GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 10, 2023

Crystal Bader
Country Comfort, Spectrum Of Light LLC
1356 East Dayton Rd.
Caro, MI 48723

RE: License #: AS790385117
Investigation #: 2023A0572016
Country Comfort, Spectrum Of Light

Dear Ms. Bader:

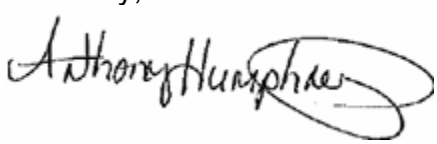
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 643-7960.

Sincerely,



Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAIN QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS790385117
Investigation #:	2023A0572016
Complaint Receipt Date:	01/04/2023
Investigation Initiation Date:	01/09/2023
Report Due Date:	03/05/2023
Licensee Name:	Country Comfort, Spectrum Of Light LLC
Licensee Address:	1356 East Dayton Rd. Caro, MI 48723
Licensee Telephone #:	(989) 672-9326
Administrator:	Crystal Bader
Licensee Designee:	Crystal Bader
Name of Facility:	Country Comfort, Spectrum Of Light
Facility Address:	1754 Mertz Rd Caro, MI 48723
Facility Telephone #:	(989) 286-3088
Original Issuance Date:	02/06/2017
License **Status:**	REGULAR
Effective Date:	02/06/2022
Expiration Date:	02/05/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's caregiver, Katie Browning, was mean and verbally abusive towards her at the hospital.	Yes

III. METHODOLOGY

01/04/2023	Special Investigation Intake 2023A0572016
01/04/2023	APS Referral APS made referral.
01/09/2023	Special Investigation Initiated - Letter
01/25/2023	Inspection Completed On-site Licensee, Crystal Bader; Staff, Jamie Dixon; Staff, Katie Browning, Resident A, B, C, D and E.
01/27/2023	Contact - Telephone call made Resident A's Family Member #1.
01/27/2023	Contact - Telephone call made APS Investigator, Tyler Erla.
01/27/2023	Inspection Completed-BCAL Sub. Compliance
02/02/2023	Face to face – Contact Resident D.
02/08/2023	Contact - Telephone call made Complainant.
02/09/2023	Contact - Telephone call received Complainant #2.
02/10/2023	Exit Conference Licensee, Crystal Bader.

ALLEGATION:
Resident A's caregiver, Katie Browning, was mean and verbally abusive towards her at the Hospital.

INVESTIGATION:
On 01/04/2023, the local licensing office received a complaint for investigation. Adult Protective Services (APS) made a referral to Licensing and are conducting their own investigation.

On 01/25/2023, I made an unannounced onsite to Country Comfort, Spectrum Of Light, located in Tuscola County Michigan. Interviewed and/or observed were Licensee, Crystal Bader; Staff, Jamie Dixon; Staff, Katie Browning, Resident A, B, C, D and E.

On 01/25/2023, I interviewed Licensee, Crystal Bader regarding the allegation. She informed that Resident A is declining, and they have to speak to her louder and constantly remind her to pick up her feet, so she does not fall. Resident A needs commands all the way through because she is becoming more delayed cognitively. Resident A tends to walk with her walker too far from her body and needs to be reminded constantly not to do so, so she does not fall. They assumed that she was losing her hearing, but Family Member #1 believes that she is losing her thought process as it takes longer for her to process things. Ms. Bader described Ms. Browning as her best and longest tenure worker.

On 01/25/2023, I interviewed Staff, Jamie Dixon regarding the allegation. She informed that she has never witnessed or heard Ms. Katie Browning being mean or cursing at Resident A or any other residents. Ms. Browning sometimes must repeat herself several times because it seems as if she is hard of hearing. Resident A has a sore on the bottom of her toe, so she must be reminded constantly to pick up her feet so that she won't reopen the wound.

On 01/25/2023, I interviewed Staff, Katie Browning regarding the allegation. Ms. Browning informed that she was loud with Resident A at the hospital, but not yelling at her. Resident A drags her feet while she walks. She had a 4-wheel walker which causes her to almost fall because she has the walker pushed in front of her too far and her feet can't keep up. They have since changed her walker to a 2-wheel walker with the wheels in the front and two tennis balls in the back, which helps slow her down a bit. They decided that due to the allegations to get her a wheelchair and she just received a new one about a week ago. They are now using the wheelchair out in public because people outside the facility do not understand that staff must keep giving her commands and it may appear that she is being chastised, but they have to speak constantly and loudly for her to understand. Ms. Browning informed that during the alleged incident, Resident A nearly fell, and Ms. Browning tweaked her back which caused her to yell, "You have to pick up your feet." Ms. Browning informed that she may have used some words that she shouldn't have used during

that moment. She informed that those words were profanity, but it wasn't directed at Resident A.

On 01/25/2023, I observed Resident A sitting in the living room watching television. She was dressed appropriately, and she appeared to be receiving adequate care and supervision. Resident A has advanced dementia and would not be a good interview.

