GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 30, 2025

Christopher Wadley
1629 North Carolina St
Saginaw, MI 48602

RE: License #:	AF730398732
Investigation #:	2025A0123055
	Promise Land

Dear Christopher Wadley:

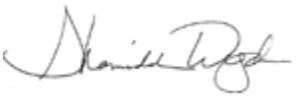
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing, and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action 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 (517) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF730398732
Investigation #:	2025A0123055
Complaint Receipt Date:	09/10/2025
Investigation Initiation Date:	09/11/2025
Report Due Date:	11/09/2025
Licensee Name:	Christopher Wadley
LicenseeAddress:	1629 North Carolina St Saginaw, MI 48602
Licensee Telephone #:	(989) 482-6575
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Promise Land
Facility Address:	1629 North Carolina St Saginaw, MI 48602
Facility Telephone #:	(989) 482-6575
Original Issuance Date:	07/09/2019
License Status:	REGULAR
Effective Date:	01/09/2024
Expiration Date:	01/08/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
The AFC home has not been able to manage Resident A's care. On 08/04/2025, Resident A had swelling in the face and hands. Resident A has experienced falls. Resident A was observed on one occasion with a heavily saturated brief due to not regularly being changed.	No
Additional Findings.	Yes

III. METHODOLOGY

09/10/2025	Special Investigation Intake 2025A0123055
09/10/2025	APS Referral Information received regarding APS referral.
09/11/2025	Special Investigation Initiated - Telephone I spoke with APS investigator Rebecca Robelin.
09/16/2025	Inspection Completed On-site I conducted an unannounced on-site.
09/16/2025	Contact - Telephone call made Follow-up call to APS investigator Rebecca Robelin.
09/16/2025	Contact - Telephone call received Phone call from licensee Chris Wadley.
10/03/2025	Contact - Telephone call made Interviewed Relative 1.
10/06/2025	Contact- Document Received Received text message from Relative 1.
10/09/2025	Contact - Telephone call made Left voicemail requesting return call from Resident A's case manager.
10/17/2025	Contact- Telephone call made Attempted call to Resident A's case manager. There was no answer, and the voicemail box full.

10/21/2025	Contact- Telephone call made Follow-up call with APS worker Rebecca Robelin.
10/21/2025	Inspection Completed On-Site I conducted a follow-up unannounced on-site at the facility.
10/24/2025	Contact- Telephone call made Attempted call to Resident A's case manager.
10/24/2025	Contact- Telephone call made I left a voicemail requesting a return call from SCCHMA manager Aereonna Pool.
10/24/2025	Contact- Telephone call received I received a voicemail from Saginaw County CMH manager Aereonna Pool.
10/24/2025	Contact- Document Sent I sent an email to Haley Hoyt requesting a Secretary of State search for Licensee Wadley.
10/24/2025	Contact- Document Received Received email response from Haley Hoyt.
10/27/2025	Contact- Telephone call made I left a voicemail requesting a return call from Saginaw County CMH manager Aereonna Pool.
10/28/2025	Contact- Telephone call received I received a phone call from case manager Monica Burton and manager Aereonna Pool.
10/29/2025	Exit Conference I spoke with licensee Christopher Wadley.
10/29/2025	Contact- Telephone call made I interviewed Resident A via phone.

ALLEGATION: **The AFC home has not been able to manage Resident A's care. On 08/04/2025, Resident A had swelling in the face and hands. Resident A has experienced falls. Resident A was observed on one occasion with a heavily saturated brief due to not regularly being changed.**

INVESTIGATION: On 09/10/2025, the Bureau of Community and Health Systems received a complaint stating the above allegations. In addition to the allegations noted above, the complaint also states that Resident A lives in an AFC home that is

for mostly independent adults who can come and go on their own. Resident A is unable to care for himself due to schizophrenia. Resident A has had more trouble walking lately and needs a wheelchair. Resident A probably needs to be living in assisted living due to increasing needs. The AFC home has not been able to manage Resident A's care. Resident A's health is declining, has swelling in the face and hands, and can hardly use his hands. Relative 1 provided Resident A with a wheelchair, but the home is not ensuring that Resident A uses the wheelchair, leading to falls. Licensee Christopher Wadley has said he needs to get Resident A a wheelchair which does not make sense. On one occasion, Resident A was heavily saturated with urine, due to Resident A's brief not being changed. The incident date is noted to be 08/04/2025.

