GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 27, 2026

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

RE: License #: AS390381707
Investigation #: 2026A1024025
Espanola House

Dear Ms. Nutter:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing, and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 #:	2026A1024025
Complaint Receipt Date:	04/10/2026
Investigation Initiation Date:	04/10/2026
Report Due Date:	06/09/2026
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 staff to accommodate resident needs.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/10/2026	Special Investigation Intake 2026A1024025
04/10/2026	APS Referral not warranted
04/10/2026	Special Investigation Initiated - Face to Face with direct care staff members Jennifer Graham and Marissa Cole
04/10/2026	Contact - Telephone call made with administrator/licensee designee Shelly Nutter.
04/13/2026	Inspection Completed On-site with direct care staff members Marissa Cole, Jennifer Graham and Alexander Ashbaugh
04/14/2026	Contact - Telephone call made with administrator/licensee designee Shelly Nutter
04/16/2026	Contact - Document Received *2025-2026 Fire Drills*
04/17/2026	Contact - Telephone call made with administrator/licensee designee Shelly Nutter
04/20/2026	Contact - Document Received *2024-2025 Fire Drills*
04/21/2026	Inspection Completed On-site with Marissa Cole and Jennifer Graham
04/23/2026	Contact - Document Received-*Staff Schedules*
05/11/2026	Exit Conference with administrator/licensee designee Shelly Nutter
05/22/2026	Inspection Completed-BCAL Sub. Non-Compliance

ALLEGATION: There is not sufficient staff to meet resident needs.

INVESTIGATION:

On 4/10/2026, I conducted an unannounced onsite investigation to verify CAP compliance for SIR #2026A1024015 but was not able to verify compliance therefore created a new intake for a special investigation to address allegations that there was insufficient staff to meet resident needs. I reviewed SIR #2026A1024015 dated 3/19/2026 which documented a violation due to resident personal care needs not being met specially for residents who are all "bedbound" and require total personal care assistance. This was especially concerning during overnight hours when direct care staff were sleeping. I also reviewed the facility's Corrective Action Plan (CAP) dated 4/7/2026 for SIR #2026A1024015 and signed by licensee designee Shelly Nutter. This documented that effective immediately (4/7/2026) the facility will implement a revised overnight staffing policy that incorporates the use of a standardized assessment tool to help determine appropriate staffing levels. It further stated that over the next 7 days, starting 4/7/2026, current resident need will have been reviewed using these new tools to verify that overnight staffing levels are sufficient to meet the identified individual resident needs. In addition, staff will have been re-educated on resident care plans, required overnight services, use of the acuity tool and expectations for immediate response to resident needs. It should be noted on 4/4/2026, I also provided Shelly Nutter technical assistance and provided her with a *Staffing Sufficient Assessment Checklist* to utilize in determining adequate staffing at her facility.

On 4/10/2026, I conducted an onsite investigation at the facility with direct care staff members Jennifer Graham and Marissa Cole who both stated that direct care staff members are still asleep at night despite having residents that require routine checks during sleeping hours. Jennifer Graham stated that since the last special investigation in March 2026 that required a corrective action plan, live-in staff members now go to their bedroom at 9pm as opposed to 7pm which was the previous practice. Jennifer Graham stated direct care staff wake up at least once during the overnight to check on residents otherwise residents do not have direct care staff supervision during sleeping hours. Jennifer Graham stated that Resident C requires routine checks every two hours to assure Resident C's C-PAP machine is working as designed and that Resident C's mask is on her face properly. Jennifer Graham further stated that Resident C has a hard time communicating therefore checks should be done regularly to determine if Resident C needs anything or is distressed or in pain. Jennifer Graham stated that she has asked licensee designee Shelly Nutter to hire additional staff for the overnight hours as she believes staff should be awake at night to monitor the residents who solely depend on staff members to assist them with their personal care needs such as transferring, getting a drink of water, or repositioning. However, Jennifer Graham indicated that Shelly Nutter stated she does not have the financial resources to hire additional staff at this time. Jennifer Graham stated that there are only three staff members that work at the facility and each staff member is overworked. Jennifer Graham stated additional staffing would be helpful to meet the needs of the residents without delay.

