GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 6, 2022

Steven Wilson
Whispering Pines 2 AFC, LLC
1878 Soules Rd.
Afton, MI 49705

RE: License #: AM160386603
Investigation #: 2022A0009039
Whispering Pines 2

Dear Mr. Wilson:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame for the violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please 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 (231) 356-0100.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
701 S. Elmwood, Suite 11
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM160386603
Investigation #:	2022A0009039
Complaint Receipt Date:	08/09/2022
Investigation Initiation Date:	08/10/2022
Report Due Date:	09/08/2022
Licensee Name:	Whispering Pines 2 AFC, LLC
Licensee Address:	1878 Soules Rd. Afton, MI 49705
Licensee Telephone #:	(231) 238-9715
Administrator:	Dorthy Wilson
Licensee Designee:	Steven Wilson
Name of Facility:	Whispering Pines 2
Facility Address:	1878 Soules Rd. Afton, MI 49705
Facility Telephone #:	(231) 238-9715
Original Issuance Date:	06/05/2017
License Status:	REGULAR
Effective Date:	12/05/2021
Expiration Date:	12/04/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The licensee discharged Resident A before a full 24 hours had elapsed.	Yes

III. METHODOLOGY

08/09/2022	Special Investigation Intake 2022A0009039
08/10/2022	Special Investigation Initiated – Telephone call made to adult foster care worker Ms. Jacqueline Muzyl
08/11/2022	Inspection Completed On-site Interviews with direct care worker Ms. Peggy Dunham and Resident B
09/01/2022	Contact – Telephone call made to Community Mental Health (CMH) caseworker Ms. Patricia Crist
09/01/2022	Contact – Telephone call made to Resident A's Guardian
09/02/2022	Contact – Telephone call made to licensee designee Mr. Steven Wilson
09/02/2022	Exit conference with licensee designee Mr. Steven Wilson

ALLEGATION: The licensee discharged Resident A before a full 24 hours had elapsed.

INVESTIGATION: I spoke with licensee designee Mr. Steven Wilson by phone on July 28, 2022. He told me that Resident A had assaulted Resident B and he felt he needed to issue a 24-hour emergency discharge of Resident A to assure the safety of Resident B. Resident A's Family Member had agreed to pick up Resident A and take him to the hospital to be evaluated there. I received an emergency discharge notice regarding Resident A which was written to "whom it may concern". I also received an Incident/Accident Report (BCAL-4607) about Resident A assaulting Resident B and that "(Resident A) was given a 24-hour emergency discharge from Whispering Pines 2".

I received a law enforcement report from Officer Sugg with the City of Petoskey Department of Public Safety. He was called to the hospital in Petoskey on July 28, 2022. Resident A had been taken there for a Community Mental Health (CMH)

evaluation. CMH did not deem that Resident A was a threat to himself or others at that time. Resident A's Family Member told Officer Sugg that Resident A did not have anywhere to stay. She, her husband and two children were living in a 14-foot camper. She explained that they were called by Mr. Wilson, the owner of the Whispering Pines 2 adult foster care home, and told they needed to pick Resident A up that morning. Officer Sugg questioned the appropriateness of Mr. Wilson evicting Resident A at that time. Resident A's Family Member stated that if she had known Mr. Wilson could not immediately evict Resident A like that, she would never have agreed to take him to the hospital. Officer Sugg determined that Resident A had been improperly evicted from the foster home and he told Resident A's Family Member to take him back there.

Officer Sugg then spoke with licensee designee Mr. Steven Wilson. He reported, "I spoke with Wilson on the phone and advised him that (Resident A) will be returning for the night. Wilson refused to allow (Resident A) to return. Wilson stated that (Resident A) was a threat to other residents. Wilson then stated that that he did a 24-hour emergency discharge on (Resident A) for assaulting someone. Per Wilson, this was done through (Resident A's) caseworker. I asked Wilson to explain what that meant and he stated that it removes (Resident A) from the home." Officer Sugg stated that Mr. Wilson continued to "argue his case" and that Officer Sugg ended the phone call.

