



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 24, 2026

Natalie Ptak  
CapABLE Community Living  
68860 Appleview Dr  
Washington Twp, MI 48095

RE: License #: AS500419177  
Investigation #: 2026A0617008  
CapABLE Community Living

Dear Mrs. Ptak:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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) 975-5053.

Sincerely,

A handwritten signature in blue ink, appearing to read "EJ".

Eric Johnson, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Place, Ste 9-100  
3026 W Grand Blvd  
Detroit, MI 48202

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS500419177
<b>Investigation #:</b>	2026A0617008
<b>Complaint Receipt Date:</b>	01/21/2026
<b>Investigation Initiation Date:</b>	01/21/2026
<b>Report Due Date:</b>	02/20/2026
<b>Licensee Name:</b>	CapABLE Community Living
<b>Licensee Address:</b>	68860 Appleview Dr Washington Twp, MI 48095
<b>Licensee Telephone #:</b>	(586) 994-0057
<b>Administrator:</b>	Natalie Ptak
<b>Licensee Designee:</b>	Natalie Ptak
<b>Name of Facility:</b>	CapABLE Community Living
<b>Facility Address:</b>	68860 Appleview Dr Washington, MI 48095
<b>Facility Telephone #:</b>	(586) 281-6464
<b>Original Issuance Date:</b>	02/14/2025
<b>License Status:</b>	1ST PROVISIONAL
<b>Effective Date:</b>	08/27/2025
<b>Expiration Date:</b>	02/26/2026
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
On 1/16/2026, Resident A's mother was given medications in a zip-lock bag instead of the original prescription containers. Licensee designee Natalie Ptak left the residents in the van alone at 9:30 at night to go in the house to get the medications.	Yes
Resident A was given a 30-day discharge as retaliation for making a complaint on the facility	Yes

**III. METHODOLOGY**

01/21/2026	Special Investigation Intake 2026A0617008
01/21/2026	Special Investigation Initiated - Telephone TC to Complainant
01/28/2026	Inspection Completed On-site I conducted an unannounced onsite investigation at the facility. I interviewed staff member Tom Ptak via phone as no one was home.
01/28/2026	Contact - Telephone call received TC from Mr. Ptak
01/28/2026	Contact - Telephone call made TC to Mr. Ptak
01/29/2026	Contact - Telephone call received TC from Mrs. Ptak
01/29/2026	Contact - Telephone call made TC to Mrs. Ptak
01/30/2026	Contact - Telephone call received TC from Mrs. Ptak
01/30/2026	Contact - Telephone call made I interviewed Ms. Natile Ptak
02/06/2026	Contact - Telephone call made I interviewed Resident A's mother
02/06/2026	Exit Conference

	I held an exit conference with licensee designee Mrs. Natalie Ptak
02/27/2026	Contact - Telephone call made I interviewed Resident B.

**ALLEGATION:**

**On 1/16/2026, Resident A's mother was given medications in a zip lock bag instead of original prescription containers. Licensee designee Natalie Ptak left the residents in the van alone at 9:30 at night to go in the house to get the medications.**

**INVESTIGATION:**

On 01/21/26, I received a complaint regarding the CapABLE Community Living facility. According to Complainant, on 1/16/2026 Complainant and Resident A went to the facility to get her medications because Resident A was going to stay with Complainant for a few days. Complainant reported that staff and residents were not at home upon arrival, so Complainant and Resident A waited for them to arrive. Complainant reported texting with staff Tom Ptak as well as talking to him on the phone while waiting for staff and residents to arrive at the facility. Complainant reported that staff Tom Ptak texted that "staff (he did not specify it was Natalie Ptak) would be there within 20." Complainant reported staff and residents arrived shortly thereafter and Complainant relayed this information to staff Tom Ptak who responded, "Oh good! faster than I thought." Complainant reported then receiving another text from staff Tom Ptak that stated, "Do not leave the residents alone to grab medication, get them inside first." Complainant reported texting staff Tom Ptak back telling him. "that I know you sent that text to the wrong person but that she already did." Complainant reported licensee designee Natalie Ptak left the residents in the van alone at 9:30 at night to go in the house with Resident A to get her medications.

