GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 19, 2026

Shelly Nutter
Espanola House, LLC
31785 Pawton Ln
Paw Paw, MI 49079

RE: License #: AS390381707
Investigation #: 2026A1024015
Espanola House

Dear Ms. Nutter:

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 (616) 356-0183.

Sincerely,

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

License #:	AS390381707
Investigation #:	2026A1024015
Complaint Receipt Date:	01/26/2026
Investigation Initiation Date:	01/26/2026
Report Due Date:	03/27/2026
Licensee Name:	Espanola House, LLC
Licensee Address:	31785 Pawton Ln Paw Paw, MI 49079
Licensee Telephone #:	(269) 998-3654
Administrator:	Shelly Nutter
Licensee Designee:	Shelly Nutter
Name of Facility:	Espanola House
Facility Address:	422 Espanola Ave. Parchment, MI 49004
Facility Telephone #:	(269) 998-3654
Original Issuance Date:	07/08/2016
License Status:	REGULAR
Effective Date:	01/08/2025
Expiration Date:	01/07/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
There is not sufficient direct care staff at night to accommodate Resident A's need and the needs of other residents.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/26/2026	Special Investigation Intake 2026A1024015
01/26/2026	Special Investigation Initiated – Telephone with Relative A1
01/26/2026	Contact - Telephone call made with Corrine Bradley, Milestone Senior Services
01/27/2026	Contact - Telephone call received by Tricia Wood, Ombudsman's Office
01/28/2026	APS Referral- APS already involved
01/28/2026	Contact - Telephone call made with APS Specialist Amber Price Johnson
01/28/2026	Contact-Telephone call with licensee designee Shelly Nutter
01/28/2026	Contact - Document Received-Resident A's *Health Care Appraisal (HCA), Assessment Plan for AFC Residents*, and *AFC Care Agreement*, *Program Statement*
02/06/2026	Inspection Completed On-site-with direct care staff members Marissa Cole, Jennifer Graham, Alexander Ashbaugh, Residents B, C, D
02/11/2026	Contact - Document Received-*Assessment Plan for AFC Resident* for Residents B, C and D
02/23/2026	Exit Conference-with licensee designee Shelly Nutter
02/23/2026	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: There are not sufficient direct care staff at night to accommodate Resident A's needs and the needs of other residents.

INVESTIGATION:

On 1/26/2026, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged that there are not sufficient direct care staff on duty at night to accommodate Resident A's needs and the needs of other residents.

On 1/26/2026, I conducted an interview with Relative A1 who stated that Resident A has been living in the facility since December 2025. Relative A1 stated that staff members are upset that Resident A is getting up at night and want Relative A1 to pay for Resident A to have 1:1 enhanced supervision. Relative A1 stated staff members want Relative A1 to hire and pay for an outside provider to supervise Resident A during nighttime hours because he attempts to elope from the facility and staff members usually sleep during nighttime hours. Relative A1 stated staff members sleep on the upper and lower levels of the facility whereas resident bedrooms, including Resident A's, are on the main level. Relative A1 stated this leaves residents without any supervision during nighttime hours. Relative A1 stated staff members were informed upon admission that Resident A was diagnosed with dementia, was a fall risk, and an elopement risk and would need constant supervision. Relative A1 stated these needs were documented on Resident A's *Assessment Plan for AFC Residents*, so Relative A1 stated she does not understand why the licensee would admit Resident A to the facility knowing staff members sleep at night. Relative A1 stated since Resident A has been in the home, staff members have repeatedly contacted her during the overnight hours to help redirect Resident A back to his bedroom so the staff members can go back to sleep in their bedrooms. Relative A1 stated she does not believe this action meets Resident A's supervision and personal care needs. Relative A1 stated that there are at least two staff members in the home during the day but after 7pm there is no staff member present with residents on the main level of the home until the next morning.

