



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 31, 2025

Kimberlee Waddell
NRMI LLC
PO Box 281
Whitehall, MI 49461

RE: License #: AL630412118
Investigation #: 2025A0611030
North Ridge

Dear Ms. Waddell:

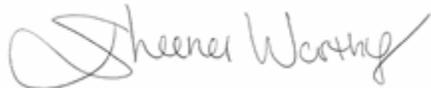
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 feel free to 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 (248) 972-9136.

Sincerely,

A handwritten signature in black ink that reads "Sheena Worthy". The signature is written in a cursive style with a large, stylized initial "S".

Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630412118
Investigation #:	2025A0611030
Complaint Receipt Date:	09/24/2025
Investigation Initiation Date:	09/25/2025
Report Due Date:	11/23/2025
Licensee Name:	NRMI LLC
LicenseeAddress:	424 17199 N. Laurel Park Dr. Livonia, MI 48152
Licensee Telephone #:	(231) 893-1462
Administrator:	Kimberlee Waddell
Licensee Designee:	Kimberlee Waddell
Name of Facility:	North Ridge
Facility Address:	25911 Middlebelt Farmington Hills, MI 48336
Facility Telephone #:	(248) 516-1370
Original Issuance Date:	06/01/2022
License Status:	REGULAR
Effective Date:	12/01/2024
Expiration Date:	11/30/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident L was left in an unsanitary condition without care for hours over multiple days due to staff absence.	Yes
Additional exit safety and food storage issues at the facility going unaddressed.	Yes

III. METHODOLOGY

09/24/2025	Special Investigation Intake 2025A0611030
09/25/2025	Special Investigation Initiated - Telephone I made a return phone call to the reporting source. The correct name of the AFC group home was confirmed with the reporting source. An attempt was made to confirm the allegations.
09/25/2025	APS Referral An Adult Protective Services (APS) referral was made.
10/01/2025	Inspection Completed On-site I completed an unannounced onsite. I interviewed the residential supervisor Erica Mabry, residential supervisor Joanne Brown, team leader Lizziette Battle, kitchen staff Lashawna Jackson, Resident C, Resident M, and Resident P. I observed the kitchen and received a copy of Resident L supervision log.
10/03/2025	Contact - Telephone call received I received a return email from Adult Protective Services worker Sara Peoples stating she was unable to make contact with Resident L before she was discharged from the AFC group home.
10/03/2025	Contact - Telephone call received I received a return phone call from staff member Erica Alexander. The allegations were discussed.

10/03/2025	Contact - Telephone call received I received a return phone call from the kitchen manager Sara Headley. The allegations were discussed.
10/03/2025	Contact - Telephone call received I received a return phone call from staff member Reshawn Nowden. The allegations were discussed.
10/08/2025	Contact - Telephone call made I left a voice message for staff member Felicia Davis requesting a call back.
10/08/2025	Contact - Telephone call received I received a return phone call from staff member Felicia Davis. The allegations were discussed.
10/09/2025	Contact - Document Received I received a copy of Resident L's assessment plan.
10/09/2025	Contact - Document Received I received a return email from Erica Mabry clarifying that Resident L was placed on general supervision (30-minutes checks) for her needs, which is part of their standard company policy.
10/21/2025	Exit Conference An attempt was made to complete an exit conference with the licensee designee Kim Waddell via telephone however; there was no answer. A voice message was left requesting a call back.
10/22/2025	Exit Conference I completed an exit conference with the licensee designee Kim Waddell via telephone.

ALLEGATION:

Resident L was left in an unsanitary condition without care for hours over multiple days due to staff absence.

INVESTIGATION:

On 09/24/25, a complaint was received and assigned for investigation alleging that on 9/20/2025, there were no staff present for the residents. Resident L was not fed breakfast. Resident L was covered in urine, and her brief was shredded with pieces stuck to her face. Resident L's family bathed and changed Resident L. On 9/21/2025, no staff was available to assist or care for Resident L until 10:20 am. There was no staff

available to lift Resident L with the Hoyer lift until after 10:30 AM. Two days in a row, residents were left in their beds, unchanged and without staff assistance. There were other staff in the building but no staff at this part of the facility. Resident L's room used to be near an exit door. The door was left unlocked for 5 days leaving Resident L and the other residents vulnerable with access to the public. The freezer at the facility has not worked for the last 3 months, leaving minimal food in the facility without a place for proper storage. Resident L has been moved to another county.

