GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 18, 2025

Aimee Davis
Friends and Family, Inc.
309 S Bailey St
Romeo, MI 48065

RE: License #: AS630012761
Investigation #: 2026A0611002
Townsend Group Home

Dear Ms. Davis:

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 #:	AS630012761
Investigation #:	2026A0611002
Complaint Receipt Date:	10/17/2025
Investigation Initiation Date:	10/21/2025
Report Due Date:	12/16/2025
Licensee Name:	Friends and Family, Inc.
LicenseeAddress:	309 S Bailey St Romeo, MI 48065
Licensee Telephone #:	(586) 372-7099
Administrator:	Aimee Davis
Licensee Designee:	Aimee Davis
Name of Facility:	Townsend Group Home
Facility Address:	2029 Hidden Lane Leonard, MI 48367
Facility Telephone #:	(248) 628-8740
Original Issuance Date:	05/11/1992
License Status:	REGULAR
Effective Date:	02/12/2024
Expiration Date:	02/11/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff members are not checking the check boxes on the medication lists, when medications are given to the resident.	Yes
Staff are eating the snacks that are purchased for the residents and will restrict them as punishment for not listening. Staff have been observed shoving food in the residents mouth. Staff are verbally abusive towards the residents.	No
A few weeks ago, Resident A was observed with a black eye. Staff were unaware as to how Resident A sustained the injury. Staff member Ann Pettiford made some inappropriate comments and/or actions towards Resident G.	Yes
Staff members smoke in the garage of the home, including marijuana, and empty beer cans have been observed in the home.	No
One staff member is allowed to bring her minor child to work for her shift. The child sleeps in an unused room in the AFC home.	Yes
Staff members are sleeping during their shifts.	No

III. METHODOLOGY

10/17/2025	Special Investigation Intake 2026A0611002
10/21/2025	Special Investigation Initiated - Letter I emailed the Adult Protective Services worker Candid Jamerson regarding the investigation.
10/21/2025	APS Referral According to one of the additional intake emails, the assigned Adult Protective Services worker is Candid Jamerson.
10/23/2025	Contact - Telephone call made I left a voice message for the Adult Protective Services worker Candid Jamerson requesting a call back.
10/24/2025	Inspection Completed On-site An unannounced onsite was completed. I interviewed staff member Patricia Roman, and the house manager Karen

	Krukowski. I received copies of Resident A's assessment plan and incident report. I also received copies of every residents MAR for the month of October.
10/28/2025	Contact - Telephone call made I left a voice message for staff member Ashley Junga requesting a copy of the staff members medication training certificates.
10/29/2025	Contact - Document Received I received a copies of medication trainings for the staff members.
10/30/2025	Contact - Telephone call made I made a telephone call to staff member Patricia Roman. Ms. Roman provided clarification regarding the medication checklist.
11/05/2025	Contact - Telephone call made I made a telephone call to the assistant manager Michelle Waterloo. The allegations were discussed.
11/05/2025	Contact - Telephone call made I contacted the AFC group home and spoke with Resident B.
11/05/2025	Contact - Telephone call made I left a voice message for staff member Kristen Nanni requesting a call back.
11/05/2025	Contact - Telephone call made I left a voice message for former staff member Anne Pettiford requesting a call back.
11/05/2025	Contact – Telephone call received I received a return phone call from Resident A's guardian, Jim Starks. The allegations were discussed.
11/05/2025	Contact – Telephone call received I received a return phone call from former staff member Ann Pettiford. The allegations were discussed.
11/05/2025	Contact – Document Received I received a copy of an appointment information record for Resident A regarding her black eye.
11/05/2025	Contact – Document Received I completed a search on the Workforce Background Check System for former staff member Ann Pettiford.

11/05/2025	Exit Conference I completed an exit conference with the licensee designee Aimee Davis via telephone. The allegations were also discussed.
11/06/2025	Contact – Document Received I received a copy of the background checks that was completed for Anne Pettiford on 09/15/22.
11/06/2025	Contact – Telephone call made I made a telephone call to Aimee Davis to clarify which background checks was completed prior to Anne Pettiford working at the AFC group home.
11/06/2025	Contact – Telephone call made I made a telephone call to staff member Kristen Nanni. The allegations were discussed.

ALLEGATION:

Staff members are not checking the check boxes on the medication lists, when medications are given to the resident.

INVESTIGATION:

On 10/17/25, a complaint was received and assigned for investigation alleging that staff members are not checking the check boxes on the medication lists, when medications are given to the client. When the medications are passed on to other staff, it is unknown what medications have already been given to the client. When the boxes are being checked, they are sometimes pre-checked for that night, although the client has not yet taken the medication. The medications are left out for several hours in the morning in the room where the clients have access and have tried to access in the past.

