GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 12, 2025

Zubair Ahmed
Pine Tree Place LLC
5480 Parview
Clarkston, MI 48346

RE: License #: AL630079545
Investigation #: 2025A0611027
Pine Tree Place

Dear Mr. Ahmed:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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 (248) 972-9136.

Sincerely,

Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630079545
Investigation #:	2025A0611027
Complaint Receipt Date:	08/14/2025
Investigation Initiation Date:	08/20/2025
Report Due Date:	10/13/2025
Licensee Name:	Pine Tree Place LLC
Licensee Address:	5480 Parview Clarkston, MI 48346
Licensee Telephone #:	(248) 710-7056
Administrator:	Zubair Ahmed
Licensee Designee:	Zubair Ahmed
Name of Facility:	Pine Tree Place
Facility Address:	5480 Parview Clarkston, MI 48346
Facility Telephone #:	(248) 922-7266
Original Issuance Date:	02/12/1999
License Status:	REGULAR
Effective Date:	07/17/2024
Expiration Date:	07/16/2026
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The resident's weights are being estimated because proper care/ job duties are not being performed.	Yes
There is a severe lack of care given to residents by staff, such as failure to change residents every 2-3 hours, provide showers, or shaves, etc. Wounds appear on residents quickly because many residents stay in bed all day and all night without rotating or getting up.	No
Staff come in to work high off marijuana or other drugs. Staff bring marijuana and/or other drugs onto the premises.	No
The home has exceeded the capacity for the approved number of residents.	No
Additional Findings	Yes

III. METHODOLOGY

08/14/2025	Special Investigation Intake 2025A0611027
08/15/2025	APS Referral An adult protective services (APS) referral was made.
08/18/2025	APS Referral I received an email stating the Adult Protective Services denied investigating this complaint.
08/20/2025	Special Investigation Initiated - On Site I completed an unannounced onsite. I interviewed staff member Anquaneice Jones, home manager Ashly Liskey, licensee designee Zubair Ahmed, Resident L, Resident B, Resident M, and Resident K. I received copies of the residents weight record and assessment plans.
08/21/2025	Contact - Document Received I received a copy of the resident register and the August MAR for Resident X, Resident N, and Resident B. I also received an incident report for Resident B regarding her fall.

08/26/2025	Contact - Telephone call made An attempt was made to contact staff member Jordan Thompson however; there was no answer and the mailbox has not been set up.
08/26/2025	Contact - Telephone call made I left a voice message for staff member Sheeka Hightower requesting a call back.
08/26/2025	Contact - Telephone call made I made a telephone call to Nurse Sharon from A Choice. The allegations were discussed.
08/26/2025	Contact - Telephone call made I made a return phone call to staff member Sheeka Hightower. The allegations were discussed.
08/26/2025	Contact - Telephone call made I made a telephone call to the home manager Ashly Liskey. Ms. Liskey clarified information regarding the residents.
08/27/2025	Contact - Telephone call made I left a voice message for Resident B's guardian regarding her incident report.
08/27/2025	Contact - Telephone call made I attempted to contact staff member Jordan Thompson however; the phone went straight to voice mail. A voice message was left.
08/27/2025	Contact - Telephone call received I received a return phone call from Resident B's guardian. Resident B's incident was discussed.
08/27/2025	Exit Conference I completed an exit conference with the licensee designee Zubair Ahmed via telephone.
08/28/2025	Contact – Telephone call made I made a telephone call to Nurse Sharon. Nurse Sharon provided additional information regarding Resident U weight lost in 2024.
08/28/2025	Contact – Document Received I received an email from the home manager Ashly Liskey confirming Resident N’s date of admission.

ALLEGATION:

The resident's weights are being estimated because proper care/job duties are not being performed.