On 09/25/25, I made a telephone call to the reporting source. The reporting source stated Resident L has been discharged from the AFC group home due to the allegations. An attempt was made to confirm the allegations however; the reporting source kept repeating that she provided details in her complaint. The reporting source became irate and started yelling. As a result, I ended the interview.

On 09/30/25, I completed an unannounced onsite. I interviewed the residential supervisor Erica Mabry, residential supervisor Joanne Brown, team leader Lizziette Battle, kitchen staff Lashawna Jackson, Resident C, Resident M, and Resident P. I observed the kitchen and received a copy of Resident L supervision log.

On 09/30/25, I interviewed residential supervisor Erica Mabry. Joanne Brown, who is a newly hired residential supervisor was present for the interview. Ms. Mabry also had the program director Angie Dorsey on speakerphone. Ms. Brown confirmed that Resident L was discharged from the AFC group home on 09/24/25. Regarding the allegations, on the days in question Ms. Mabry was on-call (09/20/25 – 09/21/25). On 09/20/25, Resident L's mother contacted Ms. Mabry to inform her about what was aforementioned in the allegations. Resident L's mother was not visiting Resident L at the AFC group home during this time but, Resident L's aunt was present at the AFC group home. Ms. Mabry followed up with team leader Lizziette Battle. Resident L is placed on 30-minute supervision checks. Ms. Mabry stated staff member Erica Alexander was assigned to supervise and/or care for Resident L. Ms. Alexander was supposed to arrive to work at 8:00am however; she did not arrive until 8:35am. Ms. Alexander first checked on Resident L at 8:38am. Ms. Mabry stated Resident L's aunt must have arrived at the AFC group home after Ms. Alexander completed her 30-minute check with Resident L at 8:38am. When Ms. Mabry contacted Ms. Alexander, Ms. Alexander started to assist Resident L with changing her brief, bathing her, and getting her dressed. Ms. Alexander did not assist Resident L with her ADL's until after 10:00am.

Ms. Mabry stated Resident L was fed breakfast by the midnight staff Felicia Davis. Ms. Mabry stated breakfast is served at 7:00am. Ms. Mabry stated Resident L's aunt assumed Resident L did not eat breakfast because she was in bed when she arrived to the AFC group home. Resident L ate lunch at 12:00pm and there were no more issues the rest of the day. The staff are required to complete an electronic log to indicate they completed 30-minutes checks for Resident L. Ms. Alexander shift ended at 4:00pm. Ms. Mabry stated there are 13 staff members assigned to work for every day and afternoon shift. There are 12-13 staff members assigned to work during the midnight shift. The

day shift hours are 8:00am to 4:00pm. The afternoon shift hours are 4:00pm to 12:00am. The midnight shift hours are 12:00am to 8:00am.

On 09/21/25, Ms. Mabry received a phone call from Resident L's mother who was present at the AFC group home. Resident L's mother informed Ms. Mabry that Resident L's assigned staff member was not present. Ms. Mabry discovered that staff member Reshawn Nowden was assigned to supervise and/or care for Resident L however; she had not arrived to work. Ms. Nowden did not inform any supervisor that she would be late for work. Ms. Mabry contacted Ms. Battle to re-assign another staff member to provide assistance for Resident L. Ms. Mabry stated when she contacted Ms. Nowden it was 9:48am. Ms. Mabry asked Ms. Nowden why she didn't inform anyone that she would be late and; inquired about her estimated time of arrival. It is a common issue at the AFC group home for staff members to arrive late for work. Ms. Mabry stated each staff member is assigned a group of four residents to care for. When a staff member is late to work, it is expected for another staff member to automatically cover the other staff member's group of residents. However, when a staff member is late to work and the supervisor is informed, the supervisor will ensure to delegate which staff member should cover the other staff members group of residents.

Ms. Brown was asked if she was aware of the allegations and she stated she was made aware however; she was not present on the days in question nor did she speak to any of the staff members involved. As a new staff member, Ms. Brown does not work alone.

