



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

June 4, 2026

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

RE: License #: AM390076322  
Investigation #: 2026A1024028  
Mohny 1 AFC

Dear Ms. Mohny:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On April 27, 2026, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

A handwritten signature in cursive script that reads "Ondrea Johnson".

Ondrea Johnson, Licensing Consultant  
Bureau of Community and Health Systems

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AM390076322
<b>Investigation #:</b>	2026A1024028
<b>Complaint Receipt Date:</b>	04/15/2026
<b>Investigation Initiation Date:</b>	04/16/2026
<b>Report Due Date:</b>	06/14/2026
<b>Licensee Name:</b>	Mohney 1 and 2 AFC Corp.
<b>Licensee Address:</b>	1025 W Kalamazoo Ave Kalamazoo, MI 49007
<b>Licensee Telephone #:</b>	(269) 382-1448
<b>Administrator:</b>	Barbara Mohney
<b>Licensee Designee:</b>	Barbara Mohney
<b>Name of Facility:</b>	Mohney 1 AFC
<b>Facility Address:</b>	616 Walnut St Kalamazoo, MI 49007
<b>Facility Telephone #:</b>	(269) 343-4433
<b>Original Issuance Date:</b>	08/15/1999
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/04/2024
<b>Expiration Date:</b>	09/03/2026
<b>Capacity:</b>	12
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Staff member Lena Cargen grabbed Resident A's arm, pushed him and yelled at him.	Yes
Staff member Lena Cargen refused to pass Resident A's Propranolol Hydrochloride 10mg medication on 4/14/2026 as prescribed.	No
Additional Findings	Yes

**III. METHODOLOGY**

04/15/2026	Special Investigation Intake 2026A1024028
04/16/2026	Special Investigation Initiated - Face to Face with direct care staff member Emma Jean Jefferson
04/16/2026	Contact - Telephone call made with Resident A's case manager Maria Granado from Summitt Pointe
04/17/2026	Inspection Completed On-site with Residents A, B, C, D, E, F, G and direct care staff member Lena Cargen
04/21/2026	APS Referral-not warranted
04/21/2026	Contact - Telephone call received with Maria Granado
04/21/2026	Inspection Completed On-site with Resident A, direct care staff member Emma Jean, licensee designee Barb Mohney, and Lena Cargen
04/23/2026	Inspection Completed-BCAL Sub. Compliance
04/23/2026	Exit Conference with licensee designee Barb Mohney
04/23/2026	Corrective Action Plan Requested and Due on 5/08/2026
04/27/2026	Corrective Action Plan Received
04/27/2026	Corrective Action Plan Approved

**ALLEGATION: Direct care staff member Lena Cargen grabbed Resident A's arm, pushed him and yelled at him.**

**INVESTIGATION:**

On 4/15/2026, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged that direct care staff member Lena Cargen grabbed Resident A's arm, pushed him and yelled at him.

On 4/16/2026, I conducted an onsite investigation at the facility and interviewed direct care staff member Emma Jean Jefferson. Emma Jean Jefferson stated that she was not working on the morning of 4/14/2026; however, when she arrived later that day, staff member Lena Cargen informed her that Resident A had become agitated because he was unable to receive his 3:00 p.m. medication before leaving for work at 8:00 a.m., as he was scheduled to return to the facility by 3:00 p.m. Emma Jean Jefferson reported that she has not received any additional information about this incident from other residents, including Resident A, and she does not believe that Lena Cargen would intentionally mistreat him. She stated that she has no concerns regarding the incident.

On 4/16/2026, I conducted an interview with Resident A's case manager Maria Granado who stated Resident A contacted her on 4/14/2026 and reported that staff member Lena Cargen is mean to him and pushed him when he asked for his medication. Maria Granado stated that Resident A informed her he had contacted the police at the time of that incident. Maria Granado stated she has no further details about this incident, however, believes that Resident A was very concerned about this specific staff member. Maria Granado stated she has never worked with Lena Cargen.

On 4/17/2026, I conducted an onsite investigation at the facility with Residents A, B, C, D, E, F, G and direct care staff member Lena Cargen. Resident A stated on 4/14/2026, he came downstairs at 8am to eat as he usually does and asked staff member Lena Cargen if he could have his Propranolol Hydrochloride 10mg medication that he takes at 3pm. Resident A stated he wanted to take this medication to work with him to administer because he was not going to return to the facility until 3pm. Resident A stated that Lena Cargen stated that he was not able to get his 3pm medication that early since he would be returning at the time the medication was due to be administered. Resident A stated that he became upset because he wanted to take his 3pm medication with him therefore he knocked over the medication cart that was nearby and Lena Cargen grabbed his arm and tried to "drag him out of the kitchen" and pushed his face. Resident A stated that both him and Lena Cargen continued to yell back and forth at each other in front of the other residents. Resident A stated she would not stop arguing and yelling at him, so he called the police. Resident A stated that he takes accountability for pushing Lena Cargen however he pushed her after she pushed and grabbed him first. Resident A stated that he believes that Lena Cargen does not like him and is mean to him.

