January 14, 2026

Gregory Cheff
Harmony Manor LLC
PO Box 95
Atlas, MI 48411

RE: License #: AS250314310
Investigation #: 2026A0779011
Harmony Manor/Avon

Dear Gregory Cheff:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 1/12/2026, you submitted an acceptable written 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,

Christopher A. Holvey

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250314310
Investigation #:	2026A0779011
Complaint Receipt Date:	12/23/2025
Investigation Initiation Date:	12/23/2025
Report Due Date:	02/21/2026
Licensee Name:	Harmony Manor LLC
Licensee Address:	PO Box 95 Atlas, MI 48411
Licensee Telephone #:	(810) 834-9970
Administrator:	Gregory Cheff
Licensee Designee:	Gregory Cheff
Name of Facility:	Harmony Manor/Avon
Facility Address:	823 Avon Street, Flint, MI 48503
Facility Telephone #:	(810) 820-7503
Original Issuance Date:	06/25/2012
License **Status:**	REGULAR
Effective Date:	01/17/2025
Expiration Date:	01/16/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
The facility houses five residents in consistently cold conditions, with it recently being only 52 degrees in the home.	Yes
A resident recently passed away following hospitalization and she had bruising when she went to the hospital.	No
Additional Findings	Yes

III. METHODOLOGY

12/23/2025	Special Investigation Intake 2026A0779011
12/23/2025	APS Referral Complaint was received from APS centralized intake.
12/23/2025	Special Investigation Initiated On-site
12/23/2025	Inspection Completed On-site
01/12/2026	Inspection Completed On-site
01/12/2026	Contact - Telephone call made Spoke to nurse practitioner.
01/12/2026	Exit Conference Held with licensee designee, Greg Cheff.
01/12/2026	Corrective Action Plan Received
01/14/2026	Corrective Action Plan Approved.

ALLEGATION:

The facility houses five residents in consistently cold conditions, with it recently being only 52 degrees in the home.

INVESTIGATION:

On 12/23/2025, an unannounced on-site inspection was conducted. The home was observed to have working heat. The home downstairs was measured at 75-degrees and the upstairs was 77-degrees.

On 12/23/2025, four of the five residents of this home were interviewed. All four residents stated that the home might get a little cold during the night, but that they had no concerns about the heat.

On 12/23/2025, staff person, Maya Windom, stated that there was one day recently when the furnace was not working properly and the home was pretty cold. Staff Windom stated that the furnace is currently working and the home has been adequately warm lately.

On 1/12/2026, a second unannounced on-site inspection was conducted. The furnace in this home was not working and the thermostat on the wall said the home was at 52-degrees. The thermostat did not appear to be accurate, as the home appeared to be much colder than that. You could actually feel the cold through long denim pants.

On 1/12/2026, Resident A and Resident B stated that the home has been very cold for a few days. Multiple residents were viewed to be wearing winter coats and stocking caps inside the home and confirmed that they were still cold.

On 1/12/2026, Staff Windom stated that they have been having problems with the furnace and it would keep going on and off, but that it had not been working for a few days. Staff Windom stated that licensee designee, Greg Cheff, was aware of the furnace issues, but she admitted that she had not called him over the weekend to report the furnace not working.

On 1/12/2026, staff person, Sherry Joy, stated that the furnace in the home has been working sporadically for a couple weeks, but has not worked the last few days. Staff Joy stated that the home was very cold over the weekend. When asked if she had called LD Cheff over the weekend to report the furnace not working, Staff Joy stated that LD Cheff is fully aware that the furnace is not working properly.

On 1/12/2026, a phone call was made to LD Cheff regarding concerns regarding the temperature of the home. LD Cheff claimed that neither staff called him over the weekend to say that the furnace was not working. LD Cheff stated that he had a HVAC company out to the home on Friday 1/9/2026 and that when he left the home Friday

evening, the home was at 72 degrees. LD Cheff stated that he will come to the home and will make other arrangements for the residents if he could not get the furnace working.

