GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 17, 2026

Barbara Mohney
Mohney 1 and 2 AFC Corp.
1025 W Kalamazoo Ave
Kalamazoo, MI 49007

RE: License #: AM390076322
Investigation #: 2026A0581026
Mohney 1 AFC

Dear Barbara Mohney:

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AM390076322 |
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| **Investigation #:** | 2026A0581026 |
| | |
| **Complaint Receipt Date:** | 05/14/2026 |
| | |
| **Investigation Initiation Date:** | 05/14/2026 |
| | |
| **Report Due Date:** | 07/13/2026 |
| | |
| **Licensee Name:** | Mohney 1 and 2 AFC Corp. |
| | |
| **Licensee Address:** | 1025 W Kalamazoo Ave<br>Kalamazoo, MI 49007 |
| | |
| **Licensee Telephone #:** | (269) 382-1448 |
| | |
| **Administrator:** | Barbara Mohney |
| | |
| **Licensee Designee:** | Barbara Mohney |
| | |
| **Name of Facility:** | Mohney 1 AFC |
| | |
| **Facility Address:** | 616 Walnut St<br>Kalamazoo, MI 49007 |
| | |
| **Facility Telephone #:** | (269) 343-4433 |
| | |
| **Original Issuance Date:** | 08/15/1999 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 09/04/2024 |
| | |
| **Expiration Date:** | 09/03/2026 |
| | |
| **Capacity:** | 12 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>AGED |

## II. ALLEGATIONS

| | **Violation Established**? |
|---|---|
| Direct care staff failed to ensure timely medical treatment for Resident A following a fall resulting in a broken clavicle on or around 04/20/2026. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

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|---|---|
| 05/14/2026 | Special Investigation Intake - 2026A0581026 |
| 05/14/2026 | APS Referral - Kalamazoo APS received the allegations and are investigating. No referral necessary. |
| 05/14/2026 | Special Investigation Initiated – Telephone - Interview with APS specialist, Jessica Mellen. |
| 05/14/2026 | Contact - Telephone call made - Interview with AFC consultant, Ondrea Johnson. |
| 05/20/2026 | Inspection Completed On-site - Interview with staff, residents, and obtained documentation. |
| 05/20/2026 | Contact - Telephone call made - Left voicemail with Lena Cargen, direct care staff. |
| 05/20/2026 | Contact - Telephone call made - Interview with direct care staff, Emma Johnson. |
| 05/21/2026 | Contact - Telephone call received - Interview with Lena Cargen |
| 05/28/2026 | Contact - Telephone call made - Interview with licensee designee, Barbara Mohney. |
| 05/28/2026 | Contact - Telephone call made - Left voicemail with Resident A's Power of Attorney/payee, Witness 1. |
| 05/28/2026 | Inspection Completed-BCAL Sub. Compliance |
| 06/15/2026 | Exit conference with the licensee designee, Barbara Mohney. |

**ALLEGATION: Direct care staff failed to ensure timely medical treatment for Resident A following a fall resulting in a broken clavicle on or around 04/20/2026.**

**INVESTIGATION:** On 05/14/2026, I received this complaint through the Bureau of Community Health System (BCHS) online complaint system. The complaint alleged on or around 04/20/2026, direct care staff, Emma Johnson, reported to incoming staff, Lena Cargen, that Resident A had been unsteady on his feet during her shift, which resulted in Emma Johnson taking Resident A's blood pressure and pulse. The complaint further alleged that later that day, during staff Lena Cargen's shift, Resident A was observed with uneven shoulders. The complaint alleged Lena Cargen contacted emergency medical services (EMS) and Resident A was treated for a broken clavicle.

The complaint alleged Resident A was unable to explain what had occurred; however, it was later determined that he had fallen while standing on a wheeled chair attempting to hang curtains. The complaint further alleged Emma Johnson failed to report Resident A's fall to incoming staff or management and did not seek timely medical attention for Resident A.

The complaint also alleged Resident A has a hearing deficit, knows limited American Sign Language (ASL), and has minimal verbal communication abilities.

