GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

March 4, 2024

Parvinder Buttar
Country Acres Adult Care Home, Inc.
735 S. Michigan
Eaton Rapids, MI 48827

RE: License #: AM230278815
Investigation #: 2024A1033024
Country Acres Adult Care Home

Dear Ms. Buttar:

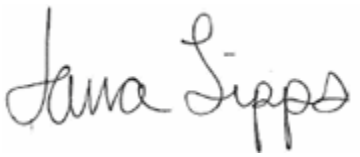
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9730.

Sincerely,



Jana Lipps, 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 #:	AM230278815
Investigation #:	2024A1033024
Complaint Receipt Date:	01/19/2024
Investigation Initiation Date:	01/24/2024
Report Due Date:	03/19/2024
Licensee Name:	Country Acres Adult Care Home, Inc.
Licensee Address:	735 S. Michigan Eaton Rapids, MI 48827
Licensee Telephone #:	(313) 415-0346
Administrator:	Parvinder Buttar
Licensee Designee:	Parvinder Buttar
Name of Facility:	Country Acres Adult Care Home
Facility Address:	735 S. Michigan Rd. Eaton Rapids, MI 48827
Facility Telephone #:	(517) 663-4494
Original Issuance Date:	10/09/2006
License Status:	REGULAR
Effective Date:	07/19/2023
Expiration Date:	07/18/2025
Capacity:	12
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There is not adequate staffing to cover the needs of the current residents due to some residents requiring a two-person assistance with transfers, mobility, personal care.	Yes
Resident A broke a bone because of a fall. She was not provided adequate supervision.	No
The residents are not being provided with adequate toileting or personal care.	No
The direct care staff yell at the residents.	No
The residents are being fed expired food products.	No

III. METHODOLOGY

01/19/2024	Special Investigation Intake 2024A1033024
01/22/2024	APS Referral- Denied APS referral.
01/24/2024	Special Investigation Initiated - On Site Interviews with direct care staff, Yuvet White, Kelsi Weaver, and Resident B. Review of resident records initiated, conducted inspection of dry pantry food, and refrigerated and frozen foods.
01/24/2024	Contact - Document Sent- Email correspondence sent to licensee designee, Parvinder Buttar.
02/27/2024	Contact – Telephone Call Made Interview with direct care staff, Jennifer Cruce, via telephone.
02/27/2024	Contact – Document Sent Email correspondence sent to licensee designee, Parvinder Buttar.
02/27/2024	Contact – Telephone Call Made Interview with direct care staff, Twanda Love, via telephone.
02/27/2024	Contact – Telephone Call Made Interview with direct care staff, Tori Defeyter, via telephone.

02/27/2024	Contact – Telephone Call Made Attempt to interview direct care staff, Nichole Quick. Voicemail message left, awaiting response.
02/27/2024	Contact – Telephone Call Made Attempt to interview direct care staff, Bridget McLaughlin. Voicemail message left, awaiting response.
02/27/2024	Contact – Telephone Call Made Attempt to interview direct care staff, Shanda Walker. No voicemail, no message left.
02/28/24	Exit Conference- Conducted, via email, at request of licensee designee, Parvinder Buttar.

ALLEGATION:

- **There is not adequate staffing to cover the needs of the current residents due to some residents requiring a two-person assist with transfers, mobility, personal care.**
- **Resident A broke a bone because of a fall. She was not provided adequate supervision.**
- **The residents are not being provided with adequate toileting or personal care.**

INVESTIGATION:

On 1/19/24 I received an online complaint regarding the Country Acres Adult Care Home, adult foster care facility (the facility). The complaint contained three separate allegations pertaining to a licensee providing adequate supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan. The three allegations were as follows:

- There is not adequate staffing to cover the needs of the current residents due to some residents requiring a two-person assist with transfers, mobility, personal care.
- Resident A broke a bone because of a fall. She was not provided adequate supervision.
- The residents are not being provided with adequate toileting or personal care.

