



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
ACTING DIRECTOR

March 13, 2024

Suzanne Lange  
5065 S. Schwass Road  
Scottville, MI 49454

RE: License #: AS530311141  
Investigation #: 2024A0870014  
Country Care AFC

Dear Suzanne Lange:

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 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.

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.

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 (231) 922-5309.

Sincerely,

A handwritten signature in dark ink, appearing to read "Bruce A. Messer". The signature is fluid and cursive.

Bruce A. Messer, Licensing Consultant  
Bureau of Community and Health Systems  
Suite 11  
701 S. Elmwood  
Traverse City, MI 49684  
(231) 342-4939

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS530311141
<b>Investigation #:</b>	2024A0870014
<b>Complaint Receipt Date:</b>	02/13/2024
<b>Investigation Initiation Date:</b>	02/13/2024
<b>Report Due Date:</b>	04/13/2024
<b>Licensee Name:</b>	Suzanne Lange
<b>Licensee Address:</b>	5065 S. Schwass Road Scottville, MI 49454
<b>Licensee Telephone #:</b>	(231) 233-0050
<b>Name of Facility:</b>	Country Care AFC
<b>Facility Address:</b>	5065 S. Schwass Road Scottville, MI 49454
<b>Facility Telephone #:</b>	(231) 233-0050
<b>Original Issuance Date:</b>	08/09/2011
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	02/09/2024
<b>Expiration Date:</b>	02/08/2026
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
The home has more residents than the license allows.	Yes
Staff member Tressa Steffes grabbed Resident B by the ear.	Yes
Staff member Tressa Steffes is stealing money from Resident A.	No
The residents are fed "outdated" food.	Yes
Additional Findings	Yes

**III. METHODOLOGY**

02/13/2024	Special Investigation Intake 2024A0870014
02/13/2024	APS Referral Case discussion by AFC Consultant Rhonda Richards with Adult Protective Services worker Jermane Mims.
02/13/2024	Special Investigation Initiated - On Site Interview with staff member Tressa Steffes.
02/15/2024	Contact - Telephone call made. Telephone interview with Tracie Parker.
02/15/2024	Contact - Telephone call made. Telephone interview with Resident G.
02/16/2024	Contact - Telephone call made. Telephone interview with Kasha Oomen.
02/16/2024	Contact - Telephone call made. Telephone interview with Staff -1.
02/16/2024	Contact - Telephone call made. Telephone interview with Resident A and Resident D
02/16/2024	Contact - Telephone call made. Telephone interview with Licensee Suzie Lange.

02/21/2024	Contact - Face to Face Follow-up on-site investigation Interviews conducted with staff member Tressa Steffes, Resident C and Resident E.
02/28/2024	Contact - Telephone call made. Telephone interview with Licensee Suzie Lange.
03/12/2024	Contact – Telephone call made. Telephone interview with Licensee Suzie Lange.
03/12/2024	Inspection Completed-BCAL Sub. Non-Compliance
03/13/2024	Exit Conference Conducted with Licensee Suzanne Lange.

**ALLEGATION: The home has more residents than the license allows.**

**INVESTIGATION:** On February 13, 2024, I conducted an unannounced on-site special investigation at the County Care AFC home. I met with staff member Tressa Steffes and informed her of the above stated allegations. Ms. Steffes stated that the facility currently has six AFC residents and a “boarder.” She noted Residents A, B, C, D, E and F all received personal care, supervision, and protection in addition to the room and board. Ms. Steffes stated that Resident G, who she described as “a boarder” is provided with three meals daily, and her bedroom, which she noted is “upstairs with the AFC residents.” She stated Resident G “keeps and takes her own medications” and does not need any “help or assistance with personal care.” Ms. Steffes noted Resident G “comes and goes when she wants.” She also noted that Resident G has a court appointed guardian.

