GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 08, 2025

Timothy Bertram
Oakridge Specialized Residential, LLC
2444 Oakridge Dr.
Flint, MI 48507

RE: License #:	AS250414567
Investigation #:	2026A0123001
	Oakridge Specialized Residential

Dear Timothy Bertram:

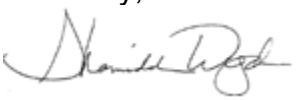
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (517) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250414567
Investigation #:	2026A0123001
Complaint Receipt Date:	10/16/2025
Investigation Initiation Date:	10/17/2025
Report Due Date:	12/15/2025
Licensee Name:	Oakridge Specialized Residential, LLC
Licensee Address:	2444 Oakridge Dr. Flint, MI 48507
Licensee Telephone #:	(833) 478-9464
Administrator:	Katrina Bailey
Licensee Designee:	Timothy Bertram
Name of Facility:	Oakridge Specialized Residential
Facility Address:	2444 Oakridge Dr. Flint, MI 48507
Facility Telephone #:	(833) 478-9464
Original Issuance Date:	02/09/2023
License Status:	REGULAR
Effective Date:	08/09/2025
Expiration Date:	08/08/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 10/06/2025 at 12:30 p.m. Resident A was found in a fetal position, naked, lying on the hardwood floor of Resident A's bedroom. Resident A usually wears a brief but did not have one on. Resident A was alone with no staff present. Everything had been removed from Resident A's room, including the bed. Staff were unable to explain why Resident A's bed and belongings are all gone.	No
Additional Findings	Yes

III. METHODOLOGY

10/16/2025	Special Investigation Intake 2026A0123001
10/16/2025	APS Referral Information received regarding APS referral.
10/17/2025	Special Investigation Initiated - On Site I conducted an unannounced on-site at the facility.
10/20/2025	Contact- Documentation Received Requested documentation received via email.
11/06/2025	Contact - Telephone call made I made an attempted call to Resident A's behavioral specialist. There was no voicemail set up, and the phone did not ring.
11/06/2025	Contact - Telephone call made I interviewed staff Janese Hall.
11/06/2025	Contact - Telephone call made I interviewed Resident A's case manager Matthew Dohreng.
11/07/2025	Contact - Telephone call made I left a voicemail requesting a return call from Guardian 1.
11/07/2025	Contact - Telephone call made I left a voicemail requesting a return call from staff Armani Hill.

11/14/2025	Contact - Telephone call received I spoke with Resident A's Guardian 1.
11/20/2025	Contact - Telephone call made I left a voicemail requesting a return call from staff Armani Hill.
11/20/2025	Contact - Telephone call made I attempted to contact staff Carnell Knox.
11/20/2025	Contact - Telephone call made I interviewed staff Swansae Radford.
11/20/2025	Contact - Telephone call made I made an attempted phone call to staff Teahja Wright.
11/20/2025	Contact - Telephone call received I interviewed staff Armani Hill.
11/25/2025	Inspection Completed On-site I conducted an unannounced follow-up visit at the facility.
11/25/2025	Exit Conference I conducted an exit conference with Tim Bertram.

ALLEGATION: On 10/06/2025 at 12:30 p.m. Resident A was found in a fetal position, naked, lying on the hardwood floor of Resident A's bedroom. Resident A usually wears a brief but did not have one on. Resident A was alone with no staff present. Everything had been removed from Resident A's room, including the bed. Staff were unable to explain why Resident A's bed and belongings are all gone.

INVESTIGATION: On 10/17/2025, I conducted an unannounced on-site visit at the facility. Administrator Katrina Bailey and Specialized Residential Services director of operations, Jordan Hopper were present. Administrator Bailey stated Resident A's primary care physician came to the home yesterday (10/16/2025) for mental health treatment, and Resident A was sent to Hurley Medical Center. Resident A's baseline is to strip out of clothing, remove briefs, and smear feces. Staff must take Resident A's bed out of the room to clean the bedroom. Resident A displays their behaviors within their bedroom for the most part. Staff struggle with Resident A taking clothing off. Resident A will also throw their bed and mattress out of the bedroom. There are stipulations on Resident A having their one on one staff during private time in Resident A's bedroom. Resident A is a one on one with staff while in the community. She stated that on 10/06/2025 Resident A's door was closed. Resident A had a pillow and blanket. Everyone is well aware of Resident A's behaviors. Staff were cleaning Resident A's room at the time, and everything was removed. Resident A's bedroom requires extensive cleaning throughout the day. Resident A's belongings

were in the hallway. Sometimes the mattress is taken outside to be sprayed down. Resident A will stuff their briefs in mattresses and has destroyed over 20 mattresses.

