GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 24, 2026

Sarah Gue
Community Living Options
626 Reed Street
Kalamazoo, MI 49001

RE: License #: AS390250889
Investigation #: 2026A0578034
Transitions of Kalamazoo

Dear Sarah Gue:

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,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390250889
Investigation #:	2026A0578034
Complaint Receipt Date:	07/06/2026
Investigation Initiation Date:	07/07/2026
Report Due Date:	09/04/2026
Licensee Name:	Community Living Options
Licensee Address:	626 Reed Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-6355
Administrator:	Sarah Gue
Licensee Designee:	Sarah Gue
Name of Facility:	Transitions of Kalamazoo
Facility Address:	1353 Oakland Drive Kalamazoo, MI 49008
Facility Telephone #:	(269) 743-2248
Original Issuance Date:	10/23/2002
License Status:	REGULAR
Effective Date:	07/06/2025
Expiration Date:	07/05/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 07/06/2026, Resident A was found unresponsive and not breathing. Emergency Services were notified but Resident A could not be resuscitated.	No
Additional Findings	Yes

III. METHODOLOGY

07/06/2026	Special Investigation Intake 2026A0578034
07/07/2026	Special Investigation Initiated - On Site
07/07/2026	APS Referral
07/07/2026	Special Investigation Completed On-site-Interview with direct care staff Ann Brun. Interview with direct care staff Trevor Johnson. Interview with direct care staff Abubakar Mustafa. Interview with direct care staff Katherine Aldrich-Harris. Interview with direct care staff Brianna Parker-Murray.
07/07/2026	Contact-Documentation Reviewed-*AFC Licensing Division Incident / Accident Report* provided by direct care staff Ann Brun.
07/07/2026	Contact-Documentation Reviewed-*AFC Licensing Division Incident / Accident Report* provided by direct care staff Abubakar Mustafa.
07/07/2026	Contact-Documentation Reviewed-*AFC Licensing Division Incident / Accident Report* provided by direct care staff Katherine Aldrich Harris.
07/07/2026	Contact-Documentation Reviewed-*AFC Licensing Division Incident / Accident Report* provided by direct care staff Trevor Johnson.
07/07/2026	Contact-Documentation Reviewed-*AFC Licensing Division Incident / Accident Report* provided by direct care staff Dominique Williams.
07/07/2026	Contact-Documentation Reviewed *Behavior Support Plan* for Resident A, dated 09/18/2025.

07/07/2026	Contact-Documentation Reviewed-*Annual Assessment* for Resident A, dated 04/22/2026.
07/07/2026	Contact-Documentation Reviewed-*Consumer Information Sheet* for Resident A.
07/07/2026	Contact-Documentation Reviewed-*Assessment Plan for AFC Residents* for Resident A, dated 05/01/2025.
08/21/2026	Contact-Documentation Reviewed-*Incident/Investigation Report Case Number: 26-008669* provided by the Kalamazoo Department of Public Safety.
08/24/2026	Contact-Documentation Reviewed-*Call For Service Detail Report CFS-9710.*
08/24/2026	Exit Conference-With licensee designee Sarah Gue.

ALLEGATION: On 07/06/2026 Resident A was found unresponsive and not breathing. Emergency Services were notified but Resident A could not be resuscitated

INVESTIGATION:

On 07/06/2026, I received this complaint through LARA-BCHS-Complaints@michigan.gov. Complainant reported that Resident A's diagnoses are unknown and that Resident A does not have a guardian. Complainant reported that on 07/06/2026, Resident A was presenting symptoms of congestion around 4AM. Complainant reported at 5AM, direct care staff at this facility checked on Resident A an Resident A was unresponsive. Complainant reported that CPR was administered to Resident A and emergency services were notified by direct care staff. Complainant alleged that at 6AM, Resident A was pronounced dead at 31 years of age.