Staff are eating the snacks that are purchased for the clients and will restrict them as punishment for not listening. Clients are often restricted water and beverages. Staff have been observed shoving food in Resident A's mouth aggressively when she does not want to finish it. This has been observed with several of the clients. No injuries were observed. Staff are verbally abusive and constantly yell and berate the clients. A few weeks ago, Resident A was observed with a black eye. Staff were unaware as to how Resident A sustained the injury. Staff members smoke in the garage of the home, including marijuana, and empty beer cans have been observed in the home.
One staff member is allowed to bring her minor child to work for her shift. The child sleeps in an unused room in the AFC home. This is concern as several of the clients in the home are known to be aggressive. Staff members are sleeping during their shifts.

NOTE: It should be noted that during this investigation, additional allegations were reported regarding former staff member Ann Pettiford stating on 10/22/2025, Ms. Pettiford asked Resident G if he got horny. Ms. Pettiford also asked Resident G if he had pubic hair. Ms. Pettiford pressed her chest against Resident G's back as if Resident G was falling backward, but Ms. Pettiford could have moved. Ms. Pettiford leaned forward and smiled while she pressed her breasts into Resident G's back. These additional allegations were reported to Adult Protective Services due to the sexual nature however; Adult Protective Services denied investigating these allegations on 10/31/25.

On 10/24/25, I completed an unannounced onsite. I interviewed staff member Patricia Roman, and the house manager Karen Krukowski. I received copies of Resident A's assessment plan and incident report. I also received copies of every residents MAR for the month of October.

On 10/24/25, I interviewed staff member Patricia Roman. Ms. Roman stated she is also the medication coordinator. Ms. Roman started working for the AFC group home in 2015 but she left and came back. There are five residents in the home. Resident A and Resident G were present during the onsite. The other three residents were at workshop. Resident A and Resident G are non-verbal. Resident A was observed laying on the couch watching T.V. Resident G was observed as hyperactive as he was walking throughout the home. Regarding the allegations, Ms. Roman stated every staff member is trained to administer medications except for Samina Hooks who works the midnight shift two nights a week (Friday's & Saturdays). The midnight shift is 10:00pm to 8:00am. Ms. Hooks midnight hours are 10:00pm to 10:00am. Ms. Roman stated there is always another staff member working with Ms. Hooks who is responsible for administering medications to the residents.

Ms. Roman denied all of the allegations pertaining to medication. The midnight staff are responsible for administering the morning medications to the residents. The dayshift hours are 8:00am to 4:00pm. The afternoon shift hours are 4:00pm to 12:00am. Ms. Roman denied ever being told or witnessing any medications being left out. Ms. Roman stated if there was an instance of medication being left out it would have been reported to her. Ms. Roman denied any resident having access to any medications. The medications are always locked up in the medication cabinet located near the file desk next to the garage door.

Ms. Roman has every residents medications organized as each resident has their own bin for their daily medications and; a separate bin for their PRN's. Each bin has the resident's name on it along with a picture of the resident. The medication bubble packets are color coordinated according to the time of day the medications are scheduled to be taken. The color pink are for the 4:00pm medications, the color blue is for the evening medications, and the color yellow is for the morning medications. I reviewed all of the bubble packets for the daily medications for each resident. It appears that each medication is being administered appropriately as the bubble packets coincide

with the correct day of the week and; none of the afternoon or evening medications were taken out of the bubble packet ahead of time.

Ms. Roman stated she is unsure as to why someone would make this allegation. However, there was a staff member who was suspended for two days after working in the AFC group home for 1 ½ week. The staff member who was suspended was Ann Pettiford. Ms. Pettiford was suspended for not completing her job duties as she was observed sitting in a recliner chair in the common area with her feet kicked up, socks and shoes off, and on her cell phone. Ms. Roman took a picture of Ms. Pettiford sitting in the recliner chair and forward me a copy of it via text message. The picture provided was accurate based on what Ms. Roman described. The picture was taken on 10/10/25. Ms. Roman stated after Ms. Pettiford was suspended, the AFC group home received a visit from Adult Protective Services.

On 10/24/25, I interviewed the home manager Karen Krukowski. Ms. Krukowski stated the allegations pertaining to medication is not true. Every staff member is trained to administer medication with the exception of Ms. Hooks who is a part-time staff member. Ms. Hooks works two midnight shifts a week. There is always a staff member working with Ms. Hooks who is responsible for administering medication.

On 10/24/25, I received copies of every resident's MAR for the month of October as well as a medication checklist for the month of October. It appears that the medications are being administered accurately as the staff are initialing the MAR according to the correct day and time, with the exception of Resident L. Resident L is prescribed Vitamin B12 daily at 8:00am. I observed a staff members initial for this medication dated 10/25/25 which is a day ahead of the day I received a copy of this MAR. It appears that the staff members initials belongs to Ms. Krukowski.

