GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 31, 2026

Joy Mbelu
Victory AFC LLC
5517 Star Flower Drive
Haslett, MI 48840

RE: License #: AS330389384
Investigation #: 2026A0577049
Victory AFC

Dear Ms. Mbelu:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care and physical plant 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330389384
Investigation #:	2026A0577049
Complaint Receipt Date:	06/18/2026
Investigation Initiation Date:	06/18/2026
Report Due Date:	08/17/2026
Licensee Name:	Victory AFC LLC
Licensee Address:	5517 Star Flower Drive Haslett, MI 48840
Licensee Telephone #:	(517) 402-3952
Licensee Designee:	Joy Mbelu
Administrator:	Joy Mbelu
Name of Facility:	Victory AFC
Facility Address:	6101 Norburn Way Lansing, MI 48911
Facility Telephone #:	(517) 402-3952
Original Issuance Date:	03/02/2018
License Status:	REGULAR
Effective Date:	09/02/2024
Expiration Date:	09/01/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED

	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

ALLEGATIONS:

	Violation Established?
There are flies, ants, and mouse holes throughout the house.	Yes
Black or dark colored mold is observed throughout the facility.	Yes
The wheelchair ramp exiting into the backyard is in poor condition.	Yes
Sinks and shower are not working properly.	Yes
There is not enough food in the facility for residents.	No
Concerns with cleanliness of the facility.	Yes
Concerns of the overall facility not being in good repair or condition.	Yes
The stove does not have knobs and cannot be used to cook with.	No
The bed linens are stained and not in good condition.	Yes
There are not enough bed linens for all residents.	No
Resident E is not being provided with personal care in accordance with Resident E's care plan.	No
Additional Findings	Yes

II. METHODOLOGY

06/18/2026	Special Investigation Intake, 2026A0577049
06/18/2026	Special Investigation Initiated - Telephone Complainant wants to remain anonymous
06/18/2026	APS Referral
06/18/2026	Referral - Recipient Rights, Ashlee Bailey, CEI-ORR.
06/23/2026	Inspection Completed On-site
07/01/2026	Contact-Telephone call made, attempted to interview Resident E.
07/09/2026	Contact-Telephone call made, attempted to interview Resident E.
07/14/2026	Contact-Telephone call made, attempted to interview Resident E.
07/14/2026	Contact-Telephone call made, Interview with Joy Mbelu, LD.

07/16/2026	Contact-Document received, copy of Resident E's AFC Assessment Plan.
	Exit Conference with licensee designee Joy Mbelu.

ALLEGATION: There are flies, ants, and mouse holes throughout the house.

INVESTIGATION:

On June 18, 2026, a complaint was received alleging that the facility has an issue with pests including flies, ants and mice.

On June 18, 2026, I interviewed Complainant who reported there are fruit flies or gnats all over the facility including coming up through the sinks and shower drains. Complainant reported that there is bug zapper in the kitchen to assist with irradicating the fruit flies/gnats.

On June 23, 2026, I completed an unannounced onsite investigation with Ashlee Bailey from the Office of Recipient Rights with Clinton, Eaton, Ingham Community Mental Health (ORR-CEI-CMH). Ms. Bailey and I entered the resident bathroom and were bombarded by fruit flies/gnats. Ms. Bailey and I observed a bug zapper on the kitchen counter with moths and fruit flies/gnats flying around it. While Ms. Bailey and I were in the basement, we also observed a fly strip that was completely covered with fruit flies/gnats. I completed a physical plant inspection and did not observe any mice, flies or concerns of additional pests beyond the fruit flies/gnats. While on-site I took a photo of the covered fly strip in the basement.

On June 23, 2026, we interviewed direct care staff (DCS) Lamar Thurmond who reported that the fruit flies/gnats infest the house during the summer, stating, "it is weird, they come and go and even the neighbors have a problem with them." DCS Thurmond reported that he has a counter bug zapper in the kitchen and bug strips in the basement to assist, but these do not always work.

On July 14, 2026, I interviewed licensee designee (LD) Joy Mbelu who reported she visits the facility at least twice a week. Ms. Mbelu reported that she is aware of the concerns of fruit flies/gnats and that this has been an ongoing issue in the facility. Ms. Mbelu reported about a year ago she hired Orkin Pest Control to eradicate the fruit flies/gnats and they have recently returned due to dampness in the facility from the sump pump in the basement and a leak under the kitchen sink which has recently been fixed. Ms. Mbelu reported the fruit flies/gnats have been an issue for a couple of months. Ms. Mbelu reported she has not contacted a pest control company for this current issue due to the expense.