On February 15, 2024, I conducted a telephone interview with Tracie Parker. Ms. Parker stated she is the court appointed legal guardian for Resident G. We discussed the above allegation. Ms. Parker stated that her expectation when she placed Resident G in the Country Care AFC home, was that Resident G would be an AFC resident, receiving adult foster care services, and is not a “boarder.” She reiterated that “I’ve never considered her to be just a boarder.” Ms. Parker stated that Resident G had previously been a resident of Country Care AFC from September 2020 through June 2023, and moved back into Country Care AFC in September 2023. She noted that she had completed the required AFC paperwork, such as the Resident Care agreement, Assessment plan and health care appraisal “the first time” but could not recall if those documents were completed when Resident G moved back into the facility in September 2023. Ms. Parker noted that she currently is paying Country Care AFC “the AFC state rate of \$1056 a month.” She reiterated that she has the same expectations of care right now as she did when Resident G lived in the AFC home from 2020 to September 2023, and that “Resident G does need AFC level of care.”

On February 15, 2024, I conducted a telephone interview with Resident G. Resident G stated she does not need much help with her personal care and can do that herself, although the “staff do remind me of stuff.” She noted she takes her own medications. Resident G stated she “signs out” of the home when she leaves.

On February 16, 2024, I conducted a telephone interview with Kasha Oomen. Ms. Oomen stated she is a case manager with West Michigan Community Mental Health Authority and works with Resident G. She stated that Resident G previously lived in the Country Care AFC home until late 2022, and then was replaced at Country Care AFC in September 2023. Ms. Oomen stated that when she placed Resident G at County Care AFC in September 2023, she “was under the impression that (Resident G) would be, and is currently, receiving AFC services.”

On February 16, 2024 and again on March 12, 2024, I conducted telephone interviews with Licensee Suzanne Lange. I informed Ms. Lange of the allegations as stated above. Ms. Lange stated that Residents A, B, C, D, E and F are all AFC residents, and that Resident G is “room and board” only. She noted that Resident G “goes back and forth to her guardians” but does have a bedroom at the AFC home, upstairs where the other facility residents have their bedrooms. Ms. Lange stated Resident G “does her own medications.” She further noted that Resident G is not, nor is any other resident, related to her or to any of the facility staff members and Resident G is not related to any other facility resident. Ms. Lange stated she charged Resident G \$1,056 per month because Resident G’s guardian, Tracie Parker, asked her how much she charges, and she said, “same as everyone else pays, \$1,056.”

<b>APPLICABLE RULE</b>	
<b>R 400.14105</b>	<b>Licensed capacity.</b>
	<p><b>(1) The number of residents cared for in a home and the number of resident beds shall not be more than the capacity that is authorized by the license.</b></p> <p><b>(2) Any occupant of a home, other than the licensee or persons who are related to the licensee, live-in staff or the live-in staff's spouse and minor children, or a person related to a resident who is not in need of foster care, shall be considered a resident and be counted as a part of the licensed capacity.</b></p>
<b>ANALYSIS:</b>	Resident G’s court appointed guardian, Tracie Parker, and her WCMCMH caseworker, Kasha Oomen, state they were under the

	<p>impression that Resident G is receiving AFC services at Country Care AFC home.</p> <p>Resident G resides in the facility, upstairs, where the other AFC residents have their bedrooms.</p> <p>Licensee Suzanne Lange states the facility has six AFC residents, Resident A, B, C, D, E and F, along with a “boarder” Resident G.</p> <p>The facility is licensed for six residents.</p> <p>Resident G is not related to Ms. Lange, not related to any of the facility staff, and is not related to any of the other facility AFC residents.</p> <p>The total of number of residents is seven and thus exceeds the licensed capacity of the facility,</p>
<b>CONCLUSION:</b>	<p><b>REPEAT VIOLATION ESTABLISHED</b>  <b>[Ref: SIR 2023A0230004, CAP dated 12/2/2022 and SIR 2021A0230006, CAP dated 2/02/2021].</b></p>

**ALLEGATION: Staff member Tressa Steffes grabbed Resident B by the ear.**

**INVESTIGATION:** On February 13, 2024, Ms. Steffes acknowledged she grabbed Resident B by the ear “as a reaction, to get her attention.” She described that “at supper time” Resident G made a comment to Resident B of “why are you so rude” because Resident B told Resident C “why are you staring at me?” Ms. Steffes said she grabbed Resident B by the ear and told Resident B “why are you being rude to (Resident C)?” Ms. Steffes denied yanking on Resident B’s ear or pulling Resident B’s head backwards.