On 09/30/25, I interviewed team leader Lizziette Battle. Ms. Battle works the dayshift for another AFC group home (South Ridge AL630412119) next to North Ridge. On 09/20/25, Ms. Battle recalls administering morning medication. Ms. Battle does not know if Resident L ate breakfast at 7:00am as Ms. Battle started her shift at 8:00am. Ms. Battle received a telephone call from Ms. Mabry asking her to check on Ms. Alexander who was assigned to care for Resident L. Ms. Alexander arrived to work around 9:00am-9:30am. Ms. Battle informed Ms. Alexander that Resident L's mother is looking for staff. Ms. Alexander then started to assist Resident L with changing her brief and transferring her to her wheelchair. Ms. Battle does not know if Resident L's brief was shredded or if any pieces of it was on her face. Ms. Battle stated Resident L has a history of tearing her brief apart. Resident L pulls her brief apart either because she is wet and wants to take it off or it's just part of her behavior.

On 09/21/25, Ms. Battle stated she recalls Ms. Nowden being late to work and not informing a supervisor. Resident L's mom was looking for staff. Ms. Battle and another staff member went into Resident L's bedroom to assist Resident L's mom as she was in the process of putting Resident L into a hoier lift. Ms. Battle assisted Resident L with getting into her wheelchair. Ms. Battle stated it is not a common issue for staff to arrive late to work.

On 09/30/25, I interviewed Resident C. Resident C has lived in the AFC group home for a few years and she loves living in the AFC group home. The staff are good. Resident C denies having any issues at the AFC group home. Resident C stated she can transfer

herself from her wheelchair to her bed but, she doesn't because she is instructed to receive help from staff. Resident C stated she receives help with toileting and bathing. The staff changes her briefs every 2-3 hours. Resident C stated she will also inform staff when she is wet and they will change her brief right away. Resident C stated the staff do their job however; Resident M gives the staff a hard time as she is mean to them. Resident C stated Resident M is a "B".

On 09/30/25, I interviewed Resident M. Resident M stated there is no one else in the AFC group home that has the same name as her. Resident M has lived at the AFC group home for several years. Resident M likes living in the AFC group home. The staff take care of her and make sure she has what she needs. The staff assist Resident M with bathing and changing her briefs. The staff changes her briefs every two hours or as often as she needs it. Resident M stated the staff never forget to change her briefs or make her sit in a wet brief for too long. Resident M stated as far as she knows the staff take care of everyone. However, Resident M stated she has a problem with a couple of the staff members because they do not think like she does, meaning they have different values. Resident M stated these staff members still do their jobs.

On 09/30/25, I interviewed Resident P. It was a little difficult to understand Resident P. Resident P stated he does not like living at the AFC group home because he wants his own home. Resident P stated the staff are great, considerate, and kind. The staff make sure he has what he needs. Resident P stated he does not need staff assistance to complete his ADL's as he can change his own brief and bath himself. Resident P stated he knows Resident L but, he said the last time he saw her was either today or yesterday. Resident P also stated Resident L is treated well by staff.

On 09/30/25, I received a copy of Resident L's supervision log. Ms. Mabry explained that the staff are only required to indicate yes or no once a day whether or not they completed 30-minute checks for Resident L. According to the supervision log, on 09/20/25, Erica Alexander indicated yes to completing her 30-minute checks for Resident L at 1:58pm. On 09/21/25, Reshawn Nowden indicated yes to completing her 30-minute checks for Resident L at 2:53pm.

On 10/03/25, I received a return phone call from staff member Erica Alexander. Ms. Alexander stated that she normally works at South Lake AFC group home (AL630412122) however; she was filling in at North Ridge on 09/20/25 and 09/21/25 during the dayshift. Ms. Alexander stated she remembers being assigned to Resident L and about three other residents on 09/20/25. Ms. Alexander could not remember if she was assigned to care for Resident L on 09/21/25. On 09/20/25, Ms. Alexander was late to work as she arrived close to 9:00am. Ms. Alexander stated she thinks she told Ms. Mabry that she was running late to work. When Ms. Alexander arrived to work, she checked on Resident L and she was asleep. Ms. Alexander stated no one else was in Resident L's bedroom. The second time Ms. Alexander checked on Resident L was before 10:00am. Resident L was still asleep at that time.