On 01/28/26, I conducted an unannounced onsite investigation at the facility. I interviewed staff member Tom Ptak via phone as no one was home. According to Mr. Ptak, all residents were away at workshop and staff would return to the home prior to the residents returning from workshop. Mr. Ptak stated that on 1/16/26, Resident A was supposed to go home with her mother for one day and then return to the facility on 1/17/26. Mr. Ptak stated that Resident A only takes medication in the mornings. On 01/15/26, he popped Resident A's medication out of its bubble pack and prepacked one day's worth of Resident A's medication into a Ziplock bag so that Resident A could take the medication with her to her day program on 1/16/26. Mr. Ptak stated he did this so when Resident A's mother picked her up on 1/16/26 from day program, she would have Resident A's medication for the morning of 1/17/26. Mr. Ptak stated that he was unsure if the day program would hold the medications, so he did not send them.

Mr. Ptak stated that he spoke with Resident A's mother, and she stated that she will come by and get the medication on the morning of 1/17/26. Mr. Ptak stated that later in

the afternoon on 1/16/26, Resident A's mother texted him and stated that she wanted to instead get the medications that evening on 1/16/26. However, at this time staff and residents were on an outing and wouldn't be home until late. Mr. Ptak stated he learned that later that evening on 01/16/26, Resident A's mother waited at the facility for staff and residents to arrive. According to Mr. Ptak, his wife, licensee designee Natalie Ptak was the staff on shift. Mr. Ptak stated that when Mrs. Ptak and the residents arrived at the facility, Mrs. Ptak left the residents in the van to go inside the home to retrieve the medications for Resident A. Mr. Ptak stated that Mrs. Ptak did so because Resident A's mother was very annoyed and upset due to waiting for an extended period of time. Mr. Ptak stated that Mrs. Ptak grabbed the prepackaged medications in the bag and gave them to Resident A's mother. Mr. Ptak stated that the facility refused to give Resident A's mother the medications in the original containers because during Christmas break, Resident A went home with all of her medications and all of the medications did not return to the facility when she came back. Mr. Ptak stated that he had concerns about the medications being improperly used while Resident A was outside of the home. Mr. Ptak stated that when residents leave the facility and require medications, there is a sign out form for medications that the facility requires the guardians/relatives to sign. The sign out form includes all of the information necessary for the medication, however Resident A's mother refused to sign the form. Mr. Ptak stated that he feels that the facility is being targeted by Resident A's mother.

On 01/30/26, I interviewed Ms. Natalie Ptak. According to Mrs. Ptak, she was not aware that when a resident leaves the facility and requires medication, she had to provide the medication in the original pharmacy containers. Mrs. Ptak stated that at the AFC she previously worked for always prepacked medications and never gave the original containers unless they were going to be gone for five days or more. Mrs. Ptak stated that on 1/16/26, when she arrived at the facility with the residents, it had recently snowed. She stated that she left the residents in the van while she cleared a pathway for the residents to enter the home safely. However, prior to clearing a pathway she went inside the home to retrieve Resident A's medication while the residents were unattended and alone in the van. Mrs. Ptak stated that she left the front door to the home open so that she could keep an eye out on the residents but admitted that she couldn't actually see the residents or the van from inside the home. Mrs. Ptak stated that the facility refused to give Resident A's mother the medications in the original containers because during the recent Christmas break, Resident A went home with all of her medications, but all of the medications did not return to the facility when she came back. Mrs. Ptak stated that she had concerns about the medications being improperly used while Resident A was outside of the home.

On 02/06/26, I interviewed Resident A's mother. According to Resident A's mother, on 1/16/2026 she called CapABLE community living to let the staff know that her daughter would be staying with her for at least a couple of nights and that she would need to pick up her medications. She stated she was informed by staff Tom Ptak that residents and staff were on an outing and he was unsure what time they would return to the home. Resident A's mother stated Mr. Ptak texted at 9:28pm to let her know that the staff would be there within 20 minutes. Resident A's mother stated right after that text

message, staff and residents arrived at the home. Resident A's mother stated she texted him to let him know that they were there. Resident A's mother then received a text meant for the staff from Tom Ptak that said "Do not leave residents alone to grab meds. Get them inside first." According to Resident A's mother, Natalie Ptak left the residents in the van while she went inside the home, got Resident A's medications and handed them to her in a Ziplock bag. Resident A's mother told Mrs. Ptak that she needed the medications in the proper container, and Mrs. Ptak said she "couldn't" do that. Resident A's mother stated that Resident A's medications never should have been handed to her in a zip lock bag instead of the prescription containers that list the medication, dosage and duration and as guardian she should have been handed the medications in their entirety in the prescribed containers when she requested them instead of being told by Natalie Ptak that she "couldn't" do that and she wouldn't. Resident A's mother sent me a picture of the medications in one zip lock bag. According to Resident A's mother, on 1/17/26, Mr. Ptak brought her more of Resident A's medications with instructions for the medications, but the medications were still in bags and not the original medication containers. Resident A's mother stated the residents were left in the van alone for approximately 7 minutes.

