



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 19, 2025

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

RE: License #: AM460417872
Investigation #: 2025A1032015
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,

A handwritten signature in black ink, appearing to read "Dwight Forde".

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 #:	2025A1032015
Complaint Receipt Date:	02/04/2025
Investigation Initiation Date:	02/04/2025
Report Due Date:	04/05/2025
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:	REGULAR
Effective Date:	07/03/2024
Expiration Date:	07/02/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was being neglected.	No
The heat was not working.	No
Additional Findings	No

III. METHODOLOGY

02/04/2025	Special Investigation Intake 2025A1032015
02/04/2025	APS Referral
02/04/2025	Special Investigation Initiated - On Site
02/05/2025	Contact - Telephone call made Interview with APS Specialist Jason Harris
03/19/2025	Inspection Completed On-site Interview with Resident A
03/19/2025	Exit Conference
03/19/2025	Contact - Document Received Email reviewed from APS Specialist Jason Harris

ALLEGATION:

INVESTIGATION:

On 2/4/25, I interviewed employee in the facility. Ms. Lathan stated that Resident B is able to toilet himself and denied every having seen him have an accident. She advised that he can be difficult to redirect regarding personal hygiene, and his nails and beard are sometimes dirty, despite staff attempts to help him clean up. She stated that he resists having his laundry done, and she has to sometimes sneak into his room to gather his clothing and bedding to be laundered.

I reviewed Resident A's health care appraisal at the facility. There were no physical conditions listed that could explain him being found in a hypothermic state, as indicated in the complaint information.

I reviewed Resident A's assessment plan at the facility. The plan reflects an ability to perform personal care tasks independently, with reminders from staff.

On 3/19/25, I interviewed Resident A in the facility. Resident A reported that things were going well in the home and that his room temperature was satisfactory. He stated that his clothing is laundered by staff, who also clean his room. He advised that he receives proper doses of medication, and that aside from mild anxiety, he is in good health.

I observed resident A to be dressed appropriately for the weather. His clean pullover was of a wooly texture, tan in color. Other than what appeared to be dried paint, his denim jeans were tidy. His grooming was fair, a long flowing beard cascading down his face. Resident A had been sitting in the living room watching TV with the other residents, awaiting meal service.

On 3/19/25, I reviewed an email from APS Specialist Jason Harris. Mr. Harris described Resident A as being the one to shut the vent to the room, as well as resisting efforts to have his room and laundry cleaned. Mr. Harris advised that he had closed his case as unsubstantiated.

APPLICABLE RULE	
R 400.14310	Resident health care.
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.

ANALYSIS:	Upon review of Resident A's HealthCare Appraisal and Assessment Plan, I was able to determine that efforts had been made to direct Resident A to attend to his own personal care and hygiene, as he was physically capable of doing so. I was able to observe Resident A, and he appeared clean.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The furnace was not working properly.

INVESTIGATION:

On 2/4/25, Ms. Lathan denied knowledge of any issues with the furnace. Ms. Lathan stated that the first floor restroom can be somewhat chilly, if residents exit the back door and leave it open. She denied that Resident A's room was cold.

I interviewed Resident B in the facility. Resident B stated that she has been at the facility since September 2024. She advised that there have been no recent issues with the heat distribution in the home other than the first floor bathroom being somewhat chilly, as it is near the back exit. Resident B stated that her room is warm and allowed me entry. The room was warm.

I observed the room temperature in Resident A's room (adjacent to Resident B's room) to be warm.

APPLICABLE RULE	
R 400.14510	Heating equipment generally.
	(2) A furnace, water heater, heating appliances, pipes, wood-burning stoves and furnaces, and other flame- or heat-producing equipment shall be installed in a fixed or permanent manner and in accordance with a manufacturer's instructions and shall be maintained in a safe condition.

ANALYSIS:	There was no evidence that the furnace was not working. The temperature in the home was comfortable. A resident and employee denied experiencing interruptions in service.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 3/19/25, 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.

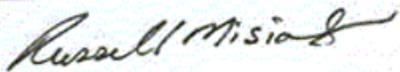


3/19/25

Dwight Forde
Licensing Consultant

Date

Approved By:



3/21/25

Russell B. Misiak
Area Manager

Date