANALYSIS:	Cigarette butts were observed on the exterior concrete walkway near the facility's front entrance; however, none were lit or smoldering, and they were cleaned up and properly disposed of by the conclusion of the investigation. The facility's home manager, Jason Smith, and additional staff stated staff clean the exterior smoking area daily and explained that residents may remove cigarette butts from the designated disposal container. Additionally, no vomit was observed during my inspection. Based on my direct observations and interviews with staff, there is insufficient evidence the facility is either in poor condition or housekeeping standards are unkempt.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A did not receive her medication two days in January 2026.

INVESTIGATION: The complaint alleged Resident A is schizophrenic and did not receive her prescribed medication on two days on or around 01/01/2026. The complaint did not specify which medications Resident A did not receive.

On 01/12/2026, Complainant stated Resident A is prescribed approximately 16 different medications, which are to be administered to her twice a day; however, on or around 01/01/2026 Complainant stated direct care staff did not administer Resident A's medication because Resident A was not awake to receive them from staff.

Shelly Stratz, APS specialist, stated she reviewed Resident A's January 2026 Medication Administration Record (MAR) during her inspections. She stated she identified concerns indicating Resident A did not receive all prescribed medications as documented. Specifically, according to her review of the MAR, direct care staff did not initial the administration of Resident A's birth control pill or Flonase on one day in January.

Additionally, Shelly Stratz stated Resident A reported to her one instance in January in which she did not receive an evening medication; however, Resident A was unable to identify which medication was missed.

During the onsite inspection, I reviewed Resident A's January 2026 MAR and did not observe any concerns at that time, including concerns indicating her Flonase medication was not administered as prescribed. Additionally, based on my review of Resident A's January 2026 MAR, I was unable to identify documentation indicating Resident A being prescribed or administered a birth control pill.

Resident A stated she received all her medications in January 2026. She was unable to identify any days or times when staff did not administer her medications.

Jason Smith and Julian Johnson stated they were not aware of any issues with Resident A's medication administration.

On 02/26/2026, during a subsequent review of Resident A's January 2026 MAR, I identified that two medications, Montelukast Sod 10 mg and Olanzapine 10 mg, which were scheduled for administration at 9 pm on 01/23, but were not initialed by direct care staff, Taqua Friday. The MAR reflected Resident A's other scheduled 9 pm medications on 01/23 were initialed by Taqua Friday.

On 02/26/2026, I contacted Jason Smith again to have him review the MAR. He confirmed there were no initials documented on the MAR for those two medications. He stated he believed the omission of initials was a documentation error.

On 02/26/2026, I interviewed direct care staff, Isis Fugon, who stated she worked the evening of 01/23 with Fanny Mills and Taqua Friday. She was unable to identify any issues or concerns regarding medications on 01/23, including medication not being available in the facility to administer.

On 02/26/2026, I interviewed direct care staff, Taqua Friday, whose statement was consistent with Isis Fugon. She stated there were no issues or concerns regarding Resident A's medication administration the evening of 01/23 and if initials were missing then it would have been due to forgetting to initial the MAR.

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 my review of Resident A's January Medication Administration Record, and interviews with staff and Resident A, staff did not initial Resident A's Montelukast Sod 10 mg and Olanzapine 10 mg medications scheduled for 9 pm on 01/23. Due to the absence of required documentation, I cannot confirm the medications were given as prescribed.
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:** **(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:	Based on my review of Resident A's January Medication Administration Record, and interviews with staff and Resident A, the scheduled 9 pm doses of Montelukast Sod 10 mg and Olanzapine 10 mg on 01/23 lacked staff initials, which does not meet the documentation requirements for a resident's individual medication log.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The licensee is illegally taking Resident A's Michigan Bridge Card and accessing Supplemental Nutrition Assistance Program (SNAP) benefits.

INVESTIGATION: The complaint alleged Resident A was required to give her Bridge Card with SNAP benefits to the facility, which the complaint alleged was "illegal".

I reviewed the licensee's status on the Bureau of Information Tracking System (BITS) and confirmed the licensee is identified as a nonprofit licensee.