LD Cheff arrived at the home approximately one hour later on 1/12/2026. After making attempts at trying to get the furnace to turn on, LD Cheff stated that he could not get the furnace to work. LD Cheff stated that he had been struggling with the furnace for two weeks, but that he could usually get it to turn back on. LD Cheff reported that the HVAC company had to order a new part for the furnace and that they were not able to come back out until 1/15/2026. When LD Cheff was told that the residents could not stay in the home without any working heat, he stated that he would work on finding other places for the residents to move to.

Approximately 30 minutes after leaving the home, a call was received from LD Cheff, who stated that he was struggling to arrange placements for all the residents to go too. LD Cheff stated that he would just like the home to be closed that day and that he would continue to work on finding other arrangements for the residents.

On 1/12/2026, a phone call was made to nurse practitioner, Tara Evans, who confirmed that she had visited this home earlier that day. NP Evans stated that the home was quite cold while she was there and that staff confirmed that they were having on-going issues with their furnace. NP Evans reported that Resident C passed during the holidays while at this home and that a person from the Medical Examiner's office reported to her that the home was only 52-degrees when Resident C's body was picked up. NP Evans was not certain on what date that occurred.

A third on-site inspection was conducted late in the afternoon on 1/12/2026. APS worker Shwanda Lee was also present at the home waiting for the two remaining residents left there to be picked up and moved out. The furnace was still not working and the home was still extremely cold. LD Cheff stated that he was able to find other living arrangements for all five residents. The last two residents were observed to be picked up, leaving no residents no longer in this home.

On 1/12/2026, an exit conference was held with licensee designee, Gregory Cheff. LD Cheff assisted in finding alternative placements for all five residents and stated that he would like the license/home to be closed. LD Cheff signed a corrective action plan confirming that fact.

APPLICABLE RULE	
R 400.653	**Room temperature.**
	Resident-occupied rooms must be heated at no less than 68 degrees Fahrenheit. While air conditioning is not required, precautions must be taken to prevent prolonged resident exposure to noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations

	must be based on a resident's health care appraisal and addressed in the resident's assessment plan.
ANALYSIS:	On 1/12/2026, the home was found to have no working furnace and the air temperature of the home was under 52 degrees. Residents and staff reported that the furnace had not been working and that the home was very cold for the last few days. On 1/12/2026, Licensee designee, Gregory Cheff, confirmed that he had been struggling with the furnace not working properly for the last two weeks and that he was not able to get the furnace to turn on. There was sufficient proof found that residents of this home had been living in this home for multiple days with the temperature being below the minimum requirement of 68 degrees.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

A resident recently passed away following hospitalization and she had bruising when she went to the hospital.

INVESTIGATION:

On 12/23/2025, Staff Windom stated that Resident C was not feeling well for a couple days, was dizzy and kept falling, so they sent her out to the hospital. Staff Windom stated that Resident C spent several days in the hospital, before returning home. Staff Windom reported that Resident C still did not seem right when she returned and still seemed very weak. Staff Windom stated that 3-5 days after returning from the hospital, she found Resident C lying on her bedroom floor. Staff Windom reported that Resident C was unresponsive, so she called 911 and they asked her to find a pulse, which she did, but it was very faint. Staff Windom stated that 911 did not instruct her to perform CPR and that the ambulance arrived 5-7 minutes later.

On 1/12/2026, Staff Joy confirmed that Resident C was sent to the hospital on 12/8/2025. Staff Joy stated that Resident C was feeling well for a few days prior and had fallen a few times, which resulted in her having bruises on her arm, hip and ankle. Staff Joy stated that no one ever witnessed Resident A's falls and they were told of the falls by Resident C. Staff Joy reported that the day Resident C went to the hospital, she was acting confused, would not eat and could not stand up. Staff Joy stated that when Resident C returned home, she was a little better and able to walk but still seemed

lethargic and confused. Staff Joy stated that the police and medical examiner came to the home when Resident C passed away and did not have any concerns.