Resident B stated that he has not seen Lena Cargen mistreat anyone including Resident A. Resident C stated that he heard Lena Cargen tell Resident A to move out

the way at which time Resident A pushed her, however he did not see or hear anything else. Residents D, E, F and G all stated that Resident A and staff member Lena Cargen were observed arguing and yelling at each which created a very loud disturbance during breakfast time. Residents E and G both stated that they heard Resident A yell to Lena Cargen “get your hands off of me” however they did not actually witness staff member Lena Cargen push or hit Resident A.

Lena Cargen stated on the morning of 4/14/2026 during breakfast time, Resident A asked if he could take his 3pm medication with him to work and she advised him that she would administer this medication to him once he returned to the facility by 3pm. Lena Cargen stated that Resident A became upset and started yelling at her and being disruptive by yelling at the other residents. Lena Cargen stated that she then placed her hip against his hip in attempts to move him away from the area at which time Resident A pushed over the medication cart. Lena Cargen stated he was yelling at her therefore she had to raise her voice as well to get him to listen to her and be heard. Lena Cargen stated Resident A then had his phone in his hand, so she placed her hand over his hand and told him that he needed to leave. Lena Cargen stated she can understand how that action might seem like a push however she did not intentionally try to push Resident A. Lena Cargen stated after speaking with other staff members, she realizes that her intervention was not very helpful and not an approved behavior management technique. Lena Cargen stated she should have handled things differently.

On 4/21/2026, I conducted an onsite investigation at the facility with licensee designee Barb Mohney who stated that she believes Lena Cargen conducted an unapproved behavior management technique by yelling at Resident A and putting her hands on him in attempts to de-escalate him. Barb Mohney stated Lena Cargen was issued a written disciplinary action notice and approved behavior management techniques were discussed with her.

While at the facility, I observed a *Written Disciplinary Notice* dated 4/18/2026 due to a physical altercation between Resident A and Lena Cargen. The *Written Disciplinary Notice* stated weekly check-ins will be completed by licensee designee Barb Mohney.

<b>APPLICABLE RULE</b>	
<b>R 400.641</b>	<b>Resident behavior interventions.</b>
	<b>(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.</b>

<b>ANALYSIS:</b>	<p>Based on my investigation which included interviews with direct care staff members Emma Jean Jefferson and Lena Cargen, licensee designee Barb Mohney, and Residents A, B, C, D, E, F, G, along with my review of Lena Cargen written disciplinary notice there is evidence that direct care staff member Lena Cargen grabbed Resident A's arm, pushed him and yelled at him.</p> <p>According to Resident A, Lena Cargen mistreated him by yelling at him, grabbing and dragging him by the arm, and pushing him in the face. Residents D, E, F and G all stated that Resident A and staff member Lena Cargen were observed arguing and yelling at each which created a very loud disturbance and both Residents E and G stated that they heard Resident A yell to Lena Cargen "get your hands off of me." However, neither resident actually witnessed direct care staff member Lena Cargen hit Resident A. According to Lena Cargen she attempted to de-escalate Resident A by yelling at him, pushing him, and grabbing his hand which are all unapproved behavior management techniques per Barb Mohney and Lena Cargen.</p> <p>Therefore, Resident A was mistreated by staff member Lena Cargen.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION: Staff member Lena Cargen refused to pass Resident A's Propranolol Hydrochloride 10mg medication on 4/14/2026 as prescribed.**

**INVESTIGATION:**

This complaint also alleged staff member Lena Cargen refused to pass Resident A's Propranolol Hydrochloride 10mg medication on 4/14/2026 as prescribed.

On 4/16/2026, I conducted an onsite investigation at the facility with direct care staff member Emma Jean Jefferson who stated on 4/14/2026 she administered Resident A's medications including his Propranolol Hydrochloride 10mg medication in the afternoon at 3pm and evening around 9pm. Emma Jean Jefferson stated that Lena Cargen administered this medication to him prior to him leaving for work at 8am therefore she has no knowledge of Resident A not receiving this medication which he regularly takes as prescribed daily.

On 4/16/2026, I conducted an interview with Resident A's case manager Maria Granado who stated Resident A reported to her that staff member Lena Cargen refused to give him his Propranolol Hydrochloride 10mg medication at his request to take with him to

his employer so he can take it while out in the community. Maria Granado stated that she is unsure if the medication was ever given to him when he returned from work.