On 1/26/2026, I conducted an interview with Resident A's case manager Corrine Bradley from Milestone Senior Services who stated that she received a complaint regarding Resident A not receiving proper supervision at night due to staff members sleeping in their personal bedrooms. Case manager Corrine Bradley stated this allegedly starts around 7pm each evening thus leaving all residents without staff supervision. Corrine Bradley stated that Resident A is diagnosed with dementia and his symptoms include getting up at night to roam the facility and has made attempts to leave the facility which is upsetting staff members. Corrine Bradley stated the facility program includes staff members sleeping at night, so now due to Resident A's behaviors they must get up during the night to keep Resident A from leaving the facility. Corrine Bradley stated that alternative placement is being explored due to Resident A

not being able to be supervised at night by staff members, which is a service that he needs.

On 1/27/2026, I conducted an interview with Tricia Wood from the Ombudsman's Office who stated that the Ombudsman's Office received a complaint concerning staff supervision in the home due to the facility not having any staff members present in the evening hours. Tricia Wood stated that she was informed that there is adequate staff in the facility up until 7pm at which time all the residents are told that they must go to bed. Tricia Wood stated she went out to the home to conduct her investigation and was advised by staff members that all the residents except for Resident A are non-ambulatory, and each resident can use a call button if they need assistance during the overnight hours. Tricia Wood stated that the call button is connected to a watch that the staff members, who are sleeping in the home, are supposed to wear however she is concerned that if staff are sleeping at night, resident needs cannot be immediately addressed even when residents use their call button system. Tricia Wood stated that her other concern is that although Resident A is asked to go to bed at 7pm, he has been coming out of his room and staff members are not present to ensure his safety.

On 1/28/2026, I conducted an interview with Shelly Nutter who stated that Resident A started demonstrating behaviors shortly after admission that direct care staff members are not equipped to manage during the nighttime hours. Shelly Nutter stated direct care staff members are asleep at night and do not normally provide awake supervision to residents. Shelly Nutter stated a direct care staff member discussed these behaviors with his doctor who stated that Resident A would benefit more from a more restrictive setting. Shelly Nutter stated after this discussion, Resident A was given a 30-day discharge notice.

On 1/28/2026, I reviewed Resident A's *Resident Care Agreement* dated 12/9/2025 and signed by Resident A's designated representative and licensee designee Shelly Nutter. The *Resident Care Agreement* documented that Resident A services include "full care assist (level 3 care)" and that Resident A requires stand-by assistance for fall precautions and "overnight monitoring." I reviewed Resident A's *Assessment Plan for AFC Residents* dated 1/1/2026 signed by Resident A's designated representative and licensee designee Shelly Nutter which documented that Resident A will wander and try to leave the home. The *Assessment Plan for AFC Residents* also documented that Resident A is a fall risk and needs extra overnight monitoring precautions. I also reviewed Resident A's *Health Care Appraisal* which documented that Resident A is diagnosed with Alzheimer's and Dementia.

I also reviewed the facility's *Program Statement* which documented that 24/7 onsite supervision will be provided in the home however I reviewed the facility's original licensing report which documented that staff members will not be awake during sleeping hours.

On 2/06/2026, I conducted an onsite investigation at the facility with direct care staff member Marissa Cole who stated that Resident A has been in the home since

December 2025 and needs assistance with most of his personal care needs. Marissa Cole stated that Resident A has dementia and one of his target behaviors is attempting to elope from the facility. Marissa Cole stated that there are at least two staff members on duty during the day, but staff goes to bed during the evening hours after 7pm. Marissa Cole stated after this is the time Resident A usually gets up, leaves his bedroom, and wanders through the facility. Marissa Cole stated this behavior has caused sleeping staff to get up to make sure Resident A does not leave the facility. Marissa Cole stated that to her knowledge Resident A's designated representative was informed at admission that staff members would be asleep at night therefore no staff members would be physically present to supervise residents after a certain time and the expectation is for all residents to stay in their bedroom, which Resident A has not been able to do. Marissa Cole stated that the live-in staff members use a call button system at night that alerts them when residents need assistance. Marissa Cole further stated that a baby monitor camera was installed in the hallway that allows staff members to monitor the hallway area near Resident A's bedroom to further monitor Resident A.