On 05/14/2026, I interviewed Kalamazoo County Adult Protective Services Specialist, Jessica Mellen. She stated she visited the facility on 05/14/2026, confirmed Resident A is deaf, and sustained a broken clavicle on or around 04/20/2026.

She stated she interviewed Emma Johnson regarding the incident who reported to her that she was working at the time of the incident but did not witness Resident A fall. Jessica Mellen stated that according to Emma Johnson, Resident B informed her that Resident A may have fallen. Emma Johnson reported to Jessica Mellen that when she checked on Resident A, he was standing and attempting to hang a curtain rod. Emma Johnson reported to Jessica Mellen that she obtained Resident A's vital signs and identified no concerns requiring medical attention at that time.

Jessica Mellen further stated that after staff, Lena Cargen, began her shift at approximately 9am on 04/20/2026, she observed an issue with Resident A's shoulder, and medical attention was subsequently sought.

Jessica Mellen stated she attempted to communicate with Resident A during her visit to the facility, but it was unsuccessful. She stated she requested interpreter services through DeafLink for a follow up interview with Resident A.

On 05/20/2026, I conducted an unannounced inspection with Jessica Mellen and DeafLink interpreter, Sunny Pfifferling. Resident A provided inconsistent information

regarding his clavicle injury and was unable to recall when hospital treatment was obtained. He demonstrated limited communication abilities, echoed portions of the interpreter's statements, and was unable to answer several orientation and follow up questions. Resident A indicated ongoing pain from his injury but also indicated he receives pain medication when requested. He further indicated that it was a deceased female staff that struck him, causing him to fall while standing on a chair; however, he was unable to communicate any identifying information about the staff or additional details about the alleged incident.

I interviewed direct care staff, Lisa Sanchez. She stated Resident A primarily communicates through writing and can indicate pain by pointing to the affected areas or his pain medication. She stated she had no firsthand information regarding the incident with Resident A because she had not been working at the time he sustained the injury. Lisa Sanchez stated she was informed by staff and by reviewing staff notes that Resident A appeared to fall while attempting to hang curtains during a time when painters were working in the facility. She identified Resident B as a possible witness to the incident. Lisa Sanchez further stated the incident was not documented by the involved staff, Emma Johnson, although staff, Lena Cargen, later completed an incident report.

Lisa Sanchez stated Resident A walked to the Emergency Room (ER) after Lena Cargen observed an apparent shoulder injury. She was unable to explain why alternative transportation was not provided to Resident A and stated there was no clear emergency transportation plan beyond contacting the facility's owner, Barbara Mohney, for assistance. She stated that staff are unable to transport residents because only one staff works at a time.

I interviewed Resident B who stated he was in the facility on the day of Resident A's incident. He stated hearing a crash while in the upstairs television room. Upon investigating, he observed Resident A on the floor in the adjacent puzzle room appearing injured. Resident B stated he notified Emma Johnson, who was cooking downstairs, and she responded immediately. He stated she assisted Resident A, and helped him to his feet. Resident B was unable to provide additional information regarding subsequent events or whether Resident A received immediate medical treatment because he went back into the television room.

I interviewed Resident C who had limited information regarding the incident. He stated he did not observe Resident A on the floor or injured but recalled Emma Johnson coming upstairs to check on Resident A on or around the time he injured his clavicle.

I reviewed Resident A's *Resident Care Agreement* (RCA), dated 05/01/2025, which documented that transportation to local appointments was included in Resident A's basic fee.

I reviewed Lena Cargen's staff note regarding Resident A from 04/20/2026 at approximately 10:30 am, Lena Cargen documented the following:

> "It looks like [Resident A's] right arm is dislocated. [Resident D] says he saw him fall in the game room, sometime after Emma left but before I got here? So: approximately 9-9:30 am. He is walking to the ER and [Witness 1] plans to meet him down there. Also notable that I heard a verbal report, (when I came in), from Emma, that she took vital signs for [Resident A] because she observed that he appeared unstable on his feet. [sort of wobbly]. I do not remember exactly what the readings were but his pulse rater seemed very low, (in 70's). The shoulder is sagging!"