On 02/06/26, I held an exit conference with licensee designee Mrs. Natalie Ptak. I discussed the report and the violations with her. Mrs. Ptak stated that she would review the report once it was received.

On 02/27/26, I interviewed Resident B. According to Resident B, she was not aware that she was left alone in the van.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(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.</b>

<b>ANALYSIS:</b>	<p>On 1/16/2026 Natalie Ptak handed Resident A's mother, Resident A's medication to her in a Ziplock bag. Resident A's mother told Mrs. Ptak that she needed the medications in the proper container, and she said she "couldn't" do that. Resident A's mother stated that her daughter's medication was not provided to her in the original prescription containers that list the medication, dosage and duration. Resident A's mother sent me a picture of the medications in one Ziplock bag.</p> <p>Mr. and Mrs. Ptak both admit to giving the medications in a Ziplock bag with none of the necessary information and instructions.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(5) A licensee, administrator, or direct care staff shall ensure that the resident or the individual who assumes responsibility for the resident has the appropriate information, medication, and instructions when the resident is out of the facility but still requires medication during that period.</b>
<b>ANALYSIS:</b>	<p>On 1/16/2026, Resident A went on an outing with her mother and was going to be gone several days. Resident A's mother requested Resident A's medication for when she will be out of the facility. Natalie Ptak handed Resident A's mother, Resident A's medication to her in a Ziplock bag. The bag was not the original container and did not have the appropriate information and instructions. Mr. and Mrs. Ptak both admit to giving the medications in a zip-lock bag with none of the necessary information and instructions.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.</b>

<b>ANALYSIS:</b>	On 01/16/26, Mrs. Ptak left the residents in the van to go inside the home to retrieve Resident A's medication while the residents were unattended, unsupervised and alone in the van. The residents were left in the van alone for approximately 7 minutes. Mrs. Ptak stated that she left the front door to the home open so that she could keep an eye on the residents but admitted that she couldn't actually see the residents or the van from inside the home. Residents could have eloped or attempted to exit the van with no assistance or supervision.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 02/27/26, I received an additional complaint that Resident A was given a 30-day discharge as retaliation for making a complaint on the facility.

On 02/27/26, I received and reviewed the 30-day discharge notice given to Resident A. According to the 30-day discharge it states that, "CapABLE Community Living can no longer provide the level of care you need for your mental and physical well-being and safety." The reason for discharge does not align with the AFC's discharge policy. According to the facility's discharge policy the following are the discharge criteria:

**Discharge Criteria:** Residents may be discharged from the adult foster care home under the following circumstances:

- **Change in Health Status:** A significant change in the residents' health requires a level of care that cannot be provided in our facility.
- **Resident's Choice:** The resident expresses a desire to leave the home, provided they are deemed capable of making this decision.
- **Non-compliance:** The resident or responsible party does not adhere to the terms of the care plan or the facility policies that may jeopardize the safety and well-being of themselves or others.
- **Behavioral Concerns:** The resident exhibits behaviors that are unsafe or disruptive, and all appropriate interventions have been attempted without success.

On 02/27/26, I sent a request to Mrs. Ptak for additional information on the reasons for discharge; in particular, details on what was the significant change in Resident A's health, what care services were being provided to Resident A prior to the significant change in Resident A's health, and what services can the facility not provide to Resident A.

On 02/27/26, Ms. Ptak sent me the following email:

“We were informed on Monday, February 9th, that Resident A would be picked up for an appointment on the morning of Wednesday, February 11th, and would be staying with the guardian for a few days. As of today, Friday, February 27th, Resident A has not returned to the AFC home, and no anticipated return date has been provided. The guardian continued to provide care in her home at Resident A’s request. At this time, CapABLE Community Living is unable to provide the required level of supervision, protection, and personal care services when Resident A is not residing in the licensed AFC setting and has expressed that they do not yet wish to return. Medications have been coordinated to the guardian’s home, per her request, to provide care in that environment. Due to these circumstances, a 30-day notice was issued.”

In addition to that email, Mrs. Ptak provided me with several copies of screenshots of emails between the facility and Resident A’s guardian. In the supporting documentation that Mrs. Ptak submitted, there is no evidence that Resident A’s guardian was made aware that Resident A being out of the home for an extended period of time was an issue.