APPLICABLE RULE	
R 400.645	**Environmental health.**
	(6) An insect, rodent, or pest control program must be maintained and carried out in a manner that continually protects the health of residents.
ANALYSIS:	Based on the information gathered during this investigation through observation and interviews, it has been determined that the facility has an infestation of fruit flies or gnats and a pest control program has not been maintained to protect the health of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Black or dark colored mold is observed throughout the facility.**
- **The wheelchair ramp exiting into the backyard is in poor condition.**

INVESTIGATION:

The complaint received on June 18, 2026, reported that the resident bathroom has black mold on the ceiling and around the bathtub. The complaint also alleged that black mold was present under the kitchen sink where there was a previous leak.

The complaint received on June 18, 2026, also reported that the wheelchair ramp that exits into the backyard is bent, flimsy and unsafe for residents.

On June 18, 2026, I interviewed Complainant who reported that the wall and ceiling in the bathroom have mold growing on them that resembles black or dark colored mold. Complainant reported that the wall behind the toilet is rotting and is covered in a substance that resembles black and white mold due to water leakage. Complainant also noted that the tiles along the floor have fallen off the wall due to the rotting of the wall. Complainant reported that there is substance that resembles black mold along the bathtub and the wall. Complainant reported that the kitchen sink has been leaking and the cupboard under the kitchen sink now appears to have a substance that resembles black mold on the bottoms shelf of the cupboard where water saturated the shelf. Complaint provided me photos of the substance resembling mold on the ceiling and wall in the resident bathroom and on the bathtub. The photos also showed a plastic container under the kitchen sink catching water leaking from the pipes. The Complainant reported that the photos were taken on the morning of June 18, 2026. I did not have any method to independently verify when these photos were taken or if the photos were of the facility.

Complainant also reported that facility has wheelchair ramps located at the front and back egresses. Complainant reported that the wheelchair ramp at the back door egress feels “weak” and unsafe.

On June 23, 2026, during the onsite investigation I observed the resident bathroom. I observed a substance that resembled black or dark colored mold on the ceiling and walls. I observed the wall behind the toilet and noted that it had rotted out causing the tiles on that same wall to fall off. I also observed that the dry wall has a mold-like substance on it due to water saturation.

In addition, I observed water damage and a substance that resembled mold had spread about six inches up the side of the kitchen cabinet under the sink.

During my unannounced on-site investigation, I observed that the mold along the bathtub and the wall has been covered with new calk. Resident A reported that the bathtub was just recalked to fix the mold problem.

I also observed that the wheelchair ramp at the front of the house, leading into the main egress of the facility to be safe and secure. Upon reviewing the wheelchair ramp exiting into the backyard, I observed that the ramp was constructed of particle board and was soft/spongey in multiple places. I observed that where the particle board pieces joined there was no other support to keep them strong and intact. I also observed the handrails on the wheelchair ramp were broken and duct taped together in places.

While at the facility on June 23, 2026, I verified the photos that were provided by Complainant were from the facility by direct sight comparison of the photos to the facility. I also took photos of the substance on the ceiling resembling mold, the decaying wall behind the toilet, the broken handle of the wheelchair ramp and the deteriorating condition of the wheelchair ramp.

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:	During the unannounced onsite investigation on June 23, 2026, I observed and took photos of the substantial areas where a mold-like substance was present along with water-related structural deterioration within the bathroom and kitchen. The mold like substance was observed on the resident bathroom ceiling and walls, around the bathtub, and under the kitchen sink. Additionally, a dark colored mold-like substance had spread up the cabinet wall following a previous leak. The wheelchair ramp located at the back of the home had broken handrails in multiple spots and duct tape was used to secure some of broken handrail spots. I also noted that the wheelchair ramp itself had multiple spongy spots and lacked overall support of the ramp making it not study and unsafe for residents use These documented conditions reflect ongoing water intrusion, decay, and inadequate maintenance throughout the facility. The presence of a dark colored mold-like substance, rotted structural materials, unrepaired water damage, and the poor condition of the wheelchair ramp and handrail demonstrates failure to maintain the environment in a manner that protects residents' health and safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(10) On the effective date of these rules, new or renovated exterior and interior stairways and ramps must have handrails on the open sides and be constructed in accordance with and inspected and approved by the state or local building authority in accordance with the Stille-DeRosset-Hale single state construction code act ,1972 PA 230, MCL 125.1501 to 125.1531.