On 10/29/25, I received medication trainings for six employees and new hire medication trainings for four employees. The following staff completed medication training:

- Keven Forth on 11/18/24 – new hire medication training on 09/16/11
- Karen Krukowski on 12/8/21 – new hire medication training on 07/15/02
- James Lewis on 07/05/22
- Kristin Nanni on 09/29/23 – new hire medication training on 07/30/10
- Patricia Roman on 01/02/18 – new hire medication training on 01/12/20
- Michelle Waterloo on 04/30/25

On 10/30/25, I made a telephone call to Ms. Roman. Ms. Roman provided clarification regarding the medication checklist for the month of October. The medication checklist is divided into two sections. The first section is entitled "medication passing staff" with three columns entitled mornings, afternoon, and midnight. The second section has the same three columns but it's entitled "medication checking staff". Ms. Roman explained that whichever staff member is assigned as the medication passer they will document their initials under the first section below the morning column. I inquired about why "N/A" was documented on several days under the second section under the morning column,

when Ms. Roman documented her initials under the first section for the same day for the same shift. It was explained that since Ms. Roman works the dayshift and the midnight staff are required to administer morning medications, there is no reason for a staff member to check the medications she administered because there are no medications to administer during her shift hours (8:00am to 4:00pm). Ms. Roman stated the afternoon staff administer the 4:00pm medications.

Ms. Roman included Ms. Krukowski in the phone conversation to ensure clarity regarding the medication checklist. Ms. Krukowski confirmed that six of the missing staff initials under the second section under the afternoon column were errors as the responsible staff member forgot to document their initials. There was also four dates missing staff initials under the second section under the midnight column. Ms. Krukowski admitted that she crossed out Ms. Pettiford initials under the first section on 10/10/25 under the afternoon column. Ms. Krukowski stated Ms. Pettiford initialed under the wrong section as she was supposed to initial under the second section indicating she checked the medications that were administered.

I confirmed with Ms. Roman and Ms. Krukowski that there was an error regarding Resident L's MAR pertaining to his Vitamin B-12. Ms. Krukowski confirmed that she worked the midnight shift on 10/23/25 and inadvertently initialed the MAR for this morning medication on 10/25/25 which was the wrong date

On 11/05/25, the assistant manager Michelle Waterloo stated she is trained to administer medications. Ms. Waterloo stated every staff is trained to administer medications except Ms. Hooks who works only two midnight shifts a week. Ms. Hooks always works with another staff member who is trained to administer medications. Ms. Waterloo stated Ms. Pettiford transferred from another AFC group home in Macomb County to this AFC group home because she had an open APS investigation. Ms. Pettiford was trained to administer medications in Macomb County but she was not allowed to administer medication in this AFC group home because she had not completed the Oakland county medication training. Ms. Pettiford did not work alone while she was employed at this AFC group home.

Ms. Waterloo denies any staff member initialing the MAR before administering medication. Ms. Waterloo stated the staff are definitely not leaving medication out as that would be a major liability especially since there are residents in the AFC group home who have Pica.

On 11/05/25, I made a telephone call to the AFC group home. An attempt was made to interview Resident B however; it did not appear that she understood a lot of the questions as she was unable to elaborate. Resident B did state that she likes living at the AFC group home and she also likes the staff as they treat her well. Resident B stated she took her medication and ate breakfast this morning. I spoke to Ms. Roman and she explained that Resident L was verbal but he was currently at workshop. Ms. Roman also stated that although Resident L is verbal he will be harder to understand because he had a stroke.

On 11/05/25, I spoke to the licensee designee Aimee Davis. Ms. Davis stated the allegations pertaining to medication is not true. The medications are always locked up in the medication cabinet. There is always a medication passer and a medication checker to ensure the medications are being administered properly. The medications are never left out as the residents in the home are extremely busy and a couple of the residents have Pica.

On 11/06/25, I made a telephone call to staff member Kristen Nanni. Regarding the allegations, Ms. Nanni stated she works part time during the midnight shift at the AFC group home. Ms. Nanni administers medication to the residents. Ms. Nanni denies witnessing anyone leaving medication out or initialing the MAR before administering the medication.

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:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Based on the information gathered during my investigation there is sufficient information to conclude that the home manager Karen Krukowski has initialed at least one MAR on the wrong date prior to a medication being administered. On 10/24/25, I received a copy of all the residents MARs for the month of October. Resident L is prescribed Vitamin B12 daily at 8:00am. I observed a staff members initial for this medication dated 10/25/25 which is a day ahead of the day I received a copy of this MAR. The staff members initials belong to Ms. Krukowski. On 10/30/25, I confirmed with Ms. Roman and Ms. Krukowski that there was an error regarding Resident L's MAR pertaining to his Vitamin B-12. Ms. Krukowski confirmed that she worked the midnight shift on 10/23/25 and inadvertently initialed the MAR for this morning medication on 10/25/25 which was the wrong date.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff are eating the snacks that are purchased for the residents and will restrict them as punishment for not listening. Staff have been observed shoving food in the residents mouth. Staff are verbally abusive towards the residents.

INVESTIGATION:

Ms. Roman denied witnessing any staff member forcing food in any of the residents mouth. Ms. Roman stated it is written in every residents assessment plan for staff to assist the resident with feeding if needed. Resident L and Resident E receives assistance with eating for every meal as Resident L's food is pureed and Resident E is blind. Resident G and Resident A will sometimes receive assistance with eating when they choose not to feed themselves. Resident B will sometimes receive assistance with eating as she likes to shove food in her mouth.