On 07/07/2026, I completed an unannounced investigation on-site at this facility and interviewed direct care staff Ann Brun regarding the allegations. Ann Brun reported serving as the home manager for this facility. Ann Brun acknowledged that Resident A had passed away on 07/06/2026 and that Resident A had repeated diarrhea and was not feeling well according to direct care staff that had worked on 07/05/2026. Ann Brun reported that another resident also had diarrhea that day and it was thought that some kind of sickness was present in the facility. Ann Brun reported it was decided to observe Resident A and provide him with fluids. Ann Brun reported that Resident A's vitals were checked and were within normal limits and if anything with Resident A condition had changed, Resident A would have been sent to the

hospital. Ann Brun reported direct care staff Trevor Johnson had reported to her at 12:04PM that it looked like Resident A had fallen as Resident A had bruising on his head, but this fall was not observed, and Resident A was not reporting any pain or discomfort. Ann Brun reported Resident A had three bruises across his forehead and some kind of mark on his nose but that Resident A reported to direct care staff that he was fine and appeared to be coherent with direct care staff. Ann Brun denied Resident A's bruising was documented or photographed in any way. Ann Brun reported receiving a phone call from overnight direct care staff Abubakar Mustafa that he had called for emergency services for Resident A around 5:30AM but she was not awake to receive this telephone call. Ann Brun reported that emergency services responded to the facility but were unsuccessful in resuscitating Resident A.

Ann Brun reported that Resident A had a significant behavioral history but had improved with recent medication changes. Ann Brun reported Resident A has a very unsteady gait which had moderately improved after the recent medication changes but clarified that Resident A walks fast and is a fall risk and will often trip on his own feet. Ann Brun identified direct care staff Trevor Johnson and Kathryn Aldrich-Harris as the staff that worked with Resident A on the previous shift before being observed by direct care staff Abubakar Mustafa during the overnight as unresponsive and not breathing. Ann Brun reported direct care staff working with Resident A on 07/05/2026 and 07/06/2026 did not notice anything "was off" with Resident A.

While at the facility, I interviewed direct care staff Trevor Johnson regarding the allegations. Trevor Johnson reported working at this facility for almost a year. Trevor Johnson acknowledged working at this facility with Resident A and on 07/05/2026. Trevor Johnson reported Resident A usually sleeps in on the weekends and on this day Resident A woke up around 9AM. Trevor Johnson reported when he entered Resident A's bedroom to wake up Resident A for medications. Trevor Johnson reported that Resident A had "stuff" on his forehead and clarified Resident A had three bumps on his forehead that were raised and red but with no larger than an inch individually and no other shades or signs of bruising. Trevor Johnson reported it is not uncommon for Resident A to demonstrate involuntary movement, so he (Trevor Johnson) thought Resident A had hit his head during the night. Trevor Johnson reported asking direct care staff Brenna Tutt, who had worked the previous night, about these marks on Resident A and Brenna Tuff did not observe Resident A with these marks before Resident A went to bed. Trevor Johnson reported informing direct care staff Brianna Parker-Murray of these marks, and an Incident Report was completed. Trevor Johnson reported Resident A got up but was struggling with balance and unsteadiness and Trevor Johonson thought Resident A might have fallen out of bed. Trevor Johnson reported that Resident A took his medications and changed his adult undergarment and lay back down in his room around 11AM. Trevor Johnson reported Relative A1 arrived at the facility around 12PM to take Resident A into the community. Trevor Johnson reported attempting to get Resident A out of his bed for this outing and Resident A refused. Trevor Johnson reported informing Relative A1 of Resident A's refusal to get out of bed and agreed that Relative A1 would attempt to motivate Resident A to get out of bed. Trevor Johnson

reported that Relative A1 was informed of Resident A's bruising and agreed that Resident A did not need to be transported to urgent care.