Complainant stated Resident A does not have a guardian and was admitted to the facility in October 2025. Complainant further stated Resident A gave the licensee her Bridge card in November 2025. I explained to Complainant that nonprofit Adult Foster Care facilities can accept resident's Bridge cards and use the funds to purchase food for meals prepared in the facility. Complainant expressed apprehension with my explanation.

Jason Smith confirmed the facility was a nonprofit and is permitted to accept resident Bridge cards. He stated residents are not forced to turn the Bridge cards over to the licensee and that Resident A willingly gave the facility permission to hold and use her Bridge card.

He further stated the Office of Inspector General (OIG) completed an investigation regarding potential misuse of Resident A's Bridge card and did not identify any concerns after reviewing the facility's food receipts. He stated the investigation was subsequently closed.

Jason Smith stated staff regularly review meals and food selections with residents to incorporate residents' preferences. He also stated the Resident Care Agreement (RCA) reflects how the licensee will manage a resident's Bridge card.

I reviewed Resident A's RCA, dated 10/03/2025, which was signed by Resident A and the licensee designee, Nichole Taylor. The RCA documented that if Resident A is eligible for food stamp benefits, she agrees to surrender her Bridge card to the facility for use in purchasing food for meals prepared in the home.

Resident A confirmed she willingly gave the licensee her Bridge card upon admission to the facility. She stated she contributes to the facility's menu and staff obtain food items she requests.

On 02/04/2026, the licensee designee, Nichole Taylor, forwarded me an email, dated 01/22/2026, from an Office of Inspector General (OIG) Investigative Support Specialist. The email documented that OIG completed a preliminary investigation and based on its review, closed the case with no further action.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	The licensee, CMHB Of CEI Counties, is a nonprofit and based on my investigation, Resident A voluntarily provided her Michigan Bridge card to the licensee and consented to its use for purchasing food for the meals prepared in the facility, as documented in her signed Resident Care Agreement, dated 10/03/2025. Resident A confirmed she was not pressured or coerced and stated staff obtains the food items that she requests. Additionally, the Office of Inspector General reviewed the facility's use of Resident A's Bridge card and did not identify any misuse. Subsequently, there is no evidence that the licensee exploited Resident A by holding or using her Bridge card.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility does not follow proper visitor procedures.

INVESTIGATION: The complaint alleged the facility does not follow proper visitor procedures. The complaint alleged visitors are supposed to be buzzed in and then checked in to ensure they are approved visitors for residents; however, the complaint alleged visitors are sometimes allowed into the facility without checking in. The complaint provided no additional information.

Shelly Stratz stated that during two visits to the facility, she experienced no issues gaining entry to interview Resident A. She stated she identified herself to staff upon arrival and was escorted to the home manager's office. She further stated residents are permitted to have visitors unless a visitor restriction is in place.

Jason Smith stated there are no visitor restrictions for residents. He explained the facility utilizes a buzzer system to alert staff when visitors arrive so staff can meet visitors at the entrance. He also stated visitors may also knock at the garage door if necessary. I did not experience any issues gaining entry to the facility during my inspection. I also observed the facility's visitor sign in sheet, which confirmed visitors are signing in.

Resident A did not identify any concerns or issues with having visitors.

Julian Johnson's and Isis Fugon's statements were consistent with Jason Smith's statement. Both stated visitors are expected to sign in upon entering the facility and that staff were not aware of any residents having visitor restrictions.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(l) Receive visitors at a reasonable time. Exceptions or visitor restrictions must be covered in the resident's assessment plan. Special consideration must be given to visitors coming from out of town or whose hours of employment warrant deviation from usual visiting hours.**
ANALYSIS:	There is no supporting evidence that any of the residents are denied the right to receive visitors at reasonable times. Staff and management stated visitors are permitted into the facility unless restrictions are documented, and the facility utilizes procedures for visitor entry and sign in. During the onsite inspection, no barriers to visitor access were observed and I did not experience difficulty gaining entry to the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 03/02/2026, I attempted to conduct the exit conference with the licensee designee, Nichole Taylor, to explain my findings. I left her a voicemail and sent her an email with my findings.

IV. RECOMMENDATION

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

03/02/2026

_____

Cathy Cushman — Date
Licensing Consultant

Approved By:

_____

Dawn N. Timm — Date
Area Manager