INVESTIGATION:

On 08/14/25, a complaint was received and assigned for investigation alleging that the facility administrator, Ashly Liskey, is guessing weights on residents because proper care/job duties are not being performed. One resident lost 20lbs in a single month, and it was not reported to the nurse practitioner. There is a severe lack of care given to residents by staff, such as failure to change residents every 2-3 hours, provide showers, or shaves, etc. Wounds appear on residents quickly because many residents stay in bed all day and all night without rotating or getting up. Staff comes in to work high off marijuana or other drugs. Staff bring marijuana and/or other drugs onto the premises. These drugs are very accessible to the residents. Management is aware of these issues. Too many residents have been living there over the max of what the building is licensed for.

On 08/20/25, I completed an unannounced onsite. I interviewed staff member Anquaneice Jones, home manager Ashly Liskey, licensee designee Zubair Ahmed, Resident L, Resident B, Resident M, and Resident K. I received copies of all the residents assessment plans and weight records.

On 08/20/25, I interviewed staff member Anquaneice Jones. Ms. Jones has worked at the AFC group home for one year. Ms. Jones works the day shift. Regarding the allegations, Ms. Jones stated the residents are weighed every first Sunday of each month. The QuickMAR system automatically prompts the staff to weigh the residents on the first of each month. The staff initial the MAR when the residents are weighed. Ms. Jones denied any residents losing a significant amount of weight this year. Ms. Jones denied any residents losing five or 20 pounds in one month.

On 08/20/25, I interviewed the home manager Ashly Liskey. Regarding the allegations, Ms. Liskey stated the residents are weighed on the first of every month. The QuickMAR system prompts the staff to weigh the residents. Ms. Liskey denied any residents not being weighed each month. The hospice residents may lose a few pounds but no one has lost 20 pounds. The hospice residents are Resident J, Resident F, and Resident B.

On 08/20/25, I interviewed the licensee designee Zubair Ahmed. Mr. Ahmed denied all of the allegations. Mr. Ahmed stated no resident has lost 20 pounds in one month.

On 08/20/25, I received copies of all the residents weight records. On 08/21/25, I received a copy of the MAR for the month of August for Resident X, Resident N, and Resident B.

According to the weight records, I did not observe any resident losing 20 pounds in one month. The majority of the weight records included a monthly comment indicating how much the residents lost or how much weight they gained from the previous month. On 02/01/24, it was recorded that Resident U weighed 119 pounds which was 19 pounds less than what she weighed in the previous month. There was a comment stating the doctor was notified. The following month, Resident U gained 8 pounds. Resident U was admitted on 11/30/23; however, her initial weight was not taken until 12/01/23. On 12/01/23, Resident U weighed 134 pounds. As of 07/01/25, Resident U weighs 181 pounds.

On 09/08/24, Resident L weighed 149 pounds, which was 12 pounds less than what he weighed in the previous month. There was a comment stating the doctor was notified. As of 07/01/25, Resident L weight was documented as 23 centimeters because he is bedbound. Resident L admission weight was 160 pounds. On 06/01/25, Resident L weighed 150 pounds.

Resident J is in hospice and has been gradually losing weight. Resident J admission weight on 11/24/23 was 190 pounds. As of 07/1/25, Resident J weighs 156 pounds.

Regarding Resident I's weight record, there was no weight recorded for the month of July 2024. On 07/01/24, "00f" was documented as the weight. There was no explanation recorded. On 10/06/24, Resident I weighed 168 which was a 20-pound weight gain from the previous month. As of 07/01/25, Resident I weighs 154 pounds.

Regarding Resident C weight record, there was no weight recorded for the month of June 2025 or July 2025.

Resident X was admitted on 08/19/25 however; his admission weight was not documented as his weight record was blank. Resident N's date of admission was not documented however; her admission weight was not documented as her weight record was blank.

Regarding Resident X's MAR, there was no section for his weight to be recorded. Resident N's MAR did include a section to document her weight. On 08/03/25, there is a comment stating Resident N refused to get her weight checked. This comment was initialed by staff member "MB". On 08/03/25, Resident B's weight was recorded on her MAR which was 132 pounds.