I also reviewed the facility's Incident Report (IR), dated 04/21/2026, which was completed by Lena Cargen. The IR documented on 04/20/2026 at approximately 10:30 am, she observed Resident A in the entrance to the home looking out the window. Lena Cargen documented it seemed Resident A's right arm was dislocated because his shoulder was sagging. She documented she called [Witness 1] and Resident A went to the local ER. Lena Cargen documented that while Resident A was gone she inquired with the other residents as to what occurred and was told Resident A was seen falling off a rolling chair while attempting to hang a curtain in his game room upstairs. The IR further documented that Resident A was treated at the local ER for a closed displaced fracture of the right clavicle.

A review of local hospital information indicated the nearest ER was approximately 0.6 miles from the facility.

On 05/20/2026, I interviewed direct care staff, Emma Johnson. She stated on the day of the incident, Resident B came downstairs sometime between approximately 7 am and 8 am and informed her Resident A may have fallen while attempting to hang curtains. She stated Resident B did not report he observed Resident A fall. Emma Johnson stated that when she checked on Resident A, he was in the puzzle room attempting to rehang the curtains. She denied observing him on the floor or appearing injured. Emma Johnson also denied hearing any sounds in the facility indicating Resident A fell.

Emma Johnson stated she redirected Resident A from hanging the curtains, obtained his vital signs, and observed no signs of pain or injury. She stated she communicates with Resident A through gestures and a writing board, as she does not know American Sign Language (ASL). She stated Resident A is generally able to communicate discomfort and pain through gestures and writing, but he did not indicate any concerns to her at that time.

Emma Johnson denied physically assaulting Resident A and denied witnessing a fall. She stated she later learned Resident A has been transported to the hospital but was unaware of the details of his treatment at the hospital or the transportation there. She stated if a resident were to have an emergency and required medical treatment she would contact 911 and licensee designee, Barbara Mohney, to coordinate transportation.

Emma Johnson further stated that Barbara Mohney contacted her at approximately 10 am and questioned her about Resident A's injury. She stated she informed Barbara Mohney that Resident A appeared fine at the time she left her shift at approximately 9 am.

On 05/21/2026, I interviewed former direct care staff, Lena Cargen. She stated that during shift change the morning of 04/20/2026, which started at approximately 9 am, Emma Johnson informed her that Resident A had been "wobbly" and unsteady on his feet that morning, but Emma Johnson did not report to her that Resident A had fallen.

Lena Cargen stated due to Emma Johnson's report of Resident A at shift change and there not being any major concerns, Lena Cargen did not check on Resident A until she observed him at approximately 10:30 am. She stated she observed Resident A with one shoulder lower than the other and he appeared to be in pain. She stated Resident A used gestures to indicate his shoulder was "broken". Lena Cargen stated Resident A can communicate through gestures, signing, reading, and use of a dry erase board.

Lena Cargen stated she contacted both Barbara Mohney and Resident A's Power of Attorney/payee, Witness 1, regarding the injury because she believed Resident A had dislocated his shoulder. Lena Cargen stated neither Barbara Mohney nor Witness 1 were able to transport Resident A to the ER. She stated EMS was also not contacted. Lena Cargen stated she was also unable to transport Resident A to the ER because she could not leave the remaining residents unsupervised. She stated that Resident A was capable of walking to the ER for treatment and he agreed to do so. She further stated Witness 1 agreed to meet him at the ER.

Lena Cargen stated Resident B returned to the facility sometime between 3 pm and 5 pm and informed her that Resident A had fallen prior to Resident B leaving for his day program at approximately 9 am. Lena Cargen stated that based upon this information, she believed Resident A's injury must have occurred prior to her arriving to work at 9 am.

