

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA DIRECTOR

August 1, 2025

Vicky Cates 3960 Sharp Rd. Adrian, MI 49256

> RE: License #: AM460064217 Investigation #: 2025A1032035

> > 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 was required. On 8/8/2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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

Dwy Inda

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM460064217
Investigation #:	2025A1032035
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Complaint Receipt Date:	06/13/2025
Investigation Initiation Data:	06/16/2025
Investigation Initiation Date:	00/10/2023
Report Due Date:	08/12/2025
Licensee Name:	Vicky Cates
Licensee Address:	3960 Sharp Rd.
	Adrian, MI 49256
The same of the sa	(547) 000 0050
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 Tallaction of	(547) 004 0000
Facility Telephone #:	(517) 264-2203
Original Issuance Date:	05/15/1996
_	
License Status:	REGULAR
Effective Date:	03/21/2024
	30,2 1122
Expiration Date:	03/20/2026
Capacity:	12
оараску.	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

Violation Established?

An employee uses substances while on shift.	Yes
Residents were improperly housed during pest control maintenance.	Yes
Employees do not assist Resident A with personal care and laundry.	No
Additional Findings	No

III. METHODOLOGY

06/13/2025	Special Investigation Intake 2025A1032035
06/16/2025	Special Investigation Initiated - Telephone
06/20/2025	Contact - Document Sent I requested Resident A's assessment plan and health care appraisal
06/25/2025	Contact - Document Received I received Resident A's health care appraisal and assessment plan
07/02/2025	Inspection Completed On-site
08/01/2025	Exit Conference

ALLEGATION:

An employee uses substances while on shift.

INVESTIGATION:

On 6/16/25, I spoke with Adult Protective Services Specialist Samantha Garcia via telephone. Ms. Garcia reported that she had spoken with employee Amanda Cilley and Resident A about the complaint.

On 7/2/25, I interviewed employee Amanda Cilley at the facility. Ms. Cilley acknowledged smoking marijuana while on duty. She advised that she does not

smoke in front of the residents and denied that doing so affects her ability to provide personal care, protection and supervision to the residents. She reported that she works very long hours and will smoke once, but that it is not a regular habit while on shift.

I interviewed Resident A in the facility. Resident A denied observing anyone smoke marijuana in the facility but stated that she smelled it.

On 8/7/25, licensee Vicky Cates acknowledged that while marijuana use in Michigan is legal, so is alcohol use, but not during working hours, which was also in keeping with her personnel policies. She advised that she has had a discussion with employees regarding this policy.

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:	Ms. Cilley admitted using marijuana while on shift. Use of substances is also proscribed by the personnel policies of the home. Therefore, a violation was established that the needs of the residents were, in those moments of use, not being met.	
CONCLUSION:	VIOLATION ESTABLISHED	

ALLEGATION:

Residents were improperly housed during pest control maintenance.

INVESTIGATION:

On 7/2/25, Ms. Cilley divulged that on the day that the facility was sprayed, no arrangements had been made for the residents to be housed elsewhere, so the bulk of them sat outside on the deck. It was raining according to her. She stated that she was able to provide the residents with lunch. She purchased pizza for them.

On 7/3/35, I received complaints via the online system which referenced the incident where residents were outside in the rain while the facility was being sprayed.

APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	While the home was being sprayed, the residents had to remain outside so as not to be exposed to the toxic spray. They were exposed to the elements for an extended period of time since no arrangements had been made to house them elsewhere.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Employees do not assist Resident A with personal care and laundry.

INVESTIGATION:

On 6/20/25, I requested Resident A's healthcare appraisal and assessment plan. The plan detailed assistance with showering, by placing a shower chair in the shower.

On 6/25/25, I received Resident A's healthcare appraisal and assessment plan.

On 7/2/25, Ms. Cilley stated that Resident A's assessment plan reflected considerable independence, but she assists with placing the shower chair in the bathroom when Resident A takes showers.

Ms. Cilley reported that Resident A threw herself to the floor one day and demanded that she be picked up. When other residents tried to assist her, Resident A grew verbally aggressive, so Ms. Cilley kept her distance. Ms. Cilley advised that Resident A called emergency medical services, and when they came, they would not give her any medications. At that point, Resident A got up and declined services. Ms. Cilley stated that the facility did it's best to return clothing to residents after being fumigated, and that she had tried to explain to Resident A. She reported that Resident A was given clean clothing to be put away but she threw them to the floor.

On 7/2/25, Resident A stated that there was some initial confusion about the extent of her independence, but things have since been smoothed over. She stated that she really needs her surgery as soon as possible. She acknowledged that

employees do assist with showers. She advised that the visiting doctor had prescribed a muscle relaxer.

I observed Resident A's room to be tidy, and clothing had been put away.

APPLICABLE RULE	
R 400.14314	Resident hygiene.
	(6) A licensee shall afford a resident the opportunity to receive assistance in bathing, dressing, or personal hygiene from a member of the same sex, unless otherwise stated in the home's admission policy or written resident care agreement.
ANALYSIS:	Resident A stated that the employees were assisting with personal care by placing the shower chair in the shower. Her assessment plan documented interventions consistent with statements from both Ms. Cilley and Resident A. The laundry was also folded and put away during my inspection.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 8/1/25, I conducted an exit conference with licensee Vicky Cates. I shared my findings.

IV. RECOMMENDATION

recommend no change to the status	of this license.
Dwy Ind	8/1/25
Dwight Forde Licensing Consultant	Date
Approved By:	
Russell Misias	8/6/25
Russell B. Misiak Area Manager	Date