GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 15, 2023

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

RE: License #: AS500378610
Investigation #: 2023A0604024
Walnut Creek Life, LLC

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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS500378610
Investigation #:	2023A0604024
Complaint Receipt Date:	06/20/2023
Investigation Initiation Date:	06/20/2023
Report Due Date:	08/19/2023
Licensee Name:	Walnut Creek Living, LLC
Licensee Address:	2695 Powderhorn Ridge Rd. Rochester Hills, MI 48309
Licensee Telephone #:	(248) 568-7194
Administrator:	Lijo Antony
Licensee Designee:	Lijo Antony
Name of Facility:	Walnut Creek Life, LLC
Facility Address:	47848 Beacon Square Dr Macomb Twp, MI 48044
Facility Telephone #:	(586) 961-6168
Original Issuance Date:	10/01/2015
License Status:	REGULAR
Effective Date:	04/01/2022
Expiration Date:	03/31/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A is being verbally abused by staff at home. He denies physical abuse but states he was pushed down on to bed.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/20/2023	Special Investigation Intake 2023A0604024
06/20/2023	APS Referral Referral received from Adult Protective Services (APS)
06/20/2023	Special Investigation Initiated - Letter Email to APS Worker, Vernece Warren
06/21/2023	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Staff, Stephanie Santos and Resident A, Resident B, Resident C and Resident D.
06/22/2023	Contact - Document Sent Email to Lijo Antony. Requested staff list
06/22/2023	Contact - Document Received Email from Lijo Antony
06/27/2023	Contact - Document Received Email from APS Worker, Jose Garcia
06/27/2023	Contact - Document Sent Email to APS Worker, Jose Garcia
07/12/2023	Contact - Document Received Email from APS Worker, Jose Garcia. Sent return email.
07/12/2023	Contