GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 22, 2022

Lijo Antony
Walnut Creek Living, LLC
2695 Powderhorn Ridge Rd.
Rochester Hills, MI 48309

RE: License #: AS500402318
Investigation #: 2022A0604017
Walnut Creek Home

Dear Mr. Antony:

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 (248) 975-5053.

Sincerely,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 West Grand Blvd Ste 9-100
Detroit, MI 48202
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500402318
Investigation #:	2022A0604017
Complaint Receipt Date:	04/06/2022
Investigation Initiation Date:	04/07/2022
Report Due Date:	06/05/2022
Licensee Name:	Walnut Creek Living, LLC
Licensee Address:	2695 Powderhorn Ridge Rd. Rochester Hills, MI 48309
Telephone #:	(248) 568-7194
Administrator:	Lijo Antony
Licensee Designee:	Lijo Antony
Name of Facility:	Walnut Creek Home
Facility Address:	25014 Trombley St Harrison Twp, MI 48045
Facility Telephone #:	(586) 477-0338
Original Issuance Date:	03/18/2020
License Status:	REGULAR
Effective Date:	09/18/2020
Expiration Date:	09/17/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A fell at the home. The owner of the home denied the fall happened and is now evicting Resident A. There is concern for Resident A's well-being and safety.	No
Additional Findings	Yes

III. METHODOLOGY

04/06/2022	Special Investigation Intake 2022A0604017
04/07/2022	Special Investigation Initiated - On Site I completed an unannounced onsite investigation. Staff, Joanne Medianero reported Resident A does not reside at this address.
04/07/2022	Contact - Telephone call made TC to Licensee Designee, Lijo Antony.
04/13/2022	Contact - Telephone call made TC to Lijo Antony. Received email requesting call.
04/18/2022	Contact - Document Sent Email to and from Lijo Antony requesting documents.
04/18/2022	Contact - Document Sent Email to Lijo Antony requesting records.
04/19/2022	Contact - Document Received Email from Lijo Antony with Resident A's assessment plan and health care appraisal.
06/01/2022	Contact- Telephone call made TC to Staff Michelle Chisnell. Unable to leave message
06/01/2022	Contact- Telephone call made TC to Staff Brittany Taylor
06/01/2022	Contact- Document Sent Email to and from Lijo Antony

06/01/2022	Contact- Telephone call made Left message for Staff Stephanie Santos.
06/02/2022	Contact- Telephone call made Left message for Complainant
06/02/2022	Exit Conference Completed exit conference with Licensee Designee, Lijo Antony by phone.

ALLEGATION:

Resident A fell at the home. The owner of the home denied the fall happened and is now evicting Resident A. There is concern for Resident A's well-being and safety.

INVESTIGATION:

On 04/06/2022, I received a licensing complaint regarding the Walnut Creek Home. The Complainant alleged that Resident A said he fell in his group home and reported it to a staff member on his hospice care team. The staff member called Complainant to report it. When the owner of the group home was asked about the incident, he denied it and wanted to have a meeting immediately. A Zoom call was held 48 hours later, and owner stated that Resident A did not fall and when asked for him to review the cameras, he said the cameras were unable to be viewed during that date and time. Resident A's roommate and another staff member witnessed Resident A's fall. On Saturday, 02/26/2022, a member of the group home staff, confirmed he did fall. After the Zoom meeting, a letter was received shifting blame and stated that he has to be removed from the home in as little as 24 hours. The Complainant is very concerned for Resident A's well-being and safety in the Walnut Creek Group Home. In addition to the immediate incident, there has been a prior incident where Resident A was injured and it raised concerned. An employee was reprimanded because of this incident.

On 03/02/2022, Lijo Antony, the licensee designee emailed a copy of the 30-day discharge notice that was provided to Resident A's Power of Attorney (POA). The discharge notice indicated that Resident A was being discharged from the facility due to his increase in care needs that are beyond staff capabilities. The notice also indicated that the communications with POA have been very hard and they cannot continue to be subjected to allegations and accusations with no basis. The notice indicates that the company and staff have been transparent to the best of their knowledge with Resident A's care. The notice indicates that if behavior related incidents arise a shorter notice of seven days or 24 hours may be enforced. Mr. Antony stated that Resident A moved out of the home on 03/04/2022.