During this unannounced on-site, I observed Resident A curled up in bed under a blanket, lying on a pillow in their bedroom. A small plastic storage container with individual drawers was observed in the corner (Resident A's dresser equivalent). A staff person, Resident A's one-on-one staff was sitting in a chair. Resident A's room was equipped with a mirror. Staff stated that Resident A's comforter was in the washer due to Resident A soiling it. The room appeared clean. There was no odor observed.

While in Resident A's room, during this unannounced on-site, I interviewed staff David Miller. Staff Miller, Resident A's one-on-one staff, stated that staff have to clean Resident A's bedroom about three to four times per shift. Resident A will urinate on the bed and on the floor. Staff Miller pointed out the mop bucket sitting outside Resident A's bedroom. Staff Miller stated that Resident A has good days and bad days.

During this unannounced on-site, I observed three other residents sitting in the living room. They appeared to be clean and appropriately dressed. Four staff were observed on shift during this on-site.

On 10/20/2025, I received requested documentation from administrator Katrina Bailey. A copy of Resident A's *Shiawassee Health & Wellness PCP* (person centered planning) *Meeting* report dated 06/05/2025 notes on page one that Resident A "*previously had one-to-one staff during daytime waking hours only, however, due to fecal smearing, destruction of property and attempted elopements from his bedroom window the behavior plan outlined additional staffing during all waking hours for safety*." It also states "[*Resident A] presents with mood liability, verbal aggression, physical aggression, property destruction, bowel, and bladder incontinence, impulsiveness, fecal smearing, low tolerance for frustration, etc*." It also notes that Resident A "*has also destroyed most items in his bedroom, including his mattress, dressers, drywall, TV,etc*." On page five, it notes that "*staff should encourage Resident A to spend time in the common areas of the home, rather than isolating in his bedroom.*" Resident A's Shiawassee Health & Wellness *Functional Behavioral Assessment and Intervention Plan* dated 10/06/2025 outlines Resident A's need for private time in Resident A's bedroom, to calm down for a few minutes, and checking every 15 minutes if Resident A is asleep. Resident A's *Assessment Plan for AFC Residents* completed 07/10/2025 notes that staff are to provide redirection when Resident A is not getting along with others, and to control aggressive behaviors. Resident A requires staff assistance with all personal care activities.

An *AFC Licensing Division- Incident/Accident Report* dated 10/10/2025, in summary, states that Resident A was taken to Memorial Healthcare Hospital in Owosso, MI for evaluation per Resident A's behavioral specialist. Resident A was transported to the hospital with no issues or concerns. For corrective measures it notes that staff will

"*continue to monitor for health and safety*." Lisa Lindsey, NP, CMH, and Guardian 1 were notified.

A second *AFC Licensing Division- Incident/Accident Report* dated 10/16/2025, in summary states that Resident A was banging on walls, refused to get dressed, and was physically aggressive with staff. Resident A threw bedding out of the room and threw feces. Resident A tried biting and pinching staff. Staff action in summary notes, staff redirected with offering food, changing scenery, talking, blocking techniques, and CPI medium hold while in standing position. Resident A's physician completed a mental health petition. Resident A was transported to Hurley Medical Center. Corrective measures were "*Staff will follow discharge instructions and consult with consumers care team.*" Lisa Lindsay, NP, community mental health, and Guardian 1 were notified.