ANALYSIS:	During the onsite investigation on June 23, 2023, I observed the wheelchair ramp exiting into the backyard was soft and spongey in places due to the wear and lack of support of the particle board. I also observed the handrails on the ramp were broken and repaired with duct tape. Consequently, the wheelchair ramp at the back of the facility is not constructed in accordance with local building authority.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The sink and shower located in the resident bathroom are not working properly.

INVESTIGATION:

The complaint received on June 18, 2026, reported there is an issue with the sink and shower in the resident bathroom not working well.

On June 18, 2026, Complainant reported there is very low water pressure at the sink and shower in the resident bathroom. Complainant reported that the kitchen sink is leaking underneath the sink and a plastic container is placed under the kitchen sink to catch the water from the leak. Complainant provided a photo of under the kitchen sink with a plastic container placed under the PVC piping catching water dripping from the PVC pipe. I could not determine from the photo provided the date the photo was taken, nor could I verify that this was the AFC facility from the photo provided.

On June 23, 2026, during the onsite investigation, I inspected the resident bathroom sink and shower and determined there was adequate water pressure. However, I also observed that the shower head was not secured to the shower wall appropriately.

I also inspected the kitchen sink but did not observe any leak underneath the kitchen sink nor did I observe the plastic container allegedly placed under the PVC piping under to collect water leaking from the kitchen sink. I interviewed Resident A who verified the leak was fixed and stated, “we just had a leak fixed under there so we no longer need a plastic container underneath the sink to catch the leaking water.”

While at the facility on June 23, 2026, I verified the photos provided by Complainant were from the facility. I also took photos of the water damage present under the sink caused by a previous leak.

The kitchen sink was observed not fitting properly into the countertop, leaving a gap of about an inch between the sink and countertop.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(6) Plumbing fixtures and water and waste pipes must be properly installed and maintained in good working condition.
ANALYSIS:	During the June 23, 2026, onsite investigation, I observed there was adequate water pressure in the resident bathroom sink and shower; however, the shower head was not properly secured to the wall. There was no leak under the kitchen sink at the time of the investigation, however I observed water damage and noted the kitchen sink itself was not properly seated in the countertop, leaving a gap of about one inch between the sink and the countertop. The unsecured shower head and improperly fitted kitchen sink, demonstrate that plumbing fixtures and related components are not being maintained in a safe and functional condition.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: There is not enough food in the facility for residents.

INVESTIGATION:

The complaint received on June 18, 2026, alleged that residents are hungry because there is insufficient amount of food in the home. The complaint reported on June 17, 2026, there was no food in the home and direct care staff had to purchase food to make resident meals.

On June 18, 2026, I interviewed Complainant who reported on June 17, 2026, they observed no food in the refrigerator or cupboards to make resident meals. Complainant reported going grocery shopping and purchased food to make meals for the day.

On June 23, 2026, Ashlee Bailey, ORR-CEICMH and I observed minimal food in the refrigerator located in the kitchen of the facility, but in the facility garage, there were additional refrigerators and freezers with plenty of food to feed the residents for at least two weeks. I also observed shelves in the basement with boxed and canned food items for resident meals. I interviewed Residents A, B, and C who all denied running out of food, but reported that all food is for mealtime and needs to be prepared so there is not a lot of easy access snack foods available.

On June 23, 2026, I interviewed DCS Lamar Thurmond who reported that LD Joy Mlebu is responsible for grocery shopping which she completes every Thursday. DCS Lamar reported there is always food to make resident meals and the facility has never been without food to make resident meals.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	Based on the information gathered through interviews and onsite investigation, there was more than ample food available to make resident meals for at least two weeks.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **The facility is not clean.**
- **The facility is not in good repair or condition.**

INVESTIGATION:

On June 18, 2026, the complaint alleged “there are concerns with overall cleanliness and the facility is not in good condition.” The complaint reported that the cupboards are covered with grease and grime and because the stove does not have knobs it cannot be used to cook resident meals.

On June 18, 2026, I interviewed Complainant who reported that overall, the facility is filthy and not in good repair. Complainant reported the following areas were not clean or were in disrepair:

- Kitchen cupboards and hood range are covered in grease, grime and dust due to not being cleaned on a regular basis. The hood range is rusting.
- Stove has grease and food running down the side of the stove that has settled on the floor.
- Floors throughout the facility have not been swept and mopped, floors are covered in dirty and a brown substance.
- Floors throughout the facility are missing sections of vinyl floor leaving subflooring visible, holes in the flooring under the bed frames in the bedrooms, and large gaps between the flooring and the baseboard filling with dirt and debris.
- Walls and doorjambs throughout the facility are covered in splattered liquid and dirt/grime.
- Walls and door jams have been damaged by Resident E’s wheelchair. The paint and drywall have been scraped off the wall by Resident E’s wheelchair. The door jams are heavily worn and damaged by Resident E’s wheelchair.