On 05/28/2026, I interviewed the licensee, Barbara Mohney. She stated Lena Cargen contacted her on the day of the incident to report a change in Resident A's condition and advised that the incident occurred during Emma Johnson's shift. Barbara Mohney stated she instructed Lena Cargen to complete an IR and to ensure Resident A received medical evaluation.

Barbara Mohney stated it was her understanding Witness 1 transported him to the ER; however, she later learned Resident A walked to the ER. Barbara Mohney stated this was not the facility's standard practice and that she was unaware Witness 1 was unable to provide Resident A with transportation. She stated that Lena Cargen did not follow up with her or notify her that alternative transportation arrangements were needed. Barbara Mohney stated that had she'd been aware of the lack in transportation arrangements for Resident A that morning she would have changed her schedule to be available.

Barbara Mohney stated Emma Johnson reported to her that Resident B had informed her Resident A may have fallen. According to Barbara Mohney, Emma Johnson reported that she observed Resident A standing on a chair, reaching for curtain rods, obtained his vital signs, and did not observe any signs of injury or distress.

On 05/28/2026, I interviewed Witness 1, who stated she was Power of Attorney and payee. Witness 1 stated that facility staff contacted her on the day Resident A sustained a broken clavicle and informed her that Resident A was holding his shoulder and appeared in pain. She stated staff believed medical attention was necessary.

Witness 1 stated she was unable to transport Resident A to the ER and understood no staff were available to provide transportation. She stated she gave permission for Resident A to walk to the ER from the facility.

Witness 1 stated staff informed her that Resident A had fallen in the facility; however, the circumstances of the fall were unclear. She stated the reported fall was corroborated by another resident per staff. Witness 1 further stated that, based on her experience working with Resident A, he has a high tolerance for pain and did not complain about his shoulder until sometime after the incident occurred. Witness 1 stated she met Resident A at the ER in the afternoon.

| **APPLICABLE RULE** | |
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| **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.** |

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| **ANALYSIS:** | Based on my investigation, there is insufficient evidence to establish that the facility failed to obtain needed health care for Resident A on or around 04/20/2026. Although Resident A's injury was not immediately identified, direct care staff, Emma Johnson, reported observing no signs of pain or injury when she initially assessed him. Once Resident A's shoulder injury and pain were identified, medical attention was sought, which was approximately mid morning on 04/20/2026 the same day as the fall. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

| **APPLICABLE RULE** | |
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| **R 400.697** | **Resident transportation.** |
| | **(1) A licensee shall ensure the availability of transportation services as provided for in a resident care agreement. A licensee shall provide or arrange transportation for residents in a certified facility.** |
| **ANALYSIS:** | Based on my investigation, the licensee failed to ensure transportation services were available to Resident A as required by his *Resident Care Agreement*, dated 05/01/2025. Facility records documented transportation services were included in Resident A's basic fee; however, after it was determined Resident A required evaluation at the ER, the facility's staff did not provide or arrange transportation, as required, and allowed Resident A to walk to the local ER, approximately 0.6 miles away with a known shoulder injury. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDING:**

**INVESTIGATION:** During the inspection, I observed multiple resident medications on a table in the dining room while staff, Lisa Sanchez, was in another room. The medications included Resident A's and Resident E's Fluticasone 50 mcg nasal spray and Resident F's Incruse Ellipta 62.5 MCH/INH IH Spray. Lisa Sanchez was unable to explain why the medications were unsecured; however, upon notification, she immediately returned the medications to the medication cart and secured them.

| 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:** | During my unannounced inspection on 05/20/2026, I observed Resident A's and Resident E's Fluticasone 50 mcg nasal sprays and Resident F's Incruse Ellipta 62.5 MCH/INH IH Spray unsecured and accessible to residents in the dining room. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 06/15/2026, I conducted my exit conference with the licensee designee, Barabra Mohney. She acknowledged the findings and agreed to submit a corrective action plan addressing the violations.

## IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

06/17/2026

Cathy Cushman Date
Licensing Consultant

Approved By:

06/17/2026

Dawn N. Timm Date
Area Manager