



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 8, 2026

Adam Frazier
Crestwood Manor LLC
5078 Solvel St
Kalamazoo, MI 49004

RE: License #: AS390095233
Investigation #: 2026A1024023
Crestwood Manor

Dear Mr. Frazier:

Attached is the Special Investigation Report for the above-mentioned 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 (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

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|---------------------------------------|--|
| License #: | AS390095233 |
| Investigation #: | 2026A1024023 |
| Complaint Receipt Date: | 03/18/2026 |
| Investigation Initiation Date: | 03/19/2026 |
| Report Due Date: | 05/17/2026 |
| Licensee Name: | Crestwood Manor LLC |
| Licensee Address: | 5078 Solvel St Kalamazoo, MI 49004 |
| Licensee Telephone #: | (269) 359-1511 |
| Administrator: | Adam Frazier |
| Licensee Designee: | Adam Frazier |
| Name of Facility: | Crestwood Manor |
| Facility Address: | 5078 Solvel Street Kalamazoo, MI 49004 |
| Facility Telephone #: | (269) 373-3842 |
| Original Issuance Date: | 04/20/2001 |
| License Status: | REGULAR |
| Effective Date: | 07/02/2024 |
| Expiration Date: | 07/01/2026 |
| Capacity: | 6 |
| Program Type: | DEVELOPMENTALLY DISABLED MENTALLY ILL AGED |

II. ALLEGATION(S)

| | Violation Established? |
|---|-----------------------------------|
| Resident A was hospitalized with unexplained fresh bruises including severe genital injury. There is concern Resident A was not provided with adequate safety and protection. | Yes |

III. METHODOLOGY

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| 03/18/2026 | Special Investigation Intake 2026A1024023 |
| 03/19/2026 | Special Investigation Initiated – Telephone with Adult Protective Services (APS) Amber Price Johnson |
| 03/19/2026 | APS Referral- APS already involved |
| 03/20/2026 | Inspection Completed On-site with direct care staff member Cliff Mutegi and Grace Ongwela |
| 03/20/2026 | Contact - Document Received <i>Incident Report, Assessment Plan for AFC Residents</i> |
| 03/23/2026 | Contact - Document Received-Resident A's <i>Behavior Treatment Plan</i> (BTP) |
| 04/03/2026 | Contact - Telephone call made with direct care staff member Tobina Jalango |
| 04/08/2026 | Contact - Telephone call made with Guardian A1 |
| 04/08/2026 | Contact - Telephone call made with Resident A's case manager Cassidy Geiger |
| 04/09/2026 | Contact - Telephone call made with Resident A's case manager Cheryl Cass |
| 04/09/2026 | Contact - Telephone call made with administrator/licensee designee Adam Frazier |
| 04/10/2026 | Exit Conference with Adam Frazier and Grace Ongwela |
| 04/24/2026 | Contact - Document Received-email correspondence with Adam Frazier |
| 05/07/2026 | Inspection Completed-BCAL Sub. Compliance |

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| | |
| 05/07/2026 | Corrective Action Plan Requested and Due on 05/22/2026 |

ALLEGATION: Resident A was hospitalized with unexplained fresh bruises including severe genital injury. There is concern Resident A was not provided with adequate safety and protection.

INVESTIGATION:

On 3/18/2026, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged Resident A was hospitalized with unexplained fresh bruises including severe genital injury. Complainant was concerned that Resident A was not provided with adequate safety and protection.

On 3/19/2026, I conducted an interview with APS Specialist Amber Price Johnson who stated she is also investigating this allegation. Amber Price Johnson stated she did not find any evidence of abuse by staff members. Amber Price Johnson stated that although staff members were unable to explain how Resident A sustained so many bruises on her body that were located on one side of her body including her genital area and face, APS believes the bruises were self-inflicted since Resident A demonstrates routine self-injurious behaviors.