On 1/24/24 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/supervisor, Yuvet White. Ms. White provided the following replies related to the three allegations:

- Ms. White reported that there are currently at least four residents who reside at the facility, who require two direct care staff members to assist with mobility, transfers, and personal care. She reported these residents to be Residents A, B, C, & D. Ms. White reported that there is currently staffing of at least two direct

care staff between the hours of 7am – 11pm, and one direct care staff scheduled between the hours of 11pm – 7am.

- Ms. White reported that Resident A had an unwitnessed fall at the facility around Thanksgiving and broke her femur. She reported that she was not present at the time of the fall and direct care staff members, Kelsi Weaver & Rebecca Finch, were present and attended to Resident A.
- Ms. White reported that all the residents receive at least two showers per week. Ms. White reported that they could receive additional showers is warranted or requested. Ms. White provided a shower schedule to demonstrate this information. Ms. White reported that she is not aware of any direct care staff members who are not following the resident shower schedule.

On 1/24/24, during on-site investigation, I interviewed Ms. Weaver. Ms. Weaver provided the following replies related to the three allegations:

- Ms. Weaver reported that there are at least three residents who require a two-person assist with mobility, transfers, and personal care. She reported these residents to be Residents A, B, & C. Ms. Weaver reported that the facility is currently staffed with at least two direct care staff members between the hours of 8am – 11pm. Ms. Weaver reported that between 11pm – 7am there is usually one direct care staff member scheduled.
- Ms. Weaver reported that she was working on the date Resident A fell at the facility and fractured her femur. Ms. Weaver reported that she had been assisting another resident in the shower, when the fall occurred. She reported that to her knowledge the fall was unwitnessed, but Ms. Finch found Resident A and was able to assist Resident A to her wheelchair. Ms. Weaver reported that prior to this fall Resident A had been independent with transfers and mobility. Ms. Weaver reported that this fall happened sometime around Thanksgiving, she could not recall the exact date. She reported that it appeared Resident A had tried to get up from the dining room table and fell. She reported that after the fall Resident A complained of pain and the paramedics were called to transport her to the emergency department for evaluation. Ms. Weaver reported that Resident A was diagnosed with a femur fracture. She reported that Resident A has since returned to the facility and now requires additional support with mobility, transfers, and personal care.
- Ms. Weaver reported that each resident is scheduled for at least two showers per week, based on the resident shower schedule. She reported that every day the direct care staff assist each resident with washing their face, underarms, and peri area. Ms. Weaver reported that recently direct care staff have started documenting resident showers in the Quick MAR computer system, where they track resident medication administration. Ms. Weaver reported that she has no concerns that any residents are not being offered and provided personal care at the facility.

On 1/24/24 during the on-site investigation at the facility, I interviewed Resident E. Resident E reported that she is offered personal care from direct care staff members on

a regular basis. She reported she can have a shower, “whenever I want.” She had no concerns to report about the facility or the staffing at this time.

During the on-site investigation on 1/24/24 I reviewed the following documents:

- *Shower Schedule*
    - This document lists each resident in the facility as being scheduled for at least two showers per week.
- *AFC Licensing Division -Incident/Accident Report (IR),* for Resident A, dated 12/4/23. This document was signed by Ms. Finch and reported, “[Ms. Weaver] and I were assisting other residents when another resident’s daughter came in to tell me that [Resident A] was on the ground in the dining room. I went down to the dining room, seen her laying there, asked her if she was okay and if anything hurt. I examined her the best I could. Did not see anything until after she got up and into the living room. Her left knee seemed a bit swollen. Gave her ice to put on it.”
- *Assessment Plan for AFC Residents.*
    - This document was reviewed for each resident currently residing in the facility. None of the assessment plans reviewed reported the need for a two-person assist with mobility, transfers, and personal care for any of the current residents.

On 1/25/24 I received email correspondence from licensee designee, Parvinder Buttar. This email correspondence reported direct care staff members at the facility have recently started using the Quick MAR computer system to track medication administration on 1/1/24. She further reported direct care staff members are trialing tracking resident showers in the Quick MAR system and began tracking these showers around 1/9/24. Ms. Buttar provided the Quick MAR *ADL Log*, for the month of January 2024, for eleven residents. I reviewed this document and was able to determine that each of these residents had been offered/provided at least two showers per week from direct care staff, as documented on this log.

