



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 26, 2026

Johnny Welsh
CC's Villa LLC
41 W. Lorraine St.
Peck, MI 48466

RE: License #: AS760391684
Investigation #: 2026A0572015
CC's Villa

Dear Johnny Welsh:

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 (517) 643-7960.

Sincerely,

A handwritten signature in black ink that reads "Anthony Humphrey". The signature is written in a cursive style with a large, looping flourish at the end of the name.

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS760391684
Investigation #:	2026A0572015
Complaint Receipt Date:	12/15/2025
Investigation Initiation Date:	12/18/2025
Report Due Date:	02/13/2026
Licensee Name:	CC's Villa LLC
Licensee Address:	41 W. Lorraine St. Peck, MI 48466
Licensee Telephone #:	(810) 378-5550
Administrator:	Larissa Kuhn
Licensee Designee:	Johnny Welsh
Name of Facility:	CC's Villa
Facility Address:	41 W. Lorraine Peck, MI 48466
Facility Telephone #:	(810) 378-5550
Original Issuance Date:	07/06/2018
License Status:	REGULAR
Effective Date:	01/06/2025
Expiration Date:	01/05/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff, Sandra Allen was yelling and calling Resident A fat and smelly.	No
Unsafe heating was used due to a nonfunctioning furnace, placing residents at risk.	No
An untrained individual was hired to administer medications.	No
Additional Findings	Yes

III. METHODOLOGY

12/15/2025	Special Investigation Intake 2026A0572015
12/18/2025	Special Investigation Initiated - On Site
12/18/2025	Contact - Face to Face Home Manager, Sandy Allen; Resident B, Resident C and Annette Welsh.
12/18/2025	Inspection Completed-BCAL Sub. Compliance
01/21/2026	Contact - Telephone call made Resident A's Case Manager, Samantha Hood.
01/22/2026	Contact - Telephone call made Resident A's Public Guardian.
01/23/2026	Contact - Document Sent Licensee Designee, Johnny Welsh.
01/23/2026	Contact - Telephone call made Licensee Designee, Johnny Welsh.
01/26/2026	Exit Conference Licensee Designee, Johnny Welsh.

ALLEGATION:

Staff, Sandra Allen was yelling and calling Resident A fat and smelly.

INVESTIGATION:

On 12/15/2025, the local licensing office received a complaint for investigation. I will make an onsite at CC's Villa within the week.

On 12/18/2025, I made an unannounced onsite at CC's Villa, located in Sanilac County Michigan. Interviewed was Staff Sandra Allen, Resident B and Resident C. Resident A was not interviewed as Resident A was with family at the time of my onsite.

On 12/18/2025, I interviewed Home Manager, Sandra Allen regarding the allegation. Sandra Allen denied ever yelling or calling Resident A any names. Sandra Allen informed me that she had an issue with Resident A not wanting to take a shower, so she created a shower log for Resident A to follow which is a shower every two days. Resident A doesn't like to shower or clean her room but wants to work in the community. Sandra Allen explained to Resident A that good hygiene is important while being in public spaces. It's in Resident A's Assessment to give her reminders regarding cleaning her room and completing her hygiene, but Resident A just yells at them for doing so. The fire inspector was upset with the home due to not having enough room to safely enter and exit Resident A's bedroom.

On 12/18/2025, I reviewed Resident A's Assessment Plan. Resident A has issues with controlling aggressive behaviors as Resident A has a history of physical aggression, elopement and property destruction. In regard to household chores and hygiene, Resident A can complete those tasks independently but needs reminders from staff.

On 12/18/2025, I spoke with Resident B briefly as cognitively Resident B is not a good interview. Resident B informed that she loves her home and Sandra Allen is very nice to her.

On 12/18/2025, I interviewed Resident C regarding the allegation. Resident C denied that Home Manager, Sandra Allen, yells at or calls any of the residents names.

On 12/18/2025, I interviewed Staff, Annette Welsh regarding the allegation. She has only been working for a week and just came in town from out of state to help her brother who is the owner out because they are closing next month. In the week that she worked, she has not witnessed Sandra Allen yelling or calling Resident A any names.

On 01/21/2026, I contacted Resident A's Case Manager, Samantha Hood, regarding the allegation. Samantha Hood informed that this is the first that she is hearing this

as Resident A never mentioned any yelling or name calling. Samantha Hood informed that Resident A does have a long history of making things up.

On 01/22/2026, I contacted Resident A's Public Guardian regarding the allegation. Resident A never mentioned anything regarding the Home Manager yelling at her and calling her names. As a team, they were working with Resident A, trying to encourage her to keep her bedroom clean and stay up on her hygiene.