Officer Sugg had also documented in his report that he spoke with the law enforcement officer who had responded to the 911 call at Whispering Pines that morning. The officer noted that Resident B had "small, superficial cuts" on his head from Resident A. Emergency Medical Services (EMS) looked Resident B over and did not feel he needed further treatment. The officer did not arrest Resident A at that time or remove him from the home.

I spoke with adult protective services worker Ms. Jacqueline Muzyl by phone on August 10, 2022. Resident A did assault Resident B at the facility. She said that she believed that the facility pressured Resident A's Family Member to take Resident A even though she didn't have anywhere for him to stay. She and her family are living in a camper. She is not his guardian, only his payee. Resident A does not currently have a guardian although they plan on looking into that. Resident A's Family Member was told to take Resident A to the hospital to have him assessed. He was assessed but was not determined to be a threat to himself or others at that time. Resident A's Family Member did not have anywhere to take him. She took him back to her camper for the night and Resident A spent the night in her vehicle. There was no room for him in the camper and it would not be appropriate for Resident A to be around children even if there had been room for him in the camper. Ms. Muzyl stated that the next night, she was able to put him up in a hotel for several days. Resident A's Family Member did stay with him at the hotel because he cannot be by himself. She did know that Resident A had assaulted an elderly resident at the home. Law enforcement was very concerned about how Whispering Pines had handled the situation. They believed personnel pressured

Resident A's Family Member to take Resident A even though they did not have an appropriate place for him to stay. Ms. Muzyl stated that she also spoke with Community Mental Health (CMH) caseworker Ms. Patricia Crist who has been looking for a place for Resident A to reside. So far, she has been unsuccessful finding a licensed facility for him.

I made an unannounced site visit at the Whispering Pines 2 adult foster care home on August 11, 2022. I spoke with direct care worker Peggy Dunham at that time. She said that she was present when Resident A assaulted Resident B. She went to get Resident B for breakfast and saw that he had blood on his head. He told her that Resident A had hit him. She saw that he had a lump on his head which was also bleeding. Resident A admitted that he hit Resident B. They were fighting over cigarettes. Ms. Dunham said that she called 911 at that time. She said that she did feel that Resident A was a danger to the other residents at that time. The police showed up as well as the owners, Mr. and Mrs. Wilson. Resident A does not have a guardian but has a sister who lives in the area. Mr. Wilson called the sister and told her that he was issuing a "24-hour discharge" of Resident A. The husband of Resident A's Family Member was there at about 10:00 a.m. to pick Resident A up.

I also spoke with Resident B during my visit. I saw that he had a healing wound on the top of his head. Resident B said that Resident A hit him on the head.

I spoke with Resident A's CMH caseworker Patricia Crist by phone on September 1, 2022. She was contacted on the morning of July 28, 2022, about Resident A assaulting Resident B. Law enforcement was called but did not believe that the incident warranted Resident A's arrest. Mr. Wilson told Resident A's Family Member to take Resident A to the hospital to be assessed. He was assessed by another CMH worker but was not deemed to be a threat at that time. After the foster home refused to take Resident A back that evening, Resident A spent the night in Resident A's Family Member's vehicle. She did not have anywhere for him to stay.

I also spoke with Resident A's Family Member by phone on September 1, 2022. She said that she is now Resident A's guardian but she was not at the time he was evicted from Whispering Pines. Resident A was "his own guardian" at that time. Resident A's Family Member said that she got a call on the morning of July 28, 2022, from a police officer asking her if she could take Resident A "for the day". She also spoke with Mr. Wilson by phone at that time. He asked her to take Resident A to the hospital so his medications could be assessed. Resident A's Family Member stated that she was at work at the time and could not leave right then. She asked her husband to go get Resident A. When her husband arrived, they gave him all of Resident A's belongings including his medication. He was also given a check for $100 which he was told was to be used for housing. Resident A's Family Member did take Resident A to the hospital but they did not believe that he was a threat to himself or others. Officer Sugg, whom she met there, instructed her to take Resident A back to the Whispering Pines foster home. This was late that night or early the next morning. She was enroute to the Whispering Pines foster home when

she received a telephone call from a Cheboygan County Sheriff's deputy. He told her that the foster home did not want Resident A back "under any circumstances". She said that she did not know what to do at that point other than taking him back to their camper. She knew that he could not stay at a hotel by himself. Resident A's Family Member said that Resident A ended up spending the night in her vehicle.

