



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 15, 2026

Champaign Brown
Serenity Meadows Assisted Living LLC
426 E. Bloomfield
Royal Oak, MI 48073

RE: License #: AS630418267
Investigation #: 2026A0611006
Serenity Meadows Assisted Living

Dear Ms. Brown:

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 grey ink that reads "Sheena Worthy". The signature is fluid and cursive, with a large loop at the beginning of the word "Sheena".

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 #:	AS630418267
Investigation #:	2026A0611006
Complaint Receipt Date:	12/05/2025
Investigation Initiation Date:	12/05/2025
Report Due Date:	02/03/2026
Licensee Name:	Serenity Meadows Assisted Living LLC
Licensee Address:	426 E. Bloomfield Royal Oak, MI 48073
Licensee Telephone #:	(313) 346-7646
Administrator:	Champaign Brown
Licensee Designee:	Champaign Brown
Name of Facility:	Serenity Meadows Assisted Living
Facility Address:	426 E. Bloomfield Royal Oak, MI 48073
Facility Telephone #:	(248) 206-7975
Original Issuance Date:	07/10/2024
License Status:	REGULAR
Effective Date:	01/10/2025
Expiration Date:	01/09/2027
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The AFC group home has sent Resident H to school without his swipe badge that is needed for his Vegus Nerve Stimulator (VNS) to treat his seizures. There has been some confusions on his medication as the home doesn't send all of it when he comes to school or it is in a bag without a legible label.	Yes
Resident H made a shooting gesture at school. Jardon schools called the group home for a threat assessment to ask if they had any guns or weapons in the home. There is a concern about the safety of the residents.	No

III. METHODOLOGY

12/05/2025	Special Investigation Intake 2026A0611006
12/05/2025	Contact - Telephone call made I left a voice message for the reporting source requesting a call back.
12/05/2025	Special Investigation Initiated - Telephone I contacted Jardon schools to get clarity regarding the allegations and to identify who the allegations are about. I was told to call back when the secretary returns from break.
12/09/2025	Contact - Telephone call made I made a telephone call to the reporting source. The allegations were discussed.
12/09/2025	Contact - Telephone call made I made a telephone call to Nurse Stephanie Fowler-Eaglan who works at Jardon school. The allegations were discussed.
12/16/2025	Inspection Completed On-site I completed an unannounced onsite. I interviewed staff member Devin Williams and staff member Kimani Troup. I reviewed Resident H MAR for the month of December.
12/26/2025	Contact - Telephone call made I left a voice message for staff member Alaken Martin requesting a call back.

12/26/2025	Contact - Telephone call made I made a telephone call to staff member Mary Trenell. The allegations were discussed.
12/26/2025	Contact - Telephone call made I made a telephone call to the licensee designee Champaign Brown. The allegations were discussed.
12/26/2025	Contact - Document Received I received a picture of Resident H bubble packet for his Clonazepam and a picture of his third MAR sheet including his nasal spray.
12/29/2025	Contact - Telephone call made I made a telephone call to Resident H mother. The allegations were discussed.
12/29/2025	Contact - Telephone call made I made a telephone call to staff member Alaken Martin. The allegations were discussed.
12/29/2025	Exit Conference I completed an exit conference with the licensee designee Champaign Brown via telephone.

ALLEGATION:

The AFC group home has sent Resident H to school without his swipe badge that is needed for his Vegus Nerve Stimulator (VNS) to treat his seizures. There has been some confusions on his medication as the home doesn't send all of it when he comes to school or it is in a bag without a legible label.

INVESTIGATION:

On 12/05/25, a complaint was received and assigned for investigation alleging that the AFC group home sent Resident H to school without his swipe badge that is needed for his Vegus Nerve Stimulator (VNS) to treat his seizures. There has been some confusions on his medication as the home doesn't send all of it when he comes to school or it is in a bag without a legible label. In October, Resident H ended up in the ICU due to bruises and bite marks on him from the group home. In the last week, Resident H made a shooting gesture. Jardon schools called the group home for a threat assessment to ask if they had any guns or weapons in the home. Champaign Brown answered and was completely unprofessional yelling and screaming on the phone. Champaign Brown said that they had all weapons locked up correctly. On the home's

website, they have 2 staff members in scream outfits holding knives to each other's throats. There is a concern about the safety of the residents.

NOTE: This investigation does not address the allegations pertaining to Resident H being in the hospital for bite marks and bruises as this complaint was previously investigated and completed on 11/20/25 SIR #2025A0465028 and was found unsubstantiated. On 12/09/25, this information was further confirmed by Resident H former Easter Seals case manager Kayla Singleton. Ms. Singleton stated the incident occurred the first night Resident H moved into the AFC group home in September 2025. Resident H was sent to the ICU because he was attacking staff at the AFC group home and due to his behaviors being severe, there were concerns he would hurt someone. Ms. Singleton denied any safety or abuse concerns regarding the staff at the AFC group home. Ms. Singleton stated the home appeared safe and she never observed any weapons.

On 12/09/25, I made a telephone call to the reporting source. Regarding the allegations, the reporting source provided the name of Resident H. The reporting source confirmed that Resident H is Autistic and non-verbal. Resident H attends a vocational program Monday through Friday from 8:00am to 2:30pm. Resident H has a medical device inserted inside of his chest and; he has a second device that he carries with him in a bag. In the event of Resident H experience symptoms of a seizure, he will use the second device to swipe against his chest to minimize the seizure. The reporting source stated about six weeks ago, Resident H arrived at school without his second medical device which could have led to a medical issue if he had a seizure. Resident H is prescribed a liquid medication to treat his seizures. Resident H is prescribed to take this medication during lunch time. Resident H lunch time is scheduled from 10:50am to 11:30am.

The reporting source stated the AFC group home would send Resident H liquid medication in a bag where the label is illegible as it has been soaked by another liquid source. The reporting source stated there has been an instance where this medication has been sent to the school after it has expired. It is an on-going issue with the AFC group home not sending Resident H medication to school with him. The reporting source stated yesterday was the most recent incident where Resident H arrived to school without his medication. The reporting source described an instance where the owner of the AFC group home (Champaign Brown) stated the reason why Resident H did not have his medication at school, was because he was leaving school early at 12:00pm.

On 12/09/25, I made a telephone call to Nurse Stephanie Fowler-Eaglan. Nurse Stephanie works at Resident H vocational school. Nurse Stephanie stated as far as she knows, Resident H is prescribed the following medications:

- Lacosamide 300 mg twice a day
- Eflincarbazetine 400mg twice a day
- Diazepam 5mg 5ML dose PRN

- Valtoco 20mg nasal spray PRN
- Xecopri 150mg
- Abilify 5mg
- Clonazepam

Nurse Stephanie stated Resident H was administered Diazepam at school until 12/02/25. Resident H's Diazepam was replaced with Valtoco. Nurse Stephanie is not sure if Resident H is currently prescribed to take Diazepam at the AFC group home. Nurse Stephanie stated the school only administers Resident H Valtoco and Abilify. Nurse Stephanie stated she is responsible for administering Resident H medications however; if she is not available then the secretary (Jessica) is trained to administer medications and; every staff member is trained to administer Valtoco. Resident H also has a Vegus Nerve Stimulator (VNS) which is a magnet that Resident H uses to swipe over his medical device that is inserted inside his chest to minimize his seizures.

Nurse Stephanie stated there has been multiple issues with the AFC group home not sending Resident H medications to school and/or sending the wrong medication. The reason why Resident H was prescribed Valtoco to replace Diazepam because the label for the Diazepam would be soaked from a liquid substance which made the label illegible. Although the school is no longer administering the Diazepam, Resident H arrived to school yesterday with the Diazepam and the Valtoco nasal spray. The Valtoco was missing the box with the label on it. The school contacted the AFC group home and they agreed to bring the label box to the school so that his Valtoco could be administered. Nurse Stephanie stated she has spoken with Champaign Brown but, she is not helpful with regards to the medication issues nor is she willing to work with her.

