



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 19, 2026

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

RE: License #: AM460417872
Investigation #: 2026A1032044
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) 356-0100.

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 #:	2026A1032044
Complaint Receipt Date:	07/23/2026
Investigation Initiation Date:	07/23/2026
Report Due Date:	09/21/2026
Licensee Name:	Country House Care, L.L.C.
Licensee Address:	1395 Seneca Street, Adrian, MI 49221
Licensee Telephone #:	(517) 442-2161
Administrator:	Lela Shank, Designee
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:	07/03/2026
Expiration Date:	07/02/2028
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

Violation Established?	
The facility did not properly supervise Resident A, leading to a delayed police response.	No

III. METHODOLOGY

07/23/2026	Special Investigation Intake 2026A1032044
07/23/2026	Special Investigation Initiated - Telephone Text message to licensee Lela Shank
07/23/2026	APS Referral No APS referral made-APS Screenout
08/04/2026	Inspection Completed On-site Interview with Resident B, Employee Rose Whittington and document review
08/06/2026	Contact - Document Received Copy of Incident Report on Resident A's disappearance received
08/13/2026	Contact - Document Sent I requested the missing person's report filed with the Morenci City Police Department
08/17/2026	Contact - Document Received Police report of a missing person-Resident A
08/18/2026	Contact - Telephone call received Interview with Guardian A1

08/18/2026	Exit Conference
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ALLEGATION:

The facility did not properly supervise Resident A, leading to a delayed police response.

INVESTIGATION:

On 7/23/26, I contacted licensee Lela Shank by text, to determine whether Resident A had been found. Ms. Shank advised that Resident A had been found but had been transferred to a hospital for treatment and observation.

On 8/4/26, I interviewed employee Rose Whittington in the facility. Ms. Whittington stated that on the day in question, Resident A sat outside on the back porch smoking after lunch. She surmised that an hour had passed before she checked on her and noticed that she was gone. She recalled that no one was outside with Resident A at the time since the residents who smoke usually congregate at the front of the facility. She stated that the police were contacted as well as Guardian A1.

I interviewed Resident B in the facility. Resident B did not have any information to provide about Resident A leaving but stated that the facility has been running well recently after a problematic employee was terminated.

I reviewed Resident A's assessment plan, which indicated that Resident A could move about the community independently. There was nothing indicating that Resident A required enhanced supervision or was an elopement risk.

On 8/6/26, I reviewed the incident report authored by employee Rose Whittington. The incident occurred on 7/20/26. The report noted that Guardian A1 and the police were contacted the day that Resident A went missing.

On 8/13/26, I requested a copy of the missing person's report.

On 8/17/26, I received the missing person's report from the Morenci City Police Department. The report verified that New Beginnings staff had notified the police about Resident A's absence. Resident A was located by a relative per the report and police followed the relative to Hickman Hospital where she was assessed. The missing person's report is dated 7/21/26.

On 8/18/26, I left a message for Guardian A1 to make contact with me.

On 8/18/26, Guardian A1 contacted me by telephone and reported that Resident A's assessment plan will be updated to include walks with another person. He stated that Resident A decided to go for a walk and got lost, but did not tell staff that she was leaving the facility. He advised that after she was hospitalized psychiatrically, her medications were changed and she seems more coherent. He mentioned that she would be leaving soon to vacation with her mother briefly in another state then return to the facility.

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:	I reviewed Resident A's assessment plan which stated that she could move independently in the community. A report was made to the Morenci City Police Department on 7/20/26; subsequently, the report became a 'missing person's report' since Resident A was not located within 24 hours of the report being filed. Therefore, a timely report was made to the police. Resident A was not considered an elopement risk at the time, however Ms. Shank and Guardian A1 have adjusted Resident A's supervision level. As such there is insufficient evidence to establish a violation since there was substantial compliance with reporting requirements and supervision levels per the documents reviewed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 8/19/26, I conducted an exit conference with licensee designee Lela Shank. I shared my findings and Ms. Shank agreed with the conclusions reached. Ms. Shank advised that Resident A's supervision level would be updated to reflect closer observation, especially as it relates to community movement.

IV. RECOMMENDATION

I recommend that the status of this license remains unchanged.

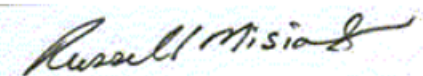


8/19/26

Dwight Forde
Licensing Consultant

Date

Approved By:



8/19/26

Russell B. Misiak
Area Manager

Date