On 3/20/2026, I conducted an onsite investigation at the facility with Cliff Mutegi and Grace Ongwela. Cliff Mutegi stated that he regularly works with Resident A who has continuous behaviors of flopping to the ground and hitting her body and face against any solid object nearby to harm herself. Cliff Mutegi stated that he recently went with Resident A to the ER because she was experiencing issues with walking on her own and seemed fatigued and unbalanced. Cliff Mutegi stated that hospital staff sent her home and did not find any apparent issues, however, referred her to see a neurologist in April 2026. Cliff Mutegi stated while at the hospital, the doctor found excessive bruises on Resident A's body and on her vulva area. Cliff Mutegi stated he is not exactly sure how she sustained bruises to her genital area since Resident A often exhibits self-injurious behaviors every day which usually only result in bruises to her body and face. Cliff Mutegi stated that it is possible that Resident A sustained excessive bruising and bruising to her vulva without staff knowledge during the times she is in her bedroom alone while she is in crisis. Cliff Mutegi clarified that Resident A requests to be alone in her bedroom during these times. Cliff Mutegi stated that Resident A has the right to be alone if she makes this request therefore staff members will usually leave Resident A alone in her bedroom with the door ajar, so they are able to hear her, however they are unable to see her which helps Resident de-escalate more quickly. Cliff Mutegi stated that Resident A routinely tries to hurt herself daily even with enhanced supervision and it's challenging to keep her protected due to Resident A fast movements when she is having a crisis episode. Cliff Mutegi stated that Resident A also refuses to wear her helmet and currently has started defecating on herself which has made it more difficult to manage Resident A's behaviors.

Grace Ongwela stated that Resident A has enhanced staff supervision with two staff with her within arm's length at all times due to Resident A's target behavior of routine self-harm. Grace Ongwela stated that if Resident A wants direct care staff to leave her alone, she has the right to make that choice even when she is having a crisis episode. Grace Ongwela stated if Resident A requests to be alone, staff members still must be in sight of Resident A therefore if she is in her bedroom, the door must remain open. Grace Ongwela stated that over the past three months, Resident A has demonstrated new behaviors of defecating on herself at least 3 to 4 times a day, so it is believed that the bruising to her vulva area is caused by this new behavior. Grace Ongwela stated that Resident A has also been having balance issues and cannot independently walk on her own which began to occur after Resident A had a medication change. Grace Ongwela stated that an increase in falls and head banging has occurred as Resident A demonstrates these behaviors every day which causes Resident A to sustain bruises to her body and face. Grace Ongwela further stated that Resident A does not like to wear her helmet, which is part of her treatment plan and tends to get more agitated when staff attempts to put this protective gear on her head. Grace Ongwela stated that staff have met with Resident A's mental health treatment team regarding these new frequent behaviors and Resident A's case manager Cassidy Geiger is working closely with staff members to determine how to get Resident A the best care.

On 3/20/2026, I reviewed the facility's *Incident Report* dated 3/13/2026 written by Robina Jalango. This report documented that Resident A woke up appearing generally tired as she had not slept well during the night. Later in the day, staff members observed Resident A to appear to be extremely tired still and subsequently became nonresponsive. The *Incident Report* documented that 911 was called and transported Resident A to the hospital.

I also reviewed the facility's *Incident Report* dated 3/11/2026 written by Robina Jalango which documented that after Resident A took her nighttime medication, she went into the living and began to move throughout the house flopping on the floor landing on her buttocks, and at times striking her head. Staff attempted multiple verbal redirections however these were met with refusals. This report stated that a protective helmet was applied, however Resident A became agitated and more physically active, moving back and forth occasionally hitting her herself on the walls which occurred through the night requiring close supervision. This report documented that Resident A sustained multiple injuries to her body including old injuries that were reinjured.

I reviewed the facility's *Incident Report* dated 3/09/2026 written by Cliff Mutegi which documented that Resident A exhibited self-injurious behaviors while under staff supervision as she moved rapidly between her bedroom, dining room and living room making it difficult for staff to position themselves to fully shield and block potential injury. Resident A repeatedly fell which caused an existing wound on her forehead to be impacted, which caused this area to bruise and bleed slightly. Over time, Resident A was able to respond to staff's prompts and gradually calmed down.

I reviewed the facility's *Incident Report* dated 3/08/2026 written by Cliff Mutegi which documented that Resident A exhibited self-injurious behaviors while moving rapidly throughout the home repeatedly bumping walls and nearby surfaces. This report documented that due to Resident A's speed and unpredictability of her movements staff were unable to intervene before some contacts occurred and as a result Resident A sustained minor injuries/bruises to her forehead, beneath her left eye, her chin, neck, right elbow and lower back. These behaviors lasted for 4 hours.