On 2/27/24 I interviewed direct care staff, Jennifer Cruce, via telephone. Ms. Cruce reported that she began working at the facility in December 2023 and recently took a leave of absence due to medical issues. She provided the following responses related to the three allegations:

- Ms. Cruce reported that while she was working at the facility there were two residents who required the assistance of two direct care staff members with mobility, transfers, and personal care. She reported these two residents to be Resident A & Resident D. Ms. Cruce reported that when Resident A returned home from the rehabilitation center, after breaking her femur, she required two people to assist with transfers, mobility and personal care. She reported that as Resident A progressed through her rehabilitation at the facility she was doing better and became a one person assist. Ms. Cruce reported that Resident D has Parkinsons disease and becomes very stiff when direct care staff attempt to transfer her. She reported that the safest way to manage her transfers is for two direct care staff to assist, otherwise the direct care staff

risk injury to the resident and to themselves. Ms. Cruce reported that she worked the 3pm to 11pm shift at the facility. She reported that most days, after 6pm she was alone in the facility as the only direct care staff member to provide for resident care. Ms. Cruce reported that the prior shifts would assist her in getting residents ready for bed and then they would leave around 6pm. Ms. Cruce reported that there was always only one direct care staff member scheduled to work from 11pm to 7am during her time working at the facility.

- Ms. Cruce reported that she was not employed at the time when Resident A fell and broke her femur. She reported that she had heard other direct care staff talking about this event but felt since she did not have direct knowledge of the incident she could not verify any rumors from factual information. She reported that Resident A returned to the facility, from her stay at a rehabilitation facility and did require the assist of two direct care staff to manage her needs due to the femur fracture. Ms. Cruce reported that Resident A progressed with her rehabilitation and now only requires a one person assist with mobility, transfers, and personal care.
- Ms. Cruce reported that during her time working at the facility she did not observe any residents who appeared to have not been provided adequate personal care/showering. She reported that she provided all personal care required for the residents and had no concerns about other direct care staff not providing for resident personal care needs.

On 2/27/24 I interviewed direct care staff, Twanda Love, via telephone. Ms. Love reported that she began working at the facility about one month ago. She provided the following information regarding the three allegations:

- Ms. Love reported that she typically works the 3pm to 11pm shift at the facility. She reported that one the 3pm to 11pm shift there are typically two direct care staff schedule to provide care. She reported that on occasion, if someone calls in for their shift, this may leave them with one direct care staff for this shift, but she noted this does not happen often. She reported that the midnight shift, 11pm to 7am varies from having one to two direct care staff scheduled. She reported that there are times when only one direct care staff will work the 11pm to 7am shift. Ms. Love reported that there are two residents who possibly require a two-person assist with mobility, transfers, and/or personal care. She reported that Resident C remains and there are some direct care staff who cannot provide for her care, independently. Ms. Love reported that Resident D requires a two-person assist with mobility and transfers due to her nervous behavior and anxiety. She reported that Resident D is afraid she will experience a fall and it is safer to use two direct care staff when assisting her with mobility and transfers.
- Ms. Love reported that she was not employed at the time when Resident A experienced a fall in which she fractured her femur. She has no direct information about this incident.
- Ms. Love reported that she does not provide for resident showers as she works 2nd shift (3pm to 11pm) and the showers are performed by direct care staff working 1st shift (7am to 3pm). Ms. Love reported that she helps residents with their toileting needs and additional personal care that may be required when they

are preparing for bed. She reported that she has never had concerns about residents not receiving their showers or personal care and indicated that all residents are scheduled for regular showers at the facility.

On 2/27/24 I interviewed direct care staff, Tori Defeyter, via telephone. Ms. Defeyter reported that she has worked at the facility since November 2023. Ms. Defeyter reported that she works 1st shift (7am to 3pm). Ms. Defeyter provided the following information regarding the three allegations:

