GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 15, 2026

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

RE: License #: AS390011445
Investigation #: 2026A1024043
Oak Creek Home

Dear Ms. Evans:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity and repeat quality of care violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

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

License #:	AS390011445
Investigation #:	2026A1024043
Complaint Receipt Date:	08/19/2026
Investigation Initiation Date:	08/19/2026
Report Due Date:	10/18/2026
Licensee Name:	Community Living Options
Licensee Address:	626 Reed Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-6355
Administrator:	Fiorella Spalvieri
Licensee Designee:	Felicia Evans
Name of Facility:	Oak Creek Home
Facility Address:	2416 Oakcreek Drive Kalamazoo, MI 49004
Facility Telephone #:	(269) 343-6355
Original Issuance Date:	09/14/1990
License Status:	1ST PROVISIONAL
Effective Date:	01/12/2026
Expiration Date:	07/11/2026
Capacity:	6
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff failed to provide safety and protection to Resident A because Resident A went missing while at a community outing baseball game.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/19/2026	Special Investigation Intake 2026A1024043
08/19/2026	APS Referral-not warranted
08/19/2026	Special Investigation Initiated – Telephone with direct care staff member Karmya Coleman and Talia Williams
08/19/2026	Contact - Telephone call made with licensee designee Felicia Evans
08/20/2026	Contact - Document Received-*Assessment Plans for AFC Residents* for Residents A, B, C, and D; *Staff Schedule:* Resident A's Individualized Plan of Service (IPOS)
08/20/2026	Contact - Telephone call made with direct care staff member Raheem Washington
08/31/2026	Inspection Completed On-site with direct care staff member James Gainey
09/09/2026	Exit Conference with licensee designee Felicia Evans
09/09/2026	Inspection Completed-BCAL Sub. Non-Compliance

ALLEGATION: Staff failed to provide safety and protection to Resident A because Resident A went missing while at a community outing baseball game.

INVESTIGATION:

On 8/19/2026, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged that direct care staff failed to provide safety, supervision and protection to Resident A after he went missing while at a community outing baseball game.

On 8/19/2026, I conducted an interview with licensee designee Felicia Evans who stated that numerous staff and residents from Community Living Options including herself, residents, and staff members from Oak Creek Home, went to Detroit for a baseball game on 08/13/2026. Licensee designee Felicia Evans confirmed that there were a few residents who wandered away from the group after the game was over. Licensee designee Felicia Evans confirmed that this included Resident A but stated that it is not unusual “to lose residents and later find them” during big outings. Felica Evans stated that while conducting a head count after the game near the stadium restrooms, it was discovered that two individuals from a Community Living Options non-licensed program were unaccounted for, so staff assigned to this program went looking for them. Meanwhile, licensee designee Felicia Evans stated direct care staff member James Gainey noticed that Resident A was also not with the group. Licensee designee Felicia Evans stated that two staff from Oak Creek Home were working with Resident G, so direct care staff from other non-licensed programs and licensed AFC facilities searched for Resident A who was found standing outside the exit door of the stadium by staff member Raheem Washington. Licensee designee Felicia Evans stated that after Resident A was found, the group walked to the bus without incident. Licensee designee Felicia Evans confirmed that Resident A requires staff supervision while in the community and she does not know why Resident A decided to walk away from the group after the game. Licensee designee Felicia Evans stated that she does not believe that direct care staff members lost track of Resident A rather that “[Resident A] lost the group” since he was the one who wandered off. Lastly, licensee designee Felicia Evans stated that she did not believe an incident report was warranted after Resident A could not be located at the end of the baseball game for at least 15 minutes. Subsequently, Resident A’s guardian was not notified of this incident.