While at the facility, I reviewed Resident C's *Assessment Plan for AFC Residents* (plan) which documented that Resident C requires assistance with all personal care needs including mobility and transferring. Resident C was described as "bedbound" and requiring assistance from staff with sitting up in her bed, transferring or other personal care needs. It should be noted that this plan did not document if Resident C requires one or two staff members to assist her with her personal care needs.

I reviewed Resident D's *Assessment Plan for AFC Residents* (plan) which documented that Resident D requires assistance with all personal care needs and requires two direct care staff members to assist her with toileting, bathing, hygiene and mobility. This plan 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 plan also documented that Resident D was also described as "bedbound."

I also reviewed Resident E's *Assessment Plan for AFC Residents* (plan) which documented that Resident E requires total care assistance for all personal care needs and was also described as "bedbound". It should be noted that this plan did not document if Resident E requires one or two staff members to assist her with her personal care needs.

On 4/10/2026, I conducted an interview with licensee designee Shelly Nutter who stated that she believes since the residents mostly sleep through the night, she does not require staff to be awake during the overnight hours. Despite Resident C, Resident D and Resident E requiring direct care staff assistance with personal care needs and transfers, Shelly Nutter stated that she believes the call button system that is used has been effective in alerting staff members when residents need assistance. Shelly Nutter stated live-in staff members wake up and go downstairs to meet resident needs after being alerted by the call system. I noted that during SIR#2026A1024015 residents reported that staff members are not immediately available when assistance is needed. Shelly Nutter stated that she also implemented an observation overnight log that allows staff to record their observations when they make their rounds at least once during the overnight hours which shows that residents are typically asleep during the nighttime hours. Shelly Nutter stated that the assessment plans for all residents have not changed since SIR# 2026A1024015 was completed by this consultant in March 2026. Shelly Nutter stated she plans to speak with hospice staff members with her hope being to change all resident *Assessment Plans for AFC Residents* to reflect that each resident only needs one direct care staff member to assist with personal care needs including transfers and that each resident does not need to be checked on during nighttime hours for any reason. Shelly Nutter stated that she recognizes that Resident D needs "some monitoring" during nighttime hours since she is on oxygen 24/7 and uses a C-PAP machine during the overnight which requires staff members to check the machine regularly and to assure Resident D's mask is in place since she has a history of having issues with her mask staying on her face. Shelly Nutter stated that Resident E was recently admitted to the facility but she stated was unsure of Resident E's personal care needs however believes that Resident E does not require supervision at night although

she relies on staff members for all her personal care needs and is described as “bedbound.”

On 4/13/2026, I conducted an onsite investigation at the facility with direct care staff members Jennifer Graham, Marrissa Cole and Alexander Ashbaugh who all stated that since the unannounced onsite investigation on 4/10/2026, staff members have been awake during overnight hours and record their observations of residents on the overnight log. These staff members further stated that Shelly Nutter is also now working in the home to assist residents as needed during the overnight hours. However, all three direct care staff members stated being overwhelmed with working the additional awake overnight hours and their regular daytime shifts. All three staff members interviewed reported that they still believe additional staff are needed to adequately meet resident needs. In addition, all three staff members stated licensee designee Shelly Nutter has not hired any new direct care staff but has indicated that she is going to start looking for part-time, additional staff.

On 4/21/2026, I conducted an onsite investigation at the facility with direct care staff members Jennifer Graham and Marrisa Cole. Upon arrival, I interviewed Marrisa Cole and requested that she demonstrate a fire drill to ensure sufficient staffing ratios were in place and resident needs were being met. Marissa Cole stated that she was not able to conduct a fire drill with the three residents in the facility, as all the residents, with the exception of Resident C, require two direct care staff to assist with transferring and she was the only staff member working. Marissa Cole stated she would have to contact live-in staff member Jennifer Graham, who was not working and is currently upstairs in her bedroom, to assist her in demonstrating a fire drill.