Ms. Roman stated the staff bring their own food to eat during their shifts and; they never eat the residents food. There are instances where the staff will bring in a pizza for the staff and residents to eat together as a family. Ms. Roman denies staff restricting food or beverages from the residents or using food or beverages as a form of punishment. The residents have unlimited access to food and beverages. The residents always receive three meals a day as well as snacks. Towards the end of my onsite, I observed Ms. Roman give Resident A and Resident G a snack. Resident A and Resident G sat at the kitchen table to eat their snack without any assistance.

Ms. Roman denied any staff member being verbally abusive towards any resident. The AFC group home does not have a high turnover rate as all of the staff members have worked at the AFC group home for years.

Ms. Krukowski denied any staff member shoving food in a residents mouth. Resident L requires assistance with eating for every meal. However, the other residents can feed themselves unless they ask for staff assistance. Ms. Krukowski denies any staff member eating the residents food. The staff bring their own food to work. Ms. Krukowski stated the staff do not use food or beverages as a form of punishment with the residents. The residents have unlimited access to food and beverages. The residents are fed three meals a day in addition to snacks.

Ms. Krukowski has never witnessed or been informed about a staff member being verbally abusive towards a resident. Ms. Krukowski confirmed that all of the staff members have worked in the AFC group home for years. Ms. Waterloo is the newest staff member as she has worked at the AFC group home for a year.

On 10/24/25, I observed a refrigerator and deep freezer in the garage. There was a substantial amount of food found in the deep freezer and a nice amount of food found in the refrigerator. I also found an adequate supply of food in the refrigerator and freezer

located in the kitchen. There is an abundance of food/snacks inside the pantry. Ms. Roman explained that the refrigerator and freezer in the kitchen is locked to prevent the residents who are diagnosed with Pica from getting into the refrigerator and/or freezer.

Ms. Waterloo stated the staff do not force feed the residents. The residents eat when they want to eat and they stop when their ready. The staff do not restrict the residents from any food or beverages or use food/beverages as a form of punishment. The staff members do not eat the residents snacks. Ms. Waterloo stated when the staff prepare meals they cook enough food for the staff to eat with the residents as a family. Ms. Waterloo stated the residents get more than enough food to eat. Ms. Waterloo denies any staff member being verbally abusive to any resident.

On 11/05/25, Ms. Davis denies any staff member being abusive towards the residents. The staff members have worked at the AFC group home for at least five years or more with the exception of Ms. Waterloo. The staff members are protective over the residents which is why they reported Ms. Pettiford's behavior because they were concern. With the exception of Ms. Pettiford, Ms. Davis reiterated that she has never had any concern with any of the staff as they treat the residents like family and; they bend over backwards for the residents.

Ms. Davis denied any staff member shoving food in any residents mouth. Ms. Davis stated if the residents don't want to eat then they won't eat. There are no restrictions on food or beverages in the home. The residents can request food/beverages at any time. Ms. Davis stated the refrigerator and freezer have locks on them only because there are residents in the home who have Pica and; this information is documented in their assessment plan. The staff bring their own snacks to eat during their shifts. Ms. Davis stated the staff will cook enough food for the residents as well as the staff so that they can have a family-style meal. Ms. Davis stated the staff are encouraged to eat as a family with the residents. The staff will also spend money out of their own pocket and buy a pizza for the residents.

On 11/06/25, I spoke to staff member Kristen Nanni. Ms. Nanni stated the staff do not shove food in the residents mouth. Ms. Nanni stated if the residents do not want to eat then they can be given oral supplements. The staff do not restrict the residents from eating or drinking, nor is food used as a form of punishment. Ms. Nanni denies anyone verbally abusing the residents. There has never been a concern regarding the residents being abused.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of

	the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	There is no evidence to support the allegation pertaining to the staff shoving food in residents' mouths. Each staff interviewed denied forcing a resident to eat. During my onsite, I observed Resident G and Resident A in the home. Both residents appeared comfortable and content in the AFC group home. I also observed Ms. Roman give Resident G and Resident A a snack. Both residents were sitting at the kitchen table and appeared capable of feeding themselves without any issue.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(e) Withhold food, water, clothing, rest, or toilet use.**
ANALYSIS:	Based on the information gathered, there is no evidence to support any staff member restricting the residents from eating their snacks as a form of punishment. I observed a refrigerator and deep freezer in the garage. There was a substantial amount of food found in deep freezer and a nice amount of food found in the refrigerator. I also found an adequate supply of food in the refrigerator and freezer located in the kitchen. There is an abundance of food/snacks inside the pantry. The licensee designee Aimee Davis, explained that staff will cook enough food for the residents as well as the staff in order for the staff to sit down with the residents and eat with them as a family.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of

	the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(ii) Verbal abuse.**
ANALYSIS:	There is no evidence to support this allegation regarding the staff being verbally abusive towards the residents. The AFC group home does not have a high turnover rate, as the majority of the staff members have worked in the home for years. Ms. Davis stated she has never had any concerns regarding any staff member being abusive towards any resident. The staff are protective over the residents and they treat them like family.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **A few weeks ago, Resident A was observed with a black eye. Staff were unaware as to how Resident A sustained the injury.**
- **Staff member Ann Pettiford made some inappropriate comments and/or actions towards Resident G.**