Trevor Johnson reported Relative A1 had been successful in getting Resident A out of bed on previous occasions. Trevor Johnson reported Relative A1 was successful in getting Resident A out of bed and assisted Resident A in the shower. Trevor Johnson reported standing outside of the bathroom while Relative A1 assisted Resident A. Trevor Johnson reported hearing a noise in the bathroom when Relative A1 came out of the bathroom and requested assistance. Trevor Johnson reported that he thought maybe that Resident A had fallen again, but when he observed Resident A, Resident A was standing in the shower. Trevor Johnson reported Resident A needed assistance with scrubbing himself as a large amount of feces was on Resident A. Trevor Johnson reported that he had laid a towel down on the bathroom floor and when Resident A stepped out of the shower, Resident A was incontinent of bowel. Trevor Johnson reported he informed Relative A1 about this occurrence and added that Resident A was incontinent of bowel twice while attempting to shower. Trevor Johnson reported reviewing this occurrence with direct care staff Brenna Tutt and direct care staff Brenna Tutt reported that she had observed Resident A being repeatedly incontinent of bowel on previous occasions. Trevor Johnson reported these observations were reported to Relative A1 and it was agreed that Resident A would stay at this facility instead of going on their planned outing. Trevor Johnson reported Relative A1 left and approximately 30 minutes later, Resident A was incontinent of bowel again. Trevor Johnson reported Resident A has a standing order for as needed medications and was provided with a dose of milk of magnesia. Trevor Johnson reported that Resident A no longer had any incontinence as a result of this medication and was able to put his briefs on by himself and denied any assistance from direct care staff. Trevor Johnson reported that Resident A had clothes but didn't want to put them on and instead wanted to return to bed to sleep more. Trevor Johnson reported Resident A returned to bed and was offered a carbonated beverage and yogurt about an hour and a half after returning to bed. Trevor Johnson reported Resident A was monitored every 10-15 minutes for the remainder of his shift until 8:30PM. Trevor Johnson reported during this time he continued to offer Resident A meals but Resident A verbally declined and informed Trevor Johnson that he just wanted to sleep. Trevor Johnson reported that he assumed Resident A had some type of stomach sickness. Trevor Johnson reported Resident A's vitals continued to be monitored and were not concerning.

Trevor Johnson reported it is not uncommon for Resident A or any other resident to experience diarrhea while residing at this facility. Trevor Johnson reported he would have been concerned with this condition if he had observed any blood and denied observing anything with Resident A's diarrhea that was concerning.

Trevor Johnson reported the bruising he observed on Resident A appeared to be pink in color right below Resident A's hairline. Trevor Johnson reported it looked like Resident A had been rubbing these bruises or they had just happened. Trevor Johnson this type of injury for Resident A was not uncommon due to Resident A's

history of falling. Trevor Johnson reported Resident A's blood pressure when he first examined Resident A was 99/95 with a blood oxygen level of 98%. Trevor Johnson reported he communicated to the night shift (Abubakar Mustafa) what Resident A was experiencing.

While at the facility, I interviewed direct care staff Abubakar Mustafa regarding the allegations. Abubakar Mustafa reported working at this facility for the last ten years. Abubakar Mustafa acknowledged working the overnight shift on 07/05/2026 when Resident A passed away. Abubakar Mustafa reported being informed that Resident A was sick and had diarrhea but had fallen asleep. Abubakar Mustafa reported at 11PM he checked on Resident A in his bedroom and Resident A was not displaying any signs of discomfort. Abubakar Mustafa reported that he checked on Resident A every 20 to 30 minutes since Abubakar Mustafa arrived at this facility.

Abubakar Mustafa reported that around 1AM, he observed Resident A to still be sleeping, but noted Resident A sounded congested. Abubakar Mustafa reported that he consulted with direct care staff Brenna Tutt and they both decided to wake up Resident A to check on him. Abubakar Mustafa reported Resident A woke up and replied, "yeah I'm okay". Abubakar Mustafa reported Resident A changed his briefs and got into clothing and went back to sleep.

