GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 10, 2025

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

RE: License #: AS390095233
Investigation #: 2025A1024032
Crestwood Manor

Dear Adam Frazier:

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 June 25, 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. 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.

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 #:	AS390095233
Investigation #:	2025A1024032
Complaint Receipt Date:	05/19/2025
Investigation Initiation Date:	05/19/2025
Report Due Date:	07/18/2025
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?
Staff member pulled Resident A to the ground, got on top of her and pulled her hair.	No
Additional Findings	Yes

III. METHODOLOGY

05/19/2025	Special Investigation Intake 2025A1024032
05/19/2025	Special Investigation Initiated – Telephone with Recipient Rights Officer (RRO) Faith Witte
05/19/2025	Contact - Document Received-*Incident Report*
05/19/2025	Contact - Document Received-Resident A's Behavior Treatment Plan (BTP)
05/20/2025	Contact - Document Received-*Staff Schedule*
05/28/2025	Contact - Telephone call made with mental health case manager Cheryl Cass
05/30/2025	Inspection Completed On-site-with direct care staff members Robina Jalango and Grace Ongwela
05/30/2025	Contact - Telephone call made with administrator/licensee designee Adam Frazier
06/12/2025	Contact - Telephone call made with direct care staff member Anna Muengeshr
06/18/2025	Exit Conference with licensee designee Adam Frazier
06/18/2025	Inspection Completed-BCAL Sub. Compliance
06/18/2025	Corrective Action Plan Requested and Due on 07/09/2025
06/25/2025	Corrective Action Plan Received
06/25/2025	Corrective Action Plan Approved
06/25/2025	APS Referral-not warranted

ALLEGATION: Staff member pulled Resident A to the ground, got on top of her and pulled her hair.

INVESTIGATION:

On 5/19/2025, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged a staff member pulled Resident A to the ground, got on top of her, and pulled her hair.

On 5/19/2025, I conducted an interview with RRO Faith Witte who stated that she is also investigating this allegation due to a neighbor of the facility reporting that they saw a staff member fighting with Resident A while outside in the backyard of the facility.

On 5/19/2025, I reviewed the facility's *Incident Report* dated 4/25/2025 which stated that at 5:04pm a staff member received a phone message which expressed concern regarding an interaction between a resident and direct care staff member Anna Muengeshr that took place in the backyard of the facility. Following receipt of the voicemail, a thorough investigation was conducted, and it was determined direct care staff member Anna Muengeshr was outside with Resident A who became agitated and attempted to leave the backyard area to strike her head against the metal exterior siding of the home. The report stated, in response, direct care staff member Anna Muengeshr appropriately employed MANDT de-escalation techniques in an effort to prevent Resident A from injuring herself. The report stated direct care staff member Anna Muengeshr gently took hold of Resident A's wrist to redirect her and guided her to a seated position on the ground. While kneeling, direct care staff member Anna Muengeshr positioned Resident A's wrist across their lower thighs to minimize risk of harm while allowing the resident to de-escalate in a calm and supported position. The report stated, once Resident A's agitation subsided, direct care staff member Anna Muengeshr and Resident A returned inside the facility to prepare dinner.

On 5/19/2025, I reviewed Resident A's *Behavior Treatment Plan* (BTP) dated 1/14/2025 which stated that Resident A has developmental delays in all areas resulting from "hydrocephaly, holoprosencephaly, mental retardation, and visual impairment." The BTP stated Resident A has target behaviors of physical aggression, offensive behavior, being uncooperative, destructive, isolative and displaying disruptive behavior and self-injurious behaviors such as hitting her head. The BTP stated Resident A will bang her head on hard surfaces, sometimes causing open areas and bruising and Resident A requires enhanced staffing of two staff members 24/7 daily.