On February 13, 2024, I attempted to conduct an interview with Resident B but was unable to complete a reliable interview due to her developmental disabilities and significant hearing loss.

On February 15, 2024, Resident G stated she observed staff member Tressa Steffes grab Resident B by the ear and pull her head backwards. She stated that it occurred at dinner time, at the kitchen table. Resident G noted this “happened a couple weeks ago” and that Resident B “looked shocked.” She also informed me of an incident “last week” where she stated that Ms. Steffes was coming upstairs and Ms. Steffes “shoved” her, pushing on her arm, and pointed for her to go back into her bedroom. She noted that Ms. Steffes had a “mean face.” Resident G noted the

“shove almost knocked her over and she lost her balance.” She also stated she had a light bruise on her arm, but it has since faded away.

On February 16, 2024, I conducted a telephone interview with Resident D. Resident D stated she observed Ms. Steffes pull on Resident B’s ear. She noted this occurred at the dinner table and that Ms. Steffes “pulled so hard it pulled (Resident B) back in her chair.” Resident D noted that Resident B put her hand on her ear “like it hurt.” Resident D stated she was told by Resident G that Ms. Steffes had pushed her, although she did not see it herself. Resident D noted she observed a bruise on Resident G’s arm, which was said to be from the alleged push.

On February 16, 2024, I conducted a telephone interview with Resident A. He stated he had heard about Ms. Steffes grabbing Resident B by the ear but did not see it firsthand.

On February 16, 2024, Ms. Lange stated she was told, by Ms. Steffes, that she had grabbed Resident B’s ear “to get her attention to wash her hands.”

<b>APPLICABLE RULE</b>	
<b>R 400.14308</b>	<b>Resident behavior interventions prohibitions.</b>
	<p><b>(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:</b></p> <p><b>(b) Use any form of physical force other than physical restraint as defined in these rules.</b></p>
<b>ANALYSIS:</b>	<p>Staff member Tressa Steffes acknowledged that she grabbed Resident B by the ear “as a reaction, to get her attention.”</p> <p>Resident G stated she observed Ms. Steffes grab Resident B by the ear and pull her head backwards.</p> <p>Resident D stated she observed Ms. Steffes pull on Resident B’s ear “so hard it pulled (Resident B) back in her chair.”</p> <p>Resident G stated Ms. Steffes shoved her arm causing a bruise.</p> <p>Resident D stated she observed a bruise on Resident G’s arm which was said to have been from Ms. Steffes shoving her.</p> <p>Staff member Tressa Steffes did use a form of physical force with Resident B.</p>



<b>CONCLUSION:</b>	<b>REPEAT VIOLATION ESTABLISHED</b> <b>[Ref: SIR 2021A0230005, CAP dated 01/11/2021]</b>
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**ALLEGATION: Staff member Tressa Steffes is stealing money from Resident A.**

**INVESTIGATION:** Ms. Steffes denied that she is “stealing money” from Resident A or any of the other facility residents. She noted that she has sold some residents “Scentsy” products. She explained that she is an independent sales consultant for Scentsy, which is a line of home décor and scented products, such as candles and diffusers. She denied overcharging anyone or not delivering products that they had purchased. Ms. Steffes stated all purchases were at the request of the resident. Additionally, she showed me a sales receipt for the items she stated Resident A had purchased. The receipt was dated October 30, 2023, and was for \$296.80 for various items. She stated that all of the items were provided to Resident A when they arrived at the facility.

Resident A stated that he did purchase some “Scentsy” items from Ms. Steffes along with a teddy bear. He noted that he was unsure of how many items he purchased or how much money he spent on these items. He also was unsure if he received all of the items which he paid for, noting that “it might not be right” but he was not sure.

Residents C and E both stated that they have never purchased “Scentsy” items from Ms. Steffes.

Resident D stated she has purchased “Scentsy” items from Ms. Steffes. She stated she feels that she received the items she paid for.