On 11/06/2025, I interviewed former home manager, staff Janese Hall. Staff Hall stated that she was fired from the facility. Staff Hall stated that she was at another licensed facility on 10/06/2025 when Resident A's behavioral specialist called her. Staff Hall stated that Resident A's furniture and belongings were never kept in the bedroom prior to the adult protective services investigation of this complaint. Staff Hall stated that Resident A currently has a wooded platform for a bedframe that was drilled to the bedroom wall, and staff have been keeping a mattress in Resident A's bedroom. Staff Hall stated that Guardian 1 interferes with Resident A's care/medication, and Guardian 1 does not think Resident A is sick. She stated that management goes with flow of what Guardian 1 wants. Staff Hall stated that it is normal behavior for Resident A to not keep clothing or briefs on. Guardian 1 did not want to put this behavior in the plan of service, but it is Resident A's baseline behavior. Resident A has a bed, but it is always in the hallway, because management does not want to keep replacing mattresses. Staff Hall stated that management will tell investigators it is because Resident A does not like anything to be in his room. Resident A had been destroying about three to four mattresses per month. The facility was providing cheap, blue, "jail" mattresses for Resident A instead of purchasing something more suitable for a person with high behaviors. Resident A does not have a dresser, but there will be one when an investigator goes out there. The facility uses plastic storage containers with drawers. All residents' clothing are kept in the hallway, as none of the residents have dressers. Staff Hall stated that staff have to go into other resident bedrooms to find clothing for Resident A. Staff Hall stated that there is a long black storage cube in the hallway used for clothing. Staff Hall stated that if you try to get Resident A to the bathroom, he may get feces outside of his bedroom, but Resident A does not purposely smear feces outside of his bedroom. Staff Hall stated that Resident A does get alone time. Resident A has a 16 hour one-on-one staffing, except during alone time, but Resident A cannot communicate with staff when he wants alone time. Staff Hall stated that Resident A's behaviors are nothing new to management or community mental health. Staff Hall stated that Resident A was sleeping on the floor, and Resident A's behaviorist from community mental health had been out to the home several times and saw Resident A on the floor. Staff Hall stated that Resident A's bedroom was staged during the

facility's last AFC licensing renewal inspection. Staff Hall stated that it is not in Resident A's assessment plan for Resident A's bed to be on the floor.

On 11/06/2025, I spoke with Resident A's community mental health case manager Matthew Dohring from Shiawassee Health & Wellness. CSM Dohring stated it's a normal occurrence for Resident A to be on the floor. Resident A has a lot of behaviors including biting, punching, kicking, and smearing feces over the bed, and furniture. Staff have to remove the items from Resident A's room to clean it. Resident A strips out of clothing. CSM Dohring stated he was informed Resident A was in the middle of a behavior (on 10/06/2025), and staff were trying to clean the bedroom. CSM Dohring stated that he does not think anything deliberate occurred. He visits the facility monthly to see Resident A, sometimes planned, and sometimes unannounced. Resident A's bed and mirror were in the room during a visit on October 29th or October 30th, 2025. CSM Dohring stated that plastic storage container in Resident A's room is something that Resident A tried to pick up and throw at staff and started hitting staff. CSM Dohring stated it is common for staff to pick things up and sit them outside Resident A's room. Resident A is very spontaneous and hard to redirect. Resident A will stay awake for 24 to 72 hours at a time. Resident A sees a psychiatrist. Historically, Guardian 1 is hesitant to medication changes, but recently with all of this occurring with Resident A, the psychiatrist has worked with Guardian 1 and added Lithium to Resident A's current medications. Guardian 1's hesitation comes from a place of not wanting to harm Resident A. CSM Dohring stated that Resident A will smear feces mostly in his bedroom, and the bathroom sometimes. Resident A will also throw feces at staff. Resident A's bedroom is equipped with shatter resistant windows. Resident A will destroy tear resistant mattresses by ripping them apart, and stuffing feces inside the mattresses. CSM Dohring stated that the facility is looking for a bed that can be secured to the wall and floor. CSM Dohring stated that Kaylyn Hoy, Resident A's previous behavioral specialist, was a contract employee and no longer works for Shiawassee Health & Wellness. He stated that Resident A's on-on-one staffing is for during waking hours. Resident A does have a right to go into the bedroom and close the door. Staff are to do 15 minute checks when Resident A is sleeping as Resident A has a history of eloping. CSM Dohring stated that if staff were to stop Resident A from going into his room to lay on the floor, it may lead to increased behaviors. Resident A has lived in the facility for about three years. Staff have to mop the floors multiple times a day, and staff are good at cleaning up behind Resident A. He stated that he thinks staffing is sufficient to meet Resident A's needs, and staff does the best they can. Resident A is not physically violent. There's been a few times CSM Dohring has seen staff redirect Resident A from another resident because Resident A has grabbed other residents' food, or blanket.

