



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 5, 2026

Asif Zeeshan
Montrose AFC, LLC
8340 W Potter Road
Flushing, MI 48433

RE: License #: AM250410641
Investigation #: 2026A0872040
Concerned Country Care

Dear Asif Zeeshan:

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,

A handwritten signature in black ink that reads "Susan Hutchinson". The script is cursive and fluid, with the first name "Susan" and last name "Hutchinson" clearly legible.

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY AND SEXUAL CONTENT**

I. IDENTIFYING INFORMATION

License #:	AM250410641
Investigation #:	2026A0872040
Complaint Receipt Date:	06/26/2026
Investigation Initiation Date:	06/30/2026
Report Due Date:	08/25/2026
Licensee Name:	Montrose AFC, LLC
Licensee Address:	8340 W Potter Road Flushing, MI 48433
Licensee Telephone #:	(517) 414-2188
Administrator:	Asif Zeeshan
Licensee Designee:	Asif Zeeshan
Name of Facility:	Concerned Country Care
Facility Address:	11122 W. Wilson Rd Montrose, MI 48457
Facility Telephone #:	(517) 414-2188
Original Issuance Date:	01/18/2022
License Status:	REGULAR
Effective Date:	07/18/2024
Expiration Date:	07/17/2026
Capacity:	12
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was taken to Hurley Medical Center due to inappropriate and aggressive behaviors. Resident A was medically discharged but his AFC home refused to allow him to return.	Yes

III. METHODOLOGY

06/26/2026	Special Investigation Intake 2026A0872040
06/30/2026	Special Investigation Initiated - Letter
06/30/2026	APS Referral I made an APS referral via online
07/08/2026	Inspection Completed On-site Unannounced
07/10/2026	Contact - Telephone call received I interviewed the home manager, Hope Pattison
07/28/2026	Contact - Document Sent I emailed HM Pattison requesting information about this complaint
07/29/2026	Contact - Document Received AFC documentation received
08/03/2026	Contact - Telephone call made I interviewed VAAA supports coordinator, Erica Duncan
08/05/2026	Contact - Telephone call made I interviewed Guardian A1
08/05/2026	Exit Conference I conducted an exit conference with the licensee designee, Asif Zeeshan
08/05/2026	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A was taken to Hurley Medical Center due to inappropriate and aggressive behaviors. Resident A was medically discharged but his AFC home refused to allow him to return.

INVESTIGATION: On 07/08/2026, I conducted an unannounced onsite inspection of Concerned Country Care (CCC) Adult Foster Care facility. I interviewed staff Carlena Cavazos and observed three residents. The residents I observed were all clean, dressed appropriately, and were appropriately supervised by staff. Resident A is no longer living at this facility, so I could not interview him.

Staff Cavazos said that she has worked at this facility for 3 years and she worked with Resident A. She said that the residents in this facility are elderly and/or physically handicapped. According to Staff Cavazos, Resident A was sexually inappropriate with other residents and staff while he lived at this facility. Resident A would go into another resident's room and make sexual comments. Resident A also asked Staff Cavazos if he could touch her "ass" and he kept trying to touch the female staff's bottoms and breasts. Some of the other residents' family members complained to staff about Resident A's behavior and said that Resident A was making the residents uncomfortable. Staff Cavazos told me that Resident A suffers from dementia that keeps getting worse which is negatively affecting his behavior.

According to Staff Cavazos, she was told that on 06/25/2026 Resident A had grabbed staff inappropriately and he was being aggressive, so he was sent to the hospital. Staff Cavazos said that all Resident A's belongings are still in his room, and she does not know when they will be picked up. According to Staff Cavazos, Guardian A1 was aware of Resident A's inappropriate behaviors and she was in the process of trying to find a new placement for Resident A that consists of all male residents.

On 07/10/2026, I interviewed the home manager (HM), Hope Pattison, via telephone. HM Pattison said that while Resident A resided at this facility, he began displaying inappropriate sexual behaviors to other residents and staff. Resident A was groping staff and other residents and was making vulgar comments. HM Pattison said that she reached out to Resident A's guardian, personal care physician (PCP), and case manager for assistance, but his behavior continued to worsen so he was given a 30-day discharge notice. HM Pattison said that she gave this notice in writing to Resident A's guardian, PCP, and case manager. After being provided with the discharge notice, all individuals began looking for a new placement for Resident A. HM Pattison stated eventually Resident A was accepted to Medilodge of Montrose which is a long-term skilled nursing home. His move-in date was unknown.

According to HM Pattison, on 06/25/2026, Resident A groped 2nd shift staff and he became aggressive. HM Pattison reached out to his PCP, guardian, and case manager and all individuals agreed that Resident A needed to be sent to Hurley Medical Center for evaluation. HM Pattison told me that Resident A's PCP said that she would contact Hurley and have Resident A be admitted under a direct admission order. Therefore, HM Pattison provided an emergency discharge notice to Resident A with the understanding

that once Resident A was released from the hospital, he would be admitted to Medilodge of Montrose and would not be returning to CCC AFC. HM Pattison stated that she later found out that Medilodge refused to admit Resident A but at that time, her facility was not willing to allow him to return. HM Pattison said that she believed that the emergency discharge notice and the fact that Resident A secured a new placement meant that her facility was not required to allow him back to the facility. I explained that since Resident A was discharged from Hurley and sent back to her via ambulance, she was required to accept him back but instead staff denied him admission.

On 07/27/2026, I reviewed AFC documentation related to this complaint. I reviewed an Incident/Accident Report (IR) dated 06/14/26 completed by staff Wendy Rierson regarding Resident A. According to the IR, Resident A approached Staff Rierson from behind and grabbed both her breasts.

