



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 22, 2026

Georgia Cameron & Renee Cameron
805 Okemos Rd.
Mason, MI 48854

RE: License #: AF330384262
Investigation #: 2026A0007025
Walnut Acres AFC

Dear Georgia Cameron & Renee Cameron:

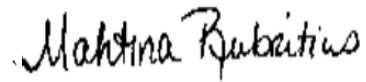
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 335-5985.

Sincerely,

A handwritten signature in black ink that reads "Mahtina Rubritius". The signature is written in a cursive style with a large initial 'M'.

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF330384262
Investigation #:	2026A0007025
Complaint Receipt Date:	04/01/2026
Investigation Initiation Date:	04/01/2026
Report Due Date:	05/31/2026
Licensee Name:	Georgia Cameron & Renee Cameron
Licensee Address:	805 Okemos Rd. Mason, MI 48854
Licensee Telephone #:	(517) 676-2021
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Walnut Acres AFC
Facility Address:	805 Okemos Rd. Mason, MI 48854
Facility Telephone #:	(517) 604-9492
Original Issuance Date:	06/27/2017
License Status:	REGULAR
Effective Date:	12/23/2025
Expiration Date:	12/22/2027
Capacity:	4
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was hospitalized in the ICU, amid concerns of severe neglect at her group home, including unsanitary conditions.	Yes
Resident A may have been assaulted by staff.	No
Additional Findings	Yes

III. METHODOLOGY

04/01/2026	Special Investigation Intake - 2026A0007025
04/01/2026	Special Investigation Initiated – Telephone to Robert Lindley, APS Worker. Discussion.
04/01/2026	APS Referral - Received.
04/06/2026	Inspection Completed On-site - Unannounced - Face to face contact with Robert Lindley, APS, Georgia Cameron, Licensee, Renee Cameron, Licensee, Warren Cameron, Responsible Person, Resident B, Resident C, and a family member of the licensee.
04/16/2026	Contact - Document Received - Email from Renee Cameron, Licensee. She measured the room for the new carpet, and it will be installed next week. She will send photos once completed. A follow-up email was sent to the licensee.
04/24/2026	Contact - Document Received - Email from Renee Cameron, Licensee. Status update regarding the carpet provided.
05/07/2026	Contact - Document Received - Email from Renee Cameron, Licensee. Photo of the new carpet installed.
05/12/2026	Contact - Document Sent -Email to Robert Lindley, APS. Information and status update requested.
05/12/2026	Contact - Document Received- Email from Robert Lindley, APS. Information and status update provided.
05/19/2026	Contact - Document Received- Email to and from Robert Lindley. Clarification received. The allegations were substantiated for medical neglect.

05/19/2026	Contact - Telephone call made to Resident A, phone number not accepting calls.
05/19/2026	Contact - Telephone call made to Relative A1, message left. I requested a return phone call. Relative A1 returned my call that evening.
05/19/2026	Contact - Telephone call made to the facility, no answer.
05/19/2026	Contact - Document Sent - Email to Renee Cameron, Licensee. I requested a return phone call.
05/19/2026	Contact – Telephone call Received - From Renee Cameron, Licensee. Documents requested.
05/19/2026	Contact – Document Received - From Renee Cameron, Licensee. Requested documents received.
05/20/2026	Contact - Telephone call made to Relative A1. Interview with Relative A1 and Resident A.
05/20/2026	Inspection Completed On-site - Unannounced - Face to face contact with Georgia Cameron, Licensee, Warren Cameron, Responsible Person, two of their great grandchildren, Resident B and Resident C.
05/22/2026	APS Referral – Made.
05/22/2026	Exit Conference conducted with Renee Cameron, Licensee.

ALLEGATIONS:

- **Resident A was hospitalized in the ICU, amid concerns of severe neglect at her group home, including unsanitary conditions.**
- **Resident A may have been assaulted by staff.**

INVESTIGATION:

As a part of this investigation, I reviewed the written complaint, and the following additional information was noted:

[Resident A] (65) resides in Walnut Acres AFC in Mason, MI, with three residents and three adults. Resident A's diagnoses are severe confusion, dehydration, and low blood pressure. Resident A can ambulate without assistance. Resident A's legal guardian is unknown. On 03/27/26, Resident A was transported to [Hospital #1], and she is currently receiving care in the ICU. There is a concern that the

staff are not caring for Resident A in the home. The home smells like wet mildew and mold, and the home is filthy. The kitchen is not clean, and there are dirty dishes throughout home. The front porch is in disarray. Resident A's room has dried skin on the floor and hair underneath the bed. The bathroom has not been cleaned, swept or mopped. It is unknown how long Resident A's bedding has gone unchanged. There is trash overflowing in Resident A's bedroom. In the middle of the week, 03/24/2026, or 03/25/2026, one of the staff members put their hands on Resident A, and it is unknown if Resident A had any injuries. Resident A has been sick in the facility since December 2025. There is a concern that the staff are not qualified to care for the residents in the home.

