GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 28, 2021

Jeffrey Shepard
Walnut Ridge Country Estate, LLC
P.O. Box 518
Stockbridge, MI 49205

RE: License #: AL330280995
Investigation #: 2021A0584017
Walnut Ridge Country Estate, LLC

Dear Mr. Shepard:

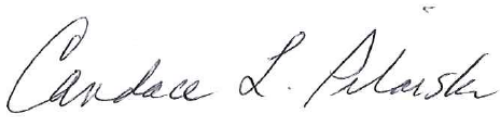
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- 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 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) 284-9727.

Sincerely,



Candace Pilarski, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-8967

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330280995
Investigation #:	2021A0584017
Complaint Receipt Date:	05/06/2021
Investigation Initiation Date:	05/06/2021
Report Due Date:	07/05/2021
Licensee Name:	Walnut Ridge Country Estate, LLC
Licensee Address:	4077 Oakley Rd. Stockbridge, MI 49285
Licensee Telephone #:	(517) 851-7501
Administrator:	Jennifer Flores
Licensee Designee:	Jeffrey Shepard
Name of Facility:	Walnut Ridge Country Estate, LLC
Facility Address:	4077 Oakley Rd. Stockbridge, MI 49285
Facility Telephone #:	(517) 851-7501
Original Issuance Date:	12/27/2007
License Status:	REGULAR
Effective Date:	12/30/2019
Expiration Date:	12/29/2021
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

05/06/2021

	Violation Established?
On 4/13/21, Resident A was sent to the hospital by AFC direct care staff after being observed not feeling well. Resident A was transferred to U of M Hospital for treatment of brain bleed suspected to be from trauma. Since surgery, Resident A has not improved and not able to make decisions. Direct care staff and manager were unable to provide information regarding incident or information regarding next of kin.	No
Additional Findings	Yes

III. METHODOLOGY

05/06/2021	Special Investigation Intake 2021A0584017
05/06/2021	Special Investigation Initiated - Telephone Phone call to U of M Social Worker-left voicemail to call back.
05/06/2021	Contact - Document Sent Email to Talaina Cummins, Adult Protective Services Worker, Ingham County Department of Health and Human Services
05/06/2021	Contact - Telephone call received from Talaina Cummins
05/06/2021	Contact - Telephone call made to Dawn Timm, AFC Consultant Manager
05/27/2021	Contact - Face to Face with Tisha Weirauch, direct care worker.
05/27/2021	Contact - Face to Face with Anissa Olmstead, CMH case manager
05/27/2021	Contact - Telephone call received with Jennifer Flores, Administrator.
06/02/2021	Contact - Document Sent- Email to Jenny Flores
06/14/2021	Contact - Document Receive- Email from Jennifer Flores
06/25/2021	Inspection Completed-BCAL Sub. Compliance
06/28/2021	Exit Conference via email to Jeff Shepard, licensee designee

ALLEGATION:

On 4/13/21, Resident A was sent to the hospital by AFC direct care staff after being observed not well. Resident A was transferred to U of M Hospital for treatment of brain bleed suspected to be from trauma. Since surgery, Resident A has not improved and not able to make decisions. Direct care staff and manager were unable to provide information regarding incident or information regarding next of kin.

INVESTIGATION:

On 5/6/2021, I conducted a phone interview with Adult Protective Services case worker, Talaina Cummins of the Ingham County Department of Health and Human Services. Ms. Cummins stated that she does have a complaint regarding Resident A being admitted to the hospital with a brain bleed and needing surgery. Ms. Cummins stated that Resident A was not able to cognitively answer any questions and did not have a guardian. Ms. Cummins stated that a guardian petition has been submitted at this time. Ms. Cummins stated that she has been following Resident A's hospitalization since April 2021. I mentioned to Ms. Cummins that I will be investigating rule violations, and this is the first time learning of these allegations that occurred about a month ago. Ms. Cummins provided Resident A's Community Mental Health case manager name of Anissa Olmstead and the number of University of Michigan Hospital (U of M) social work office for follow up contacts.

On 5/27/21, I conducted a face-to-face interview with direct care worker, Tisha Weirauch. Ms. Weirauch is familiar with Resident A but was not the worker on duty that noticed he was not well on April 12, 2021. Ms. Weirauch stated that Ms. Flores, the administrator was involved during the call to have Resident A taken to the hospital. Ms. Weirauch stated that the residents in the facility are not able to adequately answer questions and Resident A's roommate is completely non-verbal.

