GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 20, 2026

Jennia Cook
Community Health Care Management
1805 E Jordan
Mt. Pleasant, MI 48858

RE: License #: AM370085651
Investigation #: 2026A1029051
Country Place II

Dear Ms. Cook:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 07/17/2026, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM370085651
Investigation #:	2026A1029051
Complaint Receipt Date:	06/08/2026
Investigation Initiation Date:	06/09/2026
Report Due Date:	08/07/2026
Licensee Name:	Community Health Care Management
Licensee Address:	2033 Westbrook, Ionia, MI 48846
Licensee Telephone #:	(989) 773-6320
Administrator:	Jennia Cook
Licensee Designee:	Jennia Cook
Name of Facility:	Country Place II
Facility Address:	1807 E. Jordan, Mount Pleasant, MI 48858
Facility Telephone #:	(989) 773-6320
Original Issuance Date:	07/02/2001
License Status:	REGULAR
Effective Date:	07/13/2026
Expiration Date:	07/12/2028
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from Country Place II and entered a neighbor's home without permission.	Yes

III. METHODOLOGY

06/08/2026	Special Investigation Intake 2026A1029051
06/09/2026	Special Investigation Initiated – Email to complainant
06/09/2026	Contact - Telephone call received from complainant
06/17/2026	Inspection Completed On-site – face to face with licensee designee Jennia Cook, Jamie Blizzard, Tina Prescott, Angie Strayer, and Resident A at Country Place II
06/18/2026	APS Referral made to Centralized Intake-complaint was assigned to Caitlin Fick
06/18/2026	Referral - Recipient Rights- ORR referral made to Recipient Rights
06/23/2026	Contact - Email Sent to complainant
07/02/2026	Contact – Email exchange with Citizen 1
07/15/2026	Contact - Document Sent- Email from Ms. Cook with AFC Incident / Accident Reports
07/16/2026	Contact - Telephone call made to direct care staff members Robert Lockey, LD Jennia Cook, Bruce Smith, Brian Davis (left message), Angela Loiselle (left message), Elizabeth Scharaswak, Bradley Clancey, MCN case manager Melissa Blaniios (left message)
07/16/2026	Exit conference with licensee designee Jennia Cook, Corrective Action Plan received from Ms. Cook.
07/17/2026	Contact – Email to APS worker Caitlin Fick.

ALLEGATION: Resident A eloped from Country Place II and entered a neighbor's home without permission.

INVESTIGATION:

On 06/08/2026 a complaint was received from Bureau of Community and Health Systems online complaint system with allegations that Resident A eloped on multiple occasions from the facility. According to the complaint allegations, Resident A entered Citizen 1's home without permission on at least one occasion and this was captured on a Ring camera. According to the Ring camera footage Resident A walked into this neighbor's home, walked inside for around a minute and then left the home. Adult Protective Services (APS) Caitlin Fick has also been assigned to investigate these concerns.

On 06/09/2026 I contacted Citizen 1 who stated there have been two incidents involving Resident A attempting to enter her home. Citizen 1 stated she did not report the incident that occurred two years ago. Citizen 1 stated she has installed a better lock on her door and plans to keep it locked more consistently. Citizen 1 stated she does not know if anything was stolen from her home. Citizen 1 stated the individual who entered her home appeared to be a male between 40–60 years of age. Citizen 1 also stated she did not see any direct care staff members on her camera footage and has no idea whether any direct care staff members were near Resident A during the 05/28/2026 incident.

On 06/17/2026 I conducted an unannounced on-site investigation at Country Place II and interviewed licensee designee Jennia Cook and direct care staff member/home manager Jamie Blizzard. Ms. Blizzard and Ms. Cook both reported that Resident A entered a neighboring home across the street and that a direct care staff member was immediately behind him. Ms. Blizzard stated Resident A engaged in similar behavior at his former AFC home but had not done so while living at Country Place II. Ms. Blizzard verified on her phone that she was contacted by former direct care staff member Bradley Clancey on 05/28/2026 at 4:34 PM notifying her of this incident.