I reviewed another IR dated 06/24/2026 regarding Resident A completed by staff Kim Keener. According to this IR, when Staff Keener was completing checks, she knocked on Resident A's door, and he told her to come in. When she entered his room, she found him fondling himself. She went to leave the room and he said, "No, don't leave! I need something to suck on!"

I reviewed an IR dated 06/25/2026 regarding Resident A completed by Staff Keener. According to this report, at approximately 10pm, the ambulance brought Resident A back to the AFC facility from the hospital. Staff Keener refused to accept him into the home and told ambulance staff that Resident A's doctor and guardian want him ordered back to the hospital. Resident A was transported back to the hospital.

I reviewed a 30-day written discharge notice dated 06/22/2026 completed by the licensee designee, Asif Zeeshan. According to this document, Concerned Country Care AFC is no longer able to provide services to Resident A. The notice states that CCC will continue working with Resident A's treatment team to find alternative placement and coordinate discharge planning.

According to Resident A's *Health Care Appraisal*, he is diagnosed with Alzheimer's disease. According to his *Assessment Plan*, he does not have unrestricted community access. His *Assessment Plan* says that he does not exhibit aggressive, self-injurious, and/or inappropriate sexual behaviors.

On 08/03/2026, I interviewed Resident A's Valley Area Agency on Aging supports coordinator (SC), Erica Duncan. According to SC Duncan, on 06/22/26, she received an IR from HM Pattison regarding Resident A exhibiting inappropriate sexual behavior toward staff. On that date, she also received a 30-day notice which stated that CCC would continue working with VAAA and Guardian A1 to find a new placement for him.

SC Duncan said that on 06/26/2026, she received a telephone call from Hurley Medical Center stating that CCC sent Resident A to the hospital on 06/25/2026. Resident A was medically cleared for discharge and was sent back to CCC via ambulance, but CCC

staff refused to allow him back into the residence. SC Duncan said she contacted HM Pattison on 06/26/2026 and HM Pattison confirmed that CCC would not allow Resident A to return to their facility because of Resident A's behaviors. According to SC Duncan, she and Guardian A1 were unable to find a placement for Resident A. Therefore, he remained at Hurley Medical Center until 07/16/2026 at which time he was placed at Burton Comfort Care AFC. SC Duncan said that Resident A was never officially admitted to Hurley Medical Center because medical staff told her there was no medical or psychiatric reason to admit him.

On 08/05/2026, I interviewed Guardian A1 via telephone. Guardian A1 confirmed that Resident A resided at CCC AFC under a contract with VAAA. On 06/25/2026, her office received an IR from HM Pattison stating that Resident A was sent to the hospital due to inappropriate sexual behavior. Guardian A1 was also sent a 30-day eviction notice. Guardian A1 and VAAA began searching for a new placement. In the meantime, Resident A was sent back to CCC AFC after being medically discharged but staff would not allow him admission to the home. Therefore, he remained at Hurley Medical Center until 07/16/26 at which time he was placed at Burton Comfort Care. Guardian A1 confirmed that Resident A was never officially admitted to Hurley Medical Center because medical staff said there was no medical or psychiatric reason to admit him. Resident A remains at Burton Comfort Care AFC.

Guardian A1 told me that her office has been Resident A's guardian for several years. Prior to this incident of inappropriate sexual behavior, he did not exhibit problematic behaviors. Guardian A1 confirmed that Resident A was not given an appropriate discharge notice and he remained at Hurley Medical Center for almost three weeks because a placement was unable to be found for him.

On 08/05/2026, I conducted an exit conference with the licensee designee (LD), Asif Zeeshan. I discussed the results of my investigation and explained which rule violation I am substantiating. LD Zeeshan said that he does not agree that this constitutes a rule violation. He said that his facility and staff could not deal with Resident A's behavior and the guardian refused to admit him to another AFC even though LD Zeeshan found two other possible placements for him. LD Zeeshan stated that CCC AFC has all female staff and aged residents who are vulnerable. Resident A exhibited extremely inappropriate sexual behaviors and staff were no longer comfortable caring for him. In addition, other residents' family members contacted him with concerns about their loved ones possibly no longer being safe at this facility.

LD Zeeshan confirmed that Resident A was given a 30-day discharge notice on or around 06/22/2026 and that due to his ongoing inappropriate behavior, he was sent to Hurley Medical Center on 06/25/2026. According to LD Zeeshan, Resident A's PCP agreed that CCC AFC staff was no longer able to care for Resident A and she supported his admission to Hurley Medical Center. LD Zeeshan acknowledged that Resident A was transported back to CCC AFC on 06/25/2026 and he instructed staff not to allow Resident A admission to the facility. LD Zeeshan agreed to complete and

submit a corrective action plan, but he said that he feels the system is broken when dealing with mentally ill individuals.

APPLICABLE RULE	
R 400.687	Resident admission and discharge policy; house rules; change of residency; provision of resident records.
	(7) A licensee shall not discharge a resident to a setting without an address or to a hospital emergency department.
ANALYSIS:	On 06/25/2026, Resident A was sent to Hurley Medical Center due to inappropriate and aggressive behavior. He was medically cleared to return to CCC AFC later 06/25/2026. When ambulance staff transported him back to the facility, staff refused to allow him admission. According to VAAA supports coordinator, Erica Duncan, and Guardian A1, Resident A remained at Hurley Medical Center until 07/16/2026 at which time a placement was found for him. SC Duncan and Guardian A1 said that Resident A was never officially admitted to Hurley Medical Center. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

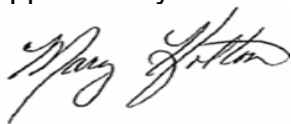


August 5, 2026

Susan Hutchinson
Licensing Consultant

Date

Approved By:



August 5, 2026

Mary E. Holton
Area Manager

Date