Abubakar Mustafa reported around 4AM, Resident A was observed sleeping and still sounded congested. Abubakar Mustafa reported that he again woke up Resident A and asked if he was okay and Resident A responded "yes". Abubakar Mustafa reported at around 5AM or 5:30AM, he opened Resident A's bedroom door, and it looked like Resident A was sleeping but Abubakar Mustafa noted that it didn't sound like Resident A was breathing. Abubakar Mustafa reported he called Resident A by name and touched him and shook him and when Resident A did not respond, he pulled Resident A from the bed and began CPR. Abubakar Mustafa reported calling 911 and they also instructed him to do CPR. Abubakar Mustafa reported emergency services were at this facility within five minutes and took over CPR and continued to do so for 30-40 minutes. Abubakar Mustafa reported at the end of this time, Resident A had no pulse.

Abubakar Mustafa acknowledged observing three "tiny spots" on Resident A's forehead, but denied these spots were blue or purple in color. Abubakar Mustafa reported these spots appeared reddish in color and one was also on Resident A's nose.

On 07/07/2026, I interviewed direct care staff Katherine Aldrich-Harris regarding the allegations. Katherine Aldrich-Harris reported working at this facility for over 6 months. Katherine Aldrich-Harris reported working at an adjoining facility on 07/05/2026, and when she arrived at this facility, Relative A1 was outside and explained that Resident A was too sick to come with her on a planned outing. Katherine Aldrich-Harris reported she was informed that Resident A had diarrhea which was not uncommon and was also observed with bruising on his face as if

Resident A had hit his face on something. Katherine Aldrich-Harris reported that Relative A1 was amicable and that this was not the first time Resident A had diarrhea repeatedly. Katherine Aldrich-Harris reported this information was reported to Ann Brun and Resident A's vitals were taken which seemed within range and that Resident A was responsive and able to put on his own briefs.

On 07/07/2026, I interviewed direct care staff Brianna Parker-Murray regarding the allegations. Brianna Parker-Murray reported working at this facility for over two years. Brianna Parker-Murray reported that she was only at this facility a few hours on 07/05/2026 but was informed that Resident A had an upset stomach and diarrhea. Brianna Parker-Murray acknowledged that Resident A had experienced a similar illness before. Brianna Parker-Murray denied being witness to any other incident but suspected Resident A's illness may have been related to a foodborne illness that had recently been reported in Kalamazoo County. Brianna Parker-Murray confirmed that Resident A was provided with milk of magnesia in response to his illness.

On 07/07/2026, I reviewed the *AFC Licensing Division Incident / Accident Report* provided by direct care staff Ann Brunn regarding the allegations. The *AFC Licensing Division Incident / Accident Report* by Ann Brun included the following information:

> "I was on call Sunday when Trevor Johnson called me indicating that [Resident A] was having severe diarrhea and needed to assist him in the shower and seemed week and unstable. He said he had a few bruises from possible falls in his room that [Resident A] indicated to Trevor. I told Trevor to take his vitals and monitor closely as there were others who had been sick as well, that knowing [Resident A]'s medical baseline if he felt that [Resident A] needed to be seen to take him in to prompt care or ER. Trevor messaged me at 1:42 PM and said [Resident A]'s vitals were fine and was in bed resting. I received no other calls until Abubakar Mustafa called me at 5:30 AM to report on the situation that had occurred with Resident A being unresponsive and calling 911.
>
> Abubakar indicated that [Resident A] woke up in the middle of the night due to soiling his brief. He assisted [Resident A] by cleaning him up and said [Resident A] was even able to pull up his brief. Abubakar said he asked [Resident A] if he was OK and said his usual "yeah" response. Abubakar said around 4:00 AM he heard [Resident A] sound a bit congested and went to check on him. He said he propped the door open so he could listen in and monitor him. Abubakar stated he went back after 5 to check on [Resident A] and found him non responsive and proceeded to do CPR until the ambulance came and worked on [Resident A] for about an hour until pronounced deceased at 6:00 AM."

