



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 21, 2026

Cajetan Kimfon
Country Square Adult Foster Care LLC
1929 11 Mile Road
Auburn, MI 48611

RE: License #:	AL090402268
Investigation #:	2026A0123051
	Country Square AFC

Dear Cajetan Kimfon:

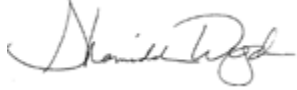
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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 (517) 643-7960.

Sincerely,

A handwritten signature in cursive script, appearing to read "Shamidah Wyden".

Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL090402268
Investigation #:	2026A0123051
Complaint Receipt Date:	08/04/2026
Investigation Initiation Date:	08/07/2026
Report Due Date:	10/03/2026
Licensee Name:	Country Square Adult Foster Care LLC
Licensee Address:	1929 11 Mile Road Auburn, MI 48611
Licensee Telephone #:	(989) 662-4514
Administrator:	Cajetan Kimfon
Licensee Designee:	Cajetan Kimfon
Name of Facility:	Country Square AFC
Facility Address:	1929 11 Mile Road Auburn, MI 48611
Facility Telephone #:	(989) 662-4514
Original Issuance Date:	02/25/2020
License Status:	REGULAR
Effective Date:	08/25/2024
Expiration Date:	08/24/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 08/02/2026, Resident A had a fall with a possible broken nose. First responders arrived at the facility and were unable to locate a staff person for approximately 45 minutes. There is concern that appropriate onsite care and supervision is not being provided to residents in the facility.	Yes

III. METHODOLOGY

08/04/2026	Special Investigation Intake 2026A0123051
08/07/2026	Special Investigation Initiated - On Site I conducted an unannounced on-site at the facility.
09/02/2026	APS Referral Information received regarding APS referral.
09/02/2026	Contact - Telephone call made I spoke with adult protective services investigator Bethany Hornbacher.
09/02/2026	Contact- Document Sent I sent an email requesting documentation from the facility.
09/08/2026	Contact- Document Received I received requested documentation.
09/18/2026	Contact- Telephone call made I interviewed licensee designee Cajetan Kimfon.
09/18/2026	Exit Conference I spoke with licensee designee Cajetan Kimfon via phone.

ALLEGATION: On 08/02/2026, Resident A had a fall with a possible broken nose. First responders arrived at the facility and were unable to locate a staff person for approximately 45 minutes. There is concern that appropriate onsite care and supervision is not being provided to residents in the facility.

INVESTIGATION: On 08/02/2026, The Bureau of Community and Health Systems received the allegations noted above. The complaint also states that the Beaver

Township Fire Department received a 911 dispatch for a female resident that had fallen, possible broken nose, with blood everywhere at the AFC home. An onsite care giver was unable to be contacted. The fire department responded to the scene and was also unable to locate staff after numerous attempts knocking loudly on doors. Central Dispatch was able to contact a staff person about 31 minutes after the fire department responded to the facility who reported that LD Cajetan Kimfon may be deceased. The staff person went into an area of the facility where a light was now on, and a few minutes later LD Kimfon came outside. Resident A was transported to a hospital in Midland by ambulance for treatment. Resident B reported they were unable to locate the staff person, so Resident B picked Resident A up from the floor. There is concern that appropriate on site care and supervision is not being provided to residents in the facility.

On 08/07/2026, I conducted an unannounced on-site at the facility. I interviewed Resident A and Resident B. Resident A stated that there were no staff person present upstairs on 08/02/2026. Staff were downstairs in the laundry room and did not hear anything through the intercom, or the first responders banging on the door. Resident A stated that they didn't know if they should call the ambulance. Resident C called 911. Resident A reported last seeing staff that day at 8:00 pm during medication pass time, and it was either LD Kimfon or staff Eugene Nyukighan. Resident A stated that around 12:30 am or 1:00 am is when the first responders were banging on the door. Resident A stated that she slipped on some urine or water that was on the bathroom floor and hit her head on the floor. Resident A reported having a broken and bloody nose. Resident A denied knowing if the intercom system is in the laundry room. Resident A reported she uses a walker but did not have it in the bathroom because the walker cannot fit in the bathroom. Resident A stated that Resident B helped her get up from the floor. Resident A reported having had two other previous falls. Resident A stated that she leaves the bathroom light on now.

Resident A was observed to have very noticeable bruising across the bridge of her nose, and under her eyes during this interview. Bruising was observed on Resident A's arm as well. Resident A stated that it was from a hospital IV (intravenous needle).