On 5/28/2025, I conducted an interview with Resident A's mental health case manager Cheryl Cass who stated that she provides case management to Resident A who suffers from severe mental illness that causes her to demonstrate self-injurious behaviors regularly. Cheryl Cass stated that Resident A's behavior severely puts her at risk of harm which is why she is assigned enhanced supervision for two staff to be with her at

all times. Cheryl Cass stated that behavior management is needed to ensure Resident A's safety.

On 5/30/2025, I conducted an onsite investigation at the facility with direct care staff members Robina Jalango and Grace Ongwela. Robina Jalango stated that she was working with Resident A when she started to act out and hit her head and throw her body against hard surfaces in attempts to injure herself while in the living room. Robina Jalango stated as Resident A was acting out, she stormed out of the back door to go outside, and Anna Muengeshr immediately followed her where Resident A attempted to hit her head against the house. Robina Jalango stated that while Resident A and Anna Muengeshr were outside, she stayed inside the home to pick up the wall décor that was knocked off the wall by Resident A therefore she did not witness the incident that took place outside. However when Resident A and Anna Muengeshr returned inside Anna Muengeshr informed her that Resident A continuously attempted to hit her head against the exterior of the house and ground therefore Anna Muengeshr utilized physical behavior management by grabbing her hands while she was on the ground. Robina Jalango stated that when Resident A and Anna Muengeshr returned inside the home, the police arrived at the home called by the neighbor at which time all staff members were interviewed by law enforcement who left without having any concerns. Robina Jalango stated Resident A was not harmed in any way by any staff member.

Grace Ongwela stated that on 4/25/2025, Resident A started acting out by demonstrating self-injurious behaviors such as hitting her head and throwing her body against any surface inside the home and then Resident A ran outside to the back of home at which time staff member Anna Muengeshr followed her. Grace Ongwela stated after about five minutes, Anna Muengeshr and Resident A came back inside the home and the incident was de-escalated. Grace Ongwela stated shortly after the incident a neighbor called and left a voicemail stating that she witnessed a staff member fighting with a resident and then a police officer also came to the home who stated that they were also called about the incident. Grace Ongwela stated they explained to the police office that Anna Muengeshr did not hit or mistreat Resident A but instead used behavior management by holding her hands to de-escalate her and to keep her from hitting her head against surfaces outside which is an effective technique for her. Grace Ongwela stated the police interviewed staff members and found no concerns. Grace Ongwela stated that Resident A was not harmed in any way by any staff member.

While at the facility, I observed Resident A sleeping in her bedroom with two staff members present in her bedroom.

On 5/30/2025, I conducted an interview with administrator/licensee designee Adam Frazier who stated he was notified that a neighbor called and stated that she witnessed a resident being mistreated in the backyard of the home and after an internal investigation was conducted he found that staff utilized an approved behavior management technique to de-escalate Resident A when she was attempting to hit her head on the house and ground. Adam Frazier stated he does not believe Resident A

was harmed and mistreated in any way and believes Anna Muengeshr responded appropriately to keep her safe.

On 6/12/2025, I conducted an interview with direct care staff member Anna Muengeshr who stated that on 4/25/2025 Resident A became agitated and started throwing herself around and attempting to hit her head on walls. Anna Muengeshr stated during this incident, Resident A was able to run outside through the back door to the backyard of the facility where she continued to throw herself around and hit herself on the head therefore she grabbed Resident A's arms while she was on the ground and eventually was able to get her to calm down just by holding her hands and telling her to calm down while she laid on the grass. Anna Muengeshr stated after about 5 minutes of being outside, they were able to return inside of the home with the other staff members. Anna Muengeshr stated she did not hit or mistreat Resident A in any way.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	Based on my investigation which included interviews with RRO Faith Witte, mental health case manager Cherly Cass, direct care staff members Robina Jalango, Grace Ongwela, and Anna Muengeshr, administrator/licensee designee Adam Frazier, along with my review of facility's incident report, Resident A's BTP there is no evidence direct care staff member Anna Muengeshr pulled Resident A to the ground, got on top of her, and pulled her hair. According to the facility's incident report, on 4/25/2025 Resident A demonstrated self-injurious behaviors therefore an approved behavior management technique was utilized by staff Anna Muengeshr to de-escalate Resident A while outside at the facility. According to Cheryl Cass Resident A's behavior severely puts her at risk of harm, which is why she is assigned enhanced supervision with two direct care staff to be with her at all times, and that behavior management is needed to ensure Resident A's safety. Anna Muengeshr denies hitting or mistreating Resident A in any way when she physically intervened to prevent Resident A from harming herself. Robina Jalango and Grace Ongwela also deny that anyone harmed Resident A in any way therefore Resident A was not mistreated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

