GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 3, 2026

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

RE: License #: AS390011445
Investigation #: 2026A1024040
Oak Creek Home

Dear Ms. Evans:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the 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
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390011445
Investigation #:	2026A1024040
Complaint Receipt Date:	06/22/2026
Investigation Initiation Date:	06/22/2026
Report Due Date:	08/21/2026
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?
Residents were left without staff supervision at a community event due to direct care staff member Abdulsamad Sulaiman falling asleep in the facility vehicle.	Yes
Additional findings:	Yes

III. METHODOLOGY

06/22/2026	Special Investigation Intake 2026A1024040
06/22/2026	Special Investigation Initiated – Letter email correspondence with Recipient Rights Officer (RRO) Suzie Suchyta
06/23/2026	APS Referral not warranted
06/23/2026	Contact - Document Received-AFC Licensing Division Accident/Incident Report
06/23/2026	Contact - Document Received Resident E's Behavior Treatment Plan (BTP)
06/25/2026	Contact - Telephone call made with direct care staff member Karmya Coleman
06/25/2026	Contact - Document Received-Abdulsamad Sulaiman's *Termination Letter*
06/26/2026	Contact - Telephone call made with Relative E1
06/26/2026	Inspection Completed On-site with direct care staff members Latroye Wheaton, and James Gainey
07/09/2026	Contact - Document Received-Abdulsamad Salaiman's Trainings
07/21/2026	Contact - Document Received-Residents A, D, E and F's *Assessment Plan for AFC Residents*
07/21/2026	Exit Conference with licensee designee Felicia Evans and Sarah Gue and Fiorella Spalvieri who are administrative staff members
07/22/2026	Inspection Completed-BCAL Sub. Non-Compliance

ALLEGATION: Residents were left without staff supervision at a community event due to direct care staff member Abdulsamad Sulaiman falling asleep in the facility vehicle.

INVESTIGATION:

On 6/22/2026, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged that residents were left without direct care staff supervision at a community event after direct care staff member Abdulsamad Sulaiman fell asleep in the facility vehicle.

On 6/22/2026, I received email correspondence from Recipient Rights Officer (RRO) Suzie Suchyta which stated that she is also investigating this allegation and will be substantiating this allegation for neglect as direct care staff Abdulsamad Sulaiman went to the parking lot to sleep in the facility vehicle while residents attended a community event at Portage Parks and Recreation. Suzie Suchyta stated all four residents were without direct care staff supervision while at this event.

On 6/23/2026, I reviewed the facility's *AFC Licensing Division-Incident/Accident Report* (report) dated 4/9/2026 written by direct care staff member James Gainey which documented that Relative E1 was in attendance with Resident E during the Kingpins Drumline performance and reported that direct care staff member Abdulsamad Sulaiman fell asleep leaving Resident A, Resident D, Resident E, and Resident F without direct care staff supervision as required for these residents. The report documented that Relative E1 stated she observed Abdulsamad Sulaiman exit the building leaving the residents behind and after the performance ended, Relative E1 gathered the remaining residents to search for Abdulsamad Sulaiman. The report documented that she discovered him in the facility van asleep in the parking lot at which time she knocked on the window several times to wake him.

I also reviewed Resident E's *Behavior Treatment Plan* (BTP) dated 2/3/2025 which documented that Resident B demonstrates significant attention seeking behaviors and has a history of physically acting out and threatening/gesturing physical harm which also includes self-injurious behaviors and elopement. Resident E has boundary issues which include inappropriate touching of the derrieres and breast of females. The BTP documents that Resident E enjoys accessing the community, however he can be easily distracted by or curious with what he sees and may depart from direct care staff or caregivers. He is generally able to be redirected and prefers the close presence of staff. The BTP documented that staff must continue to use proactive techniques to help support Resident E in the facility and community as Resident E requires staffing to be available at all times due to physical aggression and other target behaviors that could result in potential risk to others and himself. The BTP documented that staff must monitor for any environmental variables that may impact Resident E's behavior and to make adjustments or modifications as necessary on a daily basis. The BTP documents

that staff need to ensure that Resident E is aware of staff's whereabouts throughout the day, especially in the community as Resident E can be quick to leave a direct care staff member's or caregiver's side. The BTP documents that due to the safety concerns of Resident E and others, Resident E will always require staff to be close by and available while in the community.