On 8/19/2026, I conducted interviews with direct care staff members Karmya Coleman and Talia Williams who both stated that they were working when Resident A’s whereabout became unknown for about 15 minutes while at a baseball game in Detroit. Karmya Coleman stated that licensee Community Living Options took multiple residents from different licensed AFC facilities to see the Detroit Tigers baseball game on 8/13/2026. Karmya Coleman stated that six residents from Oak Creek Home attended this event along with three direct care staff members including herself, Talia Williams and James Gainey. Karmya Coleman stated that all the residents, except Resident F and Resident G, required direct care staff supervision while in the community. Karmya Coleman stated that residents were divided into groups during this outing, so she and Talia Williams were not with Resident A during the game and therefore did not see Resident A for most of the game or after the game. Karmya Coleman stated that after the game all the split groups gathered together to go to the bathroom and to account for all the residents. Karmya Coleman stated that during this time she and Talia Williams were with Resident G who was demonstrating aggressive behaviors towards other residents. Consequently, Karmya Coleman stated she had no direct knowledge that Resident A was missing until they all made it back to the bus to go back to the facility.

Talia Williams stated that she worked with James Gainey and Karmya Coleman on 8/13/2026 and took six of their residents to a baseball game in Detroit with other residents and staff members from different licensed AFC facilities and programs managed by licensee Community Living Options. Talia Williams stated that although they sat as a group while at the game, she did not see Resident A much as she was assigned to be with Residents B, C, D and G. Talia Williams stated that at the end of the game everyone from Community Living Options met as a group to conduct a head count of the residents, however she was assisting Karmya Coleman with Resident G who was behaving aggressively towards residents and staff members. Consequently, Talia Williams stated she was not aware of Resident A missing for about 15 minutes until she was on the bus. Talia Williams stated that it was reported to her that Resident A wandered away from the group and was eventually found in the stadium restroom after 10 to 15 minutes of his whereabouts being unknown. Talia Williams stated that Residents A, B, C, and D all require staff supervision at all times while in the community.

On 8/20/2026, I reviewed *Assessment Plans for AFC Residents* for Residents A, B, C, and D which documented that each of these residents require staff supervision while in the community. I also reviewed *Assessment Plans for AFC Residents* for Residents F and G which documented that these two residents can be in the community independently without staff supervision.

I also reviewed Resident A's *Individualized Plan of Service* (*IPOS)* dated 5/21/2026 and written by Integrated Services of Kalamazoo. According to this IPOS, Resident A requires monitoring and prompting when in small and large groups and is at high risk of being taken advantage of while in the community therefore staff supervision is required. The IPOS also noted that Resident A has a guardian.

On 8/20/2026, I conducted an interview with direct care staff member Raheem Washington who stated he went on the community outing to Detroit on 8/13/2026 with individuals who participate in the Community Living Options day program. Raheem Washington stated that while at the game, everyone from Community Living Options programs sat as a group, including staff and residents from Oak Creek Home. After the game, Raheem Washington stated they walked as a group to the stadium restrooms to conduct a head count of all residents and participants at which time it was discovered that two participants from the day program were not accounted. Consequently, Raheem Washington stated he went to look for those participants who were found after a few minutes of searching. Raheem Washington stated that when he returned, it was discovered that Resident A was also not with the group therefore Raheem Washington, an administrative staff member, and James Gainey went to search for Resident A while the rest of the group walked to the bus. Raheem Washington stated after about 10 minutes of searching, he found Resident A across the street from the stadium wandering around as if he was lost. Raheem Washington stated they walked to the bus without incident. Raheem Washington further stated since it was a Detroit Tigers baseball game, the area was very busy with people leaving the game and busy traffic in the area where Resident A was found.

On 8/31/2026, I conducted an onsite investigation at the facility with direct care staff member James Gainey who stated that himself, Karmya Coleman, and Talia Williams were all responsible for Residents A, B, C, D, F and G however while at the game on 8/13/2026 and they sat as a group in the stands with other staff and residents from different Community Living Options programs. James Gainey stated he did not sit near Resident A at the game, nor did he see Resident A during most of the game. James Gainey stated while preparing to leave for the game, he noticed that Resident A was not with the group while conducting a head count, so he searched for Resident A with assistance from other staff members from different Community Living Options programs. James Gainey stated that Resident A was eventually found outside the stadium by staff member Raheem Washington who walked Resident A back to the bus where all the other staff and residents were waiting. James Gainey stated he believes Resident A's whereabouts were unknown for at least 15 minutes. James Gainey confirmed that Resident A was found unharmed. James Gainey further stated Residents A, B, C, and D all require staff supervision at all times when out in the community.