On 3/23/2026, I reviewed Resident A's *Behavior Treatment Plan* (BTP) dated 1/14/2025 which documented that Resident A would wear her helmet during waking hours with 35-minute breaks every 50 to 70 minutes. This plan documented that staff must reapply the helmet to Resident A if Resident A removes the helmet. This plan documented that Resident A will have 2 to 1 staff supervision 24 hours a day, seven days a week to help keep Resident A safe and these staff members must be able to see Resident A at all times and be close enough to intervene when needed. This plan documents that staff should ensure they remain in assigned supervision proximity to Resident A at all times. This plan further documents that if Resident A requests for privacy, and she is not verbalizing threats towards herself or others, the 2-to-1 staff members may allow this and stand outside her door.

On 4/3/2026, I interviewed direct care staff member Tobina Jalango. Ms. Jalango reported that she regularly works with Resident A under a 2:1 staffing ratio due to Resident A's self-injurious behaviors. She stated that despite enhanced supervision, Resident A continues to injure herself by throwing herself on the ground and against walls and furniture. According to Ms. Jalango, Resident A's current treatment plan has not been effective, as she refuses to wear her helmet and continues to harm herself, resulting in multiple bruises on her body, head, and face. Ms. Jalango reported that these behaviors have increased since January 2026, and Resident A sometimes flops on the floor and hits herself throughout the night. Recently, Resident A has also shown severe fatigue and balance issues and can no longer walk independently.

Ms. Jalango stated that due to these behaviors, staff took Resident A to the hospital for evaluation, where multiple bruises were found on her body and vulva. She said she has no direct knowledge of how Resident A sustained bruising to certain areas, including the vulva, but believes it may have occurred while Resident A was alone in her bedroom or bathroom. She explained that although Resident A has 2:1 supervision, staff will leave her alone upon her request during self-injurious episodes, as their presence can escalate her agitation. During these periods, staff leave the door ajar so they can hear Resident A, though they cannot see her. Ms. Jalango emphasized that Resident A engages in self-injurious behaviors daily and is still able to harm herself even with enhanced staffing, as staff cannot always prevent her from hitting objects or hard surfaces when she flops or throws herself.

On 4/8/2026, I interviewed Guardian A1, who stated that Resident A has a history of self-injurious behaviors. Although Resident A continues to injure herself, Guardian A1

believes she is in a much better placement than her previous adult foster care settings. Guardian A1 explained that Resident A has long exhibited cycles of behavior, with periods of no self-injury followed by weeks of increased behaviors without an identifiable cause. She reported that Resident A is currently displaying new and worsening behaviors, including defecating on herself, flopping on the floor for hours, and being unable to walk independently. Guardian A1 confirmed these behaviors are new. She also stated that Resident A dislikes wearing her helmet, an assistive device intended to protect her head, neck, and face during episodes. Guardian A1 reported that Resident A is currently hospitalized for further evaluation to determine whether any neurological issues are contributing to these changes. However, previous medical evaluations have not identified any neurological concerns, and doctors have been unable to determine the cause of the new behaviors. Guardian A1 expressed that she believes staff are doing their best under the circumstances and that she has no concerns at this time.

On 4/8/2026, I conducted an interview with Resident A's case manager Cassidy Geiger who stated that Resident A participates in a community mental health program out of county therefore she is considered Resident A's contracted mental health case manager. Cassidy Geiger stated that her role is to provide local case management while Resident A resides in Kalamazoo County. Cassidy Geiger stated she visits Resident A regularly and has observed significant bruises to Resident A's face and body on occasion due to Resident A's self-harm behavior. Cassidy Geiger stated she has no knowledge of Resident A having recent bruises on her vulva. Cassidy Geiger stated direct care staff members usually report that although Resident A continues to hit herself against hard objects, this does not result in injury. Cassidy Geiger stated that based on her assessment she has noticed that the 2:1 staff supervision and helmet requirements for Resident A has not been effective in protecting Resident A from harming herself. Cassidy Geiger stated she has brought up the concern of Resident A continually harming herself during multiple team meetings and has also suggested Resident A relocate to a more suitable placement that can prevent or decrease Resident A's incidents of self-injurious behavior.

