



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 16, 2026

Tia Glass
Comfort And Care LLC
1758 E Clark Rd
Dewitt, MI 48906

RE: License #: AL190419090
Investigation #: 2026A0622055
Gunnisonville Meadows

Dear Ms. Glass:

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,

A handwritten signature in black ink, appearing to read 'Amanda Blasius', written in a cursive style.

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL190419090
Investigation #:	2026A0622055
Complaint Receipt Date:	07/30/2026
Investigation Initiation Date:	07/30/2026
Report Due Date:	09/28/2026
Licensee Name:	Comfort And Care LLC
Licensee Address:	5537 Silverleaf Ct. HASLETT, MI 48840
Licensee Telephone #:	(517) 802-0066
Administrator:	Tia Glass
Licensee Designee:	Tia Glass
Name of Facility:	Gunnisonville Meadows
Facility Address:	1758 E. Clark Rd LANSING, MI 48906
Facility Telephone #:	(517) 575-6021
Original Issuance Date:	02/11/2025
License Status:	REGULAR
Effective Date:	08/11/2025
Expiration Date:	08/10/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Direct care worker Jada Reyes-York administered an incorrect CBD gummy dose to Resident A twice causing impairment.	No
Staff are not properly trained to administer resident medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/30/2026	Special Investigation Intake 2026A0622055
07/30/2026	Special Investigation Initiated – Telephone call to direct care worker Crystal Hall.
08/18/2026	Inspection Completed On-site
08/24/2026	Contact - Email sent to licensee designee Tia Glass.
09/11/2026	Inspection Completed-BCAL Sub. Compliance
09/11/2026	Contact - Telephone call made to Guardian A1.
09/14/2026	Contact- Voicemail left for direct care worker, Naveah Terry
9/16/2026	Exit conference with licensee designee, Tia Glass via phone.
09/16/2026	APS referral- No APS referral made as there were no suspicions of abuse or neglect.

ALLEGATION: Direct care worker Jada Reyes-York administered an incorrect CBD gummy dose to Resident A twice causing impairment.

INVESTIGATION:

On 07/30/2026, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, direct care worker Jada Reyes-York was passing medications over the weekend and administered Resident A her prescribed CBD gummy but did not follow the instructions on the MAR requiring a half dose. Instead, she gave Resident A a full

dose. The complaint further stated that Resident A's guardian, Guardian A1, arrived at the home, questioned the situation, and was very upset.

On 07/30/2026, I interviewed direct care worker (DCW) Crystal Hall via phone. She reported that she has not yet been trained in medication administration and primarily works third shift. She stated that Resident A does have a PRN CBD gummy, but she was unaware that direct care worker Jada Reyes-York had given Resident A an incorrect dose.

On 08/18/2026, I completed an unannounced onsite investigation at Gunnisonville Meadows. I interviewed direct care worker Crystal Barclay in person. DCW Barclay stated that Resident A was given a full CBD gummy on 04/04/2026 and 04/05/2026 at 8 p.m. She explained that the original order was not specific and read, "take one gummy, by mouth, at bedtime as needed." DCW Barclay stated that they contacted the doctor and had the order updated. She also stated Guardian A1 was informed of the situation; however, no incident report was completed.

On 08/18/2026, I reviewed an updated order from Optimal Care Hospice for Resident A. According to the order dated 04/09/2026, the instructions were revised to state:

"Elderberry Gummies TCH CBN, 4/9/2026, 10mg, bedtime/PRN for insomnia. Gummies have already been cut in half; 1 half tab equals 10mg."

According to documentation, the prior order dated 06/18/2025 stated:
"1 gummy, promotes sleep, take one gummy by mouth at bedtime, as needed."

On 09/11/2026, I interviewed Guardian A1 via phone. He stated that Resident A was given an overdose of her CBD gummy and that he was upset about the situation. Guardian A1 reported that management informed him the order was not specific and was in the process of being updated to indicate the gummy needed to be cut in half. He stated that he found the situation frustrating, as there had been no prior concerns regarding the administration of this prescribed PRN medication.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	Based on the documentation reviewed, a violation was not established, as the previous order did not direct staff to cut the CBD gummy in half prior to administration. Optimal Care Hospice clarified and updated the order. After reviewing the previous order, it was confirmed that the instructions were not specific especially regarding cutting the gummy in half; therefore, a violation was not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff are not properly trained to administer resident medications.

INVESTIGATION:

On 07/30/2026, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, direct care workers are not properly trained to administer resident medications, and Complainant stated that this is concerning because the narcotic count is constantly off. The complaint came through as anonymous; therefore, additional information was unavailable.

On 07/30/2026, I interviewed direct care worker (DCW) Crystal Hall via phone. She reported that she has not been trained to administer resident medications yet and mainly works third shift. DCW Hall reported that during third shift last week, her co-worker, Naveah Terry, asked her to help with medications as she was busy. DCW Hall stated that she assisted with handing out medications to three residents. DCW Hall also stated that one of the residents required an insulin shot in the morning, and DCW Terry told her she did not know how to administer the shot as she was not medication trained. DCW Hall stated that they had to have another co-worker come in and provide the shot for the resident. DCW Hall explained that she heard the narcotic count has been off and also heard allegations that DCW Jada Reyes-York was let go for stealing.

On 08/18/2026, I completed an unannounced onsite investigation at Gunnisonville Meadows. I reviewed the narcotic medications for Resident A and confirmed that the count in the medication administration record matched the medication in the cart. I also requested to review direct care workers' training files.