This *AFC Licensing Division Incident / Accident Report* documented that administrative and responsible agencies were notified.

On 07/06/2026, I reviewed the *AFC Licensing Division Incident / Accident Report* provided by direct care staff Abubakar Mustafa which stated the following:

> "When I arrived at 11pm, I had first checked on [Resident A] who seemed to be sleeping. I checked up on him regularly. Closer to 1am, I called in another staff Brenna from next door to come over to the north side so she and I could check [Resident A] out together. We both thought he seemed to be congested in the chest area, but staff asked [Resident A] how he was feeling. He said "fine," I asked if he was okay, he said "yeah." I went ahead and cleaned up [Resident A] since he had a soiled diaper. I changed [Resident A] and put clothes on him and a new brief. His room was a bit chilly and [Resident A] likes to sleep with no clothes on and I didn't want him getting more sick [sic]. [Resident A] went back to sleep. I then checked on him closer to 4AM, still sounded a bit congested, I decided to propped open [Resident A's] door and sat in the hallway to keep monitoring [Resident A] easily [sic].
>
> Closer to 5 am I went in to check on [Resident A] and he didn't appear to be breathing. I checked his chest area for breathing signs and was listening to catching breathing sounds and [Resident A] was not breathing [sic]. I gently pulled [Resident A] from the bed to the floor with his back flat across the ground and started CPR while calling 911. 911 instructed me to do more CPR until the ambulance came. About 5 mins later, Dispatch showed up and took over CPR. They conducted CPR for about 30-40 mins and could not revive [Resident A]. At 6:05am they pronounced [Resident A] deceased. All parties were notified."

On 07/11/2026, I reviewed the *AFC Licensing Division Incident / Accident Report* provided by direct care staff Katherine Aldrich Harris which included the following information:

> "It was not uncommon for [Resident A] to sleep in past breakfast/lunch. Staff Katherine Aldrich Harris prepared breakfast and lunch for all residents setting aside [Resident A's] meals for when he woke up/was ready. Katherine Aldrich Harris arrived back from getting groceries to see [Resident A]'s mom sitting outside; a brief conversation reveals that it had been planned for [Resident A] to have an outing on 7/5/2026 but that he was "spending so much time in the bathroom" that she had been advised to reschedule. Katherine Aldrich Harris went outside and learned from other staff that [Resident A] had been having a large amount of diarrhea/incontinence and had needed to take a shower. However as soon as he got out of the shower [Resident A] was BM incontinent again and needed to be rewashed at least once. Katherine Aldrich Harris heard that [Resident A] also had bruises on his head and was appearing very weak. All staff expressed concern though [Resident A] had been known to have episodes of bad bowel incontinence. It had not happened to the degree since Katherine Aldrich Harris started working with CLO and came with added symptoms of weakness and bruising. Staff discussed taking [Resident A] in the van but it did

not have enough gas to get to the ER urgent care without first going through the process of filling up the tank. Staff discussed taking [Resident A] in a personal vehicle or calling EMS to come get vitals. Katherine Aldrich Harris was told that other staff was calling supervisor to advise. Katherine Aldrich Harris was not privy to the phone conversation. Katherine Aldrich Harris was told that staff had taken vitals and they appeared normal and so EMS was not called. Katherine Aldrich Harris was told [Resident A] had expressed wanting to go back to bed and had done so and staff continued to monitor frequently throughout the day and night. [Resident A] did not sit down to eat breakfast, lunch, afternoon snack, or dinner. Katherine Aldrich Harris was told upon arriving to work the next day that [Resident A] died the morning of 7/6.

Staff assisted [Resident A] in cleaning himself several times. Staff communicated with [Resident A] to ensure well-being during and after the incident. Staff communicated with supervisor regarding next steps/plan moving forward. Staff passed proper medications and continued to monitor [Resident A] often throughout the rest of the day and night."