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse. (iii) Derogatory remarks. (iv) Threats.
ANALYSIS:	Based on my interviews with staff and residents, there is not enough evidence to establish a licensing rule violation. Staff denied calling Resident A names or yelling at her. Informed that Resident A would become upset when encouraged to shower and clean her room. The residents interviewed informed that Home Manager, Sandra Allen, was very nice to all the residents. The Case Manager and Public Guardian informed that Resident A never complained to them in regard to being treated badly in the home by staff.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Unsafe heating was used due to a nonfunctioning furnace, placing residents at risk.

INVESTIGATION:

On 12/18/2025, I interviewed Home Manager, Sandra Allen regarding the allegation. Sandra Allen informed that the furnace was not working efficiently, so they used an electric space heater temporarily as they waited for the parts to come in. The parts came in after two days and the furnace was fixed immediately.

On 12/18/2025, I interviewed Resident C regarding the allegation. Resident C informed that the furnace went out, but not that long. They used electric heaters until the furnace was fixed.

On 12/18/2025, during my unannounced visit to the home, the temperature of the home was 72 degrees and there were no space heaters being used.

On 01/21/2026, I contacted Resident A's Case Manager, Samantha Hood, regarding the allegation. Samantha Hood informed that she wasn't aware of any issues regarding the furnace.

On 01/22/2026, I contacted Resident A's Public Guardian, regarding the allegation. The Guardian informed that she was made aware that there were some heating issues by Resident A's mother, so she contacted the home to verify and to see what they were doing to correct the issue. To the Guardian's understanding, the furnace was working, but it was not heating up to the desired temperature that was set on the thermostat. The Public Guardian sent me an email response regarding the furnace:

"So we are having issues with our furnace. It's working but we have to keep it low, so the motor doesn't burn up. We've ordered the motor and although against licensing....we've provided everyone with an electric heater. The temperature has not gotten below 63. Now due to (Resident A's) bedroom....our maintenance guy contacted the owner of the building and said that he didn't recommend her bedroom having an electric heater due to her mess. The common area is completely fine and heated to 73.... We've told (Resident A) she either needs to clean her room...or she can spend her time in the common area. Again it's not freezing...the furnace has been looked at...we know the issue just waiting for the part which should be here around the 10th-13th (of December). But it's still running just on low. We have elderly people that of course like things warmer. The issue is that her room is a fire hazard. Staff check the rooms with the heaters every 30 minutes and they are away from any danger. The furnace that is not working properly is set to 64. I hope this helps clarify. Again..... yes...electric heaters are against licensing...but we are doing everything we can to keep everyone comfortable until the part comes in."

APPLICABLE RULE	
R 400.729	Heating equipment.
	(1) Heat must be provided by an approved central heating plant or a permanently installed electrical heating system that is approved by a nationally recognized testing laboratory that uses acceptable testing methods.
ANALYSIS:	Based on my interviews with staff, case manager and guardian, there is not enough evidence to establish a licensing rules violation. The furnace was not reaching the desired temperatures, so staff used UL listed electric heaters for a few days to keep the temperature up in bedrooms. The common area was at the correct temperature. The furnace was fixed

	within a few days. Resident A was not given an electric heater due to fire hazard in her bedroom.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

An untrained individual was hired to administer medications.

INVESTIGATION:

On 12/18/2025 I interviewed Home Manager, Sandra Allen regarding the allegation. Sandra Allen informed that Annette Welsh is from out-of-state and is the sister of the owner. She is helping them close the facility due to not having enough staff. She has trained Annette Welsh in passing medications. Annette Welsh passes the morning medications because another staff quit. It's only her and two other staff members, plus Annette Welsh. Annette Welsh is only here until 01/05/2026 and then she's going back home.

On 12/18/2025, I spoke with Resident C regarding the allegation. Resident C informed that he takes medication and staff administer it to him. Resident C informed that Annette Welsh is one of the staff members who administers his medications.

On 12/18/2025, I interviewed Annette Welsh regarding the allegation. She informed that she came down from South Carolina to help her brother who is the owner because they are very short staffed. She usually works about 4 hours a day because the Administrator quit suddenly. Home Manager, Sandra Allen trained her in passing medications for two days and then observed her administering it.

On 12/18/2025, I observed the medication records. The medication records appeared to be accurate. Annette Welsh's initials were in the medication records as the person administering medications in the morning.

On 01/21/2026, I contacted Resident A's Case Manager, Samantha Hood, regarding the allegation. Samantha Hood informed that she wasn't aware of any issues regarding someone other than staff administering the medication. The home officially closed on 01/17/2025. All of the residents have been given a 30 days notice and were all moved into new placements by 01/17/2026.

On 01/22/2026, I contacted Resident A's Public Guardian, regarding the allegation. The Public Guardian was made aware by the Owner, Johnny Welsh, that they would be closing soon due to short staff. Johnny Welsh would be attempting to get staff in to assist with helping them close the facility. The Public Guardian wasn't aware of who they were getting to pass the medications. The facility closed on 01/17/2026 and Resident A moved to another home that she is familiar with in Sandusky Michigan.