Ms. Cook stated Resident A moved out of Country Place II on 04/13/2023 and then moved back in 09/2025. Ms. Cook stated she believes Resident A entered the home during the most recent incident because the homeowner was going to contact law enforcement. Ms. Cook stated Resident A had been discharged from his previous AFC home due to these behaviors. Ms. Cook stated she is worried about what could occur if Resident A elopes again. She stated she has told direct care staff members they may position themselves in front of Resident A if he attempts to enter someone else's home; however, she is concerned Community Mental Health may view this as restricting his movement. Ms. Cook expressed significant concern, noting Resident A could have been seriously harmed if the homeowner had possessed a weapon or intended to harm him.

I reviewed the following documents in Resident A's record which are summarized below:

• Behavior Treatment Plan identifying eloping as a target behavior:
To address eloping: Alarms can be placed on exit doors so direct care staff members are aware when Resident A is leaving. If Resident A threatens to run away, it is important that direct care staff members remain consistent and do not give in to his demands related to these threats. Resident A must not learn that threatening to elope results in others giving him what he wants. If Resident A actually elopes, a direct care staff member must follow him to ensure his safety, including if he elopes into the yard only. A calm approach should be used until he can be encouraged to return to the home. Once he returns, direct care staff members should verbally redirect him to an acceptable activity.
Fading/titration plan: If Resident A refrains from eloping for six months, exit alarms and the elopement procedure will be discontinued.

• Person-Centered Plan (04/15/2026): His behavior has generally improved at his current placement; however, elopements and related concerns have increased in recent months, including an isolated incident of entering a neighbor's home. Due to safety concerns, restrictive procedures (alarms on his bedroom window, bedroom door, and AFC exit doors) have been implemented. Resident A has an elopement procedure requiring direct care staff members to follow him if he leaves the home due to him going to strangers' homes and attempting to enter them. Community members have threatened to harm him if he enters their property.

• Health Care Appraisal: Diagnosis includes Schizoaffective disorder, bipolar type, and GERD. Under physical/intellectual status: Intellectual disability.

• Assessment Plan for AFC Residents: Resident A does not move independently in the community and requires direct care staff member assistance due to fall risk. He follows instructions "most of the time" but may ignore direction during increased anxiety or stress.

I reviewed the *AFC Incident/Accident Report* from the 05/28/2026 incident, which documented the below information:

> *At approximately 4:30 p.m., [Resident A] left the facility and went across the street toward a neighboring home. One direct care staff member was busy, and [Resident A] crossed the street. Direct care staff members followed [Resident A] and returned him to the unit and then to his bedroom. Management was notified. No injuries were reported, law enforcement was not listed as notified, and no corrective action was documented."*

I interviewed Resident A who stated he "went for a walk and went into someone's home." He stated he understands this is dangerous because the homeowner could have attacked him or shot him. Resident A stated he returned to the AFC afterward. Resident A stated he entered the neighbor's home to look for pills and was able to steal

some. Resident A stated law enforcement spoke with him about the incident. Resident A stated he also went to another neighbor's home where they "almost shot him with a gun," but this was verified as part of a previous incident at his former AFC home. Resident A stated he feels safe living at Country Place II and stated the direct care staff members take good care of him.

On 06/17/2026 I interviewed direct care staff member and home manager Tina Prescott. Ms. Prescott stated Resident A does not require 1:1 staffing coverage and typically remains in his room unless upset with Guardian A1. Ms. Prescott stated that from a homeowner's perspective, Resident A may have been in the home longer than staff realized, though she does not believe it was very long. Ms. Prescott stated direct care staff members Bruce Smith and Brian Davis were working with Resident A during the incident.

I observed Resident A's bedroom, which is located directly off the kitchen. Ms. Prescott stated this makes supervision easier. She stated the home does not have set times to check on him during the day but checks occur every two hours during third shift.