On 12/16/25, I completed an unannounced onsite. I interviewed staff member Devin Williams and staff member Kimani Troup. Resident H was not present as he was at his vocational program.

On 12/16/25, I interviewed staff member Devin Williams. Regarding the allegations, Resident H has resided in the AFC group home for 2½ months. Resident H attends his vocational program Monday through Friday. Resident H is only absent from his vocational program when he has a doctor's appointment. When Resident H has a doctor's appointment, he is either picked up from his vocational program by a staff member or his parents. Mr. Williams stated Resident H morning medication is administered by a midnight staff member. While Resident H is at his vocational program, he is administered Aripiprazole 5mg at 12:00pm and Clonazepam 1mg (PRN) at 2:00pm. Mr. Williams stated both of these medications are packaged in a bubble packet. Mr. Williams was not sure if the midnight staff member gives Resident H Aripiprazole and Clonazepam to Resident H bus driver or if the medication is placed in Resident H backpack. Mr. Williams stated Resident H also has a swipe badge that he takes with him to his vocational program every day.

During the onsite, I reviewed Resident H's MAR. I observed that there were a total of eight staff initials for Resident H Aripiprazole and Clonazepam. Mr. Troup explained that

staff only initial the MAR for the abovementioned medications when Resident H is not at his vocational program. I observed on 12/15/25, that Mr. Troup administered Resident H Aripiprazole and Clonazepam. Mr. Troup explained that Resident H did attend his vocational school yesterday but he also had a doctor's appointment yesterday. Resident H's dad transported Resident H to his doctor's appointment. Mr. Troup thinks the doctor's appointment was around 12:00pm. Mr. Troup also stated he thinks Resident H returned to the AFC group home shortly after 12:00pm.

Resident H MAR does not include that he is prescribed Valtoco 10mg. According to Resident H MAR, Resident H is prescribed the following medications:

- Aripiprazole 10mg at bedtime (Abilify)
- Aripiprazole 5mg at noon (Abilify)
- Clonazepam 1mg at 2:00pm (PRN)
- Clonazepam 2mg at bedtime
- Eslicarbazepine 400mg twice a day 8:00am and 8:00pm
- Lacosamide 150mg twice a day 8:00am and 8:00pm
- Xecopri 150mg daily
- Xecopri 100mg at night
- Acetaminophen 500mg as needed (PRN)
- Diazepam 5mg (PRN)

Mr. Troup stated Resident H is now given Valtoco as a PRN in the event he has a seizure. Mr. Troup does not know if Resident H Diazepam has been discontinued or not.

I observed Resident H Diazepam and Valtoco. The Diazepam bottle was inside a plastic bag and the label was clean and easily legible. The Diazepam label indicates to take 5 ml under the tongue with a long seizure lasting longer than five minutes, or two seizures without regaining consciousness. It appears that the prescription for Diazepam was filled on 11/28/25. The Valtoco was observed in a box that had not been opened. It appears that the prescription for Valtoco was filled on 12/03/25. The instructions for Valtoco indicates to instill one spray in each nostril once daily as needed for generalized seizures lasting five minutes or longer or two focal seizures without regaining consciousness. Mr. Troup stated the vocational program also has Valtoco in their possession for Resident H. Mr. Troup denied there ever being an instance where Resident H went to his vocational program without his swipe badge.

On 12/26/25, I made a telephone call to staff member Mary Trenell. Regarding the allegations, Ms. Trenell stated she works the midnight shift along with staff member Alaken Martin Monday through Thursday from 8:00pm to 8:00am. Ms. Trenell is assigned to Resident N as a 1:1 and; Ms. Martin is assigned to Resident H as a 1:1. There are two other residents in the AFC group home who do not have behavioral issues. Ms. Trenell stated Resident H is woken up at 6:30am to get ready for his vocational program. Resident H bus arrives to the AFC group home around 7:20am. Ms. Martin administers Resident H morning medications. Ms. Trenell administers

Resident N morning medications. Ms. Trenell stated Resident B is not prescribed any medications and Resident L is only prescribed medications at night which are administered by the day time staff.