I interviewed direct care staff member Jennifer Graham, who reported that she was unable to assist Marissa Cole with conducting a fire drill demonstration due to her hernia, a condition that prevents her from performing any heavy lifting. As a result, she cannot assist with transferring residents, all of whom require two staff members for safe transfers. Ms. Graham stated that she previously informed Shelly Nutter of her health condition, yet she continues to be scheduled to work alone with residents. She further explained that although she does not have formal work restrictions on file, she believes that neither she nor Ms. Cole would be able to safely evacuate the residents described as bedbound during an actual emergency and that she would need to call for additional assistance from outside the home.

On 4/23/2026, I reviewed the facility’s *Staff Schedules* for January through April 2026. The schedules showed that on multiple occasions, a single direct care staff member—specifically Jennifer Graham, Marissa Cole, or Alexander Ashbaugh—was assigned to work alone with three residents who each require two-person assistance per both staff interviews and *Assessment Plans for AFC Residents*. Additionally, on approximately four days in each of these months, the same staff member was scheduled to work an entire shift from 8:00 a.m. to 7:00 a.m. the following day without any additional staff support.

Special Investigation Report #2026A1024015 dated 03/19/2026 cited violation of Rule 400.671.1 after it was determined resident needs were not being met in a timely manner especially during sleeping hours. Residents, who were described as bedbound, reported waiting between 15 minutes and one hour after pressing the call light to receive assistance from direct care staff. It was also noted that Resident A was eloping on a regular basis during nighttime hours due to no direct care staff monitoring Resident A despite a known history of elopement. Lastly, cameras and baby monitors were being used in lieu of direct care supervision to monitor residents during nighttime hours.

APPLICABLE RULE	
R 400.671	**Resident 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, Alexander Ashbaugh, and licensee designee Shelly Nutter, along with my review of Residents C, D and E's *Assessment Plan for AFC Residents,* facility's *Corrective Action Plan (CAP),* SIR #2026A1024015 and *Staff Schedule* there is evidence that there is not sufficient staff to meet resident needs. While verifying corrective action plan compliance for SIR #2026A1024015 dated 3/19/2026, direct care staff members Marissa Cole and Jennifer Graham reported that staff members continue to sleep during nighttime hours despite having residents who are all "bedbound" and require total personal care assistance, including transfers. Both also stated Resident C continues to need to be checked during nighttime hours to assure her C-PAP machine and mask are working as required and Resident D requires hourly checks to determine her pain level. According to Residents C, D, and E's *Assessment Plan for AFC Residents,* these residents are all "bedbound" and require total personal care assistance. Specifically, Resident D requires staff supervision to monitor her pain level every hour and requires two direct care staff to assist her with her personal care needs. Per my review of *Staff Schedules* only one direct care staff member was scheduled to work from January 2026 through April 2026. In addition, according to Jennifer Graham and Marissa Cole all the residents require two direct care staff assistance with transferring so an impromptu fire drill demonstration could not be conducted due to insufficient staffing at the facility on 4/21/2026 as Marissa Cole was the only staff member working at the facility and physically able to assist with transferring the residents. I also noted after reviewing the facility's *Staff Schedule* for the months January through April of 2026 that at times the one staff member worked from 8am one day until 7am the next day with residents requiring two direct care staff for transfers and personal care. Therefore, there has not been sufficient staff on duty to provide necessary services indicated in all the residents' *Assessment Plans for AFC Residents*.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

According to Jennifer Graham, Marissa Cole and licensee designee Shelly Nutter, fire drills are practiced only four times per year. Shelly Nutter stated that the administrative rule for fire drills is very confusing and she has been following an Emergency Preparedness Planning Toolkit created by MDHHS that she found online linked to the AFC Technical Manual. Per Shelly Nutter, this toolkit stated fire drills should be completed four times a year.