On 08/26/25, I made a telephone call to Nurse Sharon. Nurse Sharon stated she is aware that the staff have to transfer Resident L on a scale in order to take his weight. Nurse Sharon cannot say for certain if that happens every month. Resident M is weighed in her wheelchair. Nurse Sharon stated Resident M's weight is checked every month. The staff will contact Nurse Sharon if a resident's weight fluctuates and; Nurse Sharon will then inform Dr. Tamera Townsend.

On 08/26/25, I made a telephone call to staff member Sheeka Hightower. Ms. Hightower stated the residents are weighed every month. Ms. Hightower is not aware of any residents not being weighed every month. Ms. Hightower denied any residents losing 20 pounds in one month.

On 08/26/25, I made a telephone call to the home manager Ashly Liskey. Ms. Liskey confirmed that a weight record has not been completed for Resident N or Resident X since they have been admitted into the AFC group home. Ms. Liskey stated she has been off work a lot since the end of July due to a death in the family and a leg injury.

On 08/28/25, I made a telephone call to Nurse Sharon. Nurse Sharon stated she does not recall off hand about Resident U losing 19 pounds last year. Nurse Sharon stated Resident U had some falls in the past and one incident caused a wound on her arm. During this time, Resident U appetite decreased as she was not eating as much. Resident U's sister also resides in the AFC group home and they do not get along. Resident U will often get emotional when she is upset with her sister and purposely stop eating. Nurse Sharon denied the staff neglecting Resident U and/or not feeding her.

On 08/28/25, I received an email from Ms. Liskey confirming that Resident N was admitted on August 1, 2025. Therefore, Resident N's weight was not documented at the time of admission.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	Based on the information gathered, there is no evidence to support that any resident has lost 20 pounds in one month. Although Resident U lost 19 pounds on 02/01/24, Nurse Sharon advised that Resident U has a history of refusing to eat. However, there is evidence to support that some residents admission weight and/or monthly weight was not documented. Resident U was admitted on 11/30/23 however; her initial weight was not taken until 12/01/23. Resident I's weight record did not include a weight for the month of July 2024. On 07/01/24, "00f" was documented as the weight. There was no explanation recorded. Resident X was admitted on 08/19/25 however; his admission weight was not documented as his weight record was blank. Resident N was admitted on August 1, 2025 however; her admission weight was not documented as her weight record

	was blank. Resident C's weight record did not include a weight for the month of June 2025 or July 2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There is a severe lack of care given to residents by staff, such as failure to change residents every 2-3 hours, provide showers, or shaves, etc. Wounds appear on residents quickly because many residents stay in bed all day and all night without rotating or getting up.

INVESTIGATION:

Ms. Jones stated the staff change the residents briefs every two hours. Resident L has one bed sore on his butt. Ms. Jones stated Resident L had this bed sore before she started working for the AFC group home. Resident L is bed bound. The staff use to put Resident L on the couch in the living area however; when his daughter would visit she would instruct staff to put him back in bed. The staff rotate Resident L every two hours. Ms. Jones stated Resident L bed sore is getting better. Resident L bed sore is treated by Nurse Sharon from A Choice. Nurse Sharon visits Resident L once a week. The staff are not responsible for caring for Resident L bed sore. The staff will change the adhesive bandage that covers Resident L's bed sore if it comes off.

Ms. Jones stated the staff follow a shower schedule for each resident. The residents receive two showers a week. Resident S is the only Resident who receives a bed bath because he is paralyzed. The staff assist the residents with their ADL's such as brushing their teeth, shaving them, and helping them get dress. Ms. Jones is not aware of any staff member neglecting to shower a resident or complete their job duties. Ms. Jones stated each male receives a shave twice a week. Resident U is the only female resident who also gets shaved once a week.

Ms. Liskey stated the staff change the residents briefs every two hours or as needed. The staff never waited more than two hours to change the residents briefs. Resident L has had one bed sore for a couple of months. Resident L is rotated every two hours when his brief is changed. Ms. Liskey stated when the staff rotate Resident L onto his side he will roll himself back onto his back. Resident L's bed sore does not cause him any pain. Resident L's daughter does not want Resident L out of bed because the recliner chair or wheelchair hurts his buttock. Resident L's bed sore has improved. Nurse Sharon visits Resident L twice a week.

