



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 #: AM460077068  
Investigation #: 2025A1032039  
Cates AFC Home

Dear Vicky Cates:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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,

A handwritten signature in black ink, appearing to read "Dwight Forde".

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**

<b>License #:</b>	AM460077068
<b>Investigation #:</b>	2025A1032039
<b>Complaint Receipt Date:</b>	07/15/2025
<b>Investigation Initiation Date:</b>	07/15/2025
<b>Report Due Date:</b>	09/13/2025
<b>Licensee Name:</b>	Vicky Cates
<b>Licensee Address:</b>	3960 Sharp Rd. Adrian, MI 49256
<b>Licensee Telephone #:</b>	(517) 902-3950
<b>Administrator:</b>	Vicky Cates
<b>Name of Facility:</b>	Cates AFC Home
<b>Facility Address:</b>	507 Dennis Adrian, MI 49221
<b>Facility Telephone #:</b>	(517) 902-3950
<b>Original Issuance Date:</b>	09/01/1997
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	11/04/2024
<b>Expiration Date:</b>	11/03/2026
<b>Capacity:</b>	12
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

## II. ALLEGATION(S)

	Violation Established?
Resident A was neglected in the home and has suspicious bruising.	No
Additional Findings	No

## III. METHODOLOGY

07/15/2025	Special Investigation Intake 2025A1032039
07/15/2025	Special Investigation Initiated - Telephone
07/15/2025	Contact - Face to Face
07/31/2025	Inspection Completed On-site
08/01/2025	Exit Conference

### ALLEGATION:

**Resident A was neglected in the home and has suspicious bruising.**

### INVESTIGATION:

On 7/15/25, I contacted Adult Protective Services Specialist Samantha Garcia, who advised that she had made contact with Resident A's guardian.

On 7/15/25, I interviewed Resident A in the community. I asked Resident A questions regarding her stay at the facility. Resident A seemed to believe that she was still living at home. Resident A was asked if she had sustained any recent injuries, to which she replied that she had fallen. I asked where the fall occurred, but Resident A was unable to provide that information. I asked Resident A about an injury to one of her knees. She was unable to say which knee was injured. She

reported that she hit her knee against a table, and pointed to the table where we sat. I observed Resident A to be generally clean in appearance.

On 7/31/25, I interviewed employee Erica Montecinos in the facility. Ms. Montecinos stated that Resident A's brother often fresh clothes for her and that Resident A is sent to programming in clean clothing. She stated that laundry is done daily, which might account for why Resident A was observed in the same clothing. Ms. Montecinos advised that Resident A is supervised when performing personal care and hygiene. Ms. Montecinos reported that Resident A has fallen but not at the facility. She stated that about a month ago Resident A fell in the community and bruised her face, then fell at the County Fair last week on an outing for community programming. Ms. Montecinos stated that Resident A is sent to programming with a change of clothing and adult briefs.

I reviewed Resident A's assessment plan and health care appraisal. The health care appraisal did not denote any conditions such as vertigo that would lead to difficulty ambulating. The assessment plan did indicate the need to remind Resident A to be careful around stairs. Resident A, per the plan, is to be supervised when performing personal care activities.

I observed Resident A's room to be tidy, with clean clothing.

<b>APPLICABLE RULE</b>	
<b>R 400.14303</b>	<b>Resident care; licensee responsibilities.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Resident A, through her interview, appeared to be a poor historian, but indicated that her injury may have been sustained in the community, which seems consistent with employee Erica Montecinos' report about patterns of injury. During my onsite inspection, I observed Resident A's room and clothing to be clean. Therefore, I have insufficient evidence to establish a violation.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

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

#### **IV. RECOMMENDATION**

I recommend no change to the status of this license.



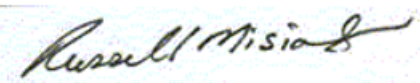
8/1/25

---

Dwight Forde  
Licensing Consultant

Date

Approved By:



8/12/25

---

Russell B. Misiak  
Area Manager

Date