- Ms. Defeyter reported that on 1st shift there are always at least two direct care staff members scheduled. She reported that as of this weekend, 3/2/24, there will always be two people scheduled on every shift. She reported this is something new the administration is trying. Ms. Defeyter reported that prior to this decision there had been one direct care staff scheduled on the 11pm to 7am shift. Ms. Defeyter reported that there are no current residents who require a two person assist with transfers, mobility, or personal care. She reported that Resident C remains in her bed and can be cared for by one direct care staff member as she does not leave her bed. Ms. Defeyter reported that, “no” one direct care staff member would not be able to evacuate Resident C from the facility in the event of an emergency including a fire. Ms. Defeyter reported that Resident A, B, & D do not require a two person assist with mobility, transfers, and personal care.
- Ms. Defeyter reported that she was not present on the date Resident A experienced a fall at the facility and fractured her femur. She reported that this resident was considered a fall risk but could transfer herself at the time of the fall. She had no additional information to contribute regarding this incident.
- Ms. Defeyter reported that residents are scheduled for showers twice per week. She reported that there is a shower schedule noting this arrangement and the showers are given on 1st shift on Mondays, Tuesdays, Thursdays, and Fridays. Ms. Defeyter reported that all residents present as well-groomed and she has no concerns about direct care staff not providing for resident personal care needs.

On 2/28/24 I had email correspondence with licensee designee, Parvinder Buttar, regarding the three allegations. Ms. Buttar provided the following responses regarding each allegation.

- Ms. Buttar reported that Resident C “consistently requires the assistance of two direct care assistants”. She further reported that occasionally Resident A and Resident D also require the assistance of two direct care staff with mobility/transfers/personal care. Ms. Buttar reported that going forward the facility will be staffed with two direct care staff on every shift. She reported that this will be implemented on 3/3/24. Ms. Buttar reported that the direct care staff know which residents require a two person assist with mobility and transfers through the process of regular shift report. She reported that this information is communicated by direct care staff/shift supervisors.
- Ms. Buttar reported that she was not present in the facility on the date Resident A experienced a fall and fractured her femur. She reported that she has no reason to suspect that Resident A was not being provided adequate supervision on this date.

- Ms. Buttar reported that she has no reason to suspect that the residents are not being provided adequate personal care/showering support from direct care staff. She reported, “Our direct care staff diligently adhere to the shower schedule, ensuring that each resident receives showers twice a week.” Ms. Buttar reported that as of 1/1/24 the direct care staff have also instituted a “skin assessment sheet” which they use to document any abnormalities in a resident’s skin appear.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based upon interviews with Ms. White, Ms. Weaver, Resident E, Ms. Buttar, Ms. Cruce, Ms. Love, & Ms. Defeyter, as well as review of *Assessment Plan for AFC Residents* forms for each resident, it can be concluded there was only one direct care staff member on the midnight shift (11pm to 7am) on a routine basis. It was noted, verbally, by each direct care staff interviewed that there was at least one resident requiring two direct care staff members to assist with mobility/transfers/personal care, and at times there were multiple residents requiring this level of care. Ms. Buttar confirmed through email correspondence that this was accurate information and noted Resident C required two direct care staff with mobility/transfers/personal care. Ms. Buttar noted staff scheduling has been modified to now account for this need and will be implemented by 3/3/24. Since this allegation was substantiated, a violation has been established. Based upon interviews with Ms. White, Ms. Weaver, Ms. Buttar, Ms. Cruce, Ms. Love, & Ms. Defeyter, as well as review of the IR for Resident A dated 12/4/23, it can be determined that there is not sufficient evidence available to identify that Resident A's fall on 12/4/23 was due to a lack of supervision and support from direct care staff. A violation will not be substantiated for this allegation. Based upon interviews with Ms. White, Ms. Weaver, Resident E, Ms. Buttar, Ms. Cruce, Ms. Love, & Ms. Defeyter, as well as review of the document, *Shower Schedule*, it can be determined that there is a lack of substantial evidence that residents are not receiving adequate support with personal care and showering. Everyone interviewed reported the same process for identifying residents who are scheduled for regular showers and providing this level of care. During the on-site investigation I noted no evidence that residents were not being provided personal care. All residents observed appeared well-kempt. A violation will not be established based on this allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff yell at the residents.