On 6/25/2026, I interviewed direct care staff member Karmya Coleman. Karmya Coleman reported that she was working at the facility on 4/9/2026 when direct care staff member Abdulsamad Sulaiman transported four residents (Residents A, D, E and F) to a community drumming event sponsored by Portage Parks and Recreation which is a program residents have attended multiple times in the past. According to Karmya Coleman, Resident A, Resident E, and Resident F require continuous direct care staff supervision while in the community. Karmya Coleman stated that when the residents returned from the outing, she was informed by James Gainey, who is the house manager, that Abdulsamad Sulaiman had left them unsupervised because he fell asleep in the facility van, despite being required to remain nearby for the duration of the event.

Karmya Coleman further stated that Relative E1, who was also attending the event, assisted residents in searching for Abdulsamad Sulaiman when he could not be located inside the event building during or after the drumming performance. Relative E1 ultimately found Abdulsamad Sulaiman asleep in the facility van parked in the lot. Karmya Coleman added that she was not surprised to learn Abdulsamad Sulaiman had fallen asleep during a community outing, as she has observed him sleeping while on duty at the facility on several occasions. She explained that she did not previously report these incidents because she ensured residents were not neglected by completing any additional tasks necessary while working alongside Abdulsamad Sulaiman.

On 6/25/2026, I reviewed Abdulsamad Sulaiman's *Termination Letter* dated 4/17/2026. This *Termination Letter* read as follows:

"Your employment has been terminated with CLO effective today, April 17, 2026. You were suspended without pay pending internal investigation on April 10 following a complaint by a parent alleging that you left the Oakcreek consumers unsupervised during an outing and were found sleeping in the CLO van while the consumers attended the outing. CLO's internal investigation determined that you violated several policies and the rights of consumers on April 9, 2026, which is unacceptable for further employment."

On 6/26/2026, I conducted an interview with Relative E1 who stated that she attended the community event on 4/9/2026, and has attended past sessions, because she enjoys watching Resident E, who is her son, beat on the drums with other community members. Relative E1 stated residents seem to really enjoy this type of community outing. Relative E1 stated on 4/9/2026 while she was watching the performance, she noticed direct care staff member Abdulsamad Sulaiman asleep in a chair during the drumming performance and then he eventually left the building leaving Residents A, D, E, and F unattended without staff supervision. Relative E1 stated that fortunately all

four residents stayed engaged at the event, however she was concerned about how she would manage Resident E because Resident E has a history of acting out in public. Relative E1 stated she did not feel comfortable that Residents A, D, E and F were left without direct care staff supervision. Relative E1 stated after the performance ended, she noticed that Abdulsamad Sulaiman was still not in sight of the residents. Relative E1 stated she took Residents A, D, E, and F with her to search for Abdulsamad Sulaiman inside the building and eventually outside the building where he was found reclined back in the driver seat of the vehicle asleep. Relative E1 stated that she knocked on the vehicle door multiple times, however he continued to sleep. Relative E1 stated she went to the passenger side of the vehicle where she was able to open the door and wake Abdulsamad Sulaiman up. Realtive E1 stated when he awoke, he simply stated that he was tired. Relative E1 stated that she was very concerned and displeased with the lack of supervision provided to residents that require supervision in the community and notified the house manager about this immediately after the event.

On 6/26/2026, I conducted an onsite investigation at the facility with direct care staff members Latroye Wheaton and James Gainey. Latroye Wheaton stated that she regularly works at the facility and was made aware that direct care staff member Abdulsamad Sulaiman “was caught sleeping” while at a community event with Residents A, D, E, and F when he was supposed to be supervision them. Latroye Wheaton stated Resident D does not require direct care supervision while in the community but needed transportation back to the facility. Latroye Wheaton stated that she has never worked with Abdulsamad Sulaiman therefore is unsure if he has ever left residents unattended to in the past.

James Gainey stated that on 4/9/2026, he received a phone call from Relative E1 who stated that direct care staff member Abdulsamad Sulaiman fell asleep while he was out with the residents during a drumming community performance and the residents could not locate him after the performance ended. James Gainey stated Relative E1 told him she assisted the residents in locating Abdulsamad Sulaiman and found him sleeping in the facility van. James Gainey stated that after an administrative internal investigation, Abdulsamad Sulaiman was terminated and has not had any contact with the residents since this incident. James Gainey stated that Abdulsamad Sulaiman did not follow company protocol and should have been within eyesight of Resident A, Resident E and Resident F. James Gainey further stated that Abdulsamad Sulaiman should never have left the performance event while being responsible to provide supervision to Residents A, E and F.