On 02/27/26, I responded to Ms. Ptak letting her know that the ability to meet the resident's needs is only required while the resident is in the home. I informed Mrs. Ptak that she did not provide me with details on what was the significant change in Resident A’s health, what care services were being provided to Resident A prior to the significant change in Resident A’s health, and what services can the facility not provide to Resident A. I informed Mrs. Ptak that based on the information provided, it appeared to be an inappropriate discharge per the facility discharge policy.

On 03/02/26, I received the following email from Mrs. Ptak:

“I am writing to provide additional context regarding our 30-day notice and to explain why, under the circumstances, we believe the notice aligns with applicable discharge standards of change in health, residents choice, non-compliance and behavior concerns.

I feel it is important to note that the language used in the 30-day notice (stating that we can no longer meet the resident’s mental and physical well-being and safety need) was intended to address her overall mental health status and engagement with the placement, not to suggest a single acute medical event or hospitalization-level change. The significant change we are identifying is behavioral and status-based, specifically her sustained choice not to reside in and/or participate in services within the licensed setting. This situation is materially different from a hospital stay for a medical procedure, which is temporary and outside of the resident’s control. In this case, the resident is making an ongoing choice to remain outside of the AFC home without a defined return plan, which directly impacts service delivery.

As outlined in our prior correspondence, Resident A has been residing with her guardian for an extended period and has not returned to the AFC home. All communication regarding her continued stay has been conveyed by her guardian,

including statements that Resident A will be staying longer and that a specific return date is not yet known. Currently, there remains no established timeline for her return to the AFC home. As a result, residential services cannot be delivered while Resident A is not present and directly relates to her mental and physical wellbeing and safety. This pattern reflects a significant shift from the original understanding at admission. At the time of placement, it was communicated that overnight stays with the guardian would not occur. Resident A has now remained away from the home for 19 consecutive days. This change is notable and, in our assessment, indicative of a material change in her mental and emotional status, particularly as it relates to her trust in and engagement with the placement. Per the emails from the guardian, Resident A has asked/made the decision to stay longer with her guardian and outside of the AFC home. These decisions are in direct correlation to Resident A's choice, and the continued absences align with voluntary discharge criteria.

Furthermore, the lack of commitment to return constitutes non-compliance and a behavioral change that impacts the operation of the home. Non-compliance is demonstrated through her absence and, in return, our inability to provide her with her obligatory services. This is in direct violation of her plan of service. The desire to be home with the guardian is a stark behavior change from when she initially moved in, as mentioned prior. This has created disruption within the therapeutic environment of Capable Community Living. Other residents have expressed confusion and concern regarding her continued absence. In addition, we are unable to bill for services while she is not residing in the home. The ongoing operational and financial impact affects the stability of the program, which in turn impacts the safety and well-being of the remaining residents. We have a responsibility to maintain a stable and compliant residential setting for all individuals served. The continued extension of her stay without a projected return date places the home in a position where we cannot reasonably plan staffing, support, or continuity of care in the AFC setting. We do budget and plan for residents to spend time at home with their families; however, with the significant number of consecutive days and no defined end in sight, we are left unable to accurately plan and budget around her ongoing absence. Under these circumstances, we are left with no reasonable alternative but to proceed with a 30-day notice so the program can remain stable and appropriately staffed for the residents who are actively in placement. Additionally, pursuant to our Specialty Services Contract with Macomb County Community Mental Health, the agency is required to comply with Thirty-Day Discharge standards and to clearly document the reason for discharge. The contract does not prohibit issuance of a 30-day notice while a resident is absent, nor does it require an AFC provider to hold a residential placement indefinitely when services cannot be delivered. The resident has not resided in the home for 19 consecutive days, residential services cannot be provided in her absence, and there is no established return date. Maintaining the placement under these circumstances would result in inaccurate bed utilization and a failure to align actual service delivery with contractual expectations. Accordingly, the issuance of a 30-day notice is consistent with our contractual obligations, licensing standards, and our responsibility to ensure that services are delivered only when a resident is actively residing in and participating in the program. For these reasons, it is our understanding that the 30-day notice (citing that

