GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 16, 2026

Vicky Cates
3960 Sharp Rd.
Adrian, MI 49256

RE: License #: AM460402968
Investigation #: 2026A1032040
Main Street Adult Foster Care

Dear Vicky Cates:

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 plan.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained.
- 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

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM460402968
Investigation #:	2026A1032040
Complaint Receipt Date:	06/16/2026
Investigation Initiation Date:	06/16/2026
Report Due Date:	08/15/2026
Licensee Name:	Vicky Cates
Licensee Address:	3960 Sharp Rd. Adrian, MI 49256
Licensee Telephone #:	(517) 902-3950
Administrator:	Vicky Cates
Name of Facility:	Main Street Adult Foster Care
Facility Address:	505 S. Main Street Adrian, MI 49221
Facility Telephone #:	(517) 263-3544
Original Issuance Date:	03/25/2020
License Status:	REGULAR
Effective Date:	09/25/2024
Expiration Date:	09/24/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A sustained a non-accidental injury.	No
There is an uncontrolled insect pest infestation.	No
A resident performed staff duties.	Yes

III. METHODOLOGY

06/16/2026	Special Investigation Intake 2026A1032040
06/16/2026	Special Investigation Initiated - Telephone Interview with APS Specialist Samantha Garcia
07/08/2026	Inspection Completed On-site
07/16/2026	Exit Conference

ALLEGATION:

Resident A sustained a non-accidental injury.

INVESTIGATION:

On 6/16/26, I spoke with Adult Protective Services (APS) Specialist Samantha Garcia by telephone. She stated that Resident A, a hospice resident, did not have an untreated wound and that Resident A's regular nurse clarified that the abrasions in question were small and likely self-inflicted.

On 7/8/26, I interviewed employee Bobbie Cilley in the facility. Ms. Cilley stated that Resident A had defecated on herself in the bed and she was trying to clean things up. She reported trying to reposition Resident A but in that process Resident A hit her head on the headboard, resulting in bruising. She advised that she called

Resident A's hospice care provider and they took Resident A out of the home temporarily. Ms. Cilley stated that Resident A had since passed away.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	There does not appear to be enough evidence to suggest that Ms. Cilley caused Resident A's injury. APS conferred with Resident A's regular nurse and reported that the injury was consistent with the explanation provided.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There is an uncontrolled insect pest infestation.

INVESTIGATION:

On 6/16/26, Ms. Garcia reported that from her observations, there was no evidence of a pest infestation in the home.

On 7/8/26, during my onsite inspection, I saw no evidence of an insect pest infestation. Generally speaking, housekeeping standards were satisfactory. The beds were made, rooms were clean.

APPLICABLE RULE	
R 400.645	**Environmental health.**
	(6) An insect, rodent, or pest control program must be maintained and carried out in a manner that continually protects the health of residents.

ANALYSIS:	There was no evidence of a pest infestation. Generally speaking, the facility was clean.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

A resident performed staff duties.

INVESTIGATION:

On 6/16/26, Ms. Garcia mentioned that she was told that another resident had assisted employee Bobbie Cilley with moving Resident A, despite there being another employee who was onsite.

On 7/8/26, Ms. Cilley stated that she had a resident assist her in cleaning up the bed sheets and propping up Resident A so that she would not fall off the bed. She felt that there was an emergent need to get assistance and that getting the live-in staff who was onsite but in another section of the house would not have been able to respond quickly. She acknowledged that the resident performed a staff function, implying that she knew this was not part of the resident's assessment plan.

I was informed that the resident who assisted Ms. Cilley in repositioning Resident A was in the community. I attempted to interview her roommate, Resident B. Resident B did not wish to be interviewed and stated that she was feeling unwell.

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. **(2) Work that is performed by a resident must be in accordance with the resident's assessment plan.**

ANALYSIS:	Ms. Cilley admitted that a resident assisted her at her request. She was aware that another employee was onsite but considered the resident being closer was more effective in dealing with Resident A's emergent needs. Since repositioning a resident is a staff function, the resident performed a duty that was not in her assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/16/26, I conducted an exit conference with licensee Vicky Cates. I shared my findings and Ms. Cates agreed with the conclusions reached, committing to providing a corrective action plan.

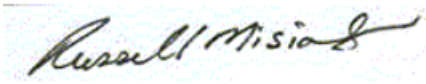
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the status of this license.

7/16/26

Dwight Forde Date
Licensing Consultant

Approved By:



7/16/26

Russell B. Misiak Date
Area Manager