On 7/9/2026, I reviewed direct care staff member Abdulsamad Sulaiman’s training records and noted he completed all required direct care staff trainings.

On 7/21/2026, I reviewed Resident A’s *Assessment Plan for AFC Residents* dated 5/5/2025 and 5/1/2026 which documented that Resident A participates in social activities with prompts and redirection from staff. Resident A does not move independently in the community and requires staff supervision in the community.

I reviewed Resident D's *Assessment Plan for AFC Residents* dated 1/8/2026 and 5/7/2026 which documented that Resident D moves independently in the community however has issues with going into strangers' vehicles and homes.

I reviewed Residents E's *Assessment Plan for AFC Residents* dated 5/5/2025 and 5/7/2026 which documented that due to elopement risk when in the community staff will be close by, and available at all times.

I reviewed Resident F's *Assessment Plan for AFC Residents* dated 5/5/2025 and 5/7/2026 which documented that Resident F participates in social activities with prompts and redirection from staff. Resident F does not move independently in the community and requires staff supervision 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 of time.

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, Latroye Wheaton, James Gainey, Relative E1, review of staff's *Termination Letter*, facility's *AFC Licensing Division Incident/Accident Report,* Residents A, D, E, and F's *Assessment Plan for AFC Residents*, and review of Resident E's *Behavior Treatment Plan* there is evidence to support that Residents A, E, and F were left without staff supervision at a community event due to direct care staff member Abdulsamad Sulaiman falling asleep in the facility vehicle. According to direct care staff member James Gainey on 4/9/2026, he was contacted by Relative E1, who stated that she observed direct care staff member Abdulsamad Sulaiman fall asleep while he was out with Residents A, D, E, and F during a drumming community outing and left these residents without staff supervision. Relative E1 also stated while watching a community performance, attended by Residents A, D, E and F and Abdulsamad Sulaiman, she observed direct care staff member Abdulsamad Sulaiman fall asleep during the drumming performance and then observed him eventually exit the building leaving Residents A, D, E and F unattended without staff supervision. During this incident, Relative E1 further stated that she assisted the residents in searching for Abdulsamad Sulaiman after the drumming performance ended and eventually found Abdulsamad Sulaiman asleep again in the facility vehicle where she had to wake him which made her uncomfortable and very concerned for the resident's protection and safety. According to James Gainey, Karmya Coleman, and Latroye Wheaton, Abdulsamad Sulaiman did not provide adequate supervision of the residents when he took them out in the community and was found sleeping as all the residents, except for Resident D, require continuous staff supervision when out in the community. This is consistent with each of these residents' assessment plans which documents that staff supervision is required when Residents A, E, and F are in the community. In addition, according to Resident E's BTP, Resident E has target behaviors that include elopement which requires staff members to not only be present but close by and available at all times therefore this enhanced supervision did not occur due to Abdulsamad Sulaiman falling asleep in the facility vehicle while in the parking lot away from the residents.

	Therefore, the licensee did not provide adequate supervision as required to Residents A, E, and F putting the protection and safety of these residents at risk.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SIR#2026A1024010 DATED 1/6/2026 AND CAP DATED 1/6/2026]**

ADDITIONAL FINDING:

INVESTIGATION:

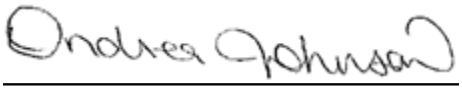
I reviewed Resident E's *Assessment Plan for AFC Residents* dated 5/5/2025 and 5/7/2026 which was not signed by Resident E or Resident E's designated representative.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	I reviewed Resident E's *Assessment Plan for AFC Residents* dated 5/5/2025 and 5/7/2026 which was not signed by Resident E or Resident E's designated representative.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/21/2026, 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.

IV. RECOMMENDATION

Due to the severity of the violations, revocation against your license is recommended.



7/23/2026

Ondrea Johnson
Licensing Consultant

Date

Approved By:

08/03/2026

Dawn N. Timm
Area Manager

Date