GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 8, 2026

Vicky Cates
3960 Sharp Rd.
Adrian, MI 49256

RE: License #: AM460077068
Investigation #: 2026A1032047
Cates AFC Home

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 for each violation as well as time frames for implementation.
- 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.

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 (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 #:	AM460077068
Investigation #:	2026A1032047
Complaint Receipt Date:	08/11/2026
Investigation Initiation Date:	08/13/2026
Report Due Date:	10/10/2026
Licensee Name:	Vicky Cates
Licensee Address:	3960 Sharp Rd. Adrian, MI 49256
Licensee Telephone #:	(517) 902-3950
Administrator:	Vicky Cates
Name of Facility:	Cates AFC Home
Facility Address:	507 Dennis Adrian, MI 49221
Facility Telephone #:	(517) 902-3950
Original Issuance Date:	09/01/1997
License Status:	REGULAR
Effective Date:	11/04/2024
Expiration Date:	11/03/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
There is a hole in the ceiling in one of the bedrooms.	Yes
Resident A is not provided with adequate or appropriate meals.	No
Resident B's health decline was not appropriately handled.	Yes

III. METHODOLOGY

08/11/2026	Special Investigation Intake 2026A1032047
08/13/2026	Special Investigation Initiated - Letter email to Guardian A1
08/13/2026	Contact - Face to Face Interview with Resident A at Hope Community Center
08/13/2026	Contact - Telephone call made Interview with Guardian A1
08/14/2026	Inspection Completed On-site Interview with Employee Amanda Wright; review of health care appraisal and resident care agreement.
08/17/2026	Contact - Telephone call received Interview with APS Specialist Randy Walsh with information on Resident A and Resident B
09/01/2026	Contact - Telephone call received Interview with Relative A1
09/10/2026	Inspection Completed On-site

	Interview with employee Brianna Post and Resident C
09/22/2026	Contact - Document Received Resident B's incident report, contacts with doctor and psychiatrist, health care appraisal and assessment plan
09/30/2026	Contact - Document Received Interview with APS Specialist Randy Walch
10/07/2026	Exit Conference exit conference with licensee designee Vicky Cates

ALLEGATION:

There is a hole in the ceiling in one of the bedrooms.

INVESTIGATION:

On 9/10/26, during on onsite inspection, I observed a resident room to be clean and arranged quite well. I did not observe any ceiling damage in the room but Resident C alerted me to damage in the closet. The plaster over the wood frame had become detached and the ceiling tiles had fallen unto the clothing rack. Resident C reported that Resident B had destroyed the pull cord that switched the light on and off and so it was on permanently. Resident C reported that the damage was there for some time.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(5) Floors, walls, and ceilings must be cleanable, maintained clean, and in good repair.
ANALYSIS:	The ceiling in Resident B's closet had a large crack, with part of the ceiling resting on the clothes rack.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A is not provided with adequate or appropriate meals.

INVESTIGATION:

On 8/13/26, I reached out to Guardian A1 via email, to see whether she had any concerns about Resident A's meals.

On 8/13/26, I interviewed Resident A at Hope Community Center. I asked Resident A if she had eaten breakfast, and she reported that she had not. She stated that she was given a peanut butter and jelly sandwich today for lunch but she could not eat it. I observed Resident A was eating a meal from a large black bowl that contained slices of meat, grapes and pretzel sticks. She stated that Guardian A1 brought it for her since she could not eat the peanut butter and jelly sandwich that the facility provided.

On 8/13/26, I interviewed Guardian A1 by telephone. Guardian A1 confirmed she had delivered a separate meal for Resident A because Resident A was allergic to the food provided.

On 8/14/26, I interviewed employee Amanda Wright in the facility. Ms. Wright stated that Resident A typically packs her own lunch at the facility before leaving for community activities. She advised that this was done to promote a sense of normalcy and independence. She stated that the only food item that Resident A does not eat is chocolate, nor does she eat caffeinated drinks. I suggested that if Resident A was improperly packing lunches, that the staff check on her to make sure she was assembling nutritious meals