On 08/18/2026, I reviewed the training files for the following direct care workers: Tymsha James, Lester Wheeler, Zerryana Miller, Crystal Hall, Phoenix Cleggett, Teresa Green, Jada Reyes-York, and Naveah Terry. Based upon the review, I found medication administration training documented for direct care workers Teresa Green and Phoenix Cleggett only.

On 08/20/2026, I emailed licensee designee Tia Glass and informed her that I was at the home for a special investigation and was unable to locate medication administration training for the following staff: Tymsha James, Lester Wheeler, Zerryana Miller, Crystal Hall, Jada Reyes-York, and Naveah Terry.

On 08/24/2026, licensee designee Tia Glass emailed me documentation of medication administration training for Tymsha James and Lester Wheeler. No documentation was received verifying that Naveah Terry, Crystal Hall or Alescia Nathan had completed and were deemed competent in medication administration.

During my unannounced onsite investigation, I requested to view the staff schedule. Upon review of the schedule for the week of 8/3 through 8/16, it was found that on 8/3; 8/4; 8/5; and 8/16, the direct care workers scheduled for third shift did not have documentation on file confirming they were trained in medication administration. The schedule read as follows:

- 8/3 11 p.m.–7:30 a.m.: Naveah Terry and Crystal Hall
- 8/4 11 p.m.–7:30 a.m.: Naveah Terry and Crystal Hall
- 8/5, 11 p.m.–7:30 a.m.: Naveah Terry and Crystal Hall
- 8/16 11 p.m.–7:30 a.m.: Naveah Terry and Trainee Alescia Nathan

On 08/24/2026, I interviewed direct care worker Venita Turman in person. She reported that she has never observed or heard that direct care worker Jada Reyes-York was stealing medications. DCW Turman stated that she has not observed the narcotic count to be off. However, she reported that she feels staff need more training days on medications. She explained that currently they receive three training days—two days shadowing another staff member and one day being observed—which differs from past practice when staff received at least a week of training. DCW Turman reported that not all staff members are medication trained and only select staff receive the training.

On 08/24/2026, I interviewed direct care worker Crystal Barclay in person, who identified herself as the administrator. She stated that direct care worker Jada Reyes-York was a good employee, was not terminated, and had submitted her two-weeks' notice. DCW Barclay stated that she has not been concerned about the narcotic count being off or about DCW Reyes-York stealing medications.

On 08/24/2026, I interviewed direct care worker Dajahnae Williams in person. She stated that she has worked at the home for three months and is medication trained. She reported feeling well trained, noting she had prior experience working at another home. DCW Williams stated that she had not heard that the narcotic count was off and that she was unaware of anyone named Jada.

On 09/14/2026, a voicemail was left for Naveah Terry. As of 09/16/2026, no response has been received.

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: (a) Be trained in the proper handling and administration of medication.
ANALYSIS:	Based on the training documentation available for review during the onsite investigation and provided via email, it was determined that Gunnisonville Meadows had direct care workers scheduled on third shift who did not have documented training in medication administration. A review of the schedule for the week of August 3–16 showed that on four third-shift days, no staff members working were trained to administer resident medications.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

At the time of the unannounced onsite investigation, I requested to view direct care workers training as there were allegations that staff are not trained properly. Upon review of direct care workers' training files, there was no documentation of training on first aid or documentation of training on cardiopulmonary resuscitation, which includes a hands-on demonstration as part of the training.

On 08/20/2026, I emailed licensee designee, Tia Glass and informed her that I was at the home for a special investigation and was unable to find direct care workers training. I requested training documentation for the following staff members: Tymsha James, Lester Wheeler, Zerryana Miller, Crystal Hall, Phoenix Cleggett, Teresa Green, Jada Reyes-York and Naveah Terry. Upon review of the documentation received on 08/24/2026, direct care workers Tymsha James, Lester Wheeler, Zerryana Miller, Crystal Hall, Phoenix Cleggett, Teresa Green, Jada Reyes-York and Naveah Terry had no training documentation of completing first aid or cardiopulmonary resuscitation with hands-on demonstration.

During my unannounced onsite investigation, I requested to view the staff schedule. Upon review of the staff schedule for the week of August 3rd-16th, none of the staff

who worked during all three shifts had verification of first aid training or cardiopulmonary resuscitation.

On 08/24/2026, I interviewed direct care worker, Crystal Barclay in person. She reported that the last CPR training held was on 8/18/2025. She stated that one training was scheduled for July 15th, 2026, but the trainer had to reschedule. DCW Barclay reported that currently a CPR training is not scheduled.

APPLICABLE RULE	
R 400.629	Direct care staff; qualifications and training.
	(5) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be trained and competent in all of the following areas before performing assigned tasks independently: (b) First aid. (c) Cardiopulmonary resuscitation, which includes a hands-on demonstration as part of the training.
ANALYSIS:	Based upon review of training documents reviewed during my unannounced onsite investigation and training documents received from licensee designee, Tia Glass, it was found that none of the direct care workers on the staff schedule for 8/3 through 8/16 had a certificate on file confirming verification of completion and competence of first aid and cardiopulmonary resuscitation training. A violation has been established as it was found that direct care workers are performing assigned tasks independently without completing first aid and cardiopulmonary resuscitation.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



9/16/2026

Amanda Blasius
Licensing Consultant

Date

Approved By:



09/16/2026

Dawn N. Timm
Area Manager

Date