On 11/14/2025, I interviewed Guardian 1 via phone. Guardian 1 stated that they think the facility is trying to meet Resident A's needs. Resident A can be difficult to manage. Resident A's baseline is anger and impulse control issues. Resident A is developmentally disabled. Resident A can be physically aggressive if he feels backed into a corner. Resident A has a new behavioral specialist now. Staff had been giving

Resident A too many directions, and it's overwhelming. Resident A was in his bedroom doing all kinds of things, including throwing the mattress and bed out of the room. Guardian 1 stated that Administrator Bailey said staff were cleaning Resident A's mattress on 10/06/2025, but it just took someone to find Resident A on the floor. Guardian 1 stated being pleased the home manger is no longer in the home, as the home manager was a lot of the issue. Guardian 1 reported believing the way Resident A was treated caused Resident A's behaviors. Resident A is not a bully but is currently acting like one at the facility. Guardian 1 stated that it was a red flag that Resident A was found on the floor with no clothing on. Guardian 1 reported believing there was more to the story, and having Resident A on the floor should not have happened. Staff could have given Resident A something to put under him. Guardian 1 reported Resident A has not had a dresser since living in the facility. Resident A's last placement also kept clothing away from Resident A, because Resident A would wear them all at once. Guardian 1 stated that the facility is trying to figure out a dresser for Resident A. Guardian 1 reported having to fight to get a television in Resident A's bedroom. Guardian 1 stated that former home manager Janese Hall said she was going to have it put in Resident A's assessment plan to not have anything in Resident A's bedroom.

Guardian 1 further reported disagreeing with Staff Hall. Guardian 1 stated that Resident A has not had things in his room in a long time, but administrator Katrina Bailey is working on it, so Resident A can have access to his belongings. Guardian 1 reported that feces smearing was not a behavior in the past, but it is what the facility is saying Resident A is doing now. Guardian 1 thinks Resident A is having accidents and does not know how to clean it up. Guardian 1 stated that Resident A has one on one staffing, but the staff did not know what that meant, and they are working on getting that worked out. Guardian 1 stated that Resident A is stripping out of his clothing, but he has no other clothes in his room to put on. Resident A has sensory issues. Guardian 1 reported being partially at fault for these issues not being addressed, but they are working on it. Resident A has severe life threatening allergies to some medications, so they have to obtain approval (of medications) from Guardian 1. Guardian 1 stated that prior to this complaint, Resident A did not have a bed in his room every day. Guardian 1 stated that a person cannot tell Resident A to "*go to bed*" because Resident A will have "*I'll show you moments*." Guardian 1 reported seeing Resident A's room with no bed, and staff will say that Resident A "*Doesn't want it in there. He throws it out*." Guardian 1 stated that Resident A has ripped mattresses at this facility but did not do this at a previous placement.

On 11/20/2025, I interviewed staff Swansae Radford via phone. Staff Radford stated that Resident A lies on the floor daily. Staff Radford stated that Resident A has a bed in his room every day, but Resident A will throw it out of the room. Staff Radford Stated that Resident A's room has a mirror, chair, bed, television, sheets, and a dresser/plastic storage drawer cart. Staff have to clean Resident A's room every day, all day on first shift due to Resident A smearing feces. One staff showers Resident A, while another cleans Resident A's room. Staff Radford stated that Resident A has a one on one staff 24 hours, but Resident A does have alone time. Staff are supposed

to be in Resident A's room at all times, or wherever Resident A is. Resident A always takes his clothing and briefs off and gets under the cover in bed.

On 11/20/2025, I interviewed staff Armani Hill. Staff Hill stated that Resident A will lay on the floor sometimes, and not on the bed. Resident A displays physical and verbal aggression, smears feces, and does not like to keep clothing on. Resident A will hit, bite, pee on the floor, scratch and beat on the wall, and property destruction. Resident A's bedroom consists of a bed, television, plastic storage cubicle with four drawers for clothing, that Resident A will throw around the room, and a chair. When asked if Resident A has ever had a larger wooden dresser, Staff Hill said no. When asked if Resident A has ever had a wardrobe, Staff Hill said no. Resident A did have a larger storage container about two years ago, but it broke. Briefs are not stored in Resident A's bedroom, but shirts and pants are kept in the storage container. When Resident A gets feces on the mattress, staff takes the mattress outside, hose it down, disinfects it, dries it off, and brings it back inside the home. This is the only extended period of time; the mattress is not in the room. Resident A will throw it out of the room, when Resident A does not want it in there. Resident A's one on one staff is supposed to be in the room with Resident A, or outside with Resident A at all times while Resident A is awake. There are times Resident A does not want staff in the room. Staff are to be outside Resident A's door when Resident A is asleep or experiencing a behavior, checking on Resident A every few minutes. Resident A's behaviors are unprovoked.