- Leather recliner chair that the leather has worn off the arms and the chair cannot be cleaned.
- Back door is covered in rust and the door frame is rotting.
- Door to the bathroom has a hole in it.
- The coating on the wall behind the stove in the kitchen is peeling off.
- Severely rotted wall behind the toilet where tiles had detached due to moisture damage.

Complainant provided photos of many of these physical plant issues; however, the photos were not dated nor was any metadata available to confirm the location where the photos were taken.

During the onsite investigation on June 23, 2026, I observed the following physical plant issues and took photos:

- Arms of a leather recliner are worn through to the filling material.
- Hood over the kitchen stove was covered in grease and dust. I also observed grease and food running down the side of the stove.
- Kitchen cupboards have significant discoloration and staining around the knobs on cabinet doors. The area appears darkened, likely from frequent handling, moisture, or residue buildup. The lower portions of the cabinet doors show peeling, chipping, and rough paint. Along the bottom edge of the cabinets, the paint appears worn and possibly flaking. The hinges show signs of age and discoloration. The drywall or backsplash area beneath the cabinets also shows patches of worn paint and areas where the surface is damaged or chipped.
- Door to the resident bathroom has a hole in it. The hole is about two inches wide and two inches long. The hole does not penetrate through the whole door, just on the outside of the door.
- While inspecting the kitchen sink for leaks, I observed that the base shelf of the cupboard that holds the kitchen sink appeared to be soggy from the leaking PVC pipe, the bottom shelf was rotten and there was mold like substance on the side and bottom of the cupboard.
- Walls and door jambs throughout the facility were chipped and gouged due to Resident E's wheelchair.
- Throughout the facility the floors have not been swept or mopped, covered with debris, food, and a brown substance.
- Walls and door jambs throughout the facility are covered with liquid splatter, food, and dirt/grime.
- Wall board behind the stove is peeling and covered with grease.
- Throughout the facility the flooring is coming up, some sections of flooring are missing, and there are holes in the flooring under the bed frames.
- I observed an absorbent incontinence pad along the bottom of the kitchen sink cabinet. In addition, I observed water damage and a mold-like substance spread about 6 inches up the side of the kitchen sink cabinet.
- Television stand was covered in dust.
- Resident bedroom walls were covered in dirt, splatters of liquid substance, the baseboard molding is damaged and paint was peeling off.

- Flooring in the resident bedrooms is damaged with holes by legs of the bed frames.

On June 23, 2026, I interviewed DCS Lamar Thurmond who reported that the stove knobs are removed and kept in the cupboard so the residents cannot use the stove. During the inspection, DCS Thurmond replaced the stove knobs, turned the stove burns and oven on to verify the stove/oven works. DCS Thurmond reported that he cleans facility at least daily.

On July 14, 2026, I interviewed Joy Mbelu who acknowledged the facility being in disrepair and apologized on the condition of the facility stating, “the condition of the facility during the onsite investigation is not a good representation of my facility and care provided. I am at the facility twice a week and I am not sure what has happened that the facility is in such disrepair, but I will get it cleaned up.”

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(5) Floors, walls, and ceilings must be cleanable, maintained clean, and in good repair.
ANALYSIS:	During the unannounced onsite investigation, I observed widespread dirt, grime, damaged walls throughout the facility, peeling wallboard, and deteriorated flooring and kitchen cupboards all of which were not maintained in good repair or clean.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.665	**Food service.**
	(6) Food service equipment and utensils must be constructed of materials that are nontoxic, easily cleaned, and maintained in good repair. Food service equipment and eating and drinking utensils must be thoroughly cleaned and air dried after each use.
ANALYSIS:	During the onsite inspection on June 23, 2026, I observed the stove and oven were working and in good repair, but the hood over the stovetop was covered with old food and grease. The documented buildup of grease, grime, and residue demonstrates a failure to maintain kitchen equipment in a clean and sanitary condition as required.
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:	The worn recliner, grease-covered kitchen surfaces, unsanitary floors, and general disrepair throughout the facility demonstrate a lack of a comfortable, clean and orderly appearance.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **The bed linens are stained and not in good condition.**
- **There are not enough bed linens for all residents.**

INVESTIGATION:

On June 18, 2026, a complaint was received alleging that there were not enough bed linens for all residents and that the bed linens available were dirty and stained.