Ms. Liskey stated Resident M is the only other resident that has a bed sore which is located on her right hip. Resident M has had a bed sore for a month. Resident M's legs have been amputated. Resident M is not bed bound as she moves around throughout the AFC group home in her wheelchair. The staff do not treat Resident L or Resident M bed sores as they are both cared for by Nurse Sharon. The staff will replace the

bandage that covers the bed sores if it comes off. Ms. Liskey stated there is no documentation recorded regarding Resident L or Resident M wound care. Nurse Sharon records her notes regarding her visits with Resident L and Resident M but, those notes are not kept in the AFC group home.

Ms. Liskey stated each resident is given a shower twice a week. Ms. Liskey stated Sunday's are make-up days for any resident that refused a shower during the week. The hospice residents have a hospice aid who gives them their showers twice a week. Ms. Liskey is not aware of any staff member not completing their job duties including the resident's ADL's. The residents are shaved when they get their showers twice a week.

Mr. Ahmed stated the residents have scheduled showers and are shaved regularly. Resident L is the only Resident with a bed sore and he is rotated every two hours.

On 08/20/25, I interviewed Resident L. Resident L was asleep in his bedroom but he woke up. Resident L was hard to understand. Resident L stated he likes staff and they treat him well. I observed Resident L's bed sore located on his buttock. The bed sore was extremely minor and had a very small opening. The bed sore did not have any discoloration and did not look painful. Overall, Resident L's buttock was red in color do to the adhesive bandage that he wears.

On 08/20/25, I interviewed Resident B. Resident B was lying in bed watching T.V. I observed Resident B to have a black right eye. Resident B stated she did not know what happened to her eye. Resident B denied anyone hurting her or falling. I asked Resident B does her eye hurt and her response was "I'm sure it does". Resident B stated the staff treat her well and take care of her. The staff assist her with showers and with getting dressed. Resident B receives one shower a week per her request. Resident B denied wearing briefs and stated she uses the bathroom on her own. I asked Ms. Liskey how Resident B received her injury and; she stated that she fell off the dining room chair. The staff called 911 but she was not taken to the hospital because her son did not want her to go to the hospital.

On 08/27/25, I received a return phone call from Resident B's guardian. The guardian is aware of the incident regarding Resident B. The incident occurred last Tuesday (8/19/25) around 6:30am. The guardian was told that Resident B got up around 6:30am stating she was hungry. A staff member sat Resident B down at the dining table. When the staff went to go make Resident B some food, Resident B fell out of the chair and hit her head. The staff called 911. Resident B has Dementia and is very stubborn. Resident B refused to go to the hospital. The guardian came to the AFC group home and offered to take Resident B to the hospital but, she said no. The AFC group home nurse and the hospice nurse evaluated Resident B and said she was fine. The guardian stated Resident B is in her 90's and she bruises easily. The guardian does not have any concerns regarding the AFC group home. The guardian has had good interactions with the staff.

On 08/21/25, I received a copy of Resident B's incident report regarding her fall. Resident B's incident report is dated 08/19/25 at 1:50pm According to the incident report, Resident B was trying to get out of the dining room chair. The staff walked away and turned around and saw Resident B on the floor. The police were called. The manager made sure Resident B was ok. Resident B's son came and told EMS he didn't want Resident B sent to the hospital as she is a hospice patient. The incident report was signed by Ms. Liskey.

On 08/20/25, I interviewed Resident M. Resident M was sitting in her recliner chair watching T.V. Resident M stated she loves living at the AFC group home. Resident M has lived at the AFC group home for about a year. Resident M stated the AFC group home is clean and all of the staff are good to her. Resident M receives a shower twice a week on Monday's and Thursday's. The staff assist with getting her dressed and brushing her teeth. I observed the bed sore on Resident M's hip. The bed sore was round and about the size of a quarter. The inner part of the bed sore was light in color and the outer part was red. Resident M stated her bed sore is being well taken care of by the nurse who visits her twice a week. The staff change her briefs about 3 or 4 times during the day and about twice at nighttime. Resident M also stated the staff changes her briefs whenever she calls them and let them know she is wet.