I interviewed direct care staff member Jennifer Graham who stated that she lives in the home and her bedroom is on the upper level. Jennifer Graham stated that Resident A has been living in the home since December 2025 and stated she expressed her concern to Relative A1 at admission regarding Resident A living in the home because he had issues with elopement and staff members would be asleep at night. Jennifer Graham stated that they agreed to "see how [Resident A] would do." Jennifer Graham stated things initially went well for Resident A as he did not have any issues with going to bed at night, however eventually Resident A started needing more assistance from staff members at night. Jennifer Graham stated this included getting Resident A his walker, redirecting Resident A from eloping from the facility, and redirecting Resident A from entering other residents' bedrooms and disturbing them. Jennifer Graham stated she discussed with Relative A1 about exploring alternative placement options since staff members needed to assist Resident A during hours when staff members were supposed to be sleeping. Jennifer Graham stated that there are at least two staff members present during the day and staff members who are asleep at night are alerted by a call button system if residents need assistance. Jennifer Graham stated that all residents in the home, except for Resident A, are bedbound and usually sleep during the night therefore staff members usually get up only 1 to 2 times during the night to assist residents when they use their call buttons. Jennifer Graham stated that although staff members are asleep at night, residents are still monitored by a baby monitor camera that is installed in the hallway of the home.

I also interviewed direct care staff member Alexander Ashbaugh who stated Resident A did not have any issues when he was initially admitted to the home, however after a few weeks, he began to attempt the leave facility or go into other resident bedrooms, which usually occurred after midnight when the staff members were in their bedrooms. Alexander Ashbaugh stated that Resident A had a hard time following the facility rules of going to bed at 7pm to ensure his safety which caused staff members to have to get up multiple times during the overnight hours to assist him. Alexander Ashbaugh stated staff members usually only must get up once per night to assist residents with things

like repositioning, getting a drink, or toileting. Alexander Ashbaugh stated that the facility uses a call button system to alert them when residents need assistance and are alerted by a watch that they wear on their wrist while they are sleeping. Alexander Ashbaugh further stated residents are monitored during the overnight hours using a baby monitor camera which is installed in the hallway.

While at the facility, I interviewed Resident B who stated that he receives adequate supervision at the home. Resident B stated that during the night hours staff goes to their bedrooms and he uses a call button when he needs staff assistance however he is told that he should only use the call button if he has an emergency situation. Consequently Resident B stated he tries not to use the call button unless he really needs assistance. Resident B further stated that it takes staff some time to respond when he uses the call button since they are in their bedrooms and he has waited one hour to two hours for assistance on more than one occasion.

I also interviewed Resident C who stated that she really likes it in the home and believes she receives adequate supervision in the home. Resident C stated that she believes she receives adequate assistance from staff at night however it takes staff about 15 to 30 minutes to respond to her when she uses the call button.

I also interviewed Resident D who stated that she believes she receives adequate supervision. Resident D stated that she cannot get up on her own and must rely on staff for this among assistance with other personal care needs. Resident D stated she usually is able to get staff assistance during the night hours however she has to wait for them to respond when she uses the call button. Resident D stated recently she had to use the call button because a resident entered her bedroom and she did not want them in her bedroom.

On 2/11/2026, I reviewed Resident B's *Assessment Plan for AFC Residents* which documented that Resident B requires assistance with all his personal care needs and requires two staff members to assist him with toileting, hygiene, bathing, getting him out of bed, and mobility needs. This plan further states that Resident B cannot move his body that well therefore requires two direct care staff to assist him with daily and evening position changes. Resident B's *Assessment Plan for AFC Residents* also documented that he is "bedbound."

I reviewed Resident C's *Assessment Plan for AFC Residents* which documented that Resident C requires assistance with all personal care needs including mobility and transferring. Resident C is bedbound and needs assistance from staff with sitting up in bed.

I reviewed Resident D's *Assessment Plan for AFC Residents* which documented that Resident D require assistance with all personal care needs and requires two direct care staff members to assist him with toileting, bathing, hygiene and mobility. This *Assessment Plan for AFC Residents* documented that Resident D has a cognitive delay therefore requires staff to check in with her every hour to check her pain level. Resident

D's *Assessment Plan for AFC Residents* also documented that Resident D is also "bedbound."