On 09/11/2025, I spoke with adult protective services investigator Rebecca Robelin. Rebecca Robelin stated that Resident A is currently hospitalized and probably will not go back to the AFC home due to Resident A's care needs. Licensee Christopher Wadley reported not knowing where Resident A was. Resident A resided at the facility for about four or five years, and the plan was for Resident A to move to a new placement anyway. Resident A had a fall, and Relative 1 is going for guardianship of Resident A.

On 09/16/2025, I conducted an unannounced on-site at the facility. I interviewed staff Alexis Wadley. Staff Wadley stated that Relative 1 refused to let staff change Resident A's brief before taking Resident A out of the home. Resident A had just finished dinner and had been taking a nap. Resident A's balance was off, Resident A was incontinent, and staff had to constantly do brief checks. Resident A did have swelling. Resident A had multiple doctor visits, blood work was completed, and no cause for the swelling was found. Resident A did not want to use a wheelchair, and staff assisted Resident A with walking. Resident A is a community mental health client. Resident A receives an injection every three months and is not on any other medications. Staff Wadley stated that Relative 1 provided Resident A with a wheelchair, but the home is not wheelchair accessible. Resident A lived in the facility for about five and a half years. Resident A had a supply of briefs, wipes, and bathed daily. Relative 1 took Resident A to the hospital due to balance issues. Relative 1 would not communicate with Licensee Christopher Wadley, and the hospital would not provide Licensee Wadley with any information. On the same day Relative 1 came to pick up Resident A, Resident A went to get up from the dinner table and fell. Relative 1 did not believe what was explained, because of a scar Resident A had on their forehead. Staff Wadley stated that this was the only fall Resident A had.

During this on-site, I reviewed documentation from Resident A's file. Resident A's *AFC- Resident Information and Identification Record* notes Resident A moved into the facility on 07/17/2020. Resident A's *Assessment Plan for AFC Residents* is dated for 07/17/2020. The assessment plan notes that the only personal care assistance Resident A required was assistance with grooming.

On 09/16/2025, I conducted a follow-up call with APS investigator Rebecca Robelin. Rebecca Robelin stated that Resident A is still in the hospital. Resident A is medically stable but has not been released. Rebecca Robelin stated that she visited Resident A on Friday (09/12/2025). Resident A was sleepy and out of it during her visit.
On 09/16/2025, I received a phone call from licensee Christopher Wadley. Licensee Wadley stated that Relative 1 is making false claims. Resident A's health is declining. Licensee Wadley took Resident A for lab work which said there was nothing wrong with Resident A. Relative 1 said they would move Resident A to a new placement, then showed up with a wheelchair. The home is not wheelchair accessible. Resident A was sitting at the table, got up, and then had a fall. Relative 1 got upset when informed that Resident A was incontinent and had to wear briefs. Resident A is bathed daily. Relative 1 complained that Resident A's brief was wet, and Relative 1 refused to let staff change Resident A's brief before taking Resident A to the hospital. Licensee Wadley stated that they tried to explain to Relative 1 that Resident A had just eaten, so it was normal for Resident A to urinate after eating. Relative 1 complained that Resident A's brief was wet. Resident A only had one fall, the one at the dining room table. Licensee Wadley stated that they tried to get Resident A in physical therapy.

Licensee Wadley stated that Resident A had swelling in the hands and face throughout Resident A's stay in the home, and Resident A did not like using the wheelchair. Resident A has annual physician visits. He stated that he does not have paperwork from doctor's visits due to Resident A being their own guardian. He stated that two to three months ago he took Resident A to the hospital to get tested for a UTI due to balance issues. He stated that he did not know Relative 1 took Resident A to the hospital, and he did not find out until the hospital called him and told him Resident A was ready for discharge. He stated that Relative 1 took Resident A out of the facility on 08/30/2025.

On 10/03/2025, I interviewed Relative 1 via phone. Relative 1 stated that Resident A is still in the hospital. Resident A is there because Resident A cannot go back to Promise Land. Resident A needs a guardian, and the hospital is keeping Resident A until the court date. Relative 1 stated that Resident A's brief was soaking wet the day Relative 1 picked Resident A up from the home, and Resident A had a scar on their forehead as well. Relative 1 stated they were told that Resident A had a fall. No one called Relative 1 to inform Relative 1 of the fall. Resident A does not talk a lot. Resident A denied that anyone hit him. Resident A said he fell down in the kitchen. Staff Alexis Wadley did not say anything about a fall, only that she did not have Relative 1's phone number. Relative 1 stated that Licensee Wadley said that Resident A fell from a chair in the dining room. Relative 1 stated that the hospital staff noted Resident A had bruising on their side. Relative 1 stated they have photos of the scar on Resident A's face. Resident A has had no swelling since being in the hospital. Resident A's eyes used to be puffy, and hands would swell. Relative 1 reported being told by Licensee Wadley that Resident A has a physician at CMU Health. Relative 1 stated that Resident A is on medication for schizophrenia, but the hospital put Resident A on medication for high blood pressure, and heart medication.