On April 1, 2026, I spoke with Robert Lindley, Adult Protective Services, and we discussed the investigation. He stated that he met with Resident A on April 1, 2026. During the 4th week of March, Resident A's sister, Relative A1, had to clean Resident A's room, so she was calling out Georgia Cameron, Licensee, about this; they were arguing. Resident A tried to calm the situation down by getting in the middle of the two of them. Georgia Cameron, Licensee, grabbed Resident A by the right arm near the shoulder. According to Robert Lindley, Resident A reported that she told Georgia Cameron, twice, to get her hands off her. Resident A reported she did not have any injuries and would not be returning to the home. It was also noted that the other resident in the home was terminally ill and may have been in her bedroom when the incident occurred. Robert Lindley informed me that he had not been to the facility yet, and we scheduled an appointment.

On April 6, 2026, Robert Lindley, APS, and I conducted an unannounced on-site investigation. We wore PPE as it was reported that individuals in the home had COVID. We made face to face contact with Georgia Cameron, Licensee, Renee Cameron, Licensee, Warren Cameron, Responsible Person, Resident B, Resident C, and a family member of the licensee.

Georgia Cameron was interviewed and she stated she asked Resident A to clean her room, as she would not allow them to clean it. Relative A1 walked in and Resident A was screaming and yelling that she was not going to clean her room. According to Georgia Cameron, Resident A's room was always kept spotless until she had a room alone. Her belongings were spreading out in the room. Georgia Cameron stated that Resident A started telling Relative A1 that they were forcing her to clean her room. Relative A1 told them how she was appreciative of everything they did. When asked if she grabbed Resident A, Georgia Cameron stated she did not. Georgia Cameron stated, "I took the glass out of her hand." Georgia Cameron informed us that the incident occurred in the kitchen, and the relative had brought over a bunch of food, which included pop and soup. Georgia Cameron stated there was a conversation with Relative A1 about who she was talking to (Warren Cameron vs. her son). Georgia Cameron denied that she grabbed Resident A by the arm or shoulder. Renee Cameron reported that she was not there, but Warren Cameron was at the home. Georgia Cameron informed us that they asked Relative A1 to move Resident A's belongings because she did not want them to touch her stuff. We

observed Resident A's room, which was not observed to be in the condition as originally described. Georgia Cameron and Renee Cameron also informed us that Resident A's room was messy, and they were able to sweep the floor. They also informed us that Resident A had been placed at the home for many years and they never had an issue.

While in the facility, I did not observe the trash to be overflowing, or dishes throughout the home, or any mold in the home.

Resident A was in the hospital at the time of the on-site investigation, and the licensees reported that Resident A had COVID. Renee Cameron informed us that Resident A was prescribed an antibiotic in January. The visiting doctor came to the facility and said Resident A's lungs were clear. Resident A then had diarrhea and they gave her Imodium. On Thursday (March 26, 2026) Resident A said it wasn't working and on Friday, March 27, 2026, she was sent to the hospital. The licensees reported that her blood pressure was fine, she did not have a high temperature, and they didn't know that it was COVID.

Robert Lindley, APS, and I interviewed Resident B in her room. Resident B described that Georgia Cameron has issues with her blood sugar, and when her levels are off, Resident B steers clear of Georgia Cameron. Resident B reported that Georgia Cameron treats Resident A "nasty." Resident B stated that she made Resident A cry and go outside. No additional information was provided. She did not confirm that she observed Georgia Cameron grab Resident A, and stated that Georgia Cameron came at her once, but then she backed up. Resident B then went on to describe how Walnut Acres AFC was the best facility. While in the room, I observed that the carpet was torn, causing a tripping hazard.

