GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 3, 2025

Frida Boyd
Suji Home LLC
PO Box 20006
Kalamazoo, MI 49019

RE: License #: AS410419083
Investigation #: 2026A0583005
Suji Home 9

Dear Ms. Boyd:

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 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 (616) 356-0100.

Sincerely,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410419083
Investigation #:	2026A0583005
Complaint Receipt Date:	10/24/2025
Investigation Initiation Date:	10/24/2025
Report Due Date:	11/23/2025
Licensee Name:	Suji Home LLC
LicenseeAddress:	2683 Green Oak Lane Kalamazoo, MI 49004
Licensee Telephone #:	(269) 207-5965
Administrator:	Frida Boyd
Licensee Designee:	Frida Boyd
Name of Facility:	Suji Home 9
Facility Address:	6246 Ivanrest Byron Center, MI 49315
Facility Telephone #:	(616) 805-5181
Original Issuance Date:	03/01/2025
License Status:	REGULAR
Effective Date:	09/01/2025
Expiration Date:	08/31/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
Facility staff failed to administer residents' medications.	Yes
Facility staff failed to contact an appropriate medical provider after residents did not receive their medications.	Yes

III. METHODOLOGY

10/24/2025	Special Investigation Intake 2026A0583005
10/24/2025	APS Referral
10/24/2025	Special Investigation Initiated - Telephone Licensee designee Frida Boyd
10/27/2025	Inspection Completed On-site
11/03/2025	Exit Conference Licensee Designee Frida Boyd

ALLEGATION: Facility staff failed to administer residents' medications.

INVESTIGATION: On 10/24/2025 I received and reviewed the facility's September 2025 Medication Administration Records via email from licensee designee Frida Boyd. I observed that on 09/04/2025 Resident A did not receive her prescribed VITAFUSION 50+ MULTI from staff Donna Johnson because "out of this, family has it on order will be delivered". I observed that on 09/08/2025 Resident B did not receive her Probiotic CAP from staff Alyson Daley because "don't have". I observed that on 09/24/2025 Resident B did not receive her prescribed BIOFREEZE GEL-4% PUMP 237ML from staff Donna Johnson because the "medication was not delivered". I observed that on 09/02/2025 Resident C did not receive her prescribed CLOZAPINE TAB 100MG from staff Alyson Daley because "don't have the medication". I observed that on 09/25/2025 Resident C did not receive her prescribed OYSTER SHELL TAB 500MG and ASPIRIN LOW TAB 81MG EC because "medication out , pharmacy is on way to deliver".

These documents were received as Corrective Action Plan (CAP) verification in reference to two licensing violations from Renewal Inspection 08/18/2025. On 08/18/2025 the facility was found to be violation of R 400.14312 (1) and R 400.14312 (4) (f) because residents were not receiving their prescribed medications and staff failed to report the medication errors to an appropriate health care provider. A CAP was received and approved on 08/21/2025.

On 10/24/2025 I interviewed licensee designee Frida Boyd via telephone. Ms. Boyd stated that she was unaware of residents not receiving their prescribed medications. She stated that she regularly audits residents' Medication Administration Records (MARs) and did not observe any indication that residents were not receiving their prescribed medications.

On 10/24/2025 I completed an online Adult Protective Services complaint.

On 10/24/2025 I interviewed staff Alyson Daley via telephone. She stated that on 09/02/2025 she could not locate Resident C's CLOZAPINE TAB 100MG in the medication cart. She stated that she later found the CLOZAPINE TAB 100MG on 09/03/2025. She stated that Resident A did not receive the 09/02/2025 dose of CLOZAPINE TAB 100MG. She stated that on 09/08/2025 she doesn't remember if Resident B received her Probiotic CAP. She acknowledged that she never contacted a medical provider to report the medication errors.

On 10/24/2025 I interviewed staff Donna Johnson via telephone. She stated that on 09/25/2025 Resident C did not receive her prescribed OYSTER SHELL TAB 500MG and ASPIRIN LOW TAB 81MG EC because the facility was out of the medications. She stated that she left a message at the prescribing physician's office but "never heard back" from the office. She stated that on 09/24/2025 Resident B did not receive her prescribed BIOFREEZE GEL-4% PUMP 237ML because the facility was out of the medication. She acknowledged that she did not contact an appropriate medical provider to alert them of the medication error. She stated that 09/04/2025 Resident A did not receive her prescribed VITAFUSION 50+ MULTI because the facility was out of the medication. She stated that she did not contact an appropriate medical provider to alert them of the medication error.

On 10/27/2025 I completed an unscheduled onsite investigation at the facility. I observed Resident A's October 2025 MAR indicates that the facility administered all medications as prescribed. I observed that the facility had all of Resident A's prescribed medications in stock.

