GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 28, 2025

Elizabeth Gaye
1464 Millbrook St SE
Grand Rapids, MI 49508

RE: License #: AF410415717
Investigation #: 2025A0467048
Cole's AFC Family Home Services

Dear Mrs. Gaye:

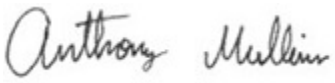
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AF410415717 |
| | |
| **Investigation #:** | 2025A0467048 |
| | |
| **Complaint Receipt Date:** | 07/16/2025 |
| | |
| **Investigation Initiation Date:** | 07/17/2025 |
| | |
| **Report Due Date:** | 09/14/2025 |
| | |
| **Licensee Name:** | Elizabeth Gaye |
| | |
| **Licensee Address:** | 1464 Millbrook St SE<br>Grand Rapids, MI 49508 |
| | |
| **Licensee Telephone #:** | 616-349-0322 |
| | |
| **Administrator:** | Elizabeth Gaye |
| | |
| **Licensee Designee:** | Elizabeth Gaye & George Cole |
| | |
| **Name of Facility:** | Cole's AFC Family Home Services |
| | |
| **Facility Address:** | 1464 Millbrook St. SE<br>Grand Rapids, MI 49508 |
| | |
| **Facility Telephone #:** | (616) 349-0322 |
| | |
| **Original Issuance Date:** | 05/09/2023 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 11/09/2023 |
| | |
| **Expiration Date:** | 11/08/2025 |
| | |
| **Capacity:** | 5 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Licensees Elizabeth Gaye and George Cole are allowing Resident A to be assaulted by Resident B. | No |
| Resident A's Medication Administration Record is not being initialed after receiving his prescribed medications. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 07/16/2025 | Special Investigation Intake<br>2025A0467048 |
| 07/17/2025 | APS Referral<br>Kent County APS worker, Brett Kortman is assigned the case |
| 07/17/2025 | Special Investigation Initiated - On Site |
| 07/23/2025 | Contact – document received from Recipient Rights Officer, Michael Kuik. |
| 08/28/2025 | Exit conference with co-owner, Elizabeth Gaye. |

**ALLEGATION: Licensees Elizabeth Gaye and George Cole are allowing Resident A to be assaulted by Resident B**.

**INVESTIGATION:** On 7/16/25, I received a LARA-BCHS online complaint stating that Resident A has been physically attacked by Resident B without intervention from the licensees, Elizabeth Gaye and George Cole. Resident B has reportedly spit on Resident A and assaulted him. It was also alleged that staff have recorded residents mocking other residents on their cell phone and being verbally and physically aggressive.

On 7/17/25, I made an unannounced onsite investigation at the facility. Upon arrival, licensee, Elizabeth Gaye answered the door and allowed entry into the home. Mrs. Gaye stated that Resident A and his mother are trying to get her in trouble. Mrs. Gaye shared that she and her husband did not receive all pertinent information about Resident A until he moved into the home. Mrs. Gaye stated that she later found out that Resident A has never had a stable home as he has been kicked out of all his previous Adult Foster Care homes. Mrs. Gaye stated that she and her family do a "great job" of caring for Resident A and make sure that all his needs are met.

Regarding Resident A being assaulted by Resident B, Mrs. Gaye confirmed that this occurs due to Resident A antagonizing Resident B and continuing to invade his

personal space. Mrs. Gaye also stated that Resident A calls Resident B names, which he doesn't like. Mrs. Gaye stated that she and her husband have informed Resident A to keep a distance between himself and Resident B, but he refuses, which leads to further altercations between the two. Mrs. Gaye stated that Resident A previously shared a room with Resident B. Due to the ongoing issues between the two residents, Mrs. Gaye and her husband put him in a room with a different resident, who he also complained about.

Mrs. Gaye stated that she and her husband served Resident A a 30-Day discharge notice in April and his case worker and mother have yet to find an alternative placement for him. Mrs. Gaye was adamant that she and her husband do not allow Resident B to assault Resident A. She also added that Resident B has assaulted other residents in the past and this behavior is being addressed through his behavior plan. Mrs. Gaye denied any knowledge of staff recording residents on their phone or making fun of other residents.

After speaking to Mrs. Gaye, Resident A arrived home from Hope Network's Day Program and agreed to be interviewed. Resident A stated that he has lived at the home less than a year. Resident A confirmed that during his time in the home, Resident B has assaulted him, including spitting, hitting and throwing items at him. Resident A stated, "I was just minding my business" when Resident B assaulted him. Resident A acknowledged that he and Resident B were previously friendly and joked around by calling each other names. However, Resident A was not aware until recently that the name calling upsets Resident B, which he has since stopped. Resident A stated that he has been told to keep away from Resident B. Resident A stated that he requested a new roommate because he didn't want to defend himself against Resident B as he knew he would hurt him. Resident A's request to switch roommates was made, and he is happy to no longer share a room with Resident B. Despite this, Resident A confirmed that he is looking for an alternative placement to avoid being around Resident B. Resident A denied any knowledge of AFC staff members recording him or other residents making fun of people.