Ms. Trenell stated Resident H is given his nasal spray that he carries in his backpack to and from his vocational program. Ms. Trenell does not know if Resident H gives the nasal spray to a staff member at the vocational program. Resident H also carries a magnet in his backpack as well for his seizures. The vocational program is in possession of Resident H bubble packets for his Abilify and Clonazepam. The vocational program administers Resident H Abilify and Clonazepam at 2:00pm. Ms. Trenell stated at the end of the month, Ms. Brown takes the new bubble packets for the next month for Resident H Abilify and Clonazepam to his vocational program. Ms. Trenell stated before Resident H was prescribed the nasal spray he was given a liquid medication but, she does not remember the name of the medication. The same process was followed with the liquid medication as Resident H would carry it in his backpack to and from the vocational program.

Ms. Trenell is not aware of any instances where Resident H went to his vocational program without any of his medications. Ms. Trenell stated she and Ms. Martin are pretty thorough with packing the medications up for their assigned residents. Ms. Trenell stated Resident H does not attend his vocational program on days he says he is not feeling well or when he is in the hospital for behavioral issues. Resident H has been hospitalized about four or five times.

On 12/26/25, I made a telephone call to the licensee designee Champaign Brown. Ms. Brown stated Resident H was admitted to the AFC group home on 09/19/25. Ms. Brown denies Resident H being sent to his vocational program without his medication or swipe badge. Ms. Brown stated the staff check Resident H backpack every morning to ensure he has his swipe badge. Prior to Resident H being prescribed his nasal spray, he was prescribed a liquid form of Diazepam as a PRN. Ms. Brown stated Resident H Diazepam was required to be refrigerated. Resident H would transport his Diazepam in a plastic bag along with his swipe badge in a plastic case bag that zips up to and from school. Ms. Brown stated she is often in communication with Nurse Stephanie at the vocational program. Nurse Stephanie has communicated that the label for the Diazepam was illegible. Ms. Brown stated the label would become illegible due to it being refrigerated at the AFC group home. Ms. Brown denied any substance being spilled on the Diazepam label. Therefore, it was decided to replace the Diazepam with the nasal spray as it would be easier to transport and the label would not be illegible.

Ms. Brown stated the Diazepam has been discontinued. Ms. Brown stated it is her process to contact the pharmacy to pick up any discontinued medications from the AFC group home. Ms. Brown was informed that I observed the Diazepam in the AFC group home on 12/16/25 and; it should have been discarded prior to then given the nasal spray was prescribed on 12/03/25. Ms. Brown did not have any documentation to verify that the pharmacy had been called to pick up the Diazepam.

Ms. Brown stated the school is in possession of Resident H Abilify and Clonazepam. Resident H is scheduled to take the Abilify at 12:00pm and the Clonazepam at 2:00pm. Ms. Brown does not know for certain if Nurse Stephanie documents when Resident H is administered his Abilify or Clonazepam. Ms. Brown was reminded that she is responsible to ensure the administration of medications are properly documented even if medications are given outside the home. The pharmacy makes a separate delivery to Resident H vocational program each month to deliver his Abilify and Clonazepam. Ms. Brown stated if there was ever an issue with the pharmacy not delivering the above-mentioned medications, Nurse Stephanie will call her to resolve the issue. Nurse Stephanie also has access to the pharmacy to contact them as well for any problems. There are two boxes of nasal spray at the AFC group home and there is a third box that gets transported to and from Resident H vocational program.

Despite Resident H MAR stating his 2:00pm Clonazepam is a PRN, Ms. Brown explained that Resident H is prescribed to take Clonazepam at 2:00pm and 8:00pm daily and he has a separate bubble packet for Clonazepam that should be administered as a PRN. It was explained to Ms. Brown that the exact label instructions are required to be documented on the MAR. I informed Ms. Brown that Resident H nasal spray was not included on his MAR. Ms. Brown stated she wrote Resident H nasal spray on a third MAR sheet by itself. Ms. Brown stated she will provide a copy of the third MAR sheet as well as pictures of all three Clonazepam labels.