Resident B was interviewed. Resident B reported being awakened by Resident A yelling. Resident B helped Resident A up from the floor. Resident A was bleeding. Resident C called 911. The first responders knocked at the front door (driveway entrance). Resident B stated that there were no staff that responded to the intercom. Staff Eugene Nyukighan passed the last round of medications that day. Resident B stated she did see LD Kimfon outside when Resident A was getting in the ambulance. LD Kimfon checked the bathroom and cleaned it up etc. Resident B stated that Resident A said there was urine on the bathroom floor. Resident B stated that a resident who shares their bathroom does urinate on the floor. Resident B stated she thought Resident A was going to bleed to death. Resident B stated that LD Kimfon said he was in the laundry room at the time of the incident.

During this on-site, I had a staff person bang on the front door of the facility, while I stood in the laundry room. I could barely hear any banging, and the washer and dryers were not active at the time. There was no intercom/call light observed in the laundry room.

On 09/02/2026, I spoke with adult protective services worker Bethany Hornbacher. She stated that the facility sent her an updated policy regarding the alarms in the facility as a corrective action plan. LD Kimfon was present at the facility the night of the incident. LD Kimfon was doing laundry and could not hear anything as the alarms may have been turned down. She stated that now staff check the call alarms at the start of each shift because they were turned down the night Resident A fell. She stated that LD Kimfon was covering a staff person who was on vacation.

On 09/08/2026, I received requested documentation via email from LD Kimfon. Resident A's *Health Care Appraisal* dated 06/17/2026, notes that Resident A is diagnosed with schizoaffective disorder, GAD, hypothyroid, hypertension, hyperlipidemia, and thrombocytopenia. Resident A is fully ambulatory. Resident A's *Assessment Plan for AFC Residents* dated 06/18/2026, notes that Resident A requires no hands on staff assistance. However, the assessment plan notes that Resident A cannot move independently in the community due to poor decision making and illogical thought process. For toileting Resident A has some nighttime incontinence and is provided with pad inserts. Staff provide verbal prompts for bathing and grooming. Bathing does require standby assist, as well as walking for long distances and stair climbing. The assessment plan states Resident A utilizes a cane. A copy of the staff schedule shows LD Cajetan Kimfon was on shift from 9:00 pm to 7:00 am, 08/01/2026 through 08/02/2026. A copy of the facility's *Resident Register* reflects that there are 16 residents in the facility to date.

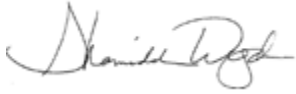
On 09/18/2026, I interviewed licensee designee Cajetan Kimfon via phone. LD Kimfon stated that on the night Resident A fell, he was doing laundry in the laundry room. First responders were knocking at the front door, and he did not hear the knocking. Residents have a call light switch in the bedrooms hardwired into the walls. LD Kimfon stated that the residents do not have call lights they can wear around their necks, but that is an option to consider. Resident A went by ambulance to the emergency room, not accompanied by staff. LD Kimfon stated that it was his understanding that the EMTs transport the residents to the emergency room with their face sheet documentation, and the hospital will call the facility for more information. LD Kimfon stated that the home is staffed as one person at night, and he was alone that night working. LD Kimfon stated that the residents on the upper level walk unassisted. There is one resident with autism (non-verbal), one resident with dementia, and one resident who is hard of hearing that lives on the upper level. Two residents on the lower level utilize wheelchairs, and two have dementia. There are two residents that require assistance getting out of bed. There are 17 residents in total. LD Kimfon stated that he does not have Resident A's discharge paperwork from the hospital as Resident A's family member picked Resident A up from the hospital.

On 09/18/2026, I conducted an exit conference with licensee designee Cajetan Kimfon. I informed Cajetan Kimfon of the findings and conclusion.

APPLICABLE RULE	
R 400.671	Staffing requirements.
	(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:	On 08/07/2026, I conducted an unannounced onsite at the facility. I interviewed Resident A and Resident B. Resident A reported having a fall on the morning of 08/02/2026. Staff did not hear the call alarm and did not respond to Resident A's room. Another resident called 911. Resident A was transported to the emergency room. Resident B assisted Resident A up from the floor. Resident A was observed during this interview to have visible facial bruising. Resident B was interviewed and confirmed that staff did not respond to the call light, Resident B assisted Resident A from the floor, and another resident called 911. Resident A's <i>Assessment Plan for AFC Residents</i> dated 06/18/2026 notes that Resident A does not require hands on staff assistance but cannot move independently in the community. On 09/18/2026, LD Kimfon confirmed that Resident A was transported to the emergency room by ambulance without staff supervision. On 09/18/2026, I interviewed licensee designee Cajetan Kimfon. He reported being the only staff present on shift the night Resident A fell. He stated that he was in the laundry room and did not hear the call alarm or EMT's knocking. He confirmed there are seventeen residents in total and multiple residents have dementia, are hard of hearing, or use wheelchairs. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC large group home license (capacity 13-20).



09/21/2026

Shamidah Wyden
Licensing Consultant

Date

Approved By:



09/21/2026

Mary E. Holton
Area Manager

Date