Ms. Alexander stated she received a phone call from Ms. Mabry stating Resident L's mother was upset as Resident L's brief was soiled and messed up. Ms. Alexander stated she was under the impression to not wake Resident L up to change her brief in order to prevent her from having a behavior issue. Ms. Alexander stated this request came from Resident L's family. Ms. Alexander stated Resident L is known for calling staff out of their name, spitting, and making it difficult for staff to change her brief. However, on the day in question, Ms. Alexander was informed by Ms. Mabry to check Resident L's brief even if she is asleep. Ms. Alexander stated when she entered Resident L's bedroom, Resident L brief was pulled apart but there was nothing on her face. Resident L's aunt was present in the bedroom. Ms. Alexander stated she changed Resident L's brief and she apologized to her aunt. Ms. Alexander spoke to Ms. Mabry again and they agreed to increase Resident L's checks from every 30-minutes to every 15-minutes for the remainder of her shift to keep a close eye on Resident L. Ms. Alexander stated she did not document her checks with Resident L.

On 10/03/25, I received a return phone call from staff member Reshawn Nowden. Ms. Nowden works the dayshift. Ms. Nowden confirmed that she worked on 09/20/25 and 09/21/25. Ms. Nowden cared for Resident L on 09/21/25. On 09/21/25, Ms. Nowden arrived late to work after 10:00am which is over two hours late. Ms. Nowden stated she thinks she informed Ms. Mabry or another manager that she was running late to work. Prior to Ms. Nowden arriving to work, Ms. Mabry contacted her to inquire about what time will she arrive to work. Ms. Nowden stated when she arrived to work she completed her rounds which included checking on Resident L. Ms. Nowden stated when she entered Resident L's bedroom, Resident L was in her wheelchair. Resident L's mother was present and upset because Ms. Nowden was late to work. Resident L's mother had to ask another staff member to assist with getting Resident L into her wheelchair.

Ms. Nowden stated normally Resident L's mother does not want Resident L up at 8:00am because Resident L gets agitated. Ms. Nowden stated Resident L's mother changed Resident L brief around 1:00pm. Ms. Nowden stated Resident L's mother did not want any assistance with changing Resident L's brief because she stated she needed to learn because Resident L will be leaving the AFC group home. Resident L's mother only asked Ms. Nowden to assist her with getting Resident L into the hooyer lift in order to transfer her into her bed. Resident L's aunt arrived around 3:00pm. Resident L's aunt also changed Resident L's brief and informed Ms. Nowden that she did not want any assistance because she wanted to learn how to do it in preparation for Resident L moving into their home. Ms. Nowden stated before Resident L's mother left, she told Ms. Nowden not to bother Resident L. Ms. Nowden explained to Resident L's mother that she has to complete her rounds. Resident L's mother told Ms. Nowden that Resident L will let her know when she needs to use the bathroom. Ms. Nowden stated Resident L can make sounds but she is not verbal. Resident L does have a bed alarm but, she is unable to use it due to limited cognitive ability.

On 10/08/25, I received a return phone call from staff member Felicia Davis. Ms. Davis works the midnight shift from 12:00am to 8:00am. On 09/20/25, Ms. Davis could not remember specifically if she was assigned to care for Resident L or if she helped out with caring for Resident L. Ms. Davis stated when Resident L first moved into the AFC group home, the midnight staff would get her up, bathe her, dress her, and then take her into the dining area to feed her breakfast. Resident L requires staff to feed her as she cannot feed herself. Ms. Davis stated she was later informed by Resident L's mother that she wanted Resident L to stay in bed later and to not feed her as she will bring her breakfast every day. Ms. Davis stated Resident L's mother would usually arrive to the AFC group home around 7:00am, which is the same time all of the residents are served breakfast. Ms. Davis stated if Resident L's mother did not arrive to the AFC group home at a certain time, then it was communicated to dayshift to bring Resident L's breakfast into her bedroom and feed her.