On 5/27/21, I conducted a face-to-face interview with Anissa Olmstead, Clinton, Eaton, Ingham County Community Mental Health caseworker. Ms. Olmstead stated that she is Resident A's case worker and has other consumers residing at this facility. Ms. Olmstead stated she makes frequent, unannounced visits to the facility and has never had any concerns about the care of the residents. Ms. Olmstead stated the main concern was that Resident A did not have a guardian, but he was able to make informed decisions prior to the hospitalization. Ms. Olmstead said the brain trauma from bleeding caused Resident A to not be able to communicate and therefore required a guardian to make decisions. Ms. Olmstead stated that Resident A has a sister and other family, but none of the family wants to be named guardian. Ms. Olmstead stated that Resident A now has Michigan Guardians to make decisions for him. Ms. Olmstead also stated that Resident A did recover from the surgery and is currently at a rehabilitation facility. Ms. Olmstead stated the plan is to have Resident A return to the Walnut Ridge or Elder Ridge facility when rehabilitation is complete. Ms. Olmstead verified that Resident A's roommate is non-

verbal and believed that the incident that caused the brain bleed was not caused by external trauma injury. Ms. Olmstead stated the information she received by contacting U of M Hospital stated there were no observable injury on Resident A's head or body upon admission such as from a fall. Ms. Olmstead stated that a public guardian was appointed for Resident A on 5/12/2021.

On 5/27/21, I reviewed Resident A's BCAL-3266, *Resident Care Agreement* that shows Resident A has signed the admission resident paperwork as his own guardian.

On 5/27/21, I conducted a phone interview with Jennifer Flores, administrator for the home. Ms. Flores stated that on April 13, 2021, she was contacted by direct care staff that Resident A was not looking well and was having trouble standing. Ms. Flores stated that she instructed the staff to contact emergency medical services. Ms. Flores stated that Resident A has had issues with UTI's in the past and thought maybe another one was affecting Resident A's health. Ms. Flores stated that EMS transported Resident A to McLaren Hospital, then the hospital requested that Resident A be transferred to U of M Hospital. Ms. Flores stated since Resident A has been his own guardian and at the time of hospitalization, she was not able to provide any other information who would be able to represent Resident A. Ms. Flores stated that Resident A has a case manager through Community Mental Health that works with him frequently. Ms. Flores stated that Community Mental Health and Adult Protective Services have gotten a public guardian to represent Resident A.

On 6/14/2021, I reviewed the hospital admittance paperwork from Dr. Jaes Jones dated 4/13/2021 that noted Resident A "last fell at the group home 1 year ago and does not take any anticoagulation or antiplatelet medications. No traumas have been witnessed." The paperwork noted, "Review of medical record from Sparrow hospital system reveals the patient had a fall on 7/28/20 which resulted in L facial tripod fracture and facial lacerations which required stiches on his face. At the time of trauma he was noted to have an essentially normal neuro exam." Dr. Jones noted, "Resident A alert and interactive. Oriented to person only. Language is fluent with intact naming, repetition, and comprehension. Cognition is globally slowed." The admittance paperwork did not list any observed signs of trauma on the head or face of Resident A that would indicate a fall or outside force to the head area.

On 6/14/21, I reviewed the admission paperwork from Medilodge of Okemos. Resident A was noted to have "nontraumatic chronic subdural hemorrhage" at the time of admission on 5/12/21.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A was admitted as a resident to the home under his own ability to sign and represent himself on legal paperwork. Resident A was observed to be having an illness on 4/13/21 which prompted the home to contact emergency medical services for an assessment. Resident A was sent to the U of M Neurological hospital for a discovered brain bleed. At the time of admission, Resident A was only oriented to self and his cognition was slowed requiring assistance with decisions. Community Mental Health and Adult Protective Services were contacted to assist with obtaining a guardian. A guardian was found while Resident A was in the hospital. The home did not witness any falls or trauma that may have caused the illness. The admittance report did not indicate any physical signs of trauma of Resident A's head or face on 4/13/21. There is not substantial evidence of a rule violation regarding the care and protection of Resident A occurred.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 5/27/21 I reviewed the resident file for Resident A. I was unable to locate an incident report regarding the hospitalization of Resident A on 4/13/21. Ms. Weirauch, the direct care worker who provided the record, stated all reports would be included in the file.

On 5/27/21, I spoke with Jennifer Flores over the phone. Ms. Flores was asked about an incident report for Resident A being sent to the hospital on 4/13/21 as one would be required to send. Ms. Flores stated that one was completed and mailed via United States Postal mail to my office address. Ms. Flores was told by me that prior to making the onsite inspection today, there was no receipt of that report to our office. Ms. Flores stated that she would send out another incident report form.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(ii) Hospitalization.**
ANALYSIS:	The incident report involving Resident A's hospitalization was not received by the department, nor did the home notify the adult foster care licensing division within 48 hours of the incident by other means.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Candace L. Pilarski

6/28/21

Candace Pilarski Date
Licensing Consultant

Approved By:

Dawn Timm 06/28/2021

Dawn N. Timm Date
Area Manager