INVESTIGATION:

On 10/24/25, Ms. Roman denied knowing how Resident A obtained a black eye. Ms. Roman stated Resident A has a history of injuring herself by head butting herself. Ms. Roman stated Resident A will usually hurt herself as a way to express that she is in pain due to a UTI or yeast infection. Resident A has a history of getting a UTI and/or yeast infection because she does not like it when staff wipe her when she is finished using the bathroom. When Resident A has to be seen by a gynecologist she has to be put to sleep in order for the doctor to examine her.

Ms. Roman stated Ms. Pettiford was terminated on 10/23/25 for not doing her job and displaying inappropriate actions towards Resident G. Resident G likes to walk backwards and; there was an instance where Resident G was walking backwards and Ms. Pettiford stood behind him and allowed him to bump up against her chest.

On 10/24/25, Ms. Krukowski confirmed that Resident A had a black eye but she does not know what happened. Resident A has a history of self-injurious behavior. Resident A was taken to an urgent care and an incident report was completed.

Ms. Krukowski confirmed the incident regarding Ms. Pettiford allowing Resident G to walk backwards into her chest area. Ms. Krukowski stated Ms. Pettiford was re-assigned to work at this AFC group home because she had an open Adult Protective Services case at a different home within the company. Due to Ms. Pettiford's open Adult Protective Services case, she was not allowed to work alone at this AFC group home.

Ms. Krukowski stated on Ms. Pettiford first day working at this AFC group home, she asked Resident G if he gets horny. Ms. Krukowski stated she walked away when she heard Ms. Pettiford's question because she was dumbfounded. Ms. Krukowski stated this past Tuesday, Ms. Pettiford asked Resident G if he has pubic hair. Ms. Pettiford told Ms. Krukowski she wanted to know because she doesn't have any pubic hair. Ms. Krukowski stated she was warned that Ms. Pettiford is eccentric.

On 10/24/25, I observed Resident A laying down on the couch watching T.V. A picture was taken of her face. I did not observe any bruises or injuries on Resident A's face.

On 10/24/25, I received a copy of an incident report regarding Resident A's black eye as well as her assessment plan. The incident report is dated 09/29/25. Ms. Roman and Michelle Waterloo are listed as the employees who witnessed the incident. The incident report was completed by Ms. Waterloo. According to the incident report, when staff arrived to the AFC group home at 8:00am, Resident A was sleeping on the couch. Resident A was very combative and displayed self-injurious behavior (SIB) the day before. When staff woke Resident A up, staff noticed bruising on her right eye, a lump on her left eye by her eyebrow with some pinkness, and a red mark on her right ear. There were no notes written in the health care chronological (HCC) regarding these injuries. These injuries were not reported by the midnight staff. Staff took Resident A in the bathroom to complete a full body check. There were no other injuries observed. Resident A was transported to 1st Choice Urgent Care in Oxford. Resident A was prescribed Bactrim 800mg for seven days. The doctor did not complete any test as Resident A was agitated.

According to Resident A's assessment plan, she is known for exhibiting self-injurious behavior such as; biting her wrist and slapping herself. It is also documented that she sometimes requires assistance with eating.

On 11/05/25, Ms. Waterloo stated Ms. Pettiford started working at this AFC group home on 09/30/25 and was terminated on 10/23/25. Ms. Pettiford was terminated for not completing her job duties and making inappropriate comments and/or actions towards Resident G. Ms. Waterloo confirmed that Ms. Pettiford asked Resident G questions about whether or not he gets horny and if he has pubic hair. Ms. Waterloo also confirmed the allegations about Ms. Pettiford allowing Resident G to walk backwards into her chest.

On 11/05/25, I received a return phone call from Resident A's guardian, Jim Starks. Mr. Starks is aware of the allegations as he spoke with Adult Protective Services. Mr. Starks stated he has no concerns regarding the care Resident A is receiving at the AFC group home. Resident A receives services from Easter Seals who visits the AFC group home once a month. Mr. Starks was also aware of Resident A having a black eye. Mr. Starks denies any concerns regarding the staff being abusive towards Resident A. Mr. Starks stated if Easter Seals had any concerns they would have communicated that to him. Mr. Starks confirmed that Resident A has a history of behavior issues.

On 11/05/25, I received a copy of an appointment information record for Resident A regarding her black eye. The form was dated 09/29/25. According to the appointment information record, Resident A was taken to 1st choice urgent care for two black eyes and a possible UTI. Under the treatment section, it states Resident A was prescribed Bactrim 160/800mg for seven days. Resident A was diagnosed with an open wound. This form was signed by a doctor whose signature was illegible. There were no concerns regarding abuse documented by the doctor. Ms. Roman also signed this form.