On 08/20/25, I interviewed Resident K. Resident K has resided at the AFC group home since October 2024. Resident K stated she likes living at the AFC group home a lot. The staff are good and makes sure she has what she needs. Resident K receives a shower twice a week. The staff assist with brushing her teeth and getting her dressed. Resident K stays in bed a lot because she is often tired. The staff changes her briefs every 2-3 hours. Resident K stated she can call staff at any time and they always appear alert and aware. The staff are always conscious about making sure her room is clean.

On 08/20/25, I received copies of all the residents assessment plans. I reviewed the assessment plans for 19 current residents and Resident C's assessment plan who is discharged from the AFC group home. There are 20 residents residing in the AFC group home as of 08/19/25. The assessment plans did not include any wound care instructions for any of the residents. During my onsite, it was reported that only Resident L and Resident M have a bed sore. Resident L and Resident M wound care was not included in their assessment plans. Resident L assessment plan was signed by his guardian on 05/13/25 however; the licensee designee Zubair Ahmed did not sign or date the assessment plan. Resident M signed her assessment plan on 04/06/25 but, the licensee designee Zubair Ahmed did not sign or date the assessment plan.

Resident C's assessment plan was signed by her guardian next to a typed date of 05/03/25. The assessment plan was not signed by Mr. Ahmed. Resident Z assessment plan was signed by her guardian next to a typed date of 05/05/25. The assessment plan was not signed by Mr. Ahmed. Resident F assessment plan was signed by his guardian next to a typed date of 06/04/25. The assessment plan was not signed by Mr. Ahmed. Resident A assessment plan was signed by his guardian next to a typed date of

01/13/25. The assessment plan was not signed by Mr. Ahmed. Resident V assessment plan was signed by her guardian next to a typed date of 01/09/25. The assessment plan was not signed by Mr. Ahmed. Resident O assessment plan was signed by her guardian next to a typed date of 01/01/25. The assessment plan was not signed by Mr. Ahmed.

Resident X was admitted on 08/19/25 however; his assessment plan was not completed.

On 08/20/25, I received a copy of the shower schedule. According to the shower schedule, Resident B, Resident M, Resident X, Resident L and Resident S take their showers on Monday's and Thursday's. Resident I, Resident O, Resident H, Resident P, Resident N and Resident K take their showers on Tuesday's and Friday's. Resident V, Resident D, Resident U, Resident F, Resident Y, Resident J, Resident A, and Resident E take their showers on Wednesday's and Saturday's. The shower schedule indicates that Sunday's are make-up days and every male resident is shaved on shower days and as needed.

On 08/26/25, I made a telephone call to Nurse Sharon. Regarding the allegations, Nurse Sharon stated she visits Resident L and Resident M at the AFC group home twice a week. Nurse Sharon was recently assigned to treat Resident X and Resident N. Nurse Sharon is treating Resident N because she has a closed head injury. Resident X is being treated because he had respiratory problems when he was in the hospital. Resident X and Resident N do not have any bed sores. However, Resident N feet are somewhat mushy but no open sores. Nurse Sharon stated she received a call yesterday from staff stating it appears that one of Resident N feet looks like a sore maybe opening up. Nurse Sharon is on her way to the AFC group home to see Resident N.

Nurse Sharon stated Resident L's bed sore is almost healed and completely closed. Resident L has a history of his bed sore re-opening up after being healed because he will not stay off his bottom. Nurse Sharon has instructed Resident L several times to not lay directly on his bottom but he refuses due to his Dementia. The staff will place pillows underneath Resident L while he is in bed but, Resident L will remove the pillows. The staff also rotate Resident L but he will roll himself back onto his butt. Nurse Sharon stated the staff do everything they are expected to do including following her instructions. Nurse Sharon stated she is the only person responsible for completing wound care with the residents. The staff are only allowed to put a dry bandage over the wound if the current bandage is wet. The staff are good with following up with Nurse Sharon with any changes regarding the residents. Nurse Sharon does not have any concerns regarding the staff or the group home. The staff complete their job duties as expected. Nurse Sharon stated the AFC group home is one of the better facilities she works at.