On 4/17/2026, I conducted an onsite investigation at the facility with Resident A and direct care staff member Lena Cargen. Resident A stated he was not able to receive his 3pm medication, Propranolol Hydrochloride 10mg, prior to leaving for work at 8am however staff Emma Jean Jefferson administered this medication to him around 3pm when he returned from work. Resident A stated that this is his normal scheduled time. Resident A stated that he takes this medication three times a day and he has not missed getting this medication however he believes Lena Cargen should have given this medication when he requested it since other staff members have done this for him in the past.

Lena Cargen stated on 4/14/2026, Resident A requested his Propranolol Hydrochloride 10mg medication scheduled for 3pm to be given to him at 8am to take with him to his worksite to administer later. Lena Cargen stated since Resident A was returning to the facility by 3pm, she advised him that she would administer this medication to him once he returned to prevent him from losing the medication. Lena Cargen stated Resident A eventually returned to the facility at 2:30pm and was administered this medication at his regularly scheduled time by Emma Jean Jefferson.

While at the facility, I reviewed Resident A's *Medication Administration Record (MAR)* for the month of April 2026 which documented that Propranolol Hydrochloride 10mg should be given to Resident A at 8am, 3pm and 9pm. I did not see any concerns with this MAR.

I also reviewed Resident A's Propranolol Hydrochloride 10mg medication in its original packaging and found no concerns.

On 4/21/2026, I conducted an onsite investigation at the facility with licensee designee Barb Mohny who stated Resident A is sometimes given his medication early to take with him while he is out in the community at work during the scheduled time he is supposed to take the medication. Barb Mohny stated to her knowledge she is not aware of Resident A not taking any of his medications regularly or staff refusing to administer his medication.

<b>APPLICABLE RULE</b>	
<b>R 400.675</b>	<b>Resident medications.</b>
	<b>(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.</b>

<b>ANALYSIS:</b>	Based on my investigation which included interviews with direct care staff members Emma Jean Jefferson and Lena Cargen and licensee designee Barb Mohney along with my review of Resident A's MAR and Propranolol Hydrochloride 10mg medication there is no evidence that allegation staff member Lena Cargen refused to pass Resident A's Propranolol Hydrochloride 10mg medication on 4/14/2026 as prescribed.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 4/21/2026, I conducted an interview with Resident A's case manager Maria Granado who stated that staff member Emma Jean Jefferson informed her while visiting with Resident A, that residents are not allowed in the living room and kitchen area after 9pm and they must wait until 7am in the morning to gain access to this area of the home. Maria Granado stated she was told the door to the living room is locked to keep residents out during those hours. Maria Granado stated that Resident A also confirmed that he is not allowed in these two common areas after 8pm.

On 4/21/2026, I conducted an onsite investigation at the facility with Emma Jean Jefferson, Lena Cargen and Barb Mohney who all confirmed that the kitchen and living room area are not accessible to any residents after 9pm. All confirmed that the interior door to the living room/kitchen area is locked until 7am the following morning for safety purposes. All denied that this restriction is included in all residents' assessment plans or individual plans of service as required.

<b>APPLICABLE RULE</b>	
<b>R 400.651</b>	<b>Living space.</b>
	<b>(1) Common use areas of the facility must be accessible to all residents unless a resident has restrictions imposed in the resident's assessment plan or individual plan of service.</b>

<b>ANALYSIS:</b>	<p>Maria Granado stated that staff member Emma Jean Jefferson informed her while visiting with Resident A, that residents are not allowed in the living room and kitchen area after 9pm and they must wait until 7am in the morning to gain access to this area of the home therefore the door to these two areas are locked to keep residents away.</p> <p>Emma Jean Jefferson, Lena Cargen and Barb Mohny also all confirmed that the kitchen and living room area are not accessible to any of the residents after 9pm so the interior door to the living room/kitchen area is locked until 7am the following morning for safety purposes.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

While at the facility, Emma Jean Jefferson, Barb Mohny and Lena Cargen all stated that Emma Jean Jefferson routinely sleeps in the living room on the living room couch. All stated being unaware that the use of resident living areas for staff sleeping purposes is prohibited.

<b>APPLICABLE RULE</b>	
<b>R 400.657</b>	<b>Bedrooms.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	While at the facility, Emma Jean Jefferson, Barb Mohny and Lena Cargen all stated that Emma Jean Jefferson routinely sleeps on the living room couch which is part of the resident living space. Resident living areas cannot be used for sleeping purposes by any person.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 4/23/2026, I conducted an exit conference with licensee designee Barb Mohny. I informed Barb Mohny of my findings and allowed her an opportunity to ask questions and make comments. On 4/27/2026, I received and approved an acceptable corrective action plan.

**IV. RECOMMENDATION**

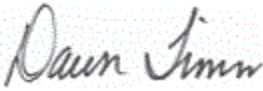
An acceptable corrective action was received and approved; therefore, I recommend the current license status remain unchanged.



Ondrea Johnson  
Licensing Consultant

6/1/2026  
Date

Approved By:



06/04/2026

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Dawn N. Timm  
Area Manager

Date