On 07/11/2026, I reviewed the *AFC Licensing Division Incident / Accident Report* provided by direct care staff Trevor Johnson which included the following information:

"[Resident A]'s mother arrived at the transitions home around 11:00 AM to pick [Resident A] up to go to lunch. Staff attempted to wake [Resident A] up several times before his mom arrived but [Resident A] only woke up to take his medication and wanted to go back to sleep. When [Resident A] woke up to take his meds I noticed several bruises on his forehead and one on his nose. It seemed to me like [Resident A] may have hit his head on something while sleeping or falling so I asked [Resident A] if he fell off the bed. [Resident A] replied "yes" that he fell off the bed. In the process of checking [Resident A] he began to have a bowel movement. His mother at the time was still there and she helped [Resident A] trying to verbally prompt him to get into the shower so he could go to family lunch event outside of the home. [Resident A] attempted to shower while his mom was in the bathroom but she asked staff to help so we could further assist with the bowel. Staff came to help with [Resident A] and observed [Resident A] being very unbalanced and twitching a little bit more than normal. Staff washed [Resident A] thoroughly and [Resident A] stepped out of the shower onto a towel so he could not slip and had another loose stool. We did this three times and every time [Resident A] would have a loose stool running down his leg and behind. So at this time staff suggested that [Resident A] stay home from the family event to be monitored better and rest. [Resident A]'s mother agreed. So after talking with mom I went and got [Resident A] an over-the-counter medication (milk of magnesia) to settle his stomach and get some relief. [Resident A] stopped having uncontrollable diarrhea and was able to dry off and put a brief on. Staff attempted to help [Resident A] put clothing on but

> [Resident A] stopped staff from assisting and went to his bedroom and laid down. Staff tucked [Resident A] undercovers and went and got him a cold water just in case his lost fluids. [Resident A] drank a big cup of water and was offered a Sprite to help with his stomach he also (had) a few sips of sprite and a few bites of yogurt
>
> Staff attempted to get [Resident A] up for lunch a few times. [Resident A] refused to get up and he replied “sleep” to me when I asked if he was hungry. At the time, staff checked on [Resident A] every 15 minutes throughout the day.”

On 07/06/2026, I reviewed *AFC Licensing Division Incident / Accident Report* related to the allegations and dated 07/05/2026. The AFC Licensing Division Incident / Accident Report was completed by direct care staff Dominique Williams and documented that when direct care staff Trevor Johnson attempted to wake up Resident A in the morning, Resident A was observed with bruising in four different spots on his head. The *AFC Licensing Division Incident / Accident* Report documented that when Resident A did wake up, it was discovered that Resident A had a liquid bowel movement during the night. The *AFC Licensing Division Incident / Accident Report* documented that Resident A had informed direct care staff that bruising on his forehead was a result of falling out of bed. The *AFC Licensing Division Incident / Accident Report* documented that direct care staff continued to help Resident A get up and take a shower. The *AFC Licensing Division Incident / Accident Report* documented that Resident A began to experience uncontrollable diarrhea for about an hour. The *AFC Licensing Division Incident / Accident Report* documented that Resident A’s relative arrived to take Resident A out for lunch but agreed with direct care staff that considering the circumstances Resident A should stay home. The *AFC Licensing Division Incident / Accident Report* documented that direct care staff suspected Resident A might have had some kind of stomach virus and provided Resident A with milk of magnesia to control Resident A’s diarrhea. The *AFC Licensing Division Incident / Accident Report* documented that within 15-20 minutes, Resident A’s stomach seemed to settle and direct care staff finished showering Resident A and Resident A proceeded to dress himself after declining any assistance from staff. The *AFC Licensing Division Incident / Accident Report* documented that Resident A returned to bed after drinking water and sprite and eating some yogurt. The *AFC Licensing Division Incident / Accident Report* documented that Resident A was observed every 15 minutes throughout the day.