I observed Resident A's assessment plan. There is no special diet listed. I examined Resident A's health care appraisal and there are no known allergies listed.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(4) Meals must meet the nutritional allowances recommended by the United States Department of Agriculture and the United States Department of Health and Human Services in the Dietary Guidelines for Americans (DGA), 2020-2025. The Dietary Guidelines for Americans 2020-2025 are adopted by reference and available to be viewed or downloaded from the U.S. Department of Agriculture and the U.S. Department of Health and Human Services at https://www.dietaryguidelines.gov at no cost at the time of adoption of these rules. A copy of these

	guidelines is available for inspection and distribution from the Bureau of Community and Health Services, Department of Licensing and Regulatory Affairs, at 611 West Ottawa Street, P.O. Box 30664, Lansing, Michigan 48909 at a cost of 15 cents per page as of the time of the adoption of these rules.
ANALYSIS:	A review of Resident A's health care appraisal and assessment plan revealed no allergies to food. It would appear that Resident A was allowed to prepare her own sack lunch, and, when it was discovered that she was not packing appropriate meals, the licensee designee agreed to have the staff monitor her more closely.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B's health decline was not appropriately handled.

INVESTIGATION:

On 8/17/26, I received information during a telephone call with Adult Protective Services Specialist Randy Walch that Resident B was recently hospitalized after weeks of not feeling well.

On 9/1/26, I interviewed Relative B1 by telephone. Relative B1 stated that Resident B is her own guardian but a petition was filed to enter into a guardianship. Relative B1 stated that Resident A had been declining for about five weeks and the facility had not informed her of Resident B's status. Relative B1 stated that there was water damage to the ceiling in Resident B's room.

On 9/10/26, I interviewed employee Bianna Post in the facility. Ms. Post stated that Resident B did experience a decline in health and that the doctor was notified. She stated that the doctor changed Resident B's medication and had the facility monitor her progress. She described Resident B as being somewhat tired and that the facility discouraged her from attending programming to keep an eye on her. Other changes observed after the new medication was added included loss of appetite and remaining in bed. Ms. Post stated that Resident B was typically someone who kept to herself. Resident B was able to perform personal care tasks such as showering but had to be prompted sometimes to change out of her dirty clothing or change for the day.

I interviewed Resident C in the facility. Resident C was asked if she, as Resident B's former roommate, had noticed any decline in her health. Resident C reported that Resident B appeared to be tired. Resident C did not have any information on whether Resident B had specifically asked for medical assistance nor did she hear Resident B complain.

On 9/30/26, I interviewed APS Specialist Randy Walch by phone. Mr. Walch stated that he had substantiated neglect against members of staff at the facility because Resident B was not taken to the hospital to have her declining health addressed after he visited her at the facility and noted her condition. He advised that Resident B is now on a pacemaker.

On 10/6/26, I reviewed the incident report detailing Resident B's condition and trip to the hospital. It was noted that Resident B was transported to the hospital at Mr. Walch's behest. The report did not that the facility had been monitoring Resident B due to continued lethargy.

I also reviewed a doctor's visit from June 2026 at the facility, as well as communication with Resident B's psychiatrist about changing a medication that may have been impacting Resident B's heart health.

On 10/7/26, I conducted an exit conference with licensee designee Vicky Cates. I explained that because two months had passed between when Resident B was seen by her doctor, and the eventual hospitalization, the facility did not respond to an adverse change in Resident B's condition in an adequate fashion. Ms. Cates stated that the facility had demonstrated compliance because they were monitoring Resident B and waiting on an appointment for neurologist, since a referral was made by Resident B's psychiatrist. I countered that while this may be true, there were several people who had expressed concern because Resident B continued to be lethargic and confused, which was not her usual presentation.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.

ANALYSIS:	I examined the last documented contact with Resident B's doctor and matched it up with the incident report date where she was ultimately hospitalized. I also considered that for five weeks, concerns had been raised about the change in Resident B's presentation. I noted that only after APS Specialist Randy Walch intervened and directed the facility to seek medical attention, was action taken. Ms. Cates did express that she was in a holding pattern as a referral had been made to a neurologist, however, given that Resident B now requires a pacemaker, it would appear that a more prompt response was required, rather than continued monitoring, given that Resident A did not improve but got worse gradually.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

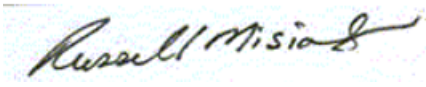
Upon receipt of an acceptable corrective action plan, I recommend that the status of this license remain unchanged.



10/8/26

Dwight Forde — Date
Licensing Consultant

Approved By:



10/9/26

Russell B. Misiak — Date
Area Manager