Robert Lindley, APS and I also interviewed Resident C in her room. Her room was observed to be neat and appeared clean. According to Resident C, Resident A kept saying she was fine and stayed in her room. Resident C stated that Relative A1 felt that they were not caring for Resident A and the first sign of her not feeling well, Renee Cameron took Resident A to the doctor. Resident C reported that it "Hurt her heart" that Resident A had to go to the hospital. Resident C informed us that Resident A gets along really well with Georgia Cameron. Resident C described her (Resident A) as a peacemaker. Resident C reported that they bonded with the family (licensee). When asked if she had observed any resident being grabbed, Resident C stated that she would not say that it had not happened, but it wasn't for violence or a mean purpose. Resident C did not confirm that there was an argument which resulted in Resident A being grabbed. Resident C stated that Georgia Cameron sometimes gets unsteady on her feet. Regarding the cleanliness of the home, Resident C stated that the licensees clean the facility, and the last time it was cleaned was on Sunday, April 5, 2026.

We also interviewed Warren Cameron, who reported that Relative A1 came over to the house, went into Resident A's room and sat down. He stated he did not hear any

arguing between Georgia Cameron and Relative A1. He also reported to assist with cleaning the house, once daily, and that Renee Cameron and Georgia Cameron also assisted. He stated that sometimes they may go for two days without mopping but they generally clean daily.

Prior to leaving the home, I informed the licensees that the carpet was torn and needed to be repaired in the resident bedroom and that front porch needed to be picked up, as there were household items, and a spray can of oil that needed to be removed. Renee Cameron removed the oil as we were leaving the facility.

On May 12, 2026, Robert Lindey, APS provided me with information regarding his interview with Resident A. The following information was noted:

Resident A reported the staff were not caring for her in the home due to everyone in the home being sick with COVID. Resident A reported that there is trash overflowing in her bedroom. Resident A reported the last week of March, the owner, Georgia Cameron, put her hands on her. Resident A reported that her sister [Relative A1] came to help her clean at the AFC home, and Relative A1 told Georgia Cameron that the AFC home was filthy. Georgia Cameron was very mad and was arguing with Resident A's sister. Resident A reported she stood in the middle of them to try and stop the argument, and Georgia Cameron grabbed her by the right arm near the shoulder. She [Resident A] reported that she told Georgia Cameron twice to get her hands off her. Resident A reported she did not have any injuries. Resident A reported that she is not cared for in the home. Resident A reported that she has been sick in the facility since December 2025.

On May 12, 2026, Robert Lindley, APS, informed me that Resident A was referred for additional services, he did not substantiate the allegations for physical abuse. He did substantiate the allegations for neglect.

A review of the Original Licensing Study report, dated June 21, 2017, reflected that the licenses were approved to provide licensed adult foster care to four residents who were aged.

On May 20, 2026, I interviewed Relative A1. She stated that she had already spoken to her attorney, Guardian A1, and law enforcement. I explained the role of licensing, and how each department investigated separate things; however, some parts of the investigations may overlap. Relative A1 stated that her sister has resided in the home for six years, and the general conditions of the home need attention. She stated that the information about the home online is different to how the home actually looks. She stated the porch needed repairs, the kitchen is usually a mess, never enough room for all the people in the home to sit at the dining room table, and the licensee has tons of family members who visit and stop by. Relative A1 stated that her sister has been sick, she had sepsis, dehydration, and immediately went into the ICU (on March 27, 2026). Relative A1 stated that Resident A was "white as a ghost," and she could barely stand. This is the second or third time her sister has had COVID. A few days before her sister went to the hospital, her sister (Resident A)

called and said the licensee was neglecting her. Resident A had diarrhea and had been sick since Christmas. Relative A1 recalled that she went to the home on either March 24, 2026, or March 25, 2026, and had taken Gatorade, soup, cough drops, and tissue to the home, sitting the items on the floor. Georgia Cameron was sitting at the round table. Her sister, Resident A and Georgia Cameron were talking. Resident A stated that she couldn't hold anything down and she had dry heaves. Relative A1 asked Resident A how long this had been going on, and she said about ten days. Relative A1 asked Resident A when she would be going back to the doctor or the emergency room. Relative A1 recalled that Resident A had a visiting doctor who came to the home about 3-4 months, and she had been recovering from pneumonia and bronchitis. During the incident, Relative A1 stated that she was talking but Georgia Cameron was talking around her, as if she wasn't there. Georgia Cameron was talking loudly and stated that it wasn't true. Relative A1 stated that Georgia Cameron walked around her and put her hands on her sister (on her shoulder), "as to shake her, as if it wasn't true." Relative A1 told Georgia Cameron to take her hands off Resident A. Resident A then pushed forward to get away. According to Relative A1, Georgia Cameron didn't want Resident A saying what she said. Georgia Cameron then told Relative A1 to go and look at Resident A's room, and that she hadn't cleaned it since November 2025. Relative A1 stated to Resident A that they should go to her room to see what she was talking about. While at the home, Relative A1 informed me that she got the broom and the Swiffer, and swept up dead skin in her sister's room, which covered about 1/2 of the dustpan.