Relative 1 stated that there is a court hearing on Monday (10/06/2025) for guardianship. Relative 1 reportedly explained to Licensee Wadley that Relative 1 would find placement for Resident A. Resident A's balance was off, so Relative 1 provided Resident A with a wheelchair. Resident A was not using the wheelchair. Resident A's mental and physical health is declining. Relative 1 is only aware of Resident A having one fall. When asked about the swelling, Relative 1 stated Resident A denied any physical abuse. Relative 1 observed Resident A in a saturated brief twice. Relative 1 stated Staff Alexis Wadley asked if Relative 1 wanted Staff Wadley to change Resident A's brief before they left the home and went to the hospital. Relative 1 reported feeling that Resident A had to be taken out of the home before something serious happened. The hospital did not really diagnose Resident A with anything. A CT scan was done on the head and the results were fine. Resident A was prescribed medications Resident A was prescribed in the past.

On 10/09/2025, and 10/17/2025, I made attempted calls to Resident A's Saginaw County Community Mental Health Authority case manager Monica Burton. I left a voicemail on 10/09/2025, requesting a return call. The subsequent call made on 10/17/2025 could not be completed as there was no answer, and the voicemail box was full.

On 10/06/2025, I received a text message from Relative 1 stating that the court granted guardianship of Resident A to Relative 1. On 10/17/2025, I made a follow-up call to Relative 1 to obtain an update on Resident A. Relative 1 stated that Resident A is temporarily placed at a nursing home in Saginaw, MI. Resident A will be placed in another adult foster care home after the nursing home stay.

On 10/21/2025, I conducted an un-announced follow-up on-site at the facility. I interviewed Resident B, Resident C, Resident D, and Resident E.

Resident B is Resident A's former roommate. Resident B reported never witnessing Resident A fall. Resident B observed Resident A in a wheelchair once. Resident A never complained about anything, and Resident A's clothing was always clean.

Resident C was interviewed. Resident C stated that Resident A was a nice person but had dementia. Staff took good care of Resident A. When asked if Resident C has observed any residents wearing wet briefs in the facility, Resident C said no, and that staff take good care of the residents. Resident C stated that staff do their laundry for them.

Resident D was interviewed. Resident D stated that Resident A did not do very well in the home. Resident A would get in the refrigerator and eat food belonging to others. Resident D stated that Resident A wore briefs and always smelled of urine, but staff did take care of Resident A. Staff would take Resident A to the bathroom and clean Resident A up. Resident D stated that this home was not suited for Resident A, and Resident A needed more care. Resident A was incontinent, and mentally out of it. Resident D reported never witnessing Resident A have any falls.

Resident E was interviewed. Resident E stated that Resident A was doing alright but would put his hands in food and drink out of syrup bottles. Staff took care of Resident A's hygiene. Resident A wore adult briefs. Resident E stated that staff would bathe Resident A once or twice daily. Resident E reported witnessing Resident A have a couple falls when Resident A's bedroom used to be upstairs. Staff moved Resident A to a first floor bedroom. Resident E did not witness Resident A have any falls just prior to Resident A moving out. Resident E stated that Resident A would not walk around in soaking wet briefs. Overall, staff did the best they could for Resident A.

On 10/28/2025, I received a call from Saginaw County CMH case manager Monica Burton and her manager Aeronna Pool. During this call, case manager Monica Burton stated the following:

Resident A had a primary care physician at CMU Health. She does not know the physician's name. Community mental health (CMH) only provided psychiatric services. If a psych appointment was missed, Licensee Wadley would reschedule it. Resident A only received injections from CMH. CSM Burton saw Resident A every two weeks. Resident A used to reside in an upstairs bedroom at the home. She never smelled any urine odor on Resident A, and Resident A never appeared to be unclean. There were a couple times she visited in the afternoon, where Resident A had not appeared to have been bathed yet, as Resident A's face hadn't been washed. Resident A would say he felt safe in the home. Relative 1 is now the legal guardian. CSM Burton stated that she observed a bruise on Resident A's head while Resident A was in the hospital. There was another bruise on Resident A's hip. There was something wrong with Resident A's hip while in the hospital, and Resident A has not been able to independently walk anymore. Resident A told CSM Burton that his hip hurt, and that he did not want to go back to the AFC home. The hospital only stated that Resident A was declining. Resident A's hospitalization was extended because of not wanting to go back to the AFC home, and because Relative 1 was seeking guardianship. Relative 1 was unaware of what day the fall occurred, but the bruise looked new. A week prior to Resident A going to the hospital, the bruise on Resident A's head was not there. There were no reported falls made to CSM Burton. All of the other residents in the home are mobile, except Resident A. Resident A moved to a downstairs bedroom earlier this year. CSM Burton stated that the facility needed more staff due to the level of care Resident A required. Resident A required assistance with toileting.