Ms. Davis stated on 09/20/25, Resident L's mother did not arrive to the AFC group home before her shift ended at 8:00am. Ms. Davis cannot remember which staff she spoke to during shift change regarding Resident L breakfast but, she did communicate that Resident L needed to be fed breakfast. Ms. Davis stated while the other residents were eating breakfast in the dining area, she was going back and forth between the dining area and Resident L's room to see if Resident L's mother had arrived but, she did not think about bringing Resident L her breakfast because she was tending to other residents. Ms. Davis is not aware of any instances where Resident L was not fed breakfast either by staff or by her mother.

On 10/09/25, I received a copy of Resident L's assessment plan. According to the eating/feeding section in the assessment plan, Resident L requires 1:1 supervision and hand over hand assistance. Furthermore, Resident L is incontinent and requires 2-3 staff to assist with brief change.

APPLICABLE RULE	
R 400.15303	Resident care; licensee responsibilities.
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident L's assessment plan requires 2-3 staff members to assist with her brief change. On 09/20/25, Ms. Alexander was assigned to care for Resident L. Ms. Alexander admitted arriving late to work on this day as she arrived close to 9:00am. Ms. Alexander checked on Resident L twice before 10:00am. Resident L was observed asleep both times Ms. Alexander checked on her. Following Ms. Alexander checking on Resident L the second time, she received a phone call from Ms. Mabry stating Resident L's brief was soiled and messed up. Ms.

	Alexander stated when she entered Resident L's bedroom, Resident L brief was pulled apart but there was nothing on her face. Resident L's aunt was present in the bedroom. Ms. Alexander changed Resident L's brief and she apologized to her aunt. In addition to Resident L's brief being soiled for an unknown period of time, Ms. Alexander did not receive assistance from another staff member when she changed Resident L's brief.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.15305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	<p>Although there was staff present in the AFC group home on the days in question, both staff that were assigned to care for Resident L during the dayshifts, arrived significantly late to work on both days (09/20/25, 09/21/25). As a result, there was a delay in changing Resident L's brief on both days. On 09/20/25, Ms. Alexander had to be instructed by Ms. Mabry two hours after her shift started to change Resident L's brief as it was soiled and pulled apart.</p> <p>On 09/21/25, Ms. Nowden arrived to work after 10:00am, which is over two hours late. When Ms. Nowden arrived to work, she completed her rounds, which included checking on Resident L. Ms Nowden stated when she entered Resident L's bedroom, Resident L was in her wheelchair. Resident L's mother was present and upset because Ms. Nowden was late to work. Resident L's mother had to ask another staff member to assist with getting Resident L into her wheelchair. As a result, Resident L's personal needs were not properly cared for in a timely manner during the beginning of the dayshift for two days in a row.</p>
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.15313	Resident nutrition.
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on the information gathered, there is sufficient evidence to support this allegation. On 09/20/25, Ms. Davis was finishing her midnight shift which was ending at 8:00am. Ms. Davis stated on 09/20/25, Resident L's mother did not arrive to the AFC group home to bring Resident L breakfast before her shift ended at 8:00am. Ms. Davis cannot remember which staff she spoke to during shift change regarding Resident L breakfast but, she did communicate that Resident L needed to be fed breakfast. Ms. Davis did not think about serving Resident L breakfast that was prepared by the AFC group home because she was tending to other residents. On 09/20/25, Ms. Alexander arrived significantly late to work. Therefore, it appears that at least 14 or more hours elapse between the evening and morning meal before Resident L was fed.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Additional exit safety and food storage issues at the facility going unaddressed.

INVESTIGATION:

On 09/30/25, Ms. Mabry stated she was aware of there being a freezer issue but she did not know any details. Ms. Dorsey interjected and advised that the AFC group home has four freezers. While one of the freezers were broken, the AFC group home did not have any issues with storing food. Ms. Dorsey could not provide any details regarding when the freezer broke or when it was repaired.

On 09/30/25, Ms. Mabry stated there was an issue with one of the exit doors. Ms. Mabry does not know how long it was not working. Resident L was moved to another bedroom but it was because her family wanted her to have a renovated bedroom. The exit door has a push bar to open the door. Ms. Dorsey advised there is a current work order to replace the door because the push bar mechanism is not working properly. As of now, you have to manually pull the push bar from the inside of the AFC group home to close the door. On the outside of the door, you have to push the door close as it does not automatically latch on its own.