Ms. Brown stated on 12/15/25, Resident H had a doctor's appointment scheduled at 2:30pm. Ms. Brown stated Mr. Troup would have picked Resident H up from school at 2:00pm. Mr. Troup transported Resident H from school to the doctor's appointment and Resident H's mom met them at the doctor's appointment. Following the doctor's appointment, Mr. Troup transported Resident H back to the AFC group home. Ms. Brown verified this information by checking a group chat between her and Resident H parents. Ms. Brown could not explain why Mr. Troup could not remember that he transported Resident H to his doctor's appointment when asked about it the day after it happened.

Ms. Brown stated Resident H has not had a seizure at the AFC group home since he has been admitted. Ms. Brown stated as far as she knows Resident H has never had a seizure at his vocational program as it has never been reported to her.

On 12/26/25, I received a copy of Resident H bubble packet of his Clonazepam 1mg bubble packet. The instructions state to take one tablet by mouth every day in the afternoon. Take one tablet twice daily as needed for anxiety (every 12 hours) not to exceed 5mg total in 24 hours period. I also received a copy of a third MAR sheet that only has Resident H Valtoco nasal spray 10mg as a PRN.

On 12/29/25, I made a telephone call to Resident H's mother. Regarding the allegations, Resident H mother stated she is happy with the care that Resident H is receiving at the AFC group home. Resident H mother denied any concerns nor did she

have any complaints regarding the staff at the AFC group home. Ms. Brown does a good job with communicating with Resident H mother as well as making sure Resident H is taken care of. Resident H mother stated Resident H receives his medication every day. Resident H is administered his Abilify and Clonazepam while at school. Resident H also takes his swipe badge with him to school.

On 12/29/25, I made a telephone call to staff member Alaken Martin. Ms. Martin works the midnight shift on Mondays through Thursdays from 8:00pm to 8:00am. Ms. Martin is a 1:1 staff member for Resident H. Ms. Martin stated she wakes Resident H up around 6:30am and he leaves for his vocational program at 7:30pm. Resident H is given his nasal spray to take with him to his vocational program. Resident H carries his nasal spray and swipe badge with him in a red bag that is located inside of his backpack. Ms. Martin stated Resident H's afternoon medications are already at his vocational program. Ms. Martin stated before Resident H was prescribed nasal spray he was prescribed Diazepam which was required to be refrigerated. Ms. Martin stated Resident H would also carry his Diazepam in his backpack on his way to his vocational program and; the Diazepam would be refrigerated at the vocational program. Ms. Martin denied there ever being an instance where Resident H went to his vocational program without his medication or with the wrong medication. Ms. Martin stated she always checks Resident H backpack to ensure he has his medication.

APPLICABLE RULE	
R 400.675	Resident medications.
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	Based on the information gathered, there is sufficient evidence to support this allegation. The staff interviewed confirmed that Resident H Valtoco nasal spray is transported in his backpack in an unsecured bag to and from his vocational program. Prior to Resident H being prescribed Valtoco nasal spray, he was prescribed a liquid form of Diazepam which was required to be refrigerated and he was also transporting this medication to and from his vocational program in an unsecured bag located inside his backpack.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.675	<p>(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:</p> <p>(b) Complete an individual medication log that contains all of the following:</p> <p>(iii) Label instructions for use.</p>
ANALYSIS:	<p>There is sufficient evidence to support this allegation. I observed Resident H's MAR for the month of December and found that the instructions for his Clonazepam are not written in its entirety based on what the instructions state on the bubble packet. According to Resident H MAR, it indicates that Resident H is prescribed Clonazepam 1mg by mouth in the afternoon. The MAR includes a time of 2:00pm and PRN is written underneath it. However, the label instructions located on the bubble packet for the Clonazepam indicates to take one tablet by mouth every day in the afternoon. Take one tablet twice daily as needed for anxiety (every 12 hours) not to exceed 5mg total in 24 hours period.</p>
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.675	<p>(7) Prescription medication that is no longer required by a resident or expired must be properly disposed of.</p>
ANALYSIS:	<p>During my onsite, I observed Resident H Diazepam. Mr. Troup was unsure if the Diazepam was discontinued or not. On 12/26/25, Ms. Brown confirmed that Resident H Diazepam was discontinued as it was replaced with his Valtoco nasal spray. Therefore, Resident H Diazepam had not been properly disposed of at the time it was discontinued on or around 12/03/25 when Resident H was prescribed Valtoco nasal spray.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident H made a shooting gesture at school. Jardon schools called the group home for a threat assessment to ask if they had any guns or weapons in the home. There is a concern about the safety of the residents.