On 06/17/2026 I interviewed direct care staff member Angie Strayer. Ms. Strayer stated she was not present during the incident but has encountered Resident A in the driveway during other occasions and she redirected him back to the AFC. Ms. Strayer stated she was unaware Resident A had entered someone else's home.

On 06/18/2026 I received a call from Office of Recipient Rights (ORR) Angela Loiselle, who stated she was aware of an incident occurring approximately two weeks prior in which Resident A entered a neighboring home. Ms. Loiselle stated Ms. Cook informed her that Resident A had eloped and returned with medications belonging to a neighbor. Resident A possessed three medication bottles. Ms. Loiselle stated Resident A is not monitored under line-of-sight supervision in the home and recommended adding direct care staff member coverage, which Ms. Cook implemented.

Ms. Loiselle stated Resident A eloped from his previous licensed AFC and entered another neighbor's home so this behavior is a pattern for him. Ms. Loiselle stated any elopement by Resident A presents an immediate risk. She stated that during a Recipient Rights training, CeeCee McIntyre demonstrated a "safe turn" procedure for Resident A to direct care staff members. Ms. Loiselle stated Resident A had gone to the same trailer park previously while living at Country Place II. Ms. Loiselle stated alarms were not documented in Resident A's plan and recommended adding an addendum authorizing bedroom door and exit door alarms. Ms. Loiselle reported Ms. Cook has attempted to address these concerns proactively and that a safety protocol will be added to include an alarm immediately on Resident A's bedroom door.

On 06/26/2026 I received an email from Citizen 1 stating there was another incident where Resident A entered her home and remained inside for approximately one minute before direct care staff members intervened and retrieved Resident A on the road after

he left her property. She provided Ring camera screenshots showing Resident A walking off her porch.

On 07/02/2026 I received another email from Citizen 1 which stated:

> *At 12:30 AM today, the gentleman returned to our property and began knocking on our door. Fortunately, we have been keeping the door locked at all times since the last incident. He continued to knock several times until a staff member drove over from across the road to retrieve him. I was unable to capture screenshots of the encounter this time.*

On 07/15/2026 I received an email from Ms. Cook providing *AFC Incident/Accident Reports* for the 07/02/2026 incident involving Resident A attempting to leave the home and enter the neighbor's residence. Ms. Cook stated the home is now staffing a second direct care staff member during third shift specifically assigned to Resident A.

I reviewed and summarized the AFC Incident/Accident Report dated 07/02/2026 as follows: At approximately 12:15 a.m., direct care staff members from Unit 3 found Resident A in the parking lot and escorted him back to Unit 2. Staff attempted to locate Resident A inside the unit but could not find him. Multiple direct care staff members searched the property and surrounding areas but were unable to locate him. At approximately 1:35, a direct care staff member located Resident A and returned him to the unit. Resident A stated he had been at a neighboring trailer attempting to break in. Law enforcement was notified. Resident A admitted attempting to break in. The responding officer spoke with Resident A regarding the seriousness of the behavior but did not indicate whether charges would be pursued. Staff noted Resident A's history of similar behavior, suspected PRN administration that day, and observed increased agitation and sleep disruption. The officer left without issuing further action.

On 07/16/2026 I interviewed direct care staff member Bruce Smith. Mr. Smith stated Resident A's behaviors sometimes vary depending on which direct care staff member is working or if Resident A has had contact with Guardian A1. Mr. Smith reported that around 4:30 p.m. on 05/28/2026, while cooking dinner, direct care staff member Brian Davis located Resident A with pill bottles taken from a neighbor's home. Mr. Smith stated Resident A became ill later, and they were concerned he may have ingested medication; however, Resident A denied doing so. Mr. Smith monitored Resident A throughout the day, and Resident A was hospitalized for pneumonia later. Mr. Smith does not know whether bloodwork was completed to determine if other medications were ingested. Mr. Smith stated he can typically tell when Resident A intends to elope because Resident A will say he is going to the "back bathroom," or he will put on his shoes. Mr. Smith stated Mr. Davis had his back turned when Resident A eloped. This occurred before 1:1 staffing or line of sight supervision was implemented. Mr. Smith stated Resident A had other attempted elopements, including an incident on 06/10/2026 where he could tell that Resident A was going to walk toward the front of the house and leave, but he was able to stop him from leaving. Mr. Smith stated he worked first shift on 07/02/2026 and Resident A was escalated in the morning but did not attempt to leave until the afternoon, following a visit with Guardian A1. Mr. Smith was able to redirect