On 11/03/2025 I completed an exit conference with licensee designee Frida Boyd via telephone. Ms. Boyd stated that she did not dispute the findings and would submit a Corrective Action Plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the

	requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	I observed that on 09/04/2025 Resident A did not receive her prescribed VITAFUSION 50+ MULTI. I observed that on 09/08/2025 Resident B did not receive her Probiotic CAP. I observed that on 09/24/2025 Resident B did not receive her prescribed BIOFREEZE GEL-4% PUMP 237ML. I observed that on 09/02/2025 Resident C did not receive her prescribed CLOZAPINE TAB 100MG. I observed that on 09/25/2025 Resident C did not receive her prescribed OYSTER SHELL TAB 500MG and ASPIRIN LOW TAB 81MG EC. Staff Alyson Daley stated that Resident A did not receive the 09/02/2025 dose of CLOZAPINE TAB 100MG. She stated that on 09/08/2025 she doesn't "remember" if Resident B received her Probiotic CAP. Staff Donna Johnson stated that on 09/25/2025 Resident C did not receive her prescribed OYSTER SHELL TAB 500MG and ASPIRIN LOW TAB 81MG EC because the facility was out of the medications. She stated that on 09/24/2025 Resident B did not receive her prescribed BIOFREEZE GEL-4% PUMP 237ML because the facility was out of the medication. She stated that 09/04/2025 Resident A did not receive her prescribed VITAFUSION 50+ MULTI because the facility was out of the medication. A preponderance of evidence was discovered during the Special Investigation. Staff fail to administer residents' medications as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED** **Repeat Violation from 08/18/2025 Renewal Inspection**

ALLEGATION: Facility staff failed to contact an appropriate medical provider after staff failed to administer residents' medications.

INVESTIGATION: On 10/24/2025 I interviewed staff Alyson Daley via telephone. She stated that on 09/02/2025 she could not locate Resident C's CLOZAPINE TAB 100MG in the medication cart. She stated that she later found the CLOZAPINE TAB 100MG on 09/03/2025. She stated that Resident A did not receive the 09/02/2025 dose of CLOZAPINE TAB 100MG. She stated that on 09/08/2025 she doesn't

“remember” if Resident B received her Probiotic CAP. She stated that she never contacted a medical provider to report the medication errors.

On 10/24/2025 I interviewed staff Donna Johnson via telephone. She stated that on 09/25/2025 Resident C did not receive her prescribed OYSTER SHELL TAB 500MG and ASPIRIN LOW TAB 81MG EC because the facility was out of the medications. She stated that she left a message at the prescribing physician’s office but “never heard back” from the office. She stated that on 09/24/2025 Resident B did not receive her prescribed BIOFREEZE GEL-4% PUMP 237ML because the facility was out of the medication. She acknowledged that she did not contact an appropriate medical provider to alert them of the medication error. She stated that 09/04/2025 Resident A did not receive her prescribed VITAFUSION 50+ MULTI because the facility was out of the medication. She acknowledged that she did not contact an appropriate medical provider to alert them of the medication error.

On 11/03/2025 I completed an exit conference with licensee designee Frida Boyd via telephone. Ms. Boyd stated that she did not dispute the findings and would submit a Corrective Action Plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	Staff Alyson Daley stated that on 09/02/2025 she could not locate Resident C’s CLOZAPINE TAB 100MG in the medication cart. She stated that Resident A did not receive the 09/02/2025 dose of CLOZAPINE TAB 100MG. She stated that on 09/08/2025 she doesn’t “remember” if Resident B received her Probiotic CAP. She acknowledged that she never contacted a medical provider to report the medication errors. Staff Donna Johnson stated that on 09/25/2025 Resident C did not receive her prescribed OYSTER SHELL TAB 500MG and ASPIRIN LOW TAB 81MG EC because the facility was out of the medications. She stated that she left a message at the prescribing physician’s office but “never heard back” from the office. She stated that on 09/24/2025 Resident B did not receive her prescribed BIOFREEZE GEL-4% PUMP 237ML because the facility was out of the medication. She

	acknowledged that she did not contact an appropriate medical provider to alert them of the medication error. She stated that 09/04/2025 Resident A did not receive her prescribed VITAFUSION 50+ MULTI because the facility was out of the medication. She acknowledged that she did not contact an appropriate medical provider to alert them of the medication error. A preponderance of evidence was discovered during the Special Investigation. Staff failed to contact an appropriate medical provider after medication errors occurred on 09/02/2025, 09/04/2025, 09/08/2025, 09/24/2025, and 09/25/2025.
CONCLUSION:	**VIOLATION ESTABLISHED** **Repeat Violation from 08/18/2025 Renewal Inspection**

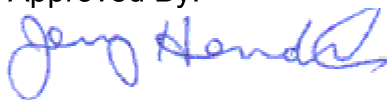
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license.

11/03/2025

Toya Zylstra Date
Licensing Consultant

Approved By:



11/03/2025

Jerry Hendrick Date
Area Manager