INVESTIGATION:

On 1/19/24 I received an online complaint regarding the facility. The complaint alleged direct care staff yell at the residents. On 1/24/24 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. White & Ms. Weaver on this date. Both, Ms. White & Ms. Weaver, reported that they have no

knowledge of any direct care staff yelling at any residents. They both reported having no knowledge of this alleged behavior. Both, Ms. White & Ms. Weaver reported that none of the residents have made any complaints to them about direct care staff members yelling at them or treating them in a derogatory manner.

On 1/24/24, during on-site investigation, I interviewed Resident E. Resident E reported that she has no knowledge of any of the direct care staff members treating any of the residents in a derogatory manner or yelling at the residents. Resident E reported that she enjoys the facility and noted, “Everyone is so nice here!”

On 2/27/24 I interviewed Ms. Cruce, via telephone. Ms. Cruce reported that she had no knowledge of any of the direct care staff members yelling at any of the residents. She reported that at times she would witness a direct care staff member become frustrated with a resident, who has dementia, as the redirection required for these residents is ongoing and repetitive, but she never felt that the residents were treated in a derogatory manner by any of the direct care staff.

On 2/27/24 I interviewed Ms. Love, via telephone. Ms. Love reported that she has never observed any direct care staff member yelling at residents or speaking with them in a derogatory manner. She had no concerns to report regarding this allegation.

On 2/27/24 I interviewed Ms. Defeyter, via telephone. Ms. Defeyter reported that the only time she has witnessed a direct care staff member yelling at a resident is regarding Resident A. She further reported that Resident A is hard of hearing and the direct care staff members must talk loudly instructions to her for her to understand. She reported that she has never observed a direct care staff speaking with any of the residents in a derogatory manner.

On 2/28/24 I received email correspondence from Ms. Buttar. Ms. Buttar reported that she is not aware of any direct care staff members who yell at the residents or speak with residents in a derogatory manner.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**

	(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.
ANALYSIS:	Based upon interviews with Ms. White, Ms. Weaver, Resident E, Ms. Cruce, Ms. Love, Ms. Buttar, & Ms. Defeyter, there is no evidence to indicate that the current direct care staff are speaking with residents in a derogatory manner. A violation cannot be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Residents are being fed expired food products.

INVESTIGATION:

On 1/19/24 I received an online complaint regarding the facility. The complaint alleged that residents at the facility are being fed expired food products. On 1/24/24 I conducted an unannounced, on-site investigation at the facility. I reviewed the food products in the kitchen cupboards and refrigerator/freezer, as well as the food in the overflow food storage area in the basement. I did not find any food products that were past their expiration date. I did not find any leftovers in the refrigerator that would have been expired.

During this on-site investigation I interviewed Ms. White & Ms. Weaver regarding the allegation. Both, Ms. White & Ms. Weaver reported that they have no knowledge of expired food products being distributed to the residents.

During the on-site investigation I interviewed Resident E. Resident E reported that she is happy with the food at the facility and reported, “it’s like homemade”.

On 2/27/24 I interviewed Ms. Cruce, via telephone. Ms. Cruce reported that the food at the facility was always served fresh. She reported that she had never observed expired food to be prepared at the facility or served to residents.

On 2/27/24 I interviewed Ms. Love, via telephone. Ms. Love reported that she has never witnessed or heard of the residents being served expired food products. She had no further information to provide regarding this allegation.

On 2/27/24 I interviewed Ms. Defeyter, via telephone. Ms. Defeyter reported that she has never witnessed or heard of the residents being served expired food products. She had no further information to provide regarding this allegation.

On 2/28/24 I received email correspondence from Ms. Buttar regarding this allegation. Ms. Buttar reported that to her knowledge the residents have never been fed expired food products. She reported that she routinely checks the pantry and the refrigerator/freezer to ensure that all products are not expired.

APPLICABLE RULE	
R 400.14402	**Food service.**
	(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.
ANALYSIS:	Based upon results of the unannounced on-site investigation and interviews with Ms. White, Ms. Weaver, Ms. Cruce, Ms. Love, Ms. Defeyter, Ms. Buttar, & Resident E, it can be determined that there is no current evidence that the residents have been served expired food products. There was no evidence of expired food in the facility on this date.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

03/04/24

_____

Jana Lipps Date
Licensing Consultant

Approved By:

03/04/2024

_____

Dawn N. Timm Date
Area Manager