On 11/26/2025, I conducted an unannounced on-site follow-up at the facility. I observed Resident A walking around the facility. Resident A was appropriately dressed in a t-shirt and pants. Resident A appeared clean and well-kept. Resident A refused to speak with me.

During this on-site, I observed multiple residents in the facility. They all appeared clean and well-kept. I observed each resident bedroom, as well as the common areas. The facility appeared clean. There were no odors observed. I did a walk-through of the facility. Other residents present were not interviewed due to limited verbal skills.

During this on-site, I interviewed staff Taquichiesa Thomas, lead staff. Staff Thomas stated that everything that staff places in Resident A's room, Resident A will destroy it, so they have to put things to the side. She stated that Resident A's bedroom has a chair, mirror, television, and bed. She stated that she heard that Resident A was on the bedroom floor, but she has never personally witnessed this. She stated that Resident A will take off briefs and clothing and rip the briefs up. Staff have to redirect Resident A. She stated that Resident A will get on the floor on his own. Staff Thomas stated that Resident A's behaviors have calmed down, and Resident A has not been throwing feces in the last month and a half. She stated that she has not witnessed Resident A throwing any feces outside of Resident A's bedroom. Staff try to redirect Resident A and then will get Resident A cleaned up immediately after the behavior. Staff Thomas stated that Resident A's bed is now secured to the wall, and Resident

A has not been ripping any mattresses lately. She stated that during her shift, Resident A's room has to be cleaned about twice a day. She stated that Resident A can go to his room alone, but staff will stay stationed outside the room, or sometimes go in and sit with Resident A.

During this on-site, I interviewed staff Teahja Wright. Staff Wright stated she started working in the facility at the end of September 2025. Staff Wright stated that she does not remember the alleged incident on 10/06/2025. Staff Wright stated that it is typical behavior for Resident A. Resident A tends to rip off clothing and will bite through a comforter set and tear it up. Staff have to clean throughout the whole shift, unless Resident A is napping. She stated that Resident A did good today. She stated that Resident A will smear his room with feces on his floor, bed, walls, and comforter. Resident A has never thrown feces at her or anyone else that she knows of. She stated that Resident A will rip off his brief and pee on the floor in his bedroom. Staff Wright stated that Resident A will lay on the floor even with the bed in the room, as Resident A likes being on the floor sometimes. She stated that Resident A's room had a bed, chair, dresser, and mirror in the room when she first started working at the facility. She stated that if there isn't room in the bedrooms, clothing is stored in storage cubicles outside the bedrooms in the hallway. She stated that Resident A's one on one staff is always with Resident A, but Resident A can have alone time and will verbally tell staff to "*leave me alone*" or "*get out*."

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	On 10/17/2025, I conducted an unannounced on-site at the facility. I interviewed administrator Katrina Bailey. She stated that Resident A's baseline behaviors are to strip out of clothing, remove briefs, and smear feces. Staff must take Resident A's bed out of the room to clean the bedroom. She stated that on 10/06/2025 Resident A's door was closed. Resident A had a pillow and blanket. Staff were cleaning Resident A's room at the time, and everything was removed. Resident A's bedroom requires extensive cleaning throughout the day. On 10/17/2025, and 11/25/2025, I observed Resident A. On 10/17/2025, Resident A was in bed under the cover. On 11/25/2025, I observed Resident A to be appropriately dressed and appeared clean. On 11/06/2025, I interviewed former home manager, staff Janese Hall. Staff Hall stated that it is normal behavior for Resident A to not keep clothing or briefs on. Staff Hall stated