On February 16, 2024, Ms. Lange stated she is not involved in in Ms. Steffes Scentsy business at all. She did note that Ms. Steffes told her that any resident purchases are made with the resident permission. Ms. Lange and I spoke at length about developing a staff personnel policy which prohibits staff from making any financial transactions, or sales, to facility residents, even with the resident or their guardian’s permission. She agreed that this was a good idea and would develop such a policy asap.

<b>APPLICABLE RULE</b>	
<b>R 400.14315</b>	<b>Handling of resident funds and valuables.</b>
	<b>(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.</b>

<b>ANALYSIS:</b>	<p>Ms. Steffes provided a sales receipt for “Scentsy” items she stated were purchased by Resident A.</p> <p>Resident A states he received “Scentsy” items from Ms. Steffes but was unsure of how many items he purchased, how much he spent or if he received all of the items he purchased.</p> <p>Direct care staff member Tereasa Steffes did not accept, take, or borrow money from Resident A.</p>
<b>CONCLUSION:</b>	VIOLATION NOT ESTABLISHED

**ALLEGATION: The residents are fed “outdated” food.**

**INVESTIGATION:** Ms. Steffes stated that she feels that the food served to the facility residents is healthy and fresh. She did note that “two or three weeks ago” some of the residents took some prepackaged food from the home and took it to their CMH programming, without her knowledge. She stated that these food items were later discovered to have mold. Ms. Steffes explained that Licensee Suzanne Lange will purchase food at a “food auction” but she will look at the items to make sure they are “ok” to eat. During my February 13, and a follow up February 21, 2024, on-site investigations I observed stored food items that Ms. Steffes stated were intended for resident consumption. I observed boxes of cereal with a “best used by” date of August 1, 2023. I also observed several loaves of bread which were stored in a reusable store supplied carry bag, sitting on the concrete floor of an unattached garage. These bags were located within a yard of a gas operated off road vehicle and what appeared to be a pile of cat litter. I further noted a cat wandering in the area of the garage. Upon reentry into the AFC facility, I confirmed with Ms. Steffes if the bread items in the garage were intended for resident consumption, which she acknowledged it was. I also noted meat, located in freezers, with “processed on” dates exceeding two years ago. I observed several steaks, chicken pieces and a turkey sitting on a counter in the facility pantry. Ms. Steffes stated these items were “thawing” and were intended to be served to the AFC residents for dinner this evening. She stated she had taken the turkey out of the freezer “yesterday” and the steaks and chicken out of the freezer “about 2:00 a.m. this morning.”

Resident A stated, “the food tastes nasty.” He noted that “we get out of date food, it happens a lot with Tressa (staff member Tressa Steffes).”

Resident C and Resident E both stated they like the food served at the facility.

Resident D stated that the food served “tastes, and its texture, is like its old.”

Resident G stated she feels that the food served at the facility is “good” except some things are old and expired. She stated, “the other day we had crackers from 2012.”

Ms. Lange stated that she goes to a “food auction” once per month and purchases food for the AFC residents. She explained that bulk food items, purchased from a wholesaler and may be damaged or soon to expire, are auctioned off at a local establishment. Ms. Lange noted the items are frozen or canned and are considered suitable for human consumption. She explained the moldy items discovered by the residents at their CMH program, were “Lunchables” and had been purchased in November 2023 and had an expiration date of December 2023. Ms. Lange noted that these “Lunchables” came frozen when she purchased them at auction. She further noted than any item, bought in bulk or at auction, that can be frozen, are placed in freezers once brought back to the AFC home.

<b>APPLICABLE RULE</b>	
<b>R 400.14402</b>	<b>Food service.</b>
	<b>(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.</b>
<b>ANALYSIS:</b>	<p>Staff member Tressa Steffes states that residents took food items to their CMH program which were later discovered to be moldy.</p> <p>Boxes of cereal with a “best used by” date of August 1, 2023, were located in the facility. Ms. Steffes stated these are intended for resident consumption.</p> <p>Turkey, chicken, and steaks were left out at room temperature overnight to thaw. Ms. Steffes states these meat items were intended for resident consumption later that day.</p> <p>Several loaves of bread were found in an unattached garage, sitting on the floor near a gas operated off road vehicle and what appeared to be a pile of cat letter. A cat was seen in the vicinity of the bread.</p> <p>Food items with mold, with expiration dates that have passed, items improperly stored in a garage, and meat items improperly thawed are not considered safe, wholesome or free from spoilage.</p>