Due to the quality of care violations identified in *Special Investigation Report #2026A1024010* dated 1/6/2026 which included R 400.681(1) staff failing to provide protection and safety to residents and R 400.641 (5) mistreatment of residents by staff, a six-month provisional license was issued therefore the facility license status is currently under a 1st provisional license. These violations were cited after direct care staff failed to intervene while two residents physically fought with one another for a lengthy period.

Due to the quality of care violations identified in *Special Investigation Report #2026A1024040* dated 8/3/2026 which included R 400.681(1) staff failing to provide protection and safety to residents, a revocation was recommended. These violations were cited after direct care staff failed to provide adequate supervision after a direct care staff member fell asleep in the facility vehicle while in the parking lot away from the residents who were at a community outing. This staff member was responsible for providing supervision to the residents attending this community event.

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 on my investigation which included interviews with direct care staff members Karmya Coleman, Talia Williams, James Gainey, and Raheem Washington, licensee designee Felicia Evans, along with my review of Resident A's *IPOS, Assessment Plans for AFC Residents* for Residents A, B, C, D, F and G there is evidence to support that Resident A was not provided with supervision and protection. Direct care staff responsible for supervising Resident A did not realize he was not with the group during the community outing at the Detroit Tigers Stadium and was missing for at least 15 minutes. According to Karmya Coleman and Talia Williams, who were both working on shift with James Gainey while on a community outing baseball game, they were assigned to Residents B, C, D, and F to provide supervision while Resident A and Resident F were assumingly with direct care staff member James Gainey however James Gainey stated that he did not sit near Resident A at the baseball game and did not see Resident A during the game most of the time. Therefore adequate supervision was not provided to Resident A during and after the game by the staff members responsible for Resident A. Subsequently, Resident A was able to wander away from staff members for at least 15 minutes before eventually being found across the street from the stadium in an area dense with traffic and people. According to Resident A's *Assessment Plan for AFC Residents,* Resident A is required to have staff supervision while in the community. According to Resident A's *IPOS*, Resident A requires monitoring while in a group setting and is at high risk of being taken advantage of while in the community. Direct care staff failed to provide protection and supervision to Resident A on 08/13/2026 in accordance with Resident A's *Assessment Plan for AFC Residents* and IPOS during an outing to the Detroit Tigers Stadium. Direct care staff were not monitoring Resident A as required, which allowed him the opportunity to walk away from the group and his whereabouts unknown for at least 15 minutes.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SIR#2026A1024010 DATED 1/6/2026 AND CAP DATED 1/6/2026]** **REPEAT VIOLATION ESTABLISHED. [SEE SIR#2026A1024040 DATED 8/3/2026.]**

APPLICABLE RULE	
R 400.693	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(e) Elopement from the facility if the resident's location is unknown.**
ANALYSIS:	According to licensee designee Felicia Evans residents will sometimes “go missing” while on big community outings” however they are eventually found therefore she did not believe an incident report was warranted after Resident A’s whereabouts became unknown for at least 15 minutes at the Detroit Tiger Stadium. Subsequently, Resident A’s guardian was not notified of this incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

I reviewed the facility’s staff schedule for August 2026, which did not document the direct care staff members who worked on 8/13/2026. According to this staff schedule on 8/13/2026 Karmya Coleman worked 3pm to 11pm, Talia Williams worked 10am to 8pm, and Troye, no last name provided, worked from 7am to 3pm.

Karmya Coleman, Talia Williams, Felicia Evans and James Gainey all stated that James Gainey worked on 8/13/2026 however he was not listed on the schedule. In addition, these staff members did not state that a direct care staff member by the first name of Troye worked at all on 8/13/2026.

APPLICABLE RULE	
R 400.639	**Staff records.**
	(3) A licensee shall maintain for 90 days a daily work schedule and assignments that includes all of the following: **(a) Names of staff on duty.**
ANALYSIS:	I reviewed the facility’s staff schedule for August 2026, which did not document the correct staff members who worked on 8/13/2026 according to multiple interviews.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Revocation of the license was recommended on 08/03/2026 and that recommendation stands given the severity and repeated violations cited in this report.



09/14/2025

Ondrea Johnson
Licensing Consultant
Date

Approved By:



09/15/2026

Dawn N. Timm
Area Manager
Date