On 07/06/2026, I reviewed the *Behavior Support Plan* for Resident A, dated 09/18/2025. The *Behavior Support Plan* for Resident A documented that Resident A is diagnosed with intermittent explosive disorder, moderate intellectual disability, oppositional defiant disorder, autism spectrum disorder and seizure.

On 07/06/2026, I reviewed the *Annual Assessment* for Resident A, dated 04/22/2026. The *Annual Assessment* for Resident A documented that Resident A is diagnosed with moderate intellectual disability, autism spectrum disorder, and oppositional defiant disorder. The *Annual Assessment* for Resident A documented

that Resident A has a history of being verbally and physically aggressive. The *Annual Assessment* for Resident A documented that since moving to this facility, Resident A's psychiatric stability and relational skills have improved.

On 07/06/2026, I reviewed the *Consumer Information Sheet* for Resident A. In addition to a diagnosis of moderate intellectual disability, autism spectrum disorder, and oppositional defiant disorder, the *Consumer Information Sheet* identified that Resident A was diagnosed with a seizure disorder.

On 07/06/2026, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 05/01/2025. The *Assessment Plan for AFC Residents* for Resident A did not identify any supervision requirements, such as line of sight or one on one staffing.

On 08/21/2026, I reviewed *Incident/Investigation Report Case Number: 26-008669* provided by the Kalamazoo Department of Public Safety (KDPS) and dated 07/06/2026. *Incident/Investigation Report Case Number: 26-008669* documented that on 07/06/2026 at approximately 5:20AM, Kalamazoo Department of Public Safet and Life EMS were dispatched to this facility regarding Resident A being found without a pulse and without breathing. Incident/Investigation Report Case Number: 26-008669 documented that KDPS and Life EMS performed lifesaving measures and CPR in an attempt to necessitate Resident A. *Incident/Investigation Report Case Number: 26-008669* documented that a medical examiner pronounced Resident A deceased at 6AM on 07/06/2026.

Incident/Investigation Report Case Number: 26-008669 documented that Resident A was found by direct care staff Abubakar Mustafa unresponsive and in his bed at approximately 5:30AM. *Incident/Investigation Report Case Number: 26-008669* documented that Abubakar Mustafa lowered Resident A to the floor to begin CPR until responding units arrived on scene.

Incident/Investigation Report Case Number: 26-008669 described Resident A as supine on his bedroom floor. *Incident/Investigation Report Case Number: 26-008669* documented that Resident A's pants appeared to be wet from urinating himself and his stomach appeared to be distended with no breathing and no pulse.

Incident/Investigation Report Case Number: 26-008669 did not document any other observations about Resident A's physical appearance. *Incident/Investigation Report Case Number: 26-008669* documented there were no signs of foul play in this investigation.

Incident/Investigation Report Case Number: 26-008669 documented that in an interview, Abubakar Mustafa reported the last time he had seen Resident A alive was at approximately 4:30AM and recalled that Resident A had "labored" breathing and described this breathing as sounding "congested". *Incident/Investigation Report Case Number: 26-008669* documented that Abubakar Mustafa moved a couch from the living room to a hallway just outside of Resident A's bedroom and propped

Resident A's bedroom open to hear if anything was wrong. *Incident/Investigation Report Case Number: 26-008669* documented that at approximately 5:30AM, he could no longer hear Resident A and entered his bedroom to find Resident A supine in his bed without a pulse and not breathing. *Incident/Investigation Report Case Number: 26-008669* documented that Abubakar Mustafa called 911 and began administering CPR. *Incident/Investigation Report Case Number: 26-008669* documented that Abubakar Mustafa was emotional in response to this event and presented with tears in his eyes.

On 08/11/2026, I contacted the Kalamazoo Couty Medical Examiner's Office regarding Resident A. The Kalamazoo County Medical Examiner's Office reported an autopsy was not yet completed for Resident A but would be provided to this department once completed. As of the date of this report, the autopsy for Resident A has not been completed.