APPLICABLE RULE	
R 400.671	**Residents care.**
	(1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.

ANALYSIS:	Based on my investigation which included interviews with direct care staff members Marissa Cole, Jennifer Graham, and Alexander Ashbaugh, Residents B, C, and D, Resident A's case manager Corrine Bradley, Tricia Wood from the Ombudsman's Office, along with my review of *Assessment Plans for AFC Residents* for Residents A, B, C, and D, the facility's program statement, and Resident A's written *Resident Care Agreement* there is evidence there is not sufficient direct care staff on duty at night to meet Resident A's supervision needs as well as the care needs of the other residents. Relative A1, Corrine Bradley and Tricia Wood all stated that there are at least two staff members in the home during the day but during the evening hours there are no staff members on the main level of the home, where resident bedrooms are located, until the next morning because staff members are asleep during the overnight hours in their private bedrooms located on the upper and lower levels. Jennifer Graham, Marissa Cole and Alexander Ashbaugh stated that all staff members are asleep during the overnight hours and residents are expected to use a call button to alert staff members when in need of assistance. Alexander Ashbaugh and Resident B both stated and confirmed that the call button should only be used for emergencies. Despite having a call button available to alert direct care staff that assistance is needed, Residents B, C and D all reported waiting an unreasonable amount of time for assistance, including from 15 minutes to over an hour before a staff member arrived to help. Lastly, a baby monitor and camera is used during nighttime hours to provide supervision in lieu of supervision from direct care staff which is not an approved form of supervision. Resident A's *Assessment Plan for AFC Residents* and *Resident Care Agreement* both clearly documented Resident A's elopement behavior during nighttime hours and need for nighttime direct care staff supervision and agreement from the licensee to provide "overnight monitoring." According to Residents B, C and D's *Assessment Plans for AFC Residents*, these residents are all "bedbound" and require total care assistance. Specifically, Resident B requires staff assistance with position changes during the evening and Resident D requires staff supervision to monitor pain level every hour. These personal care needs cannot be completed when staff members sleep during nighttime hours.

	Therefore: sufficient staff are not on duty during the overnight hours to provide necessary services indicated in all the residents' assessment plans and care agreements.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Relative A1 stated that while visiting Resident A she noticed behaviors interventions that were put in place by staff which consisted of placing chairs in the hallway of Resident A's bedroom, in front of the entryway of the living room, and in front of the primary exit door to keep Resident A from leaving his bedroom attempting to leave out the facility.

Marissa Cole, Jennifer Graham, and Alexander Ashbaugh all stated that barricades were put in place with the use of a chair in front of Resident A's bedroom door, in the hallways, and in front of the primary exit door to prevent Resident A from leaving his bedroom or the facility. In addition, a sliding door was installed in front of the primary exit door to keep Resident A from leaving the facility during overnight hours when staff members were asleep.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(d) Confine a resident in an area where egress is prevented.**

ANALYSIS:	Relative A1 stated that while visiting Resident A she observed that direct care staff members placed chairs in front of Resident A's bedroom door, hallways, and in front of the primary exit to prevent Resident A from leaving his bedroom. Direct care staff members Marissa Cole, Jennifer Graham, and Alexander Ashbaugh all confirmed placing a chair in front of Resident A's bedroom door, hallways and in front of the primary exit door to stop Resident A from eloping from the facility while direct care staff are sleeping. In addition, a sliding door was installed in front of the primary exit door and used to keep Resident A from leaving the facility during overnight hours when staff members were asleep. Therefore, Resident A was confined to a area where egress is prevented to accommodate nighttime direct care staff sleeping during that shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Direct care staff members Marissa Cole, Jennifer Graham, and Alexander Ashbaugh all stated that residents are instructed to be in their bedrooms at 7pm and are expected to stay in their bedrooms until the next morning. These staff members further stated that Resident A caused a disruption to the home due to coming out of his bedroom during the evening hours while staff members were asleep.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(b) Exercise individual constitutional rights including right to vote, right to practice religion of choice, freedom of movement, and freedom of association.**

ANALYSIS:	Direct care staff members Marissa Cole, Jennifer Graham, and Alexander Ashbaugh all stated that residents are instructed to be in their bedrooms at 7pm and are expected to stay in their bedrooms until the next morning. These staff members further stated that Resident A caused a disruption to the home due to coming out of his bedroom during the evening hours while staff members were asleep. Therefore, residents do not have freedom of movement within the facility after 7pm each evening.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility, I observed a camera installed in the facility hallway. I also observed a camera in Resident B's bedroom.