APPLICABLE RULE	
R 400.675	Resident medications.
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: (a) Be trained in the proper handling and administration of medication. prolonged use of a medication that is prescribed on an as-needed basis. The review process must include the resident's prescribing licensed health care professional and resident, resident's designated representative, and responsible agency if applicable.
ANALYSIS:	Based on my interviews there is not enough evidence to establish a licensing rules violation. Annette Welsh was trained to pass medication as there was a shortage of staff while in the midst of closing the facility. Medication records appeared to be accurate.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

Annette Welsh is providing care and supervision to vulnerable adults but is not an official employee.

INVESTIGATION:

On 12/18/2025, I interviewed Home Manager, Sandra Allen regarding the allegation. Sandra Allen informed that Annette Welsh is from out-of-state and is the sister of the owner. She is helping them close the facility due to not having enough staff. Annette Welsh is only here until 01/05/2026 and then she's going back home. Annette Welsh has not gone through the process of being an employee.

On 12/18/2025, I interviewed Annette Welsh regarding the allegation. Annette Welsh informed that she came down from South Carolina to help her brother who is the owner because they are very short staffed. Annette Welsh usually works about 4 hours a day because the Administrator quit suddenly. She's had CPR training and First Aid in South Carolina, but not in Michigan. Annette Welsh's last day will be 01/04/2026 as she will be returning home.

On 12/18/2025, I interviewed Resident A's Case Manager regarding the additional findings. She informed that she was not aware that anyone other than staff were caring for the residents but understood since they had several staff who quit and they were in the process of shutting down.

On 01/22/2026, I contacted Resident A's Public Guardian, regarding the allegation. The Public Guardian was made aware by the Owner, Johnny Welsh, that they would be closing soon due to short staff. He would be attempting to get staff in to assist with helping them close the facility. The Public Guardian wasn't aware who would be working in the home.

On 01/22/2026, I sent Licensee Designee, Johnny Welsh an email letting him know that I would be contacting him via phone for an Exit Conference and ask for something in writing indicating that he is closing CC's Villa.

On 01/23/2026, I called Licensee Designee, Johnny Welsh but the number on file belongs to someone else and the person did not know who Johnny Welsh is. I called CC's Villa home phone number and the number is disconnected. I emailed Resident A's Guardian for the phone number and she indicated that she does not have his phone number. I also went through a list of numbers from when CC's Villa was initially opened, however; they are all non-working phone numbers.

On 01/23/2026, I made several attempts to conduct an Exit Conference via phone, however; the phone numbers are changed or disconnected. I conducted an Exit Conference via email to inform Mr. Welsh that there is a licensing rules violation.

On 01/26/2026, I held an exit conference with License Designee (LD), Johnny Welsh and explained to him the findings from my special investigation. Johnny Welsh informed that he has closed the home and is no longer accepting any residents. Johnny Welsh stated he will submit a letter indicating his desire to officially close the home, after receipt of his copy of the special investigation report.

APPLICABLE RULE	
R 400.639	Staff records.
	<p>(1) A licensee shall maintain a record for each staff that contains all of the following:</p> <ul style="list-style-type: none"> (a) Name, address, telephone number, and Social Security number. (b) Copy or number of a professional or vocational license, certification, or registration if staff provides professional or vocational services. (c) Copy of a driver's license if staff provide transportation services. (d) Verification of age. (e) Verification of experience, highest level of education completed, and training. (f) Verification of not less than 2 reference checks. If reference checks cannot be obtained, documentation

	<p>verifying reference checks were attempted must be maintained.</p> <p>(g) Beginning and ending dates of employment on separation.</p> <p>(h) Health information as required by these rules.</p> <p>(i) Verification of the receipt by the staff of personnel policies and job descriptions.</p> <p>(2) Records identified in subrule (1) of this rule must be maintained for 2 years after the staff's ending date of employment.</p> <p>(3) A licensee shall maintain for 90 days a daily work schedule and assignments that includes all of the following:</p> <p>(a) Names of staff on duty.</p> <p>(b) Job titles.</p> <p>(c) Hours or shifts worked.</p> <p>(d) Date of schedule.</p> <p>(e) Scheduling changes when made.</p>
ANALYSIS:	Annette Welsh informed that she was only there to assist as the home was losing staff and there was no need to hire staff as they were closing. Annette Welsch was acting as a staff person, providing care and supervision to the residents.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this small adult foster care group home, pending the receipt of either an acceptable corrective action plan, or a letter stating LD Welsch would like to close their license (capacity 3-6).



1/26/2026

Anthony Humphrey
Licensing Consultant

Date

Approved By:



1/26/2026

Mary E. Holton
Area Manager

Date