On June 18, 2026, I interviewed Complainant who reported there is a linen closet in the hallway that had no linens in it. Complainant reported that one resident bed did not have linens on it due to the facility not having enough linens. Complainant reported that the linens that were provided were stained and dirty. Complainant provided photos of Resident A and Resident C's bedding and pillowcases, which were observed to be stained from liquid substances and very dirty. These photos were not dated nor was there verification provided that the photos were taken at the facility.

On June 23, 2026, during the onsite investigation, I observed five of the six resident beds had flat and fitted sheets and comforters that were covered in stains and dirty. I also observed that each mattress protector for the five resident beds was dirty and stained. I observed that Resident A's bed did not have a flat or fitted sheet but did have a blanket and comforter. I interviewed Resident A who reported that he does not like sheets so he only uses the top covers. Residents A, B, C, and D reported they change their sheets one time a week. Residents A, B, C, and D reported there are plenty of bed sheets and comforters available for resident use. Resident B reported that he recently purchased his own mattress because the mattress provided was not comfortable and was covered in stains.

During the onsite investigation, I observed the linen closet which had minimal linens in it. DCS Lamar Thurmond reported the bed linens were in the basement being washed which I confirmed. In the facility basement, I observed many sets of bed linens and comforters waiting to be laundered some sheets were stained and in poor condition.

APPLICABLE RULE	
R 400.669	**Linens.**
	(1) A licensee shall provide all of the following: **(a) Clean bedding in good condition that includes a minimum of a fitted sheet, top sheet, pillowcase, and blanket or comforter for each bed.**
ANALYSIS:	Based on interviews with residents and resident bed inspections, I observed resident bed linens provided were stained, dirty and in poor condition. This includes the mattress protectors, flat and fitted sheets, blankets and comforters.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.669	**Linens.**
	(3) A licensee shall maintain a minimum linen supply for twice the number of licensed beds or more as required based on resident's needs.
ANALYSIS:	During the onsite investigation on June 23,2026, I observed more than twelve sets of sets of sheets and comforters for the residents which meets the minimum requirement.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident E is not being provided with personal care in accordance with Resident E's care plan.

INVESTIGATION:

On June 18, 2026, the complaint received alleged that Resident E needs help from direct care staff with transferring and bathing. The complaint reported that Resident E uses a wheelchair for mobility due to Resident E having a stroke. The complaint reported that Resident E does not have an accessible shower in which to shower or bathe. The complaint reported that Resident E wears briefs and will sit in soiled briefs for long periods of time causing sores.

On June 23, 2026, I interviewed DCS Lamar Thurmond who reported that Resident E needs assistance with getting dressed, transferring to bed sometimes, and assistance with bathing. DCS Thurmond reported that Resident E does not feel safe taking a shower in the bathtub because he must step over the side of the bathtub to access the

bathtub/shower. DCS Thurmond reported that Resident E is given a sponge bath daily and will usually take a full shower once a week. DCS Thurmond reported that Resident E wears incontinence briefs for precaution only but can toilet himself or use a urinal. DCS Thurmon reported that Resident E changes his own briefs or will ask for assistance when needed. DCS Lamar reported that Resident E does not have any sores in his groin or buttocks areas or any other area on his body.

On June 23, 2026, Resident E was not at the facility at the time of the investigation and could not be interviewed.

On July 01, July 09, and July 14, 2026, I called the facility to interview Resident E but Resident E was not at the facility and could not be interviewed. I left a message for Resident E to call me, and no return call was received. DCS Thurmond reported that Resident E is currently not able to be interviewed due to being at a temporary placement with unknown return date.

On July 14, 2026, I interviewed LD Joy Mbelu who reported that Resident E is wheelchair bound with significant hearing loss. Ms. Mbelu reported that Resident E requires some hands-on assistance from direct care staff, such as assistance when getting in and out of the shower. Ms. Mbelu reported she is not sure how often Resident E is showered in the bathroom shower. Ms. Mbelu reported that Resident E can toilet himself but needs some assistance with dressing. Ms. Mbelu reported that she is not aware of Resident E having any sores on his body.