INVESTIGATION:

On 12/09/25, the reporting source stated Resident H school completed a threat assessment by calling the AFC group home to inquire if there were any weapons in the home. Ms. Brown denied any weapons in the home and confirmed that the utensils were locked up. The reporting source stated the AFC group home has a picture on their Facebook page of two staff members in scream outfits holding knives to each other's throats.

On 12/16/25, Mr. Troup was aware of an instance where Resident H drew a picture of a gun while at his vocational program. The licensee designee Champaign Brown did speak to the school regarding this issue and notified them that there are no weapons in the home. Mr. Troup stated scissors, pens, and utensils are locked up to ensure safety.

On 12/26/25, Ms. Brown denied any weapons of any kind in the AFC group home. The utensils are locked up in a closet located in the dining area. Ms. Brown stated when the vocational program social worker James Bellini called her regarding weapons in the home, he was belligerent and condescending which lead to them getting into a spat. Ms. Brown stated the allegations are a result from her conversation with Mr. Bellini. Mr. Bellini explained to Ms. Brown that Resident H drew a picture of a gun, knife, and X's over a person's eyes. Mr. Bellini also told Ms. Brown that Resident H informed him that there were guns and knives in the AFC group home. Ms. Brown stated she does not know how that is possible when Resident H is non-verbal. Resident H also displays high behavioral issues. Ms. Brown stated she contacted Mr. Bellini supervisor regarding their conversation and the supervisor apologized to her. Ms. Brown stated she is offended by the allegations as she goes above and beyond for her residents.

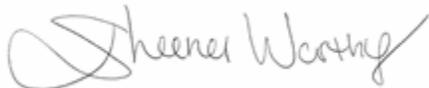
On 12/29/25, I attempted to ask Resident H's mother about whether or not there were any weapons in the AFC group home but she did not understand the questions due to the language barrier.

On 12/29/25, I completed an exit conference with the licensee designee Champaign Brown via telephone. Ms. Brown clarified that the picture of two staff members in scream outfits was not a part of her business page on Facebook. Ms. Brown stated staff member Mary Trenell took those pictures at her personal home for Halloween and the picture was shared on the AFC group home Facebook page. Ms. Brown stated the knives were fake and the picture had nothing to do with the residents or the AFC group home. I looked up the AFC group home business page on Facebook and verified that the picture was taken under the name of "Riie Shiesty" and shared on Serenity Meadows Assisted Living page. The picture did not appear to be taken at the AFC group home as the background did not match what I observed during my onsite. Ms. Brown was informed of which rule violations she will be cited on and that a corrective action plan will be required.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on the information gathered, there is no evidence to support this allegation. I observed the picture on the AFC group home Facebook page and the picture did not appear to be taken at the AFC group home. Resident H's mother did not report any concerns regarding the staff and/or any safety concerns regarding the AFC group home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

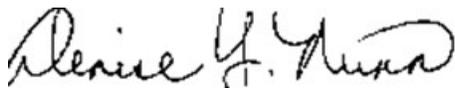
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



Sheena Worthy
Licensing Consultant

12/29/25
Date

Approved By:



01/15/2026

Denise Y. Nunn
Area Manager

Date