<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>
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**ADDITIONAL FINDINGS:** During the course of this special investigation, it was brought to my attention that the staff were dispensing prescription eye drops to Resident B. On February 21, 2024, I spoke with Ms. Steffes and asked her about this allegation. Ms. Steffes stated that she has been giving Resident B prescription eye drops and the label on the medication box states that it should have already been discarded. Ms. Steffes accompanied me to the facility medication cabinet and provide me with access to Resident B’s medications. I observed two prescription eye drop medications prescribed to Resident B. The medication Maxitrol noted on the pharmacy affixed label that this medication is to be “discard after 11/23/2023.” I observed on Resident B’s medication administration record that Ms. Steffes documented that she had dispensed this medication to Resident B on 2/12/2024. The medication Systane noted on the pharmacy affixed label that the medication is to be “discarded after 6/19/2023.” I observed on Resident B’s medication administration record that Ms. Steffes had documented that she had dispensed this medication to Resident B on 2/11/2024. Ms. Steffes stated that no other medications are being given with a “discard” date that has already past. She noted she thought it would still be ok to dispense the eye drops to Resident B because the box stated “expired” on March 2024 for the Systane drops and “expired” January 2024 for the Maxitrol drops.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(2) Medications shall be given, taken, or applied pursuant to label instructions.</b>
<b>ANALYSIS:</b>	<p>Staff member Tressa Steffes dispensed prescription medications to Resident B, which had a pharmacy label noting that the medication should be “discard (ed) after 11/23/2023” for Maxitrol and “discard (ed) after 6/19/2023” for Systane.</p> <p>Resident B’s medication administration record show that Ms. Steffes documented that she dispensed, to Resident B, the prescription eye drop Maxitrol on 2/12/2024 and Systane on 2/11/2024.</p> <p>Resident B was provided with two prescription eye drops which should have been discarded, pursuant to the label instructions.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDINGS:** Ms. Lange stated she did not have a criminal record check or clearance conducted on Resident “Boarder” G when she moved into the facility in September 2023, or at any time since.

<b>APPLICABLE RULE</b>	
<b>R 400.14201</b>	<b>Qualifications of administrator, direct care staff, licensee, and members of household: provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food serve staff.</b>
	<b>(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.</b>
<b>ANALYSIS:</b>	The licensee failed to evaluate the suitability of Resident G to be a member of the household/occupant of the household by completing a criminal background check.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDINGS:** Ms. Lange stated she did not obtain a written statement from Resident G’s physician attesting to her physician’s knowledge of Resident G’s health. She did not obtain the written statement when Resident G moved into the facility in September 2023 or anytime thereafter.

Ms. Lange stated she did not obtain written evidence that Resident G had been tested for communicable tuberculosis at the time Resident G moved into the facility in September 2023, or anytime thereafter.

<b>APPLICABLE RULE</b>	
<b>R 400.14205</b>	<b>Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.</b>
	<b>(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the physician’s knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual’s employment, assumption of duties, or occupancy in the home.</b>
	<b>(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care</b>

	<p><b>staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.</b></p>
<b>ANALYSIS:</b>	<p>The Licensee failed to obtain a written statement from Resident G's physician attesting to Resident G's health within 30 days of Resident G's occupancy in the home.</p> <p>The Licensee failed to obtain written evidence that Resident G had been tested for communicable tuberculosis before she became an occupant of the home.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On March 13, 2024, I conducted an exit conference with Licensee Suzanne Lange. I informed Ms. Lange of my finding and recommendation as stated above. Ms. Lange stated she understood the findings and that she had already corrected some of the areas cited as noncompliant above. She stated she would develop a corrective action plan to address all areas of noncompliance above.

**IV. RECOMMENDATION**

I recommend, contingent upon the submission of an acceptable corrective action plan, that the license be modified to a six-month provisional status license.

 March 13, 2024

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Bruce A. Messer, Licensing Consultant      Date

Approved By:

 March 13, 2024

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Jerry Hendrick, Area Manager      Date