Nurse Sharon stated Resident M has had her bed sore on her hip for about 2-3 weeks. Resident M likes to lay in bed a lot on her side. The staff are instructed to put a pillow

behind Resident M and ensure she stays off her side. The staff have been following these instructions.

On 08/26/25, I made a telephone call to staff member Sheeka Hightower. Ms. Hightower stated every staff member does their job including completing the ADL's for the residents. The staff follow the shower schedule. Ms. Hightower stated Resident L is rotated every 2-3 hours. The staff put pillows on his buttock but, Resident L removes the pillows. The staff changes every resident briefs every 2 hours.

APPLICABLE RULE	
R 400.15303	**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 no evidence to support that the staff members were not providing proper care to each resident based on the instructions given in their assessment plans. Resident L and Resident M are the only residents in the AFC group home who are currently being treated for a bed sore. There were no wound care instructions in their assessment plans and Nurse Sharon is the only person permitted to care for their bed sores.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based on my investigation and the information gathered, there is no evidence to support this allegation. I reviewed a shower schedule that includes set shower days for each resident. Every resident is scheduled to receive a shower twice a week. The shower schedule also indicates that every male will be shaved on shower days and as needed. The staff interviewed denied any staff member neglecting to complete their job duties including assisting the residents with their ADL's. Resident M and Resident K confirmed that they receive a shower twice a week. Resident B stated she receives a shower once a week

	per her request. The staff and the residents interviewed confirmed that the residents briefs are changed every 2-3 hours.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(11) A licensee shall contact a resident's physician for instructions as to the care of the resident if the resident requires the care of a physician while living in the home. A licensee shall record, in the resident's record, any instructions for the care of the resident.
ANALYSIS:	There is evidence to support that the licensee designee Zubair Ahmed did not record in the resident's file any instructions regarding Resident L and Resident M's wound care. Resident L has a history of being treated for a bed sore and; Resident M has been treated for a bed sore for about three weeks. Resident L and Resident M's assessment plans were not updated to include the wound care they are receiving from Nurse Sharon.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on the information gathered, there is evidence to support the allegation. The licensee designee Zubair Ahmed did not sign or date the following assessment plans for Resident L, Resident M, Resident C, Resident Z, Resident F, Resident A, Resident V, Resident O. Resident X was admitted on 08/19/25 however; his assessment plan was not completed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff come in to work high off marijuana or other drugs. Staff bring marijuana and/or other drugs onto the premises.

INVESTIGATION:

Ms. Jones denied any staff member coming to work high or under the influence of drugs. There are no drugs brought inside the AFC group home. Ms. Jones denied any instances of a resident getting access to any drugs. Ms. Jones does not know why someone would make this allegation.

Ms. Liskey is not aware of any staff coming to work high or under the influence. Ms. Liskey does not know why someone would make that allegation. Ms. Liskey stated there was one instance last year when she came into the medication room and smelled marijuana from one of the staff members personal belongings. Ms. Liskey stated she gathered all of the staff's personal belongings and took them outside and sprayed them with Lysol. Ms. Liskey does not know which staff's belongings smelled like marijuana but she addressed this issue with every staff member and told them not to let that happen again. Ms. Liskey denied any drugs or drug paraphernalia being brought into the home and/or being accessible to the residents.

Mr. Ahmed denied any staff member coming to work high or under the influence. Mr. Ahmed is not aware of any staff coming to work smelling like marijuana. Mr. Ahmed stated the staff are drug tested prior to being hired.

Resident K stated none of the staff have ever appeared under the influence of drugs. Resident K use to be a professional counselor and she would know if someone was under the influence. Resident K does not have any concerns regarding the group home. Resident M stated the staff are very attentive.