On 01/25/2023, I observed Resident B in the same living room as Resident A and she appeared to be receiving adequate care and supervision.

On 01/25/2023, I observed Resident C and D in the 2nd living room of the home watching television. Resident C was laying on the couch, while Resident D were sitting in a recliner. They both appeared to be receiving adequate care and supervision.

On 01/27/2023, I interviewed Resident A's Family Member #1 regarding the allegation. Family Member #1 was aware of the allegation and had spoken to Licensee, Ms. Bader about it, then they spoke with Staff, Katie Browning and she explained that she was using her "Mom Voice" because she was giving her commands, but she was not understanding them or slow to understand. It appeared plausible to Family Member #1 as he has had to do the same thing when he used to care for Resident A. He admits that it gets frustrating because Resident A can be told to pick up her feet and she will forget that command within seconds of someone giving it to her. He believes that Ms. Browning became frustrated and with Resident A, staff must be very patient with her because of her cognitive delay. Family Member #1 informed that a person can try to have a conversation with Resident A, but her responses will not be accurate, as he explained, "You can ask her what she had for breakfast today and she will say 'Bacon and Eggs', when in fact she didn't eat breakfast or maybe she had oatmeal." When Resident A walks, she moves her feet about two inches at a time. Family Member #1 informed that Ms. Browning spends the most time with Resident A and does all her transports, so he hopes that the allegations are not true. He does not have any concerns with the facility because he has not observed anything peculiar, but if he does see something, he has no problem filing a report.

On 01/27/2023, I spoke with APS Investigator, Tyler Erla regarding the investigation. He informed that his investigation is still pending. In his interviews with Ms. Bader, Ms. Browning and Resident A's Family Member #1, he received the same responses as I did during my interviews. He attempted to interview Resident A, but she couldn't remember who Ms. Katie Browning was and did not even remember that she had a son, so she was unable to be interviewed by APS.

On 02/02/2023, I made another unannounced visit to County Comfort, Spectrum of Light. All of the residents were sitting in the same spots that there were sitting in the last time I was there. They all appeared to be properly cared for and receiving

adequate supervision. The only resident that I was able to interview was Resident D, as all the other residents are either non-verbal or suffers from severe memory loss.

On 02/02/2023, I spoke with Resident D regarding Ms. Browning. He informed that she is nice, and he has had no issues with her. He has never observed her being disrespectful towards any of the residents in the home. He is not afraid of Ms. Browning or any other staff.

On 02/08/2023, I spoke with the Complainant regarding the allegation. She informed that she didn't see it, but 3 admissions employees saw it and a volunteer at the hospital saw it. From her understanding, Ms. Browning was very demeaning to Resident A in the parking lot when they were leaving. The volunteer offered to assist, but Ms. Browning declined and told her that Resident A knows what she's doing.

On 02/09/2023, I spoke with Complainant #2 who observe the incident between Resident A and Ms. Browning and reported it to hospital staff. She was in the parking lot, unloading her car when she heard a loud commotion. She overheard the command, "Pick up your damn feet. Keep the walker in front of you dammit!" Complainant #2 first assumed it was a hospital staff because she was wearing scrubs. She walked over to them and she believes that she may have surprised Ms. Browning when she asked if she could help her. Ms. Browning replied, "Oh no, she knows what she's doing." When Ms. Browning declined help, Complainant #2 just stood there and watched because she was afraid that she was going to shove Resident A into the vehicle if she was not able to follow her commands. Resident A did not appear to be able to follow her commands because she was shuffling her feet. Ms. Browning parked 3 quarters lengths away from the hospital entrance, instead of in a closer parking spot or right in front of the entrance where a staff member could have gotten her a wheelchair and wheeled her to the Admissions Office.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**

ANALYSIS:	During my investigation, Licensee Crystal Bader and Jamie Dixon informed that they have never witnessed Ms. Browning being mean or cursing at Resident A. Ms. Browning informed that she was loud, but not yelling at Resident A, but yelling at the action which resulted in her maybe using profanity. Complainant #2 stated Ms. Browning was using profanity when speaking to Resident A. Complainant #1 stated that 3 other hospital staff observed Ms. Browning speak demeaning to Resident A. Complainant #1 and Complainant #2 offered to assist Ms. Browning due to her inappropriate behavior towards Resident A. Ms. Browning declined their assistance.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/10/2023, an Exit Conference was held with Licensee, Crystal Bader regarding the results of the special investigation. She was informed that she would have 15 days to provide licensing an appropriate corrective action plan.

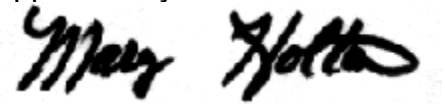
IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this small adult foster care group home, pending the receipt of an acceptable corrective action plan (Capacity 1-6).

02/10/2023

Anthony Humphrey Date
Licensing Consultant

Approved By:



02/10/2023

Mary E. Holton Date
Area Manager