GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 27, 2025

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

RE: License #: AS390291227
Investigation #: 2025A1024043
Alamo

Dear Felicia Evans:

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 July 22, 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 #:	AS390291227
Investigation #:	2025A1024043
Complaint Receipt Date:	07/07/2025
Investigation Initiation Date:	07/08/2025
Report Due Date:	09/05/2025
Licensee Name:	Community Living Options
Licensee Address:	626 Reed Street Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-6355
Administrator:	Fiorela Spalvieri
Licensee Designee:	Felicia Evans
Name of Facility:	Alamo
Facility Address:	2725 Alamo Ave. Kalamazoo, MI 49006
Facility Telephone #:	(269) 343-6355
Original Issuance Date:	07/11/2007
License **Status:**	REGULAR
Effective Date:	01/18/2024
Expiration Date:	01/17/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A consumed Resident B's medications that were crushed in his food.	Yes

III. METHODOLOGY

07/07/2025	Special Investigation Intake 2025A1024043
07/08/2025	APS Referral not warranted
07/08/2025	Special Investigation Initiated – Telephone with direct care staff member Chancellor Hughes and Kelvin Singleton
07/08/2025	Contact - Document Received-Resident B's physician script, Resident A's hospital *Discharge Summary*, *AFC Licensing Division Incident/Accident Report*
07/11/2025	Inspection Completed On-site with direct cares staff member Coriana White and Gwen Perry
07/14/2025	Contact - Document Received-additional complaint from Intake 206417 with same allegations
07/15/2025	Exit Conference with licensee designee Felicia Evans
07/15/2025	Inspection Completed-BCAL Sub. Compliance
07/15/2025	Corrective Action Plan Requested and Due on 7/30/2025
07/22/2025	Corrective Action Plan Received
07/22/2025	Corrective Action Plan Approved

ALLEGATION: Resident A consumed Resident B's medications that were crushed in his food.

INVESTIGATION:

On 7/7/2025, I received this complaint through the LARA-BCHS online complaint system. This complaint stated that Resident A consumed Resident B's medications that were crushed in Resident B's food.

On 7/8/2025, I conducted an interview with direct care staff members Chancellor Hughes and Kelvin Singleton who both stated that Resident A was recently hospitalized for taking Resident B's medications. Both stated Resident B's medications were crushed in his oatmeal and this occurred while staff was feeding Resident B. They also both stated they were not working during this time, however, they heard about the incident from other staff members.

On 7/8/2025, I reviewed Resident B's physician order which stated that Resident B's medications prescribed by Bronson Family Medicine The Groves can be crushed or sprinkled in food. These medications included: Linzess 72mcg, Gabapentin 300mg, Divalproex 125mg, Baclofen 10mg, Omeprazole 40mg, and Fexofenadine HCL 180mg.

I reviewed Resident A's hospital *Discharge Summary* dated 6/24/2025. This summary stated that Resident A was admitted to the hospital on 6/22/2024 and discharged on 6/24/2024 for multiple drug ingestion and acute metabolic toxic encephalopathy. This summary stated that staff reported Resident A grabbed a handful of medications from Resident B's pill bottle and swallowed multiple medications. It is unclear how many medications Resident A consumed. After Resident A took the medications, Resident A became altered and minimally responsive shortly after therefore EMS was called. Resident A was given antibiotics for 3 days and was discharged back to the adult foster care home.

I also reviewed the facility's *AFC Licensing Division Incident/Accident Report* dated 6/22/2025 which stated that Resident A came into Resident B's bedroom and grabbed his medications and ate his food. Staff tried to intervene and were able to get the bowl away from Resident A. In addition, staff did a quick mouth swipe to get medications from his mouth. The *AFC Licensing Division Incident/Accident Report* documented direct care staff called 911 and poison control.

While at the facility, I reviewed *Resident A's Assessment Plan for AFC Residents (plan)* dated 10/24/2024, which stated that Resident A requires staff assistance with eating meals/snacks and consumption monitoring. The plan documented that Resident A's foods are pureed, and he uses a sippy cup and straw to drink. The plan documented that Resident A can only eat soft items, and he can feed himself. The plan documented that Resident A has been known to get into the kitchen and take food that isn't pureed therefore Resident A has a physician order to lock the kitchen for Resident A's safety.

On 7/11/2025, I conducted an onsite investigation at the facility with direct care staff members Coriana White and Gwen Perry. Coriana White stated that it was reported to her by other staff members that Resident A was recently hospitalized for taking Resident B's medications and medications that were crushed in his oatmeal while staff were feeding him. Coriana White stated that both Resident A and Resident B were not home at the time of this onsite visit.

Gwen Perry stated that while staff were preparing and administering Resident B's medications in Resident B's bedroom, which is a normal occurrence as Resident B does

not like to come out of his bedroom, Resident A came into the bedroom and grabbed Resident B's medications and ate his oatmeal that also had medications crushed inside. Gwen Perry stated that staff immediately swiped Resident A's mouth to remove the medications and food and called Poison Control. Gwen Perry stated that Resident A tends to go after food therefore Resident A must be monitored closely when food is around to keep him from taking food. Gwen Perry stated that Resident A has been coming to Resident B's bedroom lately and this is the only bedroom he likes to visit in the facility. Gwen Perry further stated that kitchen restrictions have also been put in place to keep Resident A from entering the kitchen as he will attempt to take food.

On 7/14/2025, I reviewed a complaint regarding the same allegations. Complainant 1 stated her job is to investigate reportable diseases and while doing a medical review on Resident A, it was noted that he hospitalized from 6/22/2025-6/24/2025 for an accidental overdose. The complainant stated per the medical record, the AFC caregiver reported that on 6/22/2025 Resident A grabbed a handful of medications from another resident's pill bottle and swallowed multiple medications, and the medications included baclofen, gabapentin, propranolol, and clonazepam. `

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

ANALYSIS:	Based on my investigation, which included interviews with direct care staff members Chancellor Hughes, Kelvin Singleton, Coriana White, Gwen Perry, review of the *AFC Licensing Division Incident/Accident Report, Assessment Plan for AFC Residents* (plan), physician order, and *Discharge Summary* there is evidence to support the allegation Resident A consumed Resident B's medications that were crushed in his food. Direct care staff members Chancellor Hughes, Kelvin Singleton, Coriana White, and Gwen Perry all stated that Resident A was hospitalized for taking Resident B's medications and medications that were crushed in Resident B's oatmeal while staff were feeding him. Gwen Perry further stated Resident A tends to go after food therefore has to be monitored closely when food is around to keep him from taking food. Resident A has a history of coming into Resident B's bedroom therefore staff should have known to safeguard Resident B's medications to prevent Resident A from taking them. Resident A's assessment plan also stated Resident A requires consumption monitoring and has restrictions in place to prevent Resident A from taking food. Therefore, staff members did not take reasonable precautions to ensure Resident B's medications were not taken by Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/15/2025, I conducted an exit conference with licensee designee Felicia Evans. I informed Felicia Evans of my findings and allowed her an opportunity to ask questions and make comments. On 7/22/2025, 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 8/25/2025

Ondrea Johnson
Licensing Consultant

Approved By:

Dawn Timm 08/27/2025

Dawn N. Timm
Area Manager