On 11/05/25, I received a return phone call from former staff member Ann Pettiford. Regarding the allegations, Ms. Pettiford stated she only worked at the AFC group home for a week. Ms. Pettiford denied being terminated from the AFC group home. Ms. Pettiford explained that she received a call from the licensee designee Aimee Davis stating she wanted to meet with her regarding her employment. Ms. Pettiford told Ms. Davis if she does not like her work then she can fill out other job applications and leave. Ms. Pettiford stated she did not officially quit nor was she terminated but, she stopped showing up to work. Ms. Pettiford stated she thought she was doing a good job at the AFC group home as she was only there for one week. Ms. Pettiford stated an employee took a picture of her while she was on her cell phone and sent it to Ms. Davis.

When asked if she knows Resident G, Ms. Pettiford stated yes and referred to him as a “cute little boy”. When Ms. Pettiford was asked if she inquired with Resident G if he gets horny, Ms. Pettiford started laughing and said absolutely not. Ms. Pettiford also denied asking Resident G if he has pubic hair. Ms. Pettiford stated Resident G is non-verbal. Ms. Pettiford stated Resident G does not have a habit of walking backwards. Ms. Pettiford stated she absolutely did not allow Resident G to bump up against her chest. Ms. Pettiford stated the residents do not like to be touched. Ms. Pettiford referred to herself as an old lady and; she wouldn’t chest bump a young resident. Ms. Pettiford stated these allegations were made against her because the staff did not want her to work at the AFC group home because it was preventing them from getting overtime.

Ms. Pettiford was asked if she had any concerns while she was working at the AFC group home and her response was a concern pertaining to medication. Ms. Pettiford stated she was not allowed to administer medication as she was only trained to do so in Macomb County. However, Ms. Pettiford was allowed to check the medication documentation to ensure staff administered them. Ms. Pettiford stated she observed staff initialing the MAR prior to administering the medication. The staff would also place morning medications in a cup the night before and keep the cups inside the medication cabinet unlocked. Ms. Pettiford accused every staff member of doing this. Ms. Pettiford stated Ms. Krukowski is the main staff that would initial the MAR days before the medication was administered. Ms. Pettiford stated she complained about how staff were administering medications and because of that she is being retaliated against.

On 11/05/25, I completed a search on the Workforce Background Check System for former staff member Ann Pettiford. I did not find any background clearance results for Ms. Pettiford.

On 11/05/25, Ms. Davis confirmed that Ms. Pettiford was terminated due to the allegations reported pertaining to Resident G. Ms. Davis contacted Ms. Pettiford and requested to meet with her regarding her employment. Ms. Pettiford requested to meet via Zoom. Ms. Pettiford then asked Ms. Davis if she was going to fire her and if so she was not going to waist her time by attending a meeting. Ms. Davis wanted to meet with Ms. Pettiford in an effort to give her a chance to discuss her performance but, Ms. Pettiford declined to do so. Ms. Pettiford asked Ms. Davis if she could work at a different home and she was told no. Ms. Davis stated a termination letter was not mailed to Ms. Pettiford but there is one kept in her personnel file.

Ms. Davis explained when Ms. Pettiford was initially hired she was working at a community living services (CLS) home which is not a licensed AFC group home. Ms. Pettiford worked at the CLS home for about two years. Ms. Pettiford was transferred to the AFC group home because she put medication in a baggy and tapped it to a resident's body at the CLS home who was going on a leave of absence. Ms. Davis stated for this reason Ms. Pettiford was not allowed to work alone or administer medication at the AFC group home. Ms. Davis stated employees who work at a CLS home did not receive a workforce background check until about a year and a half ago. Ms. Davis is not certain if a workforce background check was completed for Ms. Pettiford. Ms. Davis was informed that I was unable to find a workforce background clearance in the system for Ms. Pettiford. Ms. Davis stated she will check her records and confirmed whether or not a workforce background check was completed.

On 11/06/25, I received an email from the licensee designee Aimee Davis providing a copy of the original background check that was completed for Ms. Pettiford. According to the background check Ms. Davis provided, Ms. Pettiford received the following background checks in 2022:

- Office of Inspector General LEIE (OIG)
- Sanctioned Provider List (SPL)
- Nurse Aide Abuse (NAR)
- Michigan Sex Offender Registry (MSOR)
- Offender Tracking Information System (OTIS)

Ms Davis stated she originally enrolled Ms. Pettiford in Greenbrier Group Home on 9/15/2022 to run the check and then removed her since she worked in an unlicensed setting. Ms. Davis also completed a workforce background check today (11/06/25) and provided a copy of the eligibility letter stating Ms. Pettiford is eligible for employment.

I made a telephone call to Ms. Davis to confirmed that Ms. Pettiford did not receive the required workforce background check prior to working at the AFC group home in September 2025. Ms. Davis explained that in 2022 a request was made for Ms. Pettiford to get fingerprinted however; she does not have the results and/or verification that Ms. Pettiford was fingerprinted. Ms. Davis stated she checked Ms. Pettiford's personnel file and could not find an eligibility letter. Ms. Davis stated she understood the

licensing requirement to ensure every employee receives a workforce background check prior to having any contact with any residents at an AFC group home.