On 4/8/2026, I interviewed Resident A's case manager, Cheryl Cass. Ms. Cass stated that although she is Resident A's assigned case manager, she does not see her often since Resident A moved out of the county; instead, a contracted case manager meets with her regularly. Ms. Cass reported that, to her knowledge, Resident A had been doing much better and she was unaware that Resident A was refusing to wear her helmet or requesting to be left alone when escalated. Ms. Cass stated that Resident A is required to have 2:1 staff supervision due to the severity of her self-injurious behaviors; however, Resident A does have the right to request privacy when she is not actively attempting to harm herself.

On 4/9/2026, I interviewed licensee designee Adam Frazier. Mr. Frazier stated that he spoke with staff regarding the hospital findings of excessive bruising on one side of Resident A's body and on her vulva; staff reported they were unsure how these bruises occurred. He stated he is aware of Resident A's new concerning behaviors, including balance issues and frequent episodes of defecating on herself. Despite being evaluated

by specialty providers, no apparent medical cause has been identified. Mr. Frazier also acknowledged that Resident A refuses to wear her helmet, but he was informed that her head-banging behavior has decreased and has been replaced by new behaviors such as throwing herself to the floor and attempting to hit other parts of her body and face. Mr. Frazier stated that despite these challenges, he believes staff have been able to keep Resident A safe and protected.

On 4/24/2026, I reviewed email correspondence from Adam Frazier which documented that a new residential provider was conducting an assessment on Resident A to determine if she would be adequate for admission in an alternate facility.

| APPLICABLE RULE | |
|------------------------|--|
| R 400.671 | Resident care. |
| | (4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record. |

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| <p>ANALYSIS:</p> | <p>Based on my investigation which included interviews with direct care staff members Cliff Mutegi, Grace Ongwela, Tobina Jalango, Resident A's case managers Cheryl Cass and Cassidy Geiger, Guardian A1 and review of the facility <i>Incident Reports</i> and Resident A's <i>Behavior Treatment Plan</i> (BTP) there is evidence to support that Resident A was not provided with supervision as required per her BTP after she was found with unexplained bruises including injury to her genital area.</p> <p>According to Resident A's BTP, she is required to have 2:1 staff supervision 24 hours a day, seven days a week to ensure her safety. Staff must be able to see Resident A at all times and remain close enough to intervene when necessary. The plan states that if Resident A requests privacy and she is not a threat to herself or others, the 2:1 staff may honor the request by standing outside her door. The plan also requires Resident A to wear a protective helmet for safety.</p> <p>Cassidy Geiger stated that based on her assessment she believes the enhanced supervision requirement and helmet requirement for Resident A has not been very effective in protecting Resident A from harming herself since she continues to sustain significant injuries.</p> <p>Cliff Mutegi and Tobina Jalango both reported that, even with the BTP in place, it is challenging to keep Resident A safe, as she continues to injure herself despite increased supervision. Both staff members also stated they are unable to determine how Resident A sustained some of her bruises, including those on her genital area. They acknowledged that Resident A is sometimes left alone even when she is a threat to herself, which contradicts the requirements outlined in her BTP.</p> <p>Although Resident A has a BTP in place, staff members have not been able to successfully execute this plan to manage Resident A's self-injurious behavior. Direct care staff interviewed admitted to leaving Resident A unsupervised despite Resident A exhibiting crisis behavior. Therefore: Resident A has not been provided with safety and protection.</p> |
| <p>CONCLUSION:</p> | <p>VIOLATION ESTABLISHED</p> |

On 4/10/2026, I conducted an exit conference with licensee designee Adam Frazier. I informed Adam Frazier of my findings and allowed him an opportunity to ask questions and make comments. Adam Frazier stated that they are hoping with medication changes, Resident A will start to demonstrate less episodes of self-harm. Adam Frazier

stated that they will continue to work with Resident A's treatment plan to help keep Resident A safe and protected.

IV. RECOMMENDATION:

Upon receipt of an acceptable corrective action plan, I recommend the current license status remains unchanged.

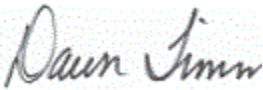


5/7/2026

Ondrea Johnson
Licensing Consultant

Date

Approved By:



05/08/2026

Dawn N. Timm
Area Manager

Date