GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 17, 2024

Lela Shank
Country House Care, L.L.C.
1395 Seneca Street
Adrian, MI 49221

RE: License #: AM460417872
Investigation #: 2024A1032030
New Beginnings

Dear Lela Shank:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM460417872
Investigation #:	2024A1032030
Complaint Receipt Date:	02/06/2024
Investigation Initiation Date:	02/08/2024
Report Due Date:	04/06/2024
Licensee Name:	Country House Care, L.L.C.
Licensee Address:	1395 Seneca Street, Adrian, MI 49221
Licensee Telephone #:	(517) 442-2161
Administrator:	Lela Shank
Licensee Designee:	Lela Shank
Name of Facility:	New Beginnings
Facility Address:	211 E. Main Street, Morenci, MI 49256
Facility Telephone #:	(517) 458-6926
Original Issuance Date:	01/03/2024
License Status:	TEMPORARY
Effective Date:	01/03/2024
Expiration Date:	07/02/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was improperly discharged from the home.	No
The home did not adequately attend to Resident A's needs for self-improvement.	No
Additional Findings	No

III. METHODOLOGY

02/06/2024	Special Investigation Intake 2024A1032030
02/08/2024	Special Investigation Initiated - Telephone Interview with complainant.
02/12/2024	Contact - Telephone call made
02/15/2024	Inspection Completed On-site
02/15/2024	Contact - Telephone call received Morenci City Police Department reports
02/28/2024	Contact - Telephone call made interview with licensee Lela Shank
03/08/2024	Contact - Face to Face Interview with former licensee Vicky Cates
03/08/2024	Contact - Document Received Resident A's last health care appraisal
04/12/2024	Exit Conference

ALLEGATION:

Resident A was improperly discharged from the home.

INVESTIGATION:

On 2/12/24, I interviewed Resident A by telephone. Resident A discussed getting into an altercation with an employee at the home. Resident A stated that she left the home and was later picked up by a Morenci City Police officer. She reported that the officer then dropped her off at the homeless shelter in Adrian, a city nearly 30 minutes away from Morenci. Resident A reported that these events occurred in October 2023.

Resident A stated that when she tried to return to the home, she was advised that she would have to seek her own transportation. She then stated that she was advised that she could not return to the home because there was a court order preventing her from having contact with the employee with home she clashed.

Resident A denied receiving written discharge paperwork from the home and was unclear about the reason.

On 2/15/24, I interviewed home owner Timothy Shank in the home. Mr. Shank stated that Resident A got into an altercation with another resident and left the home. He stated that she went to a shelter in Adrian and was now at a new AFC home. He stated that someone representing Resident A came to the home and gathered her belongings.

I reviewed two Morenci City Police reports. One report lists Resident A as the aggressor in an altercation with Resident B, and goes on to say that Lenawee County Sheriff Department deputies transported Resident A to a shelter in Adrian MI. There is no mention of an altercation between Resident A and an employee. An employee did notify the police that Resident A had left the home. The other report mentions a dispute with the home over Resident A's laptop, which was not included in the belongings gathered for her.

I interviewed Resident B in the home. Resident B discussed having an altercation with Resident A. She stated that Resident A choked her after getting upset that she was assisting the new employees in the home. Resident B felt that Resident A viewed her as betraying a former employee by assisting the new staff members. Resident B denied observing any altercation between Resident A and an employee.

On 2/28/24, I interviewed licensee designee Lela Shank via telephone. Ms. Shank stated that Resident A left the home after getting into a fight with Resident B, and that the police were called to look for her. Ms. Shank stated that Resident A

expressed to police that she did not wish to return to the home and as a result, she was discharged from the home.

On 3/8/24, I interviewed former licensee Vicky Cates in the community. Ms. Cates stated that Resident A left the home during a change of ownership of the home. She stated that Resident A went to a shelter in Adiran, then contacted her to see if she could stay at one of her homes in Adrian. Ms. Cates stated that the home in Adrian that Resident A visited, asking for shelter, is full and serves male residents. She advised me that Resident A then went to a nearby park, where she met with her. Ms. Cates stated that when she met Resident A at the park, she asked Resident A if she wanted a ride back to New Beginnings, but Resident A told her that her mother was coming to pick her up, and declined offers of a meal and a ride.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; emergency discharge;**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall 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:	Based on interviews with residents and the licensee designees, there is insufficient evidence to support a conclusion of improper discharge. Resident A was transported by police to a shelter after leaving the home. I reviewed police reports that reflect Resident A's desire to be away from the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The home did not adequately attend to Resident A's needs for self-improvement and medical care.

INVESTIGATION:

On 2/12/24, Resident A discussed having to cook and care for the other residents when employee Bobbi Cilli worked, as she would often leave the home for three

hours at a time. Resident A also mentioned that this employee used drugs in the basement. It was noted that this employee has not worked at this home for several months and was fired.

Resident A reported that she was unable to access vision care while at the home. She stated that the home would often provide her prescribed Tylenol and nasal sprays to other residents, depleting her supply prematurely.

On 2/15/24, during an onsite inspection, I noted an employee assisting a resident prepare a meal, and employee Brian Bornson reported that the residents have access to a variety of cards, board games as well as access to the community. Resident B denied observing Resident A having to cook for the residents in the home.

On 3/8/24, Ms. Cates provided me with a copy of Resident A's last health care appraisal. The document does not reflect a need for eye care. Ms. Cates stated that while she owned the home, she would facilitate visits for special care, but that a visiting doctor would come to the home.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.
ANALYSIS:	There is insufficient evidence to establish that the home did not provide proper care or that the home actively engaged in suppressing Resident A's physical needs. While there were reports of an employee who used illegal drugs, this employee had been terminated prior to the events listed as part of this investigation. I was able to observe an employee interacting with a resident to promote a positive skill in cooking.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 4/12/24, I conducted an exit conference with licensee designee Lela Shank. I shared my findings and Ms. Shank agreed with the conclusions reached.

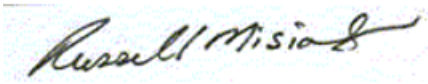
IV. RECOMMENDATION

I recommend no change to the status of this license.

4/12/24

Dwight Forde — Date
Licensing Consultant

Approved By:



4/16/24

Russell B. Misiak — Date
Area Manager