I informed Relative A1 that an unannounced on-site inspection was conducted, along with APS, and we did not observe the dead skin on the floor in the room. She informed me that when she went back to get the rest of Resident A's belongings, the room was unkept and her friend went along as a witness. She stated that Georgia Cameron sat in the living room, Warren Cameron was doing laundry and Renee Cameron just checked in to see what they were packing. They did not offer to assist them. She stated that it was unorganized and there was trash mixed in with the clothes.

Relative A1 informed me that she thought that the home staff were supposed to clean the home and provide activities of daily living. She stated that the house could use some paint, she has observed the place to be dirty, the trash was overflowing, and barn looked dilapidated. She stated that they get a lot of donations, and they're financially strapped. Relative A1 also recalled that both Georgia Cameron and Warren Cameron have been sick. Relative A1 stated that Renee Cameron runs back and forth and is always on the go; they provide inconsistent medical care, and this rings neglect and elder abuse. Relative A1 stated that Warren Cameron and Georgia Cameron sleep in the living room in the recliners. She stated that overall hygiene is lacking, the home needs maintenance and there was only so much that Renee Cameron could do. Relative A1 stated that Renee Cameron can't be in two places at one time. Relative A1 stated "This is the worst home I've seen." Relative A1 stated that they have all been sick, and the licensees, got overwhelmed, and things got out

of hand. Relative A1 stated they're "Nice people, but nice doesn't get it done."
Relative A1 stated that the licensee needed services and help.

Relative A1 also informed me that Resident A is now living with her, she is receiving services, including a nurse and social worker visiting her, and she's doing much better. Relative A1 then handed the phone to Resident A, and I interviewed her.

Resident A informed me that she resided in the home for the past six years. She stated that she had COVID twice, while residing in the home. I inquired if the licensee cleaned her room and she informed me that in the beginning they did, but things changed after her roommate passed away. Resident A stated she believed her roommate had dementia. Resident A also stated that the [previous roommate] would grab her feet during the night, and she asked that Georgia Cameron place her in another room. She stated that Warren Cameron was good at getting things done around the farm, but things were changing. She stated that both Warren and Georgia Cameron were having some health issues. I inquired if they assisted and cleaned her room and she replied, "If you don't ask, you don't get." Regarding the incident that occurred in the kitchen, Resident A informed me that she could not recall some of the details. She stated she came out to the kitchen, and "All I remember is her reaching out to grab me. I pulled my arms up, and said don't touch me, don't touch." Georgia Cameron was in the chair, she got up, and came out in the dining room, to kitchen arch way. Resident A stated, "I can't remember what I said." Resident A stated, "She (Georgia Cameron) said I was a liar." When asked what Georgia Cameron was saying she was lying about, Resident A informed it was about the room being dirty. Resident A informed me that she had been sick prior to Christmas, she was sick on her birthday, and she was sick when she was taken to the hospital on March 27, 2026. Resident A informed me that Renee Cameron took her to the hospital, and she didn't open the door to the vehicle. Resident A stated that she was struggling to find her balance. Once she got into the van, she passed out. Resident A stated that she was in the ICU for the first four days, then a step-down level, but the medical staff were still wearing their masks at that point. Resident A reported to feeling better and stated she has been well for six weeks now.

On May 20, 2026, I conducted an unannounced on-site investigation to follow up on this investigation. Upon arrival, it was noted there was trash in the yard, the yard was not maintained, there were several items on the porch area. Photos were taken for the file. Once in the area between the screen door and the front door, an odor of dog feces was observed. Upon entering the home, it was noted that the kitchen was unclean and in disarray. There were dishes in the sink and on the counter tops, the counter tops were dirty and stained, empty boxes, empty containers, food in bags on the chair along with bread and other items in bags on the kitchen floor. The stove required cleaning. Warren Cameron took out the trash while I was there. There were flies in the home and the floors throughout the home needed to be swept and mopped. The residents' bedrooms were observed and found to be neat and appropriate. I observed that the carpet had been replaced in Resident B's room. I

also observed medications sitting out in the dining room. I requested to review a copy of the *AFC Assessment Plan* for Resident A, and Georgia Cameron contacted Renee Cameron, via telephone to ask where it was located, as she had handled the file the day before. I informed that I had a follow-up question regarding the chores, and what information was documented on the assessment plan. Renee Cameron stated that Resident A did not want them to touch her stuff. I reviewed the *AFC Assessment Plan*, and it was documented that Resident A did participate in household chores, and she was able to make her own bed and put her clothing away. It was not documented that she would sweep and mop the floors or remove the trash.