On 08/24/2026, I reviewed the *Call For Service Detail Report CFS-9710* related to the allegations. The *Call For Service Detail Report CFS-9710* documented that at 5:21AM, emergency services were called regarding a male not breathing. The *Call For Service Detail Report CFS-9710* documented that Life EMS was dispatched at 5:22AM, and that the caller was attempting CPR. The *Call For Service Detail Report CFS-9710* documented that a Kalamazoo Department of Public Safety officer took over CPR at 5:27AM. The *Call For Service Detail Report CFS-9710* documented a time of death for Resident A as 6AM.

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:	Based upon my investigation, which consisted of interviews with direct care staff Ann Brun, direct care staff Trevor Johnson, direct care staff Abubakar Mustafa, direct care staff Katherine Aldrich-Harris, and direct care staff Brianna Parker-Murray, as well as observations made during an unannounced investigation on-site and a review of pertinent documentation relevant to this investigation, there was not enough evidence to substantiate the allegation that Resident A's personal need for protection and safety was not attended to at all times. Resident A was observed by multiple direct care staff with unidentifiable marks on his forehead but was coherent and responsive to questions about his condition from direct care staff. Resident A was observed by multiple direct care staff with frequent incontinence of bowel during the day on 07/05/2026, which was identified as not out of the ordinary for Resident A. During the night of 07/05/2026, Resident A was responsive to direct care staff and demonstrated what staff identified as breathing that was

	congested before being found unresponsive. Direct care staff reported finding Resident A unresponsive at 5:30AM and documentation obtained from the Kalamazoo Department of Public Safety demonstrated that responding emergency service providers arrived at this facility at 5:27AM but were unsuccessful in resuscitating Resident A. KDPS *Incident/Investigation Report Case Number: 26-008669* documented there was no evidence of foul play in the death of Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

On 07/07/2026, I interviewed direct care staff Trevor Johnson. Trevor Johnson reported that Resident A had a standing order for as needed medications and was provided with a dose of milk of magnesia due to being repeatedly incontinent of his bowels. Trevor Johnson stated once Resident A was administered milk of magnesia, Resident A no longer had any incontinence as a result of this medication and was able to put his briefs on by himself and denied any assistance from direct care staff.

On 07/07/2026, I interviewed direct care staff Brianna Parker-Murray who reported Resident A's illness may have been related to a foodborne illness that had recently been reported in Kalamazoo County. Brianna Parker-Murray confirmed that Resident A was provided with milk of magnesia in response to his illness.

On 07/06/2026, I reviewed the *Standing Medication Orders-Over the Counter* for Resident A. The *Standing Medication Orders-Over the Counter* for Resident A documented that for diarrhea, Resident A was prescribed Imodium, Pepto Bismal, Maalox or Kaopectate by physician Lesley DeLille.

On 07/06/2026, I reviewed the *Medication Log OTC* for Resident A. The *Medication Log OTC* for Resident A documented that on 07/05/2026, Resident A was administered 40ML of milk of magnesia. The *Medication Log OTC* for Resident A documented the reason for this medication was "stomach/diarrhea". The *Medication Log OTC* for Resident A documented this medication was effective.

I noted the *Standing Medication Orders-Over the Counter* for Resident A documented that Resident A was to be provided with milk of magnesia when experiencing symptoms of constipation.

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:	During interviews with direct care staff Trevor Johnson and direct care staff Brianna Parker-Murray, it was reported that in response to Resident A experiencing symptoms of diarrhea, Resident A was provided with milk of magnesia medication. Milk of magnesia is a medication prescribed to Resident A by Dr. Lesley DeLille with directions Resident A be provided with this medication for the occurrence of constipation, not for symptoms of diarrhea.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status. However, the Bureau of Community and Health Systems, Adult Foster Care Licensing division reserves the option of opening another special investigation if necessary, after reviewing Resident A's autopsy results.

08/24/2026

Eli DeLeon Date
Licensing Consultant

Approved By:

08/24/2026

Dawn N. Timm Date
Area Manager