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:	Based on the information gathered through my investigation there is insufficient information to conclude that the staff did not ensure Resident A's safety and/or protection. It was confirmed that Resident A had a black eye and she was taken to an urgent care. I reviewed an incident report and appointment information record both dated 09/29/25. The appointment information record was signed by a doctor. There were no concerns of abuse documented by the doctor. According to Resident A's assessment plan, she is known for exhibiting self-injurious behavior such as; biting her wrist and slapping herself. Resident A's guardian, Jim Starks did not report any concerns regarding the AFC group home caring for Resident A. Mr. Starks stated Resident A receives services from Easter Seals who visits the home once a month. Therefore, if Easter Seals observed any concerns it would have been communicated to him. However, there is reason to believe that Ms. Pettiford conducted herself inappropriately towards Resident G including asking inappropriate questions such as, does he get horny and if he has pubic hair. Although Ms. Pettiford denied these allegations, these allegations were confirmed by Ms. Roman, Ms. Krukowski, and Ms. Waterloo. The licensee designee Aimee Davis, confirmed the reason why Ms. Pettiford was terminated was due to the aforementioned behavior and questions above. Furthermore, the AFC group home did not ensure the well-being of Resident G and/or the other residents as a workforce background clearance check was not completed and an eligibility letter was not obtained prior to Ms. Pettiford working at the AFC group home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.

ANALYSIS:	The licensee designee Aimee Davis explained that Ms. Pettiford was working at a community living services (CLS) home for about two years prior to being transferred to the AFC group home. Ms. Davis stated up until about a year and a half ago, a workforce background clearance was not completed for employees who worked at a CLS home. It was confirmed that there is no verification to show that Ms. Pettiford received a workforce background clearance before she started working at the AFC group home in September 2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Staff members smoke in the garage of the home, including marijuana, and empty beer cans have been observed in the home.**
- **One staff member is allowed to bring her minor child to work for her shift. The child sleeps in an unused room in the AFC home.**
- **Staff members are sleeping during their shifts.**

INVESTIGATION:

Ms. Roman stated the staff members who smoke are the home manager Karen Krukowski, the assistant manager Michelle Waterloo, and staff member Kristen Nanni. The above-mentioned staff members only smoke cigarettes. The designated smoking area is in the garage or on the back patio. There is a cigarette dispenser located on the back patio and a table for the staff to sit at and smoke in the garage. The staff are only allowed to take a smoke break when there is another staff member present in the home. The staff are not allowed to smoke constantly throughout their shift. Ms. Roman denied any staff member smoking marijuana at the AFC group home. Ms. Roman has never witnessed the smell of marijuana or any drug paraphernalia in the AFC group home. I observed the table in the garage and found a pack of More slim cigarettes and a lighter. There was also an ash tray with two cigarettes in it.

Ms. Roman denied any alcoholic beverages being in the AFC group home. There is a trash can in the garage where bottles are collected. I observed the trash can and only saw bottles of soft drinks such as Mountain dew, Pepsi, Alani, and Monster.

Ms. Roman denied any staff member bringing their child to work. The staff are not allowed to bring their children to work while they are working. Ms. Roman stated the AFC group home does have holiday parties and some staff may bring their spouses with them.

Ms. Roman has never been told about any staff member sleeping during their shift. Ms. Roman stated it is not possible to sleep at the AFC group home as the home is

constantly busy. Resident G is hyperactive and Resident B will get up in the middle of the night several times to get water or to talk to staff.

Ms. Krukowski has never been informed of or witnessed any staff smoking marijuana at the AFC group home. Initially, Ms. Krukowski stated no staff member brings their child to work. In the event, the AFC group home is having a holiday party, staff are permitted to bring their children. Ms. Krukowski then stated staff member Kristen Nanni works part time during the midnight shift and she has brough her daughter to work during her shift. Ms. Nanni's daughter is four years old. Ms. Nanni's daughter will be in the common area while she is at the AFC group home. Ms. Nanni's daughter is present at the AFC group home from 10:00pm until about 10:30pm. Ms. Nanni's daughter is picked up by her dad after he gets off from work. Ms. Krukowski stated Ms. Nanni is not allowed to bring her daughter to work however; Ms. Krukowski is aware that she has done so a few times this year.

On 10/24/25, I observed four bedrooms in the AFC group home. When the home is at full capacity there are two residents in each bedroom. Since there are only five residents in the home, Resident G has his own bedroom because he likes to destroy property. Resident L and Resident E share a bedroom. Resident A and Resident B also have their own bedrooms. I observed that there is no vacant bedrooms in the home.

On 11/05/25, I made a telephone call to the assistant manager Michelle Waterloo. Ms. Waterloo has worked at the AFC group home for a year. Ms. Waterloo works all three shifts as the AFC group home is short-staffed. Regarding the allegations, Ms. Waterloo denies any staff member smoking marijuana at the AFC group home. Ms. Waterloo stated there are two designated smoking areas for cigarettes only. The staff are allowed to smoke in the garage or on the back patio where there is a cigarette dispenser. Ms. Waterloo denies observing any drug paraphernalia at the AFC group home. Ms. Waterloo stated she is 100% positive that there are no beer cans at the AFC group home. There are empty energy drink cans in the home that someone may mistake as a beer.