I completed an unannounced onsite investigation at the Walnut Creek Living on 04/07/2022. I interviewed Staff, Joanne Medianero. Ms. Medianero stated that Resident A does not reside at the home. She stated that she has worked at the home for six years and they have all female residents. I informed her that I would contact licensee designee, Lijo Antony, to confirm.

On 04/07/2022, I contacted Lijo Antony during the onsite investigation by phone. Mr. Antony stated that Resident A lived at Walnut Creek Home, however, had moved out. Mr. Antony stated that he heard that Resident A had since passed away. Mr. Antony stated that there was an incident where Resident A slid out of his wheelchair. He did not have any injuries. Mr. Antony was unable to show the family camera's video as they did not go back and far. Mr. Antony stated that there were no prior incidents. Mr. Antony indicated that the POA was difficult to work with and making false accusations against them. Resident A's obituary indicates he passed away on 04/04/2022.

On 06/01/2022, I interviewed staff, Brittney Taylor by phone. She stated that Resident A only had one fall that she was aware of at Walnut Creek. Ms. Taylor stated that she was getting off her shift and staff, Tammy, was working. She heard Resident B hollering out. Resident B hollers when something is wrong. Resident B was Resident A's roommate; however, he is now deceased. Tammy was helping another resident in their room so neither of them saw the fall, however, they found Resident A on the floor. Ms. Taylor believed that he got out of his chair and fell. She stated that no medical attention was needed. They checked Resident A over and he stated that he was not hurt. Ms. Taylor stated that she continues to work at home, however, Tammy does not.

On 06/01/2022, I attempted to interview staff, Michelle Chisnell and Stephanie Santos by phone. I did not receive return calls from Ms. Chisnell or Ms. Santos.

APPLICABLE RULE	
R 400.14305	**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:	There is not enough information to determine that Resident A's personal needs, including protection and safety, were not met in the home. Licensee Designee, Lijo Antony, stated that Resident A did slide out of his wheelchair, however, was not injured. Staff, Brittany Taylor, believed Resident A fell out of wheelchair and that he was found on the floor. Ms. Taylor nor staff, Tammy, witnessed the fall. Ms. Taylor also indicated that Resident A was not injured. Resident A and Resident B have both passed away since the alleged incident. Mr. Antony was unable to show the fall on camera's video because his recordings did not go back that far.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge police; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	Written notice was provided before discharging Resident A from the facility. On 03/02/2022, licensee designee, Lijo Antony, emailed licensing a copy of the 30-day discharge notice that was addressed to Resident A's POA. The discharge notice indicated that Resident A was being discharged from the facility due to his increase in care needs that are beyond staff capabilities. The notice also indicated that the communications with POA have been very hard and they cannot continue to be subjected to allegations and accusations with no basis.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 04/19/2022, I received Resident A's health care appraisal and assessment plan by email from licensee designee, Lijo Antony. Resident A had a current health care appraisal dated 11/26/2021. Resident A's assessment plan was completed on 06/23/2020. The plan indicated that Resident A used a walker and wheelchair and was

a fall risk. There was a note near Mr. Antony's signature that indicated, "updated 06/01/2021", however, there was no indication that new information was added. Also, there was no updated signature from resident or resident's designated representative.

I completed an exit conference with licensee designee, Lijo Antony, on 06/02/2022 by phone. I informed him of the violation found. I also informed him that a copy of the special investigation report will be mailed once approved. A corrective action plan will be requested. Mr. Antony stated that he plans to move all the residents at the Walnut Creek Home to other homes of his due to shortage of staff. He will decide if he wants to close the license at the time of renewal.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A did not have a current assessment plan. Resident A's assessment plan was completed on 06/23/2020. There was a note near Mr. Antony's signature that indicated, "updated 06/01/2021", however, there was no new information added. Also, there was no updated signature from resident or resident's designated representative. Assessment plans should be completed and signed on an annual basis.
CONCLUSION:	**VIOLATION ESTABLISHED**

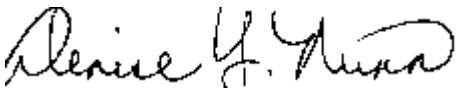
IV. RECOMMENDATION

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

06/02/2022

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



06/22/2022

Denise Y. Nunn — Date
Area Manager