While talking to Faith Witte she stated that a neighbor reported that Resident A was seen outside with one staff member therefore she believes Resident A was not provided with adequate staffing as Resident A is required to have two staff members with her at all times due to the severity of Resident A's behaviors.

While talking to Cheryl Cass she stated that Resident A requires two direct care staff members to be with her at all times due to her target behaviors of physical aggression and self-harm. Cheryl Cass stated that on multiple occasions she has visited the facility and has found the facility to lack adequate staffing to meet Resident A's staffing requirement. Cheryl Cass stated she has spoken to the licensee about this and since their conversation there has been adequate staffing in place.

While at the facility, Robina Jalango and Grace Ongwela both stated that Resident A is required to have two direct care staff members with her at all times for supervision, however Anna Muengeshr was the only staff member to go outside with Resident A after Resident A ran to the backyard while having a crisis episode.

Anna Muengeshr also stated that Resident A is required to have two direct care staff members with her at all times for supervision, however she was the only staff member that was with Resident A while outside in the backyard on 4/25/2025.

I also reviewed Resident A's BTP which stated that Resident A has two identified staff members that should be with her at all times. The BTP stated one of the staff should singularly be responsible for responding to Resident A and talking to her during the response while both staff members remain in assigned proximity to Resident A at all times.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Cheryl Cass, Faith Witte, Robina Jalango, Grace Ongwela and Anna Muengeshr all stated that Resident A is required to have two direct care staff members to be with her at all times due to her behaviors, however, Anna Muengeshr was the only direct care staff member to follow Resident A outside to provide physical intervention in attempts to de-escalate Resident A. Resident A's BTP also stated that 2 staff members should be with Resident A at all times. Therefore, Resident A was not provided with sufficient direct care staff at all times as specified by her BTP.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 5/20/2025, I reviewed the facility's staff schedule for May 2025 that ended on 5/19/2025. I observed that the facility's staff schedule did not show job titles, scheduling changes or advance work assignments.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.**

	(b) Job titles. **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	I reviewed the facility's staff schedule for May 2025 that ended on 5/19/2025 and did not show job titles, scheduling changes or advance work assignments.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Robina Jalango, Grace Ongwela and Anna Muengeshr all stated that on 4/25/2025, the door to the back of the home was left open due to it being hot in the home which is why Resident A was able to easily run outside to the backyard.

I inspected the door at the back of the facility and found no standard screen attached.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(7) Each habitable room shall have direct outside ventilation by means of windows, louvers, air-conditioning, or mechanical ventilation. During fly season, from April to November, each door, openable window, or other opening to the outside that is used for ventilation purposes shall be supplied with a standard screen of not less than 16 mesh.
ANALYSIS:	Robina Jalango, Grace Ongwela and Anna Muengeshr all stated that on 4/25/2025, the door to the back of the home was left open. I inspected the door at the back of the facility and found no standard screen attached.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/18/2025, 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 or make comments.

On 6/25/2025, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

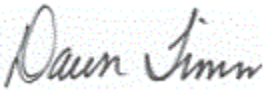
An acceptable corrective action plan was approved therefore I recommend the current license status remain unchanged.

7/9/2025

Ondrea Johnson
Licensing Consultant

Date

Approved By:



07/10/2025

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Dawn N. Timm
Area Manager

Date