On 08/26/25, I made a telephone call to staff member Sheeka Hightower. Regarding the allegations, Ms. Hightower has worked at the AFC group home for 1 ½ years. Ms. Hightower primarily works the day shift. Ms. Hightower denies witnessing any staff member under the influence of alcohol or drugs. Ms. Hightower denies ever smelling marijuana in the AFC group home. Ms. Hightower stated the home manager has never addressed the staff regarding marijuana on her shift.

APPLICABLE RULE	
R 400.15204	**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 no evidence to support that any staff member has worked at the AFC group home under the influence of drugs. The staff interviewed denied witnessing any staff member under the influence. Resident K stated none of the staff have ever appeared under the influence of drugs. Resident M stated the staff are very attentive. Ms. Liskey described an instance that occurred last year when she came into the medication room and smelled marijuana from one of the staff members personal belongings. Ms. Liskey did not know which staff's belongings smelled like marijuana but she addressed this issue with every staff member and told them not to let that happen again. Ms. Liskey denied any drugs or drug paraphernalia being brought into the home and/or being accessible to the residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The home has exceeded the capacity for the approved number of residents.

INVESTIGATION:

Ms. Jones denied the AFC group home being over capacity. There has never been more than 20 residents in the AFC group home. Each resident has their own bedroom with the exception of two bedrooms which are shared between two residents.

Ms. Liskey stated as of yesterday (8/19/25) there are a total of 20 residents in the AFC group home. Ms. Liskey denied the home ever being over capacity.

Ms. Hightower denied the AFC group home having more than 20 residents residing in the home.

APPLICABLE RULE	
R 400.15105	**Licensed capacity.**
	(1) The number of residents cared for in a home and the number of resident beds shall not be more than the capacity that is authorized by the license.

ANALYSIS:	Based on my investigation and the information gathered, there is no evidence to support this allegation. The home is licensed for 20 residents and there are currently 20 residents in the home. I observed each file in the home and there were no more than 20 current files in the home. The staff interviewed denied the home ever being over capacity.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 08/21/25, I received a copy of the resident register. According to the resident register, there are 19 current residents documented despite the fact there are 20 residents residing in the AFC group home. Resident X and Resident N are not documented on the resident register. Resident B's date of admission on the resident register is documented as 12/06/25, which is not accurate. Furthermore, I observed Resident X and Resident N's date of admission was not documented on their resident identification record.

On 08/26/25, I made a telephone call to the home manager Ashly Liskey. Ms. Liskey confirmed that Resident C was discharged from the AFC group home. Ms. Liskey could not remember exactly when Resident C was discharged but it was before the month of August 2025. Resident C's discharge date was not included on the resident register.

On 08/27/25, I completed an exit conference with the licensee designee Zubair Ahmed via telephone. Mr. Ahmed was informed that the allegations will be substantiated and a corrective action plan will be required.

APPLICABLE RULE	
R 400.15210	**Resident register.**
	A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: **(a) Date of admission.** **(b) Date of discharge.** **(c) Place and address to which the resident moved, if known.**
ANALYSIS:	The resident register is not up to date. The resident register indicates that there are 19 current residents despite the fact there are 20 residents residing in the AFC group home. Resident X and Resident N are not documented on the resident register nor is their date of admission. Resident C discharge

	date is not included on the resident register nor is her forwarding address. Resident B's date of admission on the resident register is documented as 12/06/25, which is not accurate.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(b) Date of admission.**
ANALYSIS:	Resident X and Resident N's date of admission was not documented on their resident identification record.
CONCLUSION:	**VIOLATION ESTABLISHED**

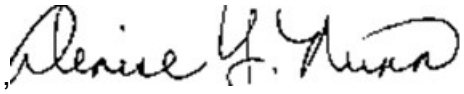
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

09/02/25

Sheena Worthy — Date
Licensing Consultant

Approved By:



09/12/2025

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Denise Y. Nunn — Date
Area Manager