I also reviewed the *AFC Incident Report* and noted that on February 18, 2026, Resident A had been taken to Urgent Care for constant coughing and not feeling well. Resident A was given medications for possible pneumonia. I reviewed another *AFC Incident Report* and noted that on March 27, 2026, at 7:30 p.m., Resident A went to Hospital #1 for not feeling well and having diarrhea for five days. Actions taken included contacting 911.

Upon exiting the residence, it was also noted that a couple of the boards on the steps were weak (left side if facing the home) and required repair.

As a part of this investigation, I reviewed the medications logs for Resident A and written notes from Renee Cameron.

- It was noted that on or about December 20, 2025, the doctor visited the home as Resident A was coughing. Her lungs were clear at that time. Resident A did not go to her family's for Christmas, as they were also not feeling well.
- On January 9, 2026, the doctor came to the home for possible pneumonia and UTI, antibiotics were prescribed and Resident A started feeling better.
- On February 18, 2026, Resident A went to Urgent Care for a constant cough and possible pneumonia. Resident A was given antibiotics for seven days and prescribed Prednisone for five days. Resident A was feeling better but still complaining of coughing.
- On March 5, 2026, the doctor was contacted for a house call, and he came out to the home on March 6, 2026. Resident A's lungs were clear. She was told the cough might last for a few more weeks.
- It was also documented from March 6, 2026, to March 22, 2026, the coughing and blowing her nose continued.
- On March 22, 2026, Resident A had loose stools and was giving Imodium three times that day. It was also documented that when she [Resident A] changed her underwear, there was only a small amount of BM observed in her underwear.

- On March 23, 2026, and March 24, 2026, the loose stools were about the same, slowing down, but not stopping. Imodium was given. Resident A's blood pressure and oxygen levels were good, and she did not have a temperature.
- On March 25, 2026, Resident A reported that she vomited. Renee Cameron inquired if it was food or phlegm, and Resident A said it was dry heaves. Her vitals were still good. Renee Cameron asked her to drink the Gatorade, but she refused and only wanted the pop that her sister brought her.
- On March 26, 2026, it was documented that Resident A was eating smaller amounts of food and her vitals were good.
- On March 27, 2026, Resident A was refusing all meals and sleeping all day. At 7:00 p.m., Resident A was dizzy and looked pale; therefore, 911 was contacted and Renee Cameron stayed with Resident A until midnight. Resident A did not return to the home.
- The medication log documented that Resident A received the PRN Imodium, three times daily, on March 22, 2026, through March 26, 2026.

On May 22, 2026, I conducted the exit conference with Renee Cameron, Licensee. We discussed the investigation and my recommendations. She agreed to submit a written corrective action plan to address the established violations.

APPLICABLE RULE	
R 400.689	Resident health care.
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.

ANALYSIS:	Based upon my investigation which consisted of unannounced on-site investigations, interviews with residents, relatives, APS, and the licensee's, it's concluded that Resident A had been ill, off and on since December 2025. While the licensee did contact the doctor or seek medical treatment at times, it's noted that Resident A had diarrhea for several days and she reported to vomit. On March 27, 2026, Resident A refused all meals and slept all day, she was dizzy and observed to look pale; 911 was contacted. Resident A was hospitalized and admitted into the ICU. Based on this information, it's concluded that there is a preponderance of the evidence to support the allegations that there was an adverse change in Resident A's health condition starting on or about March 22, 2026, including her sleeping all day and refusing meals, and health care was not sought until the evening of March 27, 2026.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.647	Safety and maintenance of premises.
	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based upon my investigation, which consisted of unannounced on-site investigations and observations, interviews with APS, a relative, the licensee's and household members, and the residents, it's concluded that there is a preponderance of the evidence, to support the allegations that the home furnishings and housekeeping standards of the home were not clean and in an orderly appearance.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.

