GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 29, 2025

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

RE: License #: AS390073055
Investigation #: 2025A1024023
Community Living Options/Old Log Trail Home

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 was required. On April 30, 2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 #:	AS390073055
Investigation #:	2025A1024023
Complaint Receipt Date:	04/08/2025
Investigation Initiation Date:	04/09/2025
Report Due Date:	06/07/2025
Licensee Name:	Community Living Options
Licensee Address:	626 Reed Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-6355
Administrator:	Fiorella Spalveri
Licensee Designee:	Sarah Gue
Name of Facility:	Community Living Options/Old Log Trail Home
Facility Address:	6156 Old Log Trail Kalamazoo, MI 49009
Facility Telephone #:	(269) 343-6355
Original Issuance Date:	09/16/1996
License Status:	REGULAR
Effective Date:	10/07/2023
Expiration Date:	10/06/2025
Capacity:	6
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was recently taken to the hospital and there is concern that staff is not making sure Resident A is getting enough fluids to drink as instructed by her primary physician.	Yes

III. METHODOLOGY

04/08/2025	Special Investigation Intake 2025A1024023
04/09/2025	Special Investigation Initiated – Emailed by Felicia Evans-*AFC Licensing Division Incident/Accident Report, Health Care Appraisal,* primary care instructions, *Assessment Plan for AFC Residents*
04/09/2025	Contact - Telephone call made with staff Felicia Evans
04/11/2025	Inspection Completed On-site with direct care staff members Shyanna Givans and Carol Durren
04/11/2025	Contact - Telephone call made with Relative A1
04/16/2025	Contact - Document Received-Emailed by staff member Felicia Evans-Resident A's *After Visit Summary*
04/22/2025	Contact - Face to Face-with administrator Fiorella Spalvieri, staff member Felicia Evans, and licensee designee Sarah Gue
04/28/2025	Exit Conference with licensee designee Sarah Gue
04/28/2025	Corrective Action Plan Requested and Due on 05/13/2025
04/30/2025	Corrective Action Plan Received
04/30/2025	Corrective Action Plan Approved

ALLEGATION: Resident A was recently taken to the hospital and there is concern that staff is not making sure Resident A is getting enough fluids to drink as instructed by her primary physician.

INVESTIGATION:

On 4/8/2025, I received this complaint through the LARA-BCHS online complaint system. This complaint stated Resident A was recently taken to the hospital and there is concern that staff is not making sure Resident A is getting enough fluids to drink as instructed by her primary physician.

On 4/9/2025, I reviewed the facility's *AFC Licensing Division-Incident/Accident Report* (incident report) dated 4/5/2025 which stated that at 12:00pm Resident A was observed nonresponsive as she could not keep her eyes open and was observed slumped over on the couch. The incident report stated that staff stayed with Resident A and called 911 who took her to Bronson Hospital where she was admitted.

I reviewed Resident A's Health Care Appraisal (HCA) dated 10/22/2025 which stated that Resident A is diagnosed with Down Syndrome, Anxiety, Depression, and GERD.

I reviewed Resident A's *Assessment Plan for AFC Residents* (assessment plan) dated 9/18/2024. According to this assessment plan, Resident A has a special diet that states that Resident A shall maintain adequate nutrition and hydration by following special dietary needs as prescribed.

I reviewed Resident A's physician order dated 1/9/2025 written by the Center for Family Medicine which stated that for medical reasons Resident A needs to drink 6 to 8 glasses of water or anything that is not caffeinated per day.

On 4/9/2025, I conducted an interview with staff member Felicia Evans who stated that she is familiar with Resident A going to the hospital recently, however did not know much about the hospital visit because Relative A1 does not share any information with staff members after hospital visits or medical routine appointments. Felicia Evans stated an incident report was written by a staff member regarding Resident A's recent hospitalization and Felicia Evans stated she knows that Resident A has a special diet which includes drinking a certain amount of water per day.

On 4/11/2025, I conducted an onsite investigation at the facility with direct care staff members Shyanna Givans and Carol Durren who both stated that they work regularly with Resident A. Both stated they are not familiar with any special diets that Resident A has and both no knowledge of special instructions for fluid intake requirements for Resident A. Both staff members also both stated that staff members keep cases of bottled water in the staff office for all residents to access and Resident A drinks large amounts of water throughout the day. Both stated they do not track how much water she drinks and don't not believe they are required to know any information on Resident A's fluid intake.

Carol Durren stated she was working on 4/5/2025 when Resident A was sent to the hospital due to her being lethargic and unresponsive while sitting at the dining room table. Carol Durren stated Resident A was coloring like she normally does when she sits at the kitchen table, and she appeared slumped over like she was sleeping which was unusual for Resident A. Carol Durren stated she immediately called 911 and Relative A1 who met her at the hospital. Carol Durren stated this incident happened once before in January 2025 at which time she was diagnosed with having pneumonia.

On 4/11/2025, I conducted an interview with Relative A1 who stated that Resident A has been to the hospital twice since January 2025 when she was diagnosed with pneumonia. Relative A1 stated recently Resident A was sent to the hospital because she was found unresponsive by staff. Relative A1 stated the hospital physician informed her Resident A had a kidney injury due to dehydration. Relative A1 stated that she is concerned because Resident A is required to drink a certain amount of water every day and staff has not been following this instruction by Resident A's physician.

On 4/16/2025, I reviewed Resident A's *After Visit Summary* which stated that Resident A was admitted to the hospital on 4/5/2025 for Altered Mental Status and discharged on 04/08/2025. The summary patient instructions stated Resident A is encouraged fluid intake to prevent dehydration and to monitor input/output and document for medical staff when coming in for appointments or hospital stays.

On 4/22/2025, I conducted interviews with administrator Fiorella Spalvieri, staff member Felicia Evans, and licensee designee Sarah Gue who all stated that Relative A1 is very challenging to work with and routinely keeps medical information from staff which makes it difficult for staff to know what's going on with Resident A's health. These staff members also all stated that staff members are going to be more adamant about attending medical appointments with Resident A and Resident A's physician order will now be posted in staff's office where staff will now be able to keep a tracking log of Resident A's fluid intake daily.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(b) Special diets.**

ANALYSIS:	Based on my investigation which included interviews with direct care staff members Shyanna Givans, Carol Durren, Felicia Evans, Relative A1, administrator Fiorella Spalvieri, licensee designee Sarah Gue, review of hospital after visit summary, incident report, assessment plan, HCA, and physician order, there is evidence direct care staff were not monitoring or documenting Resident A's fluid intake as required by Resident A's physician. Resident A was hospitalized on 04/05/2025 due to an altered mental status and was instructed to monitor fluid intake to assure hydration. Resident A's physician's order dated 1/9/25, documented that Resident A needs to drink 6 to 8 glasses of water or anything that is not caffeinated per day. Resident A's assessment plan also stated that Resident A has a special diet that states that Resident A shall maintain adequate nutrition and hydration by following special dietary needs as prescribed. Both Shyana Givans and Carol Durren stated that they work regularly with Resident A and were not familiar with any special diets that Resident A has, including a fluid intake requirement. The licensee has not followed the instructions and recommendations of Resident A's physician dated 01/09/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/28/2025, I conducted an exit conference with licensee designee Sarah Gue. I informed Sarah Gue of my findings and allowed her an opportunity to ask questions or make comments. On 4/30/2025, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was approved therefore I recommend the current license status remain unchanged.

Ondrea Johnson 5/26/2025

Ondrea Johnson Date
Licensing Consultant

Approved By:

Dawn Timm 05/29/2025

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Dawn N. Timm Date
Area Manager