On 09/30/25, Ms. Battle stated she is not aware of Resident L's bedroom being next to an exit door that does not work. Ms. Battle is aware that Resident L was moved to a different bedroom but she does not know why.

On 09/30/25, Ms. Battle stated she is not aware of a freezer not working. There is one big freezer for residents. Ms. Battle stated the freezer for the residents is always working. There is also a freezer for the staff.

On 09/30/25, I interviewed Lashawna Jackson who is one of the kitchen staff members. Ms. Jackson stated the AFC group home receives food every Monday and Thursday. There are three commercial freezers and two commercial refrigerators. Ms. Jackson stated two of the freezers stopped working in August and they received two new freezers on September 14, 2025. One freezer is used to store bread, another freezer is used to store meat, and the third freezer is used to store vegetables and potatoes. I observed each freezer and found an adequate amount of food in each freezer. The freezers were observed to be in working order and the digital temperature was displayed at the top of each freezer. Ms. Jackson stated when two of the freezers were broken it did not affect the food flow or the ability to store food. The kitchen manager Sara Headley is in charge of ordering the food each week. While two of the freezers were broken, Ms. Headley would delay the food order for a couple days to ensure they could house the food in one freezer.

On 09/30/25, Resident C stated the food is good. Resident C receives three meals a day. Resident C always receives enough food to eat. Resident C is not aware of a freezer or refrigerator not working. Resident C stated the exit door near her bedroom closes sometimes but it is not an issue.

On 09/30/25, I observed the exit door that requires repair. The door was observed propped open. Ms. Mabry stated the housekeeper propped the door open to take out the trash. I tested the door from the inside of the AFC group home and found that it automatically closed completely. However, I tested the door from the outside of the AFC group home and found it did not have positive latching. It appears that the door does not properly latch each time it is open.

On 09/30/25, Resident M stated she receives three meals a day. Resident M denies any issues with not having enough food in the AFC group home. Resident M stated she does not know about any exit door that does not work properly. Resident M stated she feels safe at the AFC group home.

On 09/30/25, Resident P stated he receives three meals a day. Resident P gets enough food to eat.

On 10/03/25, I received a return phone call from the kitchen manager Sara Headley. Regarding the allegations, Ms. Headley stated one of the freezers stopped working around mid-July 2025. At this time, the AFC group home had a two-door freezer and a three-door freezer. The three-door freezer is the freezer that stopped working. During this time, the AFC group home did not have any issues with storing food or feeding the residents. Ms. Headley stated instead of ordering frozen food, she ordered fresh food to ensure they had enough space as well as maintain an adequate supply of food. Ms. Headley stated she was still able to follow the menu. On 09/14/25, the three-door freezer was replaced. Ms. Headley stated she thinks someone may have assumed there was a lack of food because they heard a freezer was broken.

On 10/22/25, I completed an exit conference with the licensee designee Kim Waddell. Ms. Waddell was informed about the allegations and the information gathered. It was explained that the allegations will be substantiated and a corrective action plan will be required.

APPLICABLE RULE	
R 400.15403	Maintenance of premises.
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	<p>There is not enough evidence to support the allegation pertaining to proper food storage in the AFC group home. On 09/30/25, I observed three commercial freezers and two commercial refrigerators. Although, the three-door freezer stopped working in July 2025, the AFC group home still had a commercial two door freezer and two commercial refrigerators to store food. The kitchen manager Sara Headley remedy this temporary situation by ordering fresh foods instead of frozen food to ensure they had enough space as well as maintaining an adequate supply of food.</p> <p>On 09/30/25, I observed the exit door that requires repair. After testing the door from the interior and exterior of the AFC group home, it appears that the door does not properly latch each time it is open. Therefore, this exit door has not been maintained to ensure the safety and well-being of the residents.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

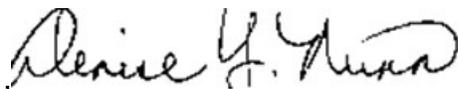
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



Sheena Worthy
Licensing Consultant

10/23/25
Date

Approved By:



10/31/2025

Denise Y. Nunn
Area Manager

Date