Prior to concluding the onsite visit, I spoke to AFC co-licensee, George Cole. Mr. Cole stated that Resident A doesn't get along with any of the residents in the home and complains about everyone. Mr. Cole confirmed that Resident B has assaulted and spit on Resident A in the past. This is reportedly a known behavior for Resident B which is addressed through his behavior plan. Mr. Cole stated that Resident B was aggressive with Resident A due to Resident A invading his personal space, despite being told not to on numerous occasions. Mr. Cole also stated that Resident A and Resident B like to joke with each other and call each other rude names, despite the issues they've had. Mr. Cole denied allowing Resident B to assault Resident A and was adamant that the altercations were a result of Resident A not doing what he and his wife asked of him. Mr. Cole stated that Resident A was served with a 30-Day discharge notice at the end of March/early April and his team has yet to find an alternative placement.

On 08/28/2025, I conducted an exit conference with co-licensee Elizabeth Gaye. She was informed of the investigative findings and denied having any questions.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.1412** | **Resident behavior management; prohibitions.** |
| | **(1) A licensee shall not mistreat or permit the mistreatment of a resident by a responsible person or other occupants of the home. Mistreatment includes any intentional action or mission which exposes a resident to a serious risk of physical or emotional harm.** |
| **ANALYSIS:** | Licensees, Elizabeth Gaye and George Cole have attempted to alleviate Resident A's concern with Resident B by changing his room and providing him with instructions to keep his distance from Resident B. Therefore, there is not a preponderance of evidence to support this applicable rule violation. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ALLEGATION: Resident A's Medication Administration Record is not being initialed after receiving his prescribed medications.**

**INVESTIGATION:** On 7/16/25, I received a complaint stating that Resident A's Medication Administration Record (MAR) is not being initialed after receiving his prescribed medications. On 7/17/25, I made an unannounced onsite investigation at the facility. Upon arrival, licensee Elizabeth Gaye answered the door and allowed entry into the home. Mrs. Gaye confirmed that Resident A and all other residents receive their medications as prescribed. However, Mrs. Gaye stated that Resident A's mother tries to intervene with Resident A taking his medications as prescribed as she wants him to take them at different times, despite what his prescription states. Mrs. Gaye stated that approximately three days ago, Resident A's mother called and accused her of not giving him his medications in a timely manner. Mrs. Gaye adamantly denied this and remained adamant that Resident A receives his medications as prescribed. It should be noted that Resident A was also interviewed regarding this and he confirmed that he receives his medications daily as prescribed.

Prior to concluding my onsite investigation, I asked Mrs. Gaye to review Resident A's MAR. While doing so, it was determined that Resident A's MARs were only initialed through 7/3/25. Therefore, there were more than 14 days' worth of medications that were not initialed after passing them. The medications include the following: Quetiapine Tab 25MG, Venlafaxine Cap 150MG, Vilazodone Tab 40MG, Vitamin D2, Vitamin D3, Buspirone Tab 30MG and other medications. Mrs. Gaye acknowledged that sometimes, she waits until the end of the month to initial

residents' MARS. I instructed Mrs. Gaye to discontinue this practice and to initial the MARs immediately after passing medication. Mrs. Gaye was receptive to this.

On 08/28/2025, I conducted an exit conference with Co-owner, Mrs. Gaye. She was informed of the investigative findings and agreed to complete a corrective action plan. Mrs. Gaye informed me that she will retake her medication administration class and have it completed by 9/30/25. This will be added to her corrective action plan.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.1418** | **Resident medications.** |
| | **(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions:**<br>**(a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.**<br>**(b) Not adjust or modify a resident's prescription medication without agreement and instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record in writing any adjustments or modifications of a resident's prescription medication.** |
| **ANALYSIS:** | Resident A's MAR was not maintained appropriately for the month of July. Co-licensee Mrs. Gaye admitted to waiting until the end of the month to complete Resident A's MAR. Therefore, there is a preponderance of evidence to support this applicable rule violation. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

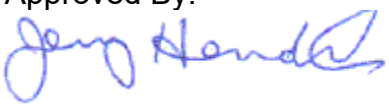
## IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no changes to the current license status.

Anthony Mullins 08/28/2025

Anthony Mullins Date
Licensing Consultant

Approved By:



08/28/2025

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Jerry Hendrick Date
Area Manager