GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 26, 2025

Lisa Sikes
Walnut Ridge Senior Living
4352 Breton Rd SE
Kentwood, MI 49546

RE: License #: AH410413166
Investigation #: 2025A1021033
Walnut Ridge Senior Living

Dear Lisa Sikes:

Attached is the Special Investigation Report for the above-mentioned 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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative and a date.

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) 284-9730.

Sincerely,
Kimberly Horst

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410413166
Investigation #:	2025A1021033
Complaint Receipt Date:	01/30/2025
Investigation Initiation Date:	01/31/2025
Report Due Date:	04/01/2025
Licensee Name:	Kentwood Care Operations LLC
Licensee Address:	1435 Coit Ave NE Grand Rapids, MI 49505
Licensee Telephone #:	(616) 308-6915
Administrator:	Diana Billow
Authorized Representative:	Lisa Sikes
Name of Facility:	Walnut Ridge Senior Living
Facility Address:	4352 Breton Rd SE Kentwood, MI 49546
Facility Telephone #:	(616) 288-4151
Original Issuance Date:	04/13/2023
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	131
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A has fallen.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/30/2025	Special Investigation Intake 2025A1021033
01/31/2025	Special Investigation Initiated - Letter message sent to APS worker for additional information
01/31/2025	APS Referral referral came from APS
02/04/2025	Inspection Completed On-site
02/26/2025	Exit Conference

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Resident A has fallen.

INVESTIGATION:

On 01/30/2025, the licensing department received a complaint from Adult Protective Services (APS) with allegations Resident A has fallen multiple times. The APS reporting source alleged Resident A tries to transfer herself and will then fall. The APS reporting source alleged the facility has only encouraged Resident A to call for help when needing assistance. APS reporting source alleged Resident A would benefit from a fall alarm, but the facility refuses to use one. APS reporting source alleged it takes a long time for staff to respond to Resident A.

On 02/05/2025, the licensing department received a similar complaint from the online complaint system.

On 02/04/2025, I interviewed administrator Diana Billow at the facility. Administrator reported Resident A will always make her opinion known and will try to do things by herself. Administrator reported if Resident A wants to do something or believes caregivers are not helping her in a timely manner, she will transfer herself. Administrator reported Resident A has had a few falls and one resulted in a foot fracture. Administrator reported most of the falls have been a slide out of the wheelchair fall. Administrator reported Resident A has hallucinated such as believing she is on a magic carpet or an airplane. Administrator reported the facility does not want to move Resident A to memory care as Resident A would disrupt the unit with her behaviors. Administrator reported the facility is waiting for a psychologist evaluation for a possible medication review. Administrator reported they do not believe a fall alarm would be beneficial as Resident A would still transfer herself and would throw the alarm in the hallway.

On 02/04/2025, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident A is very impulsive and tries to transfer herself or will put herself in the shower. SP1 reported Resident A will sometimes use her call pendent to summon staff. SP1 reported Resident A will often call “help” from her doorway. SP1 reported if Resident A is refusing medications or cares, there is little the caregivers can do to encourage Resident A to be cooperative. SP1 reported some days Resident A is very pleasant and other days she is not.

I reviewed Resident A’s call light response times for 01/29/2025-02/03/2025. The average acknowledgment time was 20.75 minutes.

I reviewed Resident A’s service plan. The service plan read,
“Behavioral: Always speaks her opinion.”

I reviewed Resident A’s incident reports. The reports read,

01/04/2025: Resident was coming out of the bathroom and fell from her wheelchair. Small bruise on knee. Reinforced the importance of requesting assistance when getting out of bed. Use call light.
01/08/2025: Resident was found sitting on the floor of her room near an end table. She said she hit her head on the table when she fell. Resident was encouraged to ask for help while transferring.
01/18/2025: Resident had a controlled slide out of her wheelchair and landed on her bottom. She had no visible injury, but said her knee and neck were hurting. She was confused and unable to recognize her room. She could not remember having a long conversation with me a hour prior to the incident. Resident was encouraged to use to the help she needs from the staff rather than trying to do things by herself.
“02/02/2025: Resident was on the floor next to the bed. Encourage resident to ask for help before she transfers.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R 325.1901	**Definitions.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Interviews conducted and review of documentation revealed Resident A has had multiple falls at the facility. After each fall, Resident A is simply encouraged to call for assistance. However, review of Resident A's call light response time revealed the average response time is 20 minutes. The facility is not ensuring the protection of Resident A by ensuring the resident is free from physical harm from falling.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's incident reports from 01/08/2025 revealed Relative A1 and Resident A's physician were contacted but there was no date or time they were contacted. Similar findings were noted with the incident on 01/18/2025.

Review of Resident A's record revealed there was no documentation of the falls.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	Review of documentation revealed the facility did not document the date and time of the notification of Resident A's incidents. In addition, the incidents were not recorded in Resident A's record.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kimberly Horst 02/12/2025

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 02/19/2025

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section