On 10/29/2025, I interviewed Resident A via phone. I asked Resident A about the care Resident A received while living at Promise Land. Resident A stated staff did not assist Resident A with dressing but did receive assistance with bathing daily. I asked Resident A if Resident A received assistance with toileting. Resident A said no. Resident A reported having about three falls. When asked if there were any injuries, Resident A said a scab on the head area. Resident A reported having swelling in the face and hands, but the swelling is "*alright now*." Resident A was asked why Resident A did not want to go back to the AFC Home, and Resident A stated, "I got my

reasons." I asked Resident A if Resident A felt safe there, Resident A said "*no*." I asked Resident A if Resident A remembers what made them feel unsafe, Resident A said "*no*." Resident A reported remembering the day they went to the hospital but does not remember why. Resident A denied being left in a wet brief. Resident A reported doing better now in the nursing home.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until a resident assessment plan is made and it is determined that the resident is suitable pursuant to the following provisions: **(a) The amount of personal care, supervision, and protection required by the resident is available in the home.**
ANALYSIS:	On 09/16/2025, I conducted an unannounced on-site at the facility. I interviewed staff Alexis Wadley. Staff Wadley denied the allegations. She stated that Relative 1 refused to allow her to change Resident A's brief the day Relative 1 picked Resident A up from the facility. Resident A required constant brief checks. She stated that Resident A only had one fall, and Resident A had been to multiple doctor visits, and no cause for Resident A's swelling was found. On 09/16/2025, I interviewed licensee Christopher Wadley via phone. Licensee Wadley denied the allegations. Licensee Wadley stated that Resident A had swelling in the hands and face throughout the time Resident A lived in the home, and that Resident A had annual physician visits. He stated that he had no documentation from the doctor's appointments due to Resident A being their own guardian. Resident A was incontinent and received daily baths. Relative 1 refused a brief change the day Relative 1 picked up Resident A. A copy of Resident A's *Assessment Plan for AFC Residents* dated 07/17/2020 was reviewed during the course of the investigation. It noted that Resident A only required assistance with grooming. On 10/03/2025, I interviewed Relative 1 via phone. Relative 1 stated that Resident A had a soaking wet brief twice, a forehead scar, and reportedly had a fall. Relative 1 stated that

	Resident A's swelling subsided while in the hospital, and that Resident A cannot go back to the AFC home. Relative 1 reported that Resident A's health was declining, and that Relative 1 told Licensee Wadley they'd find placement for Resident A. On 10/21/2025, I conducted an unannounced follow-up on-site. I interviewed Resident B, Resident C, Resident D, and Resident E. Resident B stated that Resident A's clothing was always clean and never saw Resident A fall. Resident C stated that staff took good care of Resident A. Resident C denied seeing any residents wearing wet briefs. Resident D stated that staff would clean up Resident A and take Resident A to the bathroom. Resident D denied seeing Resident A have any falls. Resident E stated staff would bathe Resident A once or twice a day and denied seeing Resident A have any falls just prior to moving out of the facility. On 10/28/2025, I spoke with Resident A's case manager Monica Burton. She never smelled any urine odor on Resident A, and Resident A never appeared to be unclean. There were no reported falls received by the case manager. On 10/29/2025, I interviewed Resident A. Resident A reported having about three falls, and a scab on his forehead from one fall. Resident A reported having swelling that is better now. Resident A reported feeling unsafe at the AFC home but did not indicate reasons why. Resident A denied being left in a wet brief. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 10/03/2025, I interviewed Relative 1 via phone. During this interview, Relative 1 stated that licensee Christopher Wadley used to live in the facility. Relative 1 stated that Licensee Wadley currently resides with his wife in another home. Relative 1 gave the name of a street in Saginaw Charter Township that she states Licensee Wadley lives on.

On 10/21/2025, I made a follow-up phone call to adult protective services worker Rebecca Robelin. During this call, Rebecca Robelin conducted a Bridges database address search for licensee Christopher Wadley. Rebecca Robelin sent a follow-up email with the address she found for Licensee Wadley that did not match the AFC

family home address. The address was for a home in Saginaw Charter Township, matching the street name Relative 1 provided.