Direct care staff members Marissa Cole, Jennifer Graham, and Alexander Ashbaugh all stated that a baby monitor camera was installed in the facility hallway and in Resident B's bedroom to provide supervision and extra monitoring while staff members sleep during nighttime hours. These staff members further stated that Resident B has epilepsy therefore staff members felt that extra monitoring was required for Resident B. Jennifer Graham stated that none of the residents have given consent to have the camera installed in the hallway and Resident B did not consent to a camera in her bedroom which would require a variance which the facility also did not have.

I reviewed the facility's program statement and confirmed there was no documentation for a camera installed in the common areas of the facility.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.**

ANALYSIS:	While at the facility, I observed a camera installed in the facility hallway. I also observed a camera in Resident B's bedroom. Marissa Cole, Jennifer Graham, and Alexander Ashbaugh all stated that a baby monitor camera was installed in the facility hallway and in Resident B's bedroom to provide supervision and extra monitoring while staff members are asleep during the night. These staff members further stated that Resident B has epilepsy therefore staff members felt that extra monitoring was required for Resident B. Jennifer Graham stated that none of the residents have given consent to have a camera installed in the hallway nor did Resident B give consent to have a camera in her bedroom. The facility program statement does not describe the use of any cameras in the facility. Consequently, these cameras, especially since there is no approval from residents and/or resident guardians, do not provide residents with privacy.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Relative A1 and case manager Corrine Bradley both stated that Resident A was told that he had to be discharged due to his increased behavior of attempting to elope from the facility and refusing to stay in his bedroom while staff members were asleep at night.

Tricia Wood and Amber Price Jones both stated that they received a complaint in their office due to an improper discharge request being issued from the licensee to Resident A. Tricia Wood stated during her investigation, staff members confirmed that Resident A was given a discharge notice due to his disruptive behaviors in the facility therefore Tricia Wood advised staff members that a written notice was required to successfully execute their discharge request.

Shelly Nutter stated that a discharge notice was given to Resident A and Relative A1 due to his increased needs for staff assistance and elopement attempts during the nighttime hours. Shelly Nutter further stated Resident A's physician also stated that Resident A would be more suitable in a more restrictive setting to manage his behaviors. Shelly Nutter stated that she was not aware that she had to provide a written discharge notice to Resident A therefore a written notice was not given to Resident A or Relative A1.

Jennifer Graham stated that Resident A was requested to find alternative placement due to Resident A's behaviors and his doctor's assessment of Resident A needing to live in a more restrictive setting however a written discharge notice was never given to Relative A1 or Resident A.

APPLICABLE RULE	
R 400.687	**Resident admission and discharge policy; house rules; change of residency; provision of resident records.**
	(4) A licensee shall provide a resident and resident's designated representative with a 30-day written notice before discharge from the facility. The notice must state the reasons for discharge and a copy of it be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	Direct care staff member Jennifer Graham and licensee designee Shelly Nutter both confirmed that Resident A and Relative A1 were verbally told to find an alternate placement for Resident A due to his increase elopement behaviors. Direct care staff member Jennifer Graham and licensee designee Shelly Nutter both also stated that the discharge request was not made in writing but only told verbally to Relative A1 and Milestone Senior Services case manager Corrine Bradley. Based on this information, no written notice of discharge was provided to Resident A or Resident A1 as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/23/2026, I conducted an exit conference with licensee designee Shelly Nutter. I informed Shelly Nutter of my findings and allowed her an opportunity to ask questions and make comments.

IV. RECOMMENDATION

Upon an acceptable corrective action plan, I recommend the current license status remains unchanged.

Ondrea Johnson
Licensing Consultant

3/17/2026
Date

Approved By:

03/19/2026

Dawn N. Timm
Area Manager

Date