I then spoke with Resident A's Family Member's husband. He said that he was contacted by his wife who told him that Resident A's foster home was asking them to take Resident A for the day. She asked him if he could go pick Resident A up there. He said that he went to the foster home and they gave him all of Resident A's belongings, all his medication and had him sign something saying that he received all of Resident A's medication. They also handed him a check for $100 and told him, "good luck". There was no discussion that they would be able to bring Resident A back during the next 24 hours. It was obvious to him that they intended for Resident A to be leaving for good.

I spoke with licensee designee Mr. Steven Wilson by phone on September 2, 2022. He said that it was a Cheboygan County Sheriff's deputy who he talked to the night of July 28, 2022. They talked about the situation and Mr. Wilson told him that he did not feel that he could keep the other residents safe from Resident A. The deputy told him that he would call Resident A's Family Member and ask her to take Resident A for the night. I told Mr. Wilson that the law enforcement officer from Petoskey reported that he, Mr. Wilson, told him that he would not take Resident A back for the night. I reminded Mr. Wilson that a 24-hour emergency discharge meant that the licensee was responsible for Resident A for at least that 24-hour period and that he also needed to ensure he went to an appropriate setting. We talked about the fact that Resident A's Family Member was not even his guardian at that time. Mr. Wilson stated that she was willing to take him and that he even gave her a $100 check for housing. I said that did not exclude him from the responsibility of caring for Resident A for at least that 24-hour period. Mr. Wilson argued that he never actually told the Petoskey officer that he refused to take Resident A back, he just kept asking him how he was supposed to keep his other residents safe from Resident A. I told him that it was his responsibility to make proper arrangements to care for Resident A. Examples of this are extra staff, having Resident A in his own bedroom with a staff sitting by his door, and Mr. Wilson himself being on-site to assist. Mr. Wilson stated that he was out of town at the time that he was contacted by law enforcement that night.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**

	(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists: (a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home. (b) Substantial risk, or an occurrence, of self-destructive behavior. (c) Substantial risk, or an occurrence, of serious physical assault. (d) Substantial risk, or an occurrence, of the destruction of property.
ANALYSIS:	It was confirmed through this investigation that there was a substantial risk, or an occurrence, of serious physical assault involving Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: (a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information: (i) The reason for the proposed discharge, including the specific nature of the substantial risk. (ii) The alternatives to discharge that have been attempted by the licensee. (iii) The location to which the resident will be discharged, if known. (b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a

	responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply: (i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located. (ii) The resident shall have the right to file a complaint with the department. (iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.
ANALYSIS:	It was confirmed through this investigation that Resident A was discharged from the facility before 24 hours had elapsed from when the responsible agency was contacted. This was on the morning of July 28, 2022, around breakfast time. He was also given into the care of a family member who did not have the appropriate setting for him. Officer Sugg from the Petoskey Department of Public Safety reported that Mr. Wilson refused to take Resident A back on the night of July 28. Resident A did hit Resident B on the head causing small, superficial cuts. Nothing else was discovered that would indicate Resident A being back in the home would cause an undue threat to the other residents if extra staffing and safeguards were put in place.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with licensee designee Mr. Steven Wilson by phone on September 2, 2022. I told him of the findings of my investigation and gave him the opportunity to ask questions.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

09/6/2022

Adam Robarge, Licensing Consultant Date

Approved By:

09/06/2022

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Jerry Hendrick, Area Manager Date