On July 16, 2026, I received a copy of Resident E's *Assessment Plan for AFC* Residents which was completed on April 10, 2026, and documented that Resident E requires assistance from direct are staff with toileting, bathing, grooming, dressing and personal hygiene. Resident E's *Assessment Plan for AFC* for Resident E did not describe specifically the type of help Resident E needs to complete each of these personal hygiene tasks or how the needs will be met.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	Resident E's *Assessment Plan for AFC* documented that Resident E requires assistance with toileting, bathing, grooming, dressing and personal hygiene which is provided by DCS Lamar Thurmond. DCS Lamar Thurmond and LD Joy Mbelu both reported that Resident E does not have any sores on his body. I was not able to interview Resident E to confirm this. Consequently, there is insufficient evidence to support the allegation that Resident E was not provided with personal care according to Resident E's care plan causing sores on his body.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite investigation on June 23, 2026, I observed three plates of food on the stove and each was covered with another plate. DCS Thurmond reported the plates of food were for residents to eat for breakfast when they were ready to eat. The plates consisted of scrambled eggs, toast, and sausage. I also observed a package of partially frozen chicken sitting on the stove thawing.

APPLICABLE RULE	
R 400.665	**Food service.**
	(4) Food must be stored at temperatures that will protect against spoilage. Cold foods must be stored at 40 degrees Fahrenheit or below and hot foods stored at 140 degrees Fahrenheit or above until served to residents, except during periods that are necessary for preparation.
ANALYSIS:	Based on my observations during the onsite investigation on June 23, 2026, food was not being protected against spoilage after being left out on the stove to be defrosted or to wait until residents were ready to eat. Food must be stored in the refrigerator after it has been cooked until it is ready to be served.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On June 23, 2026, during the onsite investigation while in the basement, I observed eight banker boxes filled with expired or discontinued resident medications in pill packs. DCS Thurmond reported that he disposes of medications when he has time. DCS

Thurmond reported there is no routine or time frame to dispose of discontinued or expired medications. DCS Thurmond reported he usually disposes of medications by dissolving medications in coffee grounds or cat litter and then pours the solution out in the backyard after the medications have dissolved.

On June 23, 2026, I interviewed Resident A who reported that he goes into the basement to do his laundry. Resident A reported that he has observed resident medications in boxes while doing his laundry.

On July 14, 2026, I interviewed LD Joy Mbelu who reported that medications are returned to the pharmacy for disposal when a medication has been discontinued or expired. Ms. Mbelu reported she thought this was the process DCS Lamar Thurmond was following until she went into the basement and found multiple banker boxes of expired and discontinued medications in the basement.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed. **(7) Prescription medication that is no longer required by a resident or expired must be properly disposed of.**
ANALYSIS:	Resident medications awaiting disposal are not being properly safeguarded. Resident A has access to medications stored in the basement prior to disposal, and there is no assurance that these medications are prevented from being used by individuals for whom they were not prescribed. Discontinued or expired resident medications are not being disposed of properly or in a timely manner.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While in the basement during the onsite investigation on June 23, 2026, I observed water on the basement floor leading into the laundry room. DCS Thurmond reported that the water was from a hose. However, upon further inspection, I determined that the furnace/air duct work was dripping water from above us onto the floor. The furnace/air duct was rusted out due to the water dripping. I also observed the top of the furnace/air duct with rust, due to the kitchen sink leaking through the floorboard onto the furnace/air duct.

I also observed the clothes dryer vent was vented to the outside of the facility with flexible duct work that is smashed and has a hole in the side of the duct.

APPLICABLE RULE	
R 400.729	**Heating equipment.**
	(2) A furnace, water heater, heating appliances, pipes, wood-burning stoves and furnaces, and other flame- or heat-producing equipment must be installed in a fixed or permanent manner and in accordance with a manufacturer's instructions and maintained in a safe condition. Clothes dryers must be properly vented to the outside using permanent metal duct work.
ANALYSIS:	During the onsite investigation on June 23,2026, I observed that the furnace/air duct system showed significant rust and deterioration caused by ongoing water leakage from both overhead ductwork and the kitchen sink above, demonstrating a lack of proper maintenance and repair. Additionally, the clothes dryer was not vented with permanent metal work as required. The dryer was connected to flexible ductwork that was crushed and had a hole in its side, instead of being vented to the outside through permanent metal ductwork as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Due to the quality of care and numerous physical plant violations cited in this report, I recommend issuance of a six-month provisional license.

Bridget Vermeesch

07/27/2026

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Bridget Vermeesch — Date
Licensing Consultant

Approved By:

Dawn Timm

07/31/2026

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Dawn N. Timm — Date
Area Manager