we can no longer safely meet the resident's physical and mental health needs within the licensed residential setting) aligns with discharge criteria related to resident choice, change in status/service needs, and behavioral or service-utilization change as demonstrated by her extended absence and the lack of an identified return plan. It is also important to note; this is the first 30-day notice CapABLE Community Living has ever issued. We intentionally used broader language in the notice to encompass the applicable discharge standards outlined in our policy while also respecting the resident's privacy and limiting unnecessary disclosure of sensitive details. If more specific or technical language is required in future notices, we are relying on licensure guidance to help educate us on the appropriate wording expectations so that we remain fully compliant. Lastly, as continued/updated correspondence, on Saturday, February 28th, the resident, her guardian, and two siblings came to the home to obtain additional medications. The guardian did not bring the medication lockbox or the requested documentation, despite being reminded on three separate occasions, including several hours before she arrived. Upon entering the home, Resident A did not speak to or make eye contact with staff, reflecting a marked change in presentation. The guardian disputed staff direction regarding proper medication transport and requested to carry the medications in her purse. Staff explained that, in accordance with CCL's medication transportation policy and applicable licensing requirements, medications cannot leave the home without appropriate secure transport. Placing medications in a purse does not ensure they remain accessible only to authorized individuals, and staff therefore cannot release them under those conditions. Ultimately, the medications were released in a second locked box, which now leaves us with one fewer secure transport container available for other residents' potential home visits. In conclusion, we remain confident in our position and in the appropriateness of the action taken and reasons stated in the notice, based on the current circumstances. At the same time, we are committed to working collaboratively and professionally toward a resolution that aligns with licensing standards and the resident's best interests. We welcome continued dialogue and are prepared to provide any additional information necessary to move this forward constructively."

On 03/2/26, I interviewed Resident A's guardian. According to Resident A's guardian, she was never made aware that Resident A being away from the home was a problem or against the facility rules. Resident A's guardian stated that she was never provided with any information that indicated that residents were not allowed to be away from the facility for an extended period of time. Resident A's guardian stated that if she knew that Resident A being away from the facility for an extended amount of time was an issue, she would have returned her sooner. Resident A's guardian stated that she would like Resident A to remain at the facility and believes the facility is retaliating against her for past complaints she has made.

On 03/02/26, I held an exit conference with licensee designee Mrs. Natalie Ptak. I discussed the report and the violations with her. Mrs. Ptak thoroughly disagreed with my findings and my investigation process. Mrs. Ptak stated that she has other reasons for issuing the 30-day discharge that was not mentioned in the notice, or in the follow-up emails. Mrs. Ptak stated that she did not think the additional information regarding

Resident A's discharge was relevant due to the most presenting issue being that Resident A not being in the home. Mrs. Ptak stated that she believed I should take into consideration the new information prior to finalizing our recommendation of Refusal to Renew. I let Mrs. Ptak know that she had multiple opportunities to provide the documentation when requested and I can only evaluate the information presented. Mrs. Ptak stated that I should have called her so that she could better understand what I was requesting. Mrs. Ptak was very emotional and upset. I told her they could submit the new information by the close of business today, but they will have an opportunity to present all of their information at compliance conference. Mrs. Ptak stated that the facility does not have a written policy that states residents are not allowed to be out of the facility for an extended period of time.

<b>APPLICABLE RULE</b>	
<b>R 400.687</b>	<b>Resident admission and discharge policy; house rules; change of residency; provision of resident records.</b>
	<b>(4) A licensee shall provide a resident and resident's designated representative with a 30-day written notice before discharge from the facility. The notice must state the reasons for discharge and a copy of it be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.</b>
<b>ANALYSIS:</b>	<p>On 02/27/26, Resident A's guardian received a 30-day discharge notice. According to the 30-day discharge it states that, "CapABLE Community Living can no longer provide the level of care you need for your mental and physical well-being and safety". According to the facility's discharge policy, it states that a Change in Health Status means a significant change in the resident's health which requires a level of care that cannot be provided in our facility. According to Mrs. Ptak, Resident A being out of the facility for an extended period time indicated a significant change is behavioral and status-based, specifically Resident A's sustained choice not to reside in and/or participate in services within the licensed setting. In the supporting documentation that Mrs. Ptak submitted, there is no evidence that Resident A's guardian was made aware that Resident A being out of the home for an extended period of time was an issue.</p> <p>Mrs. Ptak failed to provide details on what was the significant change in Resident A's health, what care services were being provided to Resident A prior to the significant change in Resident A's health, and what services can the facility not</p>

	provide to Resident A. Therefore, this is an inappropriate discharge per the facility policy.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Due to the quality of care violations while on a provisional license, I recommend revocation.



02/13/26

Eric Johnson  
Licensing Consultant

Date

Approved By:



For

03/24/2026

Denise Y. Nunn  
Area Manager

Date