ANALYSIS:	Based upon my investigation, which consisted of an unannounced on-site investigation, interviews with APS, the licensee's and household members, and residents, it's concluded that there is not a preponderance of the evidence to support the allegations that Georgia Cameron assaulted Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On May 20, 2026, I discussed the sleeping arrangements with Georgia Cameron and Warren Cameron. Georgia Cameron stated that Resident C was in Bedroom #1, Bedroom #2, was Resident A's room, but would now double as a place for Renee Cameron to sleep and a playroom for the grandchildren when they visit. I observed a bed, a highchair, and other furniture in the room. There were a couple of items on the floor (used socks and box of crackers), and the floor also needed to be swept. Resident B was in Bedroom #3. I inquired where she and Warren Cameron slept at night and she (Georgia Cameron) stated in the living room in the recliners. I observed four recliners in the living room. I also observed a baby walker and a folding chair blocking the front door. The folding chair was leaning against the front door, blocking the means of egress. Warren Cameron attempted to tell me that Renee Cameron slept in the area off the laundry room when they were at full capacity; however, it appeared that Georgia Cameron did not want him to discuss that with me, as she interrupted him speaking discouraging him not to talk about that. I informed them that a review of the Original Licensing Study Report reflected that they slept in the basement. Georgia Cameron stated that they haven't slept in the basement in years, as she wanted to be on the same level as the residents, and the last consultant told them it was okay. Georgia Cameron stated that Warren Cameron had a condition and sleeping in the recliner was better for him; in addition, that she wasn't going to sleep in a different room than him. I informed them that they would need to make changes, as no one can sleep in the living room.

APPLICABLE RULE	
R 400.657	Bedrooms.
	(2) Living rooms, dining rooms, hallways, or other rooms that are not ordinarily used for sleeping, or a room that contains a required means of egress, must not be used for sleeping purposes by anyone.

ANALYSIS:	Based upon my investigation, interviews, and observations, and admissions from the licensee, it's concluded that Georgia and Warren Cameron sleep in the living room of the home.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

On May 20, 2026, I observed medications sitting out in the dining room. Georgia Cameron informed me that they were her medications. I informed that the medications must be safeguarded and kept in a locked cabinet.

APPLICABLE RULE	
R 400.675	Resident medications.
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	I observed prescription medications in the dining area that were not kept in a locked cabinet or drawer.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

There was a mattress and box spring, and with what appeared to be a used bed pad observed on the porch/deck area. There was also a nightstand, an adult walker, baby gates and other furniture being stored on the porch/deck area. There were tipped over buckets, bird feeders, and other items strewn about on the deck area. There was an empty container, which appeared to be for the dog, along with a paper plate and scraps on the porch by the entrance to the home. There were flies swarming around the scraps. The grass around the deck was long. It was also noted that a couple of the boards on the steps were weak (left side if facing the home) and required repair.

As I was leaving, Warren Cameron approached my vehicle and informed me that they were waiting to take the items to the township and dispose of them on the 3rd Saturday of the month. I informed him that the mattress/box spring was close to the entrance/exit of the deck and that the items should be moved to another location until they could dispose of them. He informed me that they were heavy.

APPLICABLE RULE	
R 400.647	Safety and maintenance of premises.
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	There was a mattress, box spring, furniture, and other items cluttering the deck/porch area, and the general conditions were unkept. There were boards on the steps that required repair. Based on this information, it's concluded that the facility is not being maintained to provide adequately for the health, safety, and well-being of the occupants.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

On May 20, 2026, during the on-site investigation, I observed a baby walker and a folding chair blocking the means of egress.

APPLICABLE RULE	
R 400.725	Means of egress.
	(1) A means of egress must be considered the entire way and method of passage through the facility and out an exit door to free and safe ground outside the facility and must be arranged and maintained to provide free and unobstructed egress from all parts of the facility.
ANALYSIS:	On May 20, 2026, the means of egress was obstructed with a chair and walker.
CONCLUSION:	VIOLATION ESTABLISHED

During the exit conference, Renee Cameron informed me that the chair and baby walker had already been moved. The kitchen has been cleaned; she's working on the porch area and the yard. Renee Cameron stated that she would be cutting back her hours outside the home, so that she could focus more on the AFC home. She concurred with the conclusion of the investigation and agreed to submit a written corrective action plan to address the established violations.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.

Mahtina Rubritius

05/21/2026

Mahtina Rubritius
Licensing Consultant

Date

Approved By:

Dawn Timm

05/21/2026

Dawn N. Timm
Area Manager

Date