On 10/21/2025, I conducted an unannounced on-site follow-up at the facility. I interviewed all four residents and staff Alexis Wadley. I conducted the following interviews during this on-site:

Resident B is Resident A's former roommate. Resident B was interviewed in his bedroom. Resident B stated that he's lived in the facility for about five years. I asked Resident B who resides in the home. Resident B stated that he, licensee Christopher Wadley, Resident C, Resident D, and Resident E are living in the home. Resident B stated that Licensee Wadley is the owner. When asked how often Licensee Wadley is seen in the home, Resident B stated that Licensee Wadley is at the home about once a week. When asked if Licensee Wadley lives anywhere else, Resident B said "*Yeah*." When asked where else, Resident B stated, "*I don't know*."

Resident C was interviewed in his bedroom. Resident C reported having lived in the home for about six to eight years. I asked Resident C who all lives in the home. Resident C named Resident B, Resident D, and Resident E. When asked if Licensee Wadley lives in the home, Resident C said, "*No. He has his own home somewhere.*"

Resident D was interviewed in his bedroom. Resident D reported residing in the home for about five years. I asked Resident D who all resides in the home. Resident D stated that he and three other residents reside in the home. When asked if anyone else lived in the home, Resident D said "*No*." Resident D stated that staff Janiah Liddell comes and stays at night. Resident D stated there was a former resident that stayed in the middle upstairs bedroom, but that resident moved out. Resident D stated that the third bedroom upstairs is utilized by the night shift staff. Resident D stated that there are no bedrooms in the basement of the home, and the basement is only used for laundry. When asked how often Licensee Wadley comes by the home, Resident D stated "*Kinda haphazard*. *Maybe twice a week, maybe*." When asked if Licensee Wadley ever stays in the home overnight, Resident D said "*Nope*."

Resident E was interviewed at the home. Resident E reported residing in the home for over five years. Resident E stated that only the residents live in the home. Resident E stated staff are present at night. Resident E reported seeing Licensee Wadley about once a week or sometimes less than that. Resident E stated that Licensee Wadley has a wife and kids.

I interviewed staff Alexis Wadley. Staff Wadley initially stated at the beginning of this unannounced on-site visit that Licensee Wadley lives upstairs. After interviewing residents, I asked to see the basement of the home. Staff Wadley walked me to the basement. I confirmed that there are no personal living quarters in the basement. Photos were taken of the basement. Staff Wadley then confirmed that this family home is not Licensee Wadley's primary residence; after initially stating he resided in the home. Staff Wadley stated that Licensee Watley receives mail at this home.

During this on-site, I conducted a thorough walk-through of the facility. I noted that there are two bedrooms occupied by residents on the first floor of the home, located on the right hand side as you enter through the front door. There are two beds in each room. Upstairs, I noted that one of the three bedrooms upstairs is currently occupied by one resident. The middle bedroom was not occupied. I observed this bedroom to have what appeared to be belongings being stored in it. The third bedroom, identified as being used by night staff, located closer to the stairway, was observed as well. Photographs were taken of the unoccupied resident bedroom, as well as the bedroom utilized by staff. I observed one bed in each upstairs bedroom.

On 10/22/2025, a search of the Saginaw County Clerk Self-Service Web confirms that Licensee Wadley has a marriage record on file in Saginaw County dated 09/21/2024.

On 10/22/2025, I conducted a search on the BS&A Online page for Saginaw Charter Township. The name of Licensee Wadley's wife/responsible person is noted for the customer's name on the utility bill record for a home address matching the street name Relative 1 reported on 10/03/2025, and APS worker Rebecca Robelin confirmed on 10/21/2025.

On July 9, 2019, licensing consultant Crecendra Brown completed an Original Licensing Study Report (OLSR) for this facility. In the report, licensing consultant Crecendra Brown noted that the resident bedrooms were the "*upstairs front bedroom 1*", "*upstairs middle bedroom 2*", and "*upstairs back bedroom 3*." The total resident beds for each room were two beds for each room. The licensing study report does not indicate that there were any residents' bedrooms on the first floor of the home. Under *Physical Description of Facility*, on page three of the OLSR, is the following description for the physical plant:

"Promise Land is located at 1629 North Carolina Street, Saginaw, MI. The physical plant is a two-story vinyl structure with a basement. It consists of a living room, family room, dining room, full kitchen, a full bathroom and one bedroom on the first level. The second level consists of three resident bedrooms, a living room, and a full bathroom with a tub. Two bedrooms have a closet and the third bedroom has two individual wardrobes. The facility has adequate storage areas. There is a detached two car garage with a fully paved driveway. The driveway has adequate parking for staff and visitors. The facility is not wheelchair accessible. The licensee stays in the first level bedroom of the home. The property is owned by the applicant, Licensee Christopher Wadley."