Ms. Waterloo confirmed that staff member Kristen Nanni has brought her four-year-old daughter to work with her a hand full of times. Ms. Nanni brings her daughter to work with her to prevent being late to work. Ms. Nanni has permission to bring her daughter to work to ensure she arrives to work on time. When Ms. Nanni brings her daughter to work, her daughters father picks her up from the AFC group home after he gets off from work. Ms. Waterloo stated she has witnessed Ms. Nanni's daughter in the home and; stated the daughter is picked up from the home within 23 minutes of being there. While Ms. Nanni's daughter is present in the home, she is either walking around with Ms. Nanni or sitting at the kitchen table. Ms. Waterloo stated there are no empty bedrooms in the home for any child to sleep in. Ms. Waterloo denies any child sleeping in the home.

Ms. Waterloo denies any staff member sleeping while there on duty. The midnight shift are required to check on the residents either every 30 minutes or every 2 hours depending on what is written in their assessment plan.

On 11/05/25, Ms. Davis stated the staff are not permitted to use any alcohol or drugs at the AFC group home. Ms. Davis stated if a staff member was suspected to be under the influence, they would be removed from the home and required to submit a drug screening immediately. Ms. Davis stated there has never been a concern regarding a staff working under the influence. The staff are allowed to smoke cigarettes on the back patio where there is a cigarette dispenser.

Ms. Davis stated there was an instance about a year ago when Ms. Roman brought her newborn to work because she did not have a babysitter. Ms. Davis stated this was addressed immediately as staff members are not allowed to bring their children to work due to safety and liability concerns. Ms. Davis was informed that it has been reported by Ms. Krukowski and Ms. Waterloo that Ms. Nanni has brought her daughter to work several times this year. Ms. Davis stated she was not aware of Ms. Nanni bringing her daughter to work but she will address it.

Ms. Davis denied any current issues with any staff member sleeping during their shift. Ms. Davis stated there was an employee by the name of Milagros Flores who was terminated for sleeping on shift however; this incident occurred a while ago. Ms. Davis stated the AFC group home stays busy and she doesn't see how any employee could fall asleep.

On 11/05/25, an exit conference was completed with the licensee designee Aimee Davis and she was informed of which allegations will be substantiated. Ms. Davis was advised that she will be required to complete a corrective action plan.

On 11/06/25, Ms. Nanni denied any staff member smoking marijuana or drinking alcohol in the AFC group home.

Ms. Nanni confirmed that she has a daughter that she has brought to work approximately three times this year. During these instances, Ms. Nanni clocked in at 10:00pm and her daughter was picked up by her father by 10:30pm at the latest. Ms. Nanni stated that her daughters father picks up their daughter from the AFC group home after she has been there between 15-20 minutes. While Ms. Nanni's daughter is at the AFC group home, she sits at the table or in the front room with her iPad. Ms. Nanni denied her daughter ever falling asleep in the AFC group home or being in any of the residents bedrooms. Ms. Nanni stated the residents go to bed either around 10:00pm or beforehand. Ms. Nanni denied any staff member sleeping during their shifts.

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 no evidence to support the allegations pertaining to staff smoking marijuana in the AFC group home or drinking alcoholic beverages. There is a trash can in the garage where bottles are collected. I observed the trash can and only saw bottles of soft drinks such as Mountain dew, Pepsi, Alani, and Monster. I observed the table in the garage where staff members are allowed to smoke cigarettes and found a pack of More slim cigarettes and a lighter. There was also an ash tray with two cigarettes in it. However, there is evidence to support the allegation pertaining to a staff member being allowed to bring her minor child to work for her shift. The home manager Karen Krukowski and the assistant manager Michelle Waterloo confirmed that they are aware of staff member Kristen Nanni bringing her four-year-old daughter to work with her during her midnight shift on at least a hand full of times this year. Ms. Waterloo has been present at the AFC group home during one of the instances when Ms. Nanni brought her daughter to work. Ms. Waterloo stated Ms. Nanni's daughter was present at the AFC group home for 23 minutes at which time her father came to pick her up. Ms. Nanni also admitted to bringing her daughter to work on more than one occasion.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(d) Personal care, supervision, and protection.**

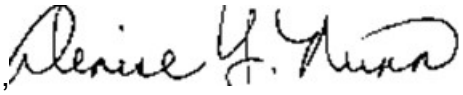
ANALYSIS:	There is no evidence to support the allegation pertaining to staff sleeping during their shift. It was consistently reported throughout interviews that the AFC group home is constantly busy as the residents are very active and it would be hard for any staff member to fall asleep.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

11/10/25
Sheena Worthy Date
Licensing Consultant

Approved By:



11/18/2025
Denise Y. Nunn Date
Area Manager