GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 29, 2025

Vicky Cates
3960 Sharp Rd.
Adrian, MI 49256

RE: License #: AM460064217
Investigation #: 2025A1032028
On The Hill 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.
- 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.

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
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AM460064217
Investigation #:	2025A1032028
Complaint Receipt Date:	04/11/2025
Investigation Initiation Date:	04/11/2025
Report Due Date:	06/10/2025
Licensee Name:	Vicky Cates
Licensee Address:	3960 Sharp Rd. Adrian, MI 49256
Licensee Telephone #:	(517) 902-3950
Administrator:	Vicky Cates
Name of Facility:	On The Hill AFC Home
Facility Address:	3446 East US 223 Adrian, MI 49221
Facility Telephone #:	(517) 264-2203
Original Issuance Date:	05/15/1996
License Status:	REGULAR
Effective Date:	03/21/2024
Expiration Date:	03/20/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Employees appear under the influence of substances.	No
Employees do not properly care for residents.	No
Employees did not follow Resident A's special diet.	No
Medication administration records were not retained.	Yes
Resident A's belongings were not kept in good condition.	Yes
Additional Findings	No

III. METHODOLOGY

04/11/2025	Special Investigation Intake 2025A1032028
04/11/2025	Special Investigation Initiated - Telephone Interview with Sheila Sears, LCMHA Case Manager
04/14/2025	Contact - Telephone call made Interview with APS Specialist Melissa Auld
04/30/2025	Inspection Completed On-site
05/13/2025	Contact - Telephone call made Interview with Guardian A1
05/16/2025	Contact - Document Received Guardian A1 sent pictures of Resident A's belongings and physical appearance.
05/16/2025	Contact - Document Sent MARs requested
05/24/2025	Exit Conference

ALLEGATION:

Employees appear to be under the influence of substances.

INVESTIGATION:

On 4/14/25, I interviewed APS Specialist Melissa Auld by telephone. Ms. Auld advised that Resident A would likely not return to the facility after being discharged from the hospital.

On 4/24/25, I interviewed Resident B in the community. Resident B reported living at the facility for several years. Resident B reported that if residents expressed a medical concern, the staff would attend to the issues. Resident B denied witnessing staff intoxicated or minimizing another resident's medical concerns.

On 4/30/25, during my onsite inspection, Ms. Cilley was able to answer questions and attend to resident needs.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	There is insufficient evidence to establish a violation. Resident B, a long-established resident, denied observing intoxicated employees on shift. I observed Ms. Cilley to be coherent during my inspection.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Employees do not properly care for residents.

INVESTIGATION:

On 4/14/25, Resident B reported that if Residents needed assistance with personal care, employees would assist, usually through prompting.

On 4/11/25, I interviewed LCMHA Case manager Sheila Sears by telephone. Ms. Sears stated that there had been an inexplicable decline in Resident A's weight and that there were sores around her face. Ms. Sears stated that Resident A had been doing well in the home until recently.

On 4/30/25, I noted that the residents appeared clean during my onsite inspection. Ms. Cilley reported that she would typically prompt residents to change their clothing or lay out clean clothing on their beds.

I reviewed Resident A's assessment plan, which documented Resident A's special diet. There was no special intervention for personal care.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	There is insufficient evidence, based on my observations, and resident reports, to establish a violation that personal care was not delivered according to Resident A's assessment plan, or that residents were generally neglected.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not follow Resident A's special diet.

INVESTIGATION:

On 4/30/25, I interviewed employee Amanda Cilley in the facility. Ms. Cilley denied telling Resident A that she was faking her medical issues. Ms. Cilley reported that Resident A would hyperventilate from time to time and that if she wanted to go to the hospital, Ms. Cilley would call Guardian A1 to advise of such. Ms. Cilley stated that the last time this happened, Guardian A1 told Resident A that she was faking and would not take her to the hospital.

Ms. Cilley reported that the special diet was followed, using a liquid thickener and soft food. She stated that Resident A used a large water bottle for long term daily use.

Ms. Cilley stated that Resident A would lick her own face, causing the skin to be chapped, then would put on a mask after being re-directed. She also stated that the mask would get dirty and Resident A refused to put on the new mask. Ms. Cilley stated that she often tried to re-direct Resident A when Resident A used her nebulizer, but Resident A resisted instruction, often breathing too quickly in the device.

I interviewed Resident C in the facility. Resident C stated that Resident A was often resistant to re-direction to the proper use of the nebulizer. Resident C stated that Resident A would often hyperventilate strategically, meaning that apparently she would exhibit the behavior around staff but not around residents.

I interviewed Resident D in the facility. Resident D denied hearing employees tell Resident A that she was faking, but did hear Guardian A1 telling Resident A that she was faking a medical crisis.

I reviewed Resident A's health care appraisal, weight record and assessment plan. The special diet documented therein was for liquid thickener.

On 5/13/25, I interviewed Guardian A1 by telephone. Guardian A1 stated that Resident A lived in the home for approximately three years, and that the care provided was relatively good. Guardian A1 described Resident A as independent. Guardian A1 stated that Resident A's soft bite food restriction was not followed and that the facility would often give Resident A bread or soup to eat. Guardian A1 reported that cups were provided but that the cups were not cleaned. Guardian A1 stated that Resident A was independent but suffered a decline that was not properly communicated, resulting in drastic weight loss and poor self care. All they would advise was that Resident A was forcing a cough.

On 5/23/25, licensee Vicky Cates reported during the exit conference that Resident A learned that she was possibly going to a higher level of care, and demonstrated non-compliance with the special diet by eating non-approved food items that she purchased herself. Ms. Cates stated that Guardian A1's long term goal was to have Resident A placed in a nursing home, and that during the bulk of Resident A's stay at the facility, there was high praise for Resident A's care.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any if the following:

	(a) Medications. **(b) Special diets.** **(c) Susceptibility to hyperthermia and hypothermia and related limitations for physical activity, as appropriate.** **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	While it must be acknowledged that Resident A experienced a sharp decline in health, there is strong evidence to suggest that the facility made an attempt to follow Resident A's special diet, and reached out to Guardian A1 with concerns.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not retain Resident A's medication administration records

INVESTIGATION:

On 5/16/25, I requested Resident A's medication record administration (MAR).

On 5/23/25, Ms. Cates reported that due to system errors, she was unable to provide a copy of the MAR.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.**

	(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Ms. Cates was unable to produce Resident A's MARs for review.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's belongings were returned in poor condition

INVESTIGATION:

On 5/16/25, Guardian A1 sent pictures detailing the condition of many of Resident A's belongings, after they were retrieved from the facility. Some of the tubs where Resident A's garments were stored appeared covered in dirt, and there were insects in some of the personal items.

On 5/23/25, Ms. Cates advised that during the period where the facility was sprayed for bedbugs, Resident A refused to let employees remove some personal items and clothing from her bedroom. Ms. Cates advised that the dirt observed on the tubs may have come from the 'Michigan Basement where the items were stored.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	There was photographic evidence of dirt in Resident A's belongings.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/23/28, I conducted an exit conference with licensee Vicky Cates. Ms. Cates advised that she would furnish the department with a corrective action plan to address the violations cited.

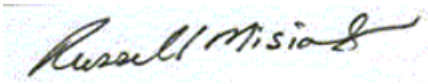
IV. RECOMMENDATION

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

5/29/25

Dwight Forde Date
Licensing Consultant

Approved By:



5/29/25

Russell B. Misiak Date
Area Manager