On page 5 of the OLSR, it states the following under *C. Applicant and Responsible Person Qualifications:*

"*The applicant acknowledges the understanding of the requirement of an adult foster care family home is that the licensee resides in the home in order to maintain this category type of adult foster care license."*

On 10/24/2025, I sent an email to Licensing and Regulatory Affairs staff person Haley Hoyt requesting a Secretary of State search for licensee Christopher Wadley. Haley Hoyt responded via email confirming that Licensee Wadley's address does not match the address for the AFC family home. The address matches the address found from the BS&A Online page for Saginaw Charter Township search, and as confirmed by APS worker Rebecca Robelin.

On 10/29/2025, I conducted an exit conference with Licensee Wadley. Licensee Wadley stated that he does live in the home, and that he has multiple properties. Licensee Wadley stated that the address that was found through the Secretary of State is his wife's home, Licensee Wadley also proposed during this conversation, issuing the residents in the home with 30-day notice and closing the home.

APPLICABLE RULE	
R400.703	**Definitions; A.**
	(5) "Adult foster care family home" means a private residence with the approved capacity to receive at least 3 but not more than 6 adults to be provided with foster care. The adult foster care family home licensee must be a member of the household and an occupant of the residence.
ANALYSIS:	On 10/03/2025, I interviewed Relative 1 who reported that licensee Christopher Wadley does not reside in the home. On 10/21/2025, I conducted an unannounced on-site follow-up at the home. I interviewed Resident B, Resident C, Resident D, and Resident E who all confirmed that the family group home is not Licensee Wadley's primary residence. During this on-site, I conducted a walk-through of the facility and did not observe a room in the home that appeared to be occupied by the owner. There was one occupied resident room on the second floor out of the three upstairs bedrooms, designated at the time of licensure to be resident rooms. The upstairs middle bedroom was unoccupied, but had stored belongings in it, and the third upstairs bedroom per Resident D is where staff sleep overnights. Two bedrooms on the first floor were occupied by three residents, with one resident in the first bedroom, and two residents in the second bedroom. The Original Licensing Study report completed on 07/09/2019, by licensing consultant Crecendra Brown, notes that Licensee

	Wadley occupied a first floor bedroom at the time of licensure. The report also notes that the applicant acknowledged at the time of licensure that the licensee is to reside in the home to maintain an AFC family group home license category. On 10/24/2025, a Secretary of State search was conducted that confirms Licensee Wadley's home address does not match the AFC family home's address. There is a preponderance of evidence of willful and substantial non-compliance, due to Licensee Wadley not residing in this AFC family home, per the above rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R400.1431	**Bedrooms generally.**
	(1) A living room, dining room, hallway, basement, or other room not ordinarily used for sleeping shall not be used for sleeping purposes by residents of the home.
ANALYSIS:	On 10/21/2025, I conducted an unannounced on-site follow-up at the home. I confirmed that Resident B, Resident C, and Resident E reside in two rooms located on the first floor of the home. During the course of this investigation, I reviewed the Original Licensing Study report completed on 07/09/2019, by licensing consultant Crecendra Brown. The OLSR notes that Licensee Wadley occupied a first floor bedroom at the time of licensure. The report indicated that the three upstairs bedrooms were licensed for resident use, with two beds in each bedroom. There is no addendum to the OLSR on file with the department that indicates the department approved the facility's floor plan change. There is no addendum on file approving the use of any first floor rooms as resident bedrooms. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 09/16/2025, I conducted an unannounced on-site at the facility. I reviewed Resident A's resident file. Resident A's *Resident Care Agreement* was dated for 01/01/2024. It was signed by Resident A and Licensee Wadley. Photographs were taken of the documentation.

On 10/21/2025, I conducted a follow-up unannounced on-site. I did not observe an up to date *Resident Care Agreement* is Resident A's file. The care agreement dated 01/01/2024 was in the file.

On 11/29/2023, licensing consultant Martin Gonzales completed a *Renewal Licensing Study Report* citing R400.1407(5). The analysis of the rule violation states, "*At the time of inspection, it was noted that the resident care agreements were not completed annually*." The corrective action plan signed by licensee Christopher Wadley states that compliance will be achieved by completing resident care agreements yearly. The responsible person is listed as Licensee Wadley. The corrections were to be completed by 12/29/2023, and continuing compliance states "*Chris will check yearly*." The corrective action plan is dated 11/28/2023.