It should be noted that I provided technical assistance to Shelly Nutter on 1/27/2026 which included key highlights of the new AFC Licensing Ruleset, and this included requirements for quarterly training on fire alarms, fire protection equipment and the emergency preparedness plan. These highlights stated practice drills, which are part of the emergency preparedness plan, must be conducted at least once a quarter per calendar year during each shift 7am to 3pm, 3pm to 11pm and 11pm to 7am.

On 4/16/2026 and 4/20/2026, I reviewed the facility's *Fire Drills* which documented fire drills with the dates and times as follows:

- 12/20/2025-8:45am
- 9/18/2025-9:45am
- 8/21/2025-12:45am
- 5/1/2025-3:45pm
- 11/15/2024-10:00am
- 8/15/2024-10:00pm
- 3/15/2024-2:00pm
- 1/15/2024-2:00pm.

APPLICABLE RULE	
R 400.619	**Emergency preparedness plan.**
	(8) A licensee shall practice the emergency preparedness plan, including the fire safety plan, at least once a quarter per calendar year during each shift, 7 a.m. to 3 p.m., 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. A record of the practices must be maintained for 2 years.

ANALYSIS:	According to Jennifer Graham, Marissa Cole and licensee designee Shelly Nutter, fire drills have been completed four times per year. Per my review of the facility *Fire Drills* log from 2024-2026, fire drills were not conducted as required during daytime, evening and sleeping hours each quarter during 2024 and 2025. At the time of the investigation no fire drills were recorded for 2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility, I observed the facility's dryer metal aluminum vent detached from the dryer located at the top side of the dryer. I also observed missing floor tiles in two areas of the kitchen entryway.

According to Jennifer Graham the dryer has not worked for the last three days due to the dryer vent repeatedly coming detached from the dryer. Jennifer Graham stated this has been a periodic issue over the last six months. Jennifer Graham stated that she put in a maintenance request for this issue, however nothing has been done to fix it. Jennifer Graham further stated that there have been times she has brought in a carbon monoxide machine due to safety concerns regarding the vent repeatedly coming detached from the dryer. Jennifer Graham stated that she also put in a maintenance request for the flooring in the kitchen, however the maintenance person, who is the licensee designee's spouse, stated that they do have the financial resources to make any repairs at this time.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants. **(5) Floors, walls, and ceilings must be cleanable, maintained clean, and in good repair.**
ANALYSIS:	While at the facility, I observed the facility's dryer metal aluminum vent detached from the dryer located at the top side of the dryer. I also observed missing floor tiles in two areas of the entryway kitchen. According to Jennfier Graham a maintenance request was made for both issues however neither has been fixed.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility, I reviewed Resident E's written *Assessment Plan for AFC Residents* and *Resident Care Agreement* and noted neither was signed by Resident E's designated representative or licensee designee Shelley Nutter as required. Jennifer Graham stated that she completed both Resident E's *Assessment Plan for AFC Residents* and *Resident Care Agreement* on 3/11/2026 however she has not been able to get relevant signatures yet.

In addition, licensee designee Shelly Nutter stated that she has been busy working on compliance with administrative rules from the previous special investigation therefore she was not part of the admission process for Resident E and did not review or sign these documents.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge. **(8) A resident care agreement must be signed by all applicable parties. A copy of the signed resident care agreement along with copies of the policies listed in subrule (6) of this rule must be provided to the resident or the resident's designated representative and maintained in the resident's record.**
ANALYSIS:	Resident E's written *Assessment Plan for AFC Residents* and *Resident Care Agreement* dated 3/11/2026 were not signed by Resident E's designated representative or licensee designee Shelley Nutter as required. Licensee designee Shelley Nutter stated she was not part of Resident E's admission process and did not review or sign these documents as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/11/2026, 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 receipt of an acceptable corrective action plan, due to the quality of care and physical plant violations cited, I recommend a six-month provisional license upon receipt of an acceptable corrective action plan.

5/22/2026

Ondrea Johnson — Date
Licensing Consultant

Approved By:

05/26/2026

Dawn N. Timm — Date
Area Manager