Resident A to his bedroom earlier that morning. He stated he uses phrases like “Hey, walk with me,” to maintain visual supervision when he cleans or needs to move around the home.

Mr. Smith stated Resident A’s increased 1:1 coverage during third shift began after the 07/02/2026 incident. Mr. Smith stated the 05/28/2026 incident was the only time Resident A obtained medications from another home. Mr. Smith reported Resident A has eloped before, but direct care staff members usually stop him before he reaches neighboring residences. Mr. Smith stated no third shift elopements have occurred since additional overnight coverage was assigned. He stated daytime supervision is challenging because there is no 1:1 and direct care staff members must divide attention among ten residents.

On 07/16/2026 I interviewed direct care staff member Elizabeth Scharaswak. Ms. Scharaswak stated she has never witnessed a successful elopement where Resident A entered another home. She stated there was an incident near the end of May or beginning of June where Resident A left through the gate while she and direct care staff member Brian Davis were working, but another direct care staff member intercepted Resident A before he reached the road. Ms. Scharaswak stated she notified Walter Bowser, who was on call, but did not recall the exact date. She stated Resident A did not make it off the property and stated she is aware of only one or two attempts of elopement but noted that increased supervision during the day and 1:1 coverage on third shift has helped prevent him from leaving.

On 07/16/2026 I completed an exit conference with licensee designee Ms. Cook. Ms. Cook stated she added a direct care staff member to serve as a 1:1 for Resident A from 10:00 p.m. to 7:00 a.m., installed a door alarm, and ensured Resident A receives line-of-sight supervision during daytime hours. Ms. Cook stated she would submit a corrective action plan addressing these concerns. Ms. Cook stated the third shift direct care staff member is specifically assigned to Resident A. She stated Resident A tends to leave when direct care staff members appear occupied. Ms. Cook stated Resident A is fast and can leave quickly without being noticed. Ms. Cook stated she hopes Resident A will not require full-time 1:1 supervision, but direct care staff members have increased monitoring and are ensuring he remains in sight. She stated direct care staff members reviewed safe intervention procedures to redirect Resident A appropriately. Ms. Cook clarified during the 07/02/2026 the neighbor’s door was locked, preventing Resident A from entering. Law enforcement responded, and Ms. Cook does not know whether charges will be pursued. Ms. Cook stated Resident A previously slept through the night but no longer does so a medication review is scheduled and will address Resident A’s lack of sleep and resulting agitation. Ms. Cook stated she was aware of the two incidents on 05/28/2026 and on 07/02/2026, but she is not aware of an additional incident on 06/26/2026.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Resident A was not provided with supervision consistent with Resident A's *Assessment Plan for AFC Residents* and *Behavior Treatment Plan*. These plans require direct care staff members to maintain awareness of Resident A's movements, use exit-door alarms, and follow Resident A any time he elopes to ensure his safety. Resident A requires assistance due to fall risk, impulsivity, and a history of entering neighboring homes. Despite these requirements, Resident A eloped multiple times attempting to enter neighbors' homes on 05/28/2026, 06/26/2026, and 07/02/2026 without appropriate direct care staff member supervision. During the incident on 05/28/2026, he was able to obtain medications prescribed to someone else.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An approved corrective action plan has been received. I recommend no change in the license status.

_____07/17/2026_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

07/20/2026

_____

Dawn N. Timm
Area Manager

Date