	that Resident A does get alone time. Staff Hall stated that Resident A was sleeping on the floor, and Resident A's behaviorist from community mental health had been out to the home several times and saw Resident A on the floor. On 11/06/2025, I spoke with Resident A's community mental health case manager Matthew Dohring from Shiawassee Health & Wellness. CSM Dohring stated he was informed Resident A was in the middle of a behavior (on 10/06/2025), and staff were trying to clean the bedroom. CSM Dohring stated that he does not think anything deliberate occurred. CSM Dohring stated that if staff were to stop Resident A from going into his room to lay on the floor, it may lead to increased behaviors. On 11/14/2025, I interviewed Guardian 1 via phone. Guardian 1 reported believing there was more to the story, and having Resident A on the floor should not have happened. Staff could have given Resident A something to put under him. On 11/20/2025, I interviewed staff Swansae Radford via phone. Staff Radford stated that Resident A lies on the floor daily. Staff Radford stated that Resident A has a one on one staff 24 hours, but Resident A does have alone time. On 11/20/2025, I interviewed staff Armani Hill. Staff Hill stated that Resident A will lay on the floor sometimes, and not on the bed. There are times Resident A does not want staff in the room. Staff are to be outside Resident A's door when Resident A is asleep or experiencing behavior, checking on Resident A every few minutes. On 11/26/2025, I interviewed staff I interviewed staff Taquichiesa Thomas. She stated that Resident A will take off briefs and clothing and rip the briefs up. Staff have to redirect Resident A. She stated that Resident A will get on the floor on his own. On 11/26/2025, I interviewed staff Teahja Wright. She stated that Resident A tends to rip off clothing. Staff Wright stated that Resident A will lay on the floor even with the bed in the room, as Resident A likes being on the floor sometimes. During the course of this investigation, I reviewed Resident A's assessment plan and behavioral plan. It notes that Resident A has high behaviors and is assigned a one on one staff person

	due to these behaviors. The plan outlines that Resident A is allowed alone time in Resident A's bedroom. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 10/17/2025, I conducted an unannounced on-site at the facility. I observed Resident A's bedroom. A small plastic storage container with individual drawers was observed in the corner (Resident A's dresser equivalent). A chair, mirror, and bed were observed. There was no wardrobe or closet observed in Resident A's bedroom.

On 11/26/2025, I conducted an unannounced on-site follow-up at the facility. I did a walk through the facility. I observed that Resident A did not have a wardrobe or closet. Administrator Bailey pointed out that they had just ordered and received another replacement wardrobe for Resident A. It was observed still in the box.

On 11/26/2025, I conducted an exit conference with licensee designee Timothy Bertram via phone. LD Bertram, stated there was a wardrobe delivered yesterday for Resident A. They are going to work on getting Resident A a bedroom with a closet or an alternative solution, as Resident A has torn up two other wardrobes. LD Bertram stated that Resident A's behaviors have decreased some, and staff keeps the home clean.

APPLICABLE RULE	
R 400.661	**Bedroom furnishings.**
	(1) Bedroom furnishings must include all of the following: **(c) Closet or wardrobe space.**
ANALYSIS:	On 10/17/2025, I conducted an unannounced on-site at the facility. I observed Resident A's bedroom. A small plastic storage container with individual drawers was observed in the corner (Resident A's dresser equivalent). A chair, mirror, and bed were observed. There was no wardrobe or closet observed in Resident A's bedroom.

	On 11/26/2025, I conducted an unannounced on-site follow-up at the facility. I conducted a walkthrough of the facility. I observed that Resident A's bedroom did not have a wardrobe or closet. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

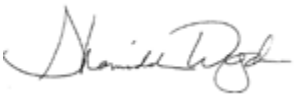
INVESTIGATION: On 11/26/2025, I conducted an unannounced on-site follow-up at the facility. I conducted a walkthrough of the facility. I observed Resident B's bedroom did not have a dresser or equivalent.

On 11/26/2025, I conducted an exit conference with licensee designee Timothy Bertram via phone. LD Bertram, stated there was a wardrobe delivered yesterday for Resident A. They are going to work on getting Resident A a bedroom with a closet or an alternative solution, as Resident A has torn up two other wardrobes. LD Bertram stated that Resident A's behaviors have decreased some, and staff keeps the home clean.

APPLICABLE RULE	
R 400.661	**Bedroom furnishings.**
	(1) Bedroom furnishings must include all of the following: **(d) Dresser or equivalent.**
ANALYSIS:	On 11/26/2025, I conducted an unannounced on-site follow-up at the facility. I conducted a walkthrough of the facility. I observed Resident B's bedroom did not have a dresser or equivalent. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

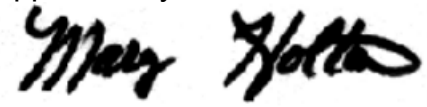
Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 3-6).



12/08/2025

Shamidah Wyden — Date
Licensing Consultant

Approved By:



12/08/2025

Mary E. Holton — Date
Area Manager