The hospital discharge paperwork for Resident C confirms that she was admitted into the hospital on 12/8/2025 and was discharged on 12/18/2025. It states that Resident A was treated for sepsis due to undetermined organism. It did not have any further recommendations regarding care or follow-up.

The home provided a copy of the AFC Licensing Division Incident/Accident Report regarding Resident A's hospitalization and death. The info I on the IR matches the information obtained during interviews with Staff Windom and Staff Joy. The IR states that Resident A was found in her bedroom deceased. 911 was called and police and ambulance arrived.

On 1/12/2026, LD Cheff stated that he was surprised that the hospital sent Resident C back home. He stated that Resident C seemed a little better and was mobile, but she still seemed a little confused and lethargic. LD Cheff stated that the hospital discharge paperwork did not instruct or recommend any specific care for Resident C.

On 1/12/2026, a phone call was made to nurse practitioner, Tara Evans, who stated that she was aware of Resident C being ill and he death. NP Evans stated that LD Cheff called her on 12/8/205, concerned about Resident C and that she instructed him to have Resident C transported to the hospital. NP Evans stated that Resident C was admitted and treated for an unknown infection, possibly a UTI, that turned sepsis. NP Evans stated that she was not able to see Resident C between her hospital stay and her death, so she is not sure what type of condition Resident C was in upon returning from the hospital. NP Evans did confirm that Resident C had been declining recently, had refused to receive physical therapy services and had some falls leading up to the hospital stay, which were probably the cause of her bruising. NP Evans reported that she is not aware of the hospital having any concerns regarding the bruising or the care Resident C received at this home. NP Evans stated that Resident C's family did not want an autopsy of Resident C completed. NP Evans reported that the physician in her office signed Resident C's death certificate on 12/23/2025, listing the cause of death to be from natural causes.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	When Resident C started to show signs of being ill, the home had Resident A sent to the hospital. Resident C had a 10-day hospital stay, before returning to this home, where she passed away a few days later. Staff reported that Resident C was mobile but still did not appear to be doing well, even after her return from the hospital and was found on the floor of her bedroom unresponsive. Resident C's Nurse practitioner reported that there were no concerns regarding Resident C's death and that the cause of death was deemed to be from natural causes. There was insufficient evidence found to prove that Resident C was not provided with adequate supervision and protection at this home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 1/12/2026, nurse practitioner, Tara Evans, stated that she visited the home earlier that day. NP Evans stated that she observed Resident D to have an odor and when she asked him when the last time he had taken a shower, Resident D told her that it had been several days because the home had no hot water. NP Evans stated that the staff at the home confirmed that the water heater at this home had not been working for several days.

During the second on-site inspection conducted on 1/12/2026, Staff Joy confirmed that the home has been without any hot water for several days and that LD Cheff was aware of the issue. The water at the kitchen sink was running for several minutes and did not get warm.

On 1/12/2026, an exit conference was held with licensee designee, Gregory Cheff. LD Cheff assisted in finding alternative placements for all five residents and stated that he would like the license/home to be closed. LD Cheff signed a corrective action plan confirming that fact.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(7) A water heater must be equipped with a thermostatic temperature control and a pressure relief valve, both of which must be in good working condition.

ANALYSIS:	On 1/12/2026, this home was observed to be without any warm running water. Staff person, Sherry Joy, confirmed that the home had been without any hot water for several days. Licensee designee, Gregory Cheff, confirmed that the water heater of the home was not currently working. There was sufficient evidence found to prove that this home's water heater was not in good working condition.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An approved written corrective action plan (CAP) was provided and accepted on 1/12/2025. The CAP requested that this license/home be closed.

1/14/2026

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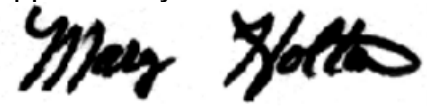
Christopher Holvey Date
Licensing Consultant

Approved By:



1/14/2026

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Mary E. Holton Date
Area Manager