On 10/29/2025, I conducted an exit conference with Licensee Wadley. Licensee Wadley proposed during this conversation, issuing the residents in the home with 30-day notice and closing the home.

APPLICABLE RULE	
R400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physician's instructions; health care appraisal.**
	(6) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency at least annually or more often if necessary.
ANALYSIS:	On 09/16/2025 and 10/21/2025, I conducted unannounced on-sites at the facility. I reviewed Resident A's file. There was no indication that the *Resident Care Agreement* on file had been reviewed since 01/01/2024. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Renewal LSR dated 11/29/2023.**

ADDITIONAL FINDINGS:

INVESTIGATION: On 09/16/2025, I conducted an unannounced on-site at the facility. I reviewed Resident A's resident file. There was no record/log of physician instruction pertaining to Resident A's care in the file for review.

On 09/16/2025, I interviewed licensee Christopher Wadley via phone, who stated that Resident A was under the care of a physician at CMU Health, as well as mental health physician through Saginaw County Community Mental Health Authority. Licensee Wadley stated that at the beginning of Resident A's stay in the home, Resident A was on blood pressure medication, but the script was discontinued. Resident A only received mental health medication injections through community mental health. Licensee Wadley stated that Resident A did annual physician visits, but he does not have any documentation from the doctor's visits because Resident A was his own guardian. Licensee Wadley stated that he set up Resident A's medical appointments.

On 10/21/2025, I conducted an unannounced follow-up visit at the facility. I reviewed Resident A's file a second time. There were no records of physician instructions observed in the file.

On 10/29/2025, I conducted an exit conference with Licensee Wadley. Licensee Wadley proposed during this conversation, issuing the residents in the home with 30-day notice and closing the home.

APPLICABLE RULE	
R400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physician's instructions; health care appraisal.**
	(8) A licensee shall record in the resident's record the physician's instructions for the care of the resident as required in subrule (7) of this rule.
ANALYSIS:	On 09/16/2025, I conducted an unannounced on-site. During this on-site, I did not observe any physician's instructions in Resident A's file. On 09/16/2025, Licensee Wadley reported via phone that he does not have any documentation from Resident A's doctor's visits. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 09/16/2025, I conducted an unannounced on-site at the facility. I reviewed Resident A's resident file. There was no weight records located in Resident A's file.

On 10/21/2025, I conducted a follow-up unannounced on-site at home. I reviewed Resident A's file again. There were no weight records. I asked staff Alexis Wadley for a copy of Resident A's weight records during this on-site. Staff Wadley stated that Licensee Wadley had that documentation with him offsite.

On 10/29/2025, I conducted an exit conference with Licensee Wadley. Licensee Wadley proposed during this conversation, issuing the residents in the home with 30-day notice and closing the home.

APPLICABLE RULE	
R400.1422	**Resident Records.**
	(1) A licensee shall complete and maintain a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(g) Weight record.**
ANALYSIS:	On 09/16/2025 and 10/01/2025, I conducted unannounced on-site visits at home. Resident A's file was reviewed during both visits. There was no weight records observed in the file. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 09/16/2025, I conducted an unannounced on-site at the facility. While standing on the front porch of the home, I noticed that there were yellow jackets or wasps entering and exiting the corner of the home's vinyl siding. There were pieces of vinyl siding missing along the corner of the siding.

On 09/16/2025, during a phone conversation with Licensee Wadley, I informed Licensee Wadley that there was an exterior wasp hive that needed to be addressed.

On 10/21/2025, I conducted an unannounced follow-up visit. I interviewed Resident E on the porch. Resident E stated that something was sprayed into the metal siding of

the home, but there are still insects flying in and out of the exterior wall. During this interview, I observed a yellow jacket or wasp enter into the opening in the siding. Resident E stated that siding falls off "*here and there*" from the home. I observed a piece of metal siding in the front yard of the home as well. Photos of the missing siding, and piece of siding on the ground were taken.

On 10/21/2025, while interviewing residents throughout the home, I noted multiple physical plant issues. While interviewing Resident B in Resident B's bedroom, I observed large dark stains on the carpet near the bedroom door. Resident B's bedroom door was also broken at the bottom hinge, and the door was observed to be difficult to open and close. There appeared to also be water stains on the ceiling near Resident B's bedroom window. Resident C and Resident E's bedroom were observed. Resident E's pillow was observed to have large dark brown stains. There was a urinal container on the side of Resident E's bed as well, that appeared to be full of urine. Excessive cobwebs and dust were observed on the walls, windows, flooring, and other surfaces in the bedroom. One of the electrical outlets in Resident C and Resident E's bedroom did not have an outlet plate cover. The window covering appeared to be held up by duct tape. Photos were taken of the physical plant issues observed.

At the bottom of the stairway leading up to the upstairs bedroom, there was a very large hole in the drywall. The drywall appeared to be broken in pieces, exposing the space behind the drywall. There was one large patch above the hole, that appeared to have been covered with dried drywall mud. A photo was taken of the hole in the drywall.

In the basement, the walls appeared to be water stained, and the paint was peeling/chipped. The cover plate of the furnace was lying on the floor, exposing the internal wiring of the furnace. On the back of the exterior of the home, there was one downspout that was observed to not extend down to the ground, and away from the structure of the home. It appeared to be at least a couple of feet above ground, and there was no downspout extension to help water drain away from the foundation. Photos of each maintenance of premises issues were taken during this on-site.

On 10/29/2025, I conducted an exit conference with Licensee Wadley. Licensee Wadley proposed during this conversation, issuing the residents in the home with 30-day notice and closing the home, and also commented on correcting the physical plan issues noted.

APPLICABLE RULE	
R400.1426	**Maintenance of premises.**
	(1) The premises shall be maintained in a clean and safe condition.
ANALYSIS:	On 10/21/2025, I conducted a walk-through of the facility and noted multiple maintenance of premises issues including cobwebs, stained bedroom carpet flooring, excessive dust, a

	broken resident bedroom door hinge, electrical outlet with no outlet plate cover, water stained bedroom ceiling, and basement walls with peeling paint. There was a large hole in the wall at the bottom of the stairway. There was a downspout in the back of the home that was not equipped with a downspout extension to carry rainwater away from the home's foundation. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R400.1433	**Bedroom Furnishings.**
	(3) A licensee shall provide a resident with a bed that is not less than 36 inches wide and 72 inches long, with comfortable springs in good condition, a clean protected mattress which is not less than 5 inches thick or 4 inches thick if of synthetic construction, and with a pillow.
ANALYSIS:	On 10/21/2025, I conducted a walk-through of the facility. Resident E's pillow was observed to have large brown stains on it. A photo was taken of the pillow. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R400.1426	**Maintenance of premises.**
	(3) A roof, exterior walls, doors, skylights, and windows shall be weathertight and watertight and shall be kept in sound condition and good repair.
ANALYSIS:	On 09/16/2025, I observed there were corner pieces of siding missing from the front of the home. On 10/21/2025, I conducted a follow-up on-site, and the exterior wall had not been fixed, and was still in disrepair. There is a preponderance of evidence to substantiate a rule violation.

CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 09/16/2025, I conducted an initial on-site investigation at the facility. I interviewed staff Alexis Wadley in the living room of the home. During this interview, I noticed that the home appeared to be dimly lit in the living room.

On 10/21/2025, I conducted a follow-up on-site. I noticed again that the living room was dark. Upon leaving the facility, I noticed that there were no lightbulbs in the light fixture in the living room ceiling. Staff Wadley stated that she would have to stand on a chair, to put new lightbulbs in the sockets. While interviewing residents in the two bedrooms on the first floor I noticed that the first bedroom to the right as you enter the home was also dimly lit. There was only one working bub out of three light fixtures on the room's ceiling fan. Photos of the light fixtures were taken during this on-site.

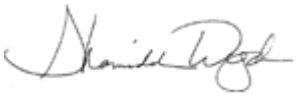
On 10/29/2025, I conducted an exit conference with Licensee Wadley. Licensee Wadley proposed during this conversation, issuing the residents in the home with 30-day notice and closing the home, and also commented on correcting the physical plant issues noted.

APPLICABLE RULE	
R400.1426	**Maintenance of premises.**
	(2) All living, sleeping, and kitchen areas shall be well lighted and ventilated.
ANALYSIS:	On 09/16/2025, and 10/21/2025, I conducted unannounced on-sites at the facility. I observed the living room to be dimly lit due to no working light bulbs in the ceiling light fixture. Resident B's bedroom appeared dimly lit as well. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/29/2025, I conducted an exit conference with Licensee Christopher Wadley. I informed Christopher Wadley of the findings and conclusions.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend a modification of the license to provisional status.



10/30/2025

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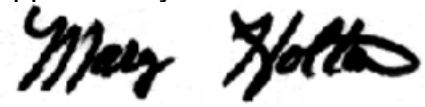
Shamidah Wyden Date
Licensing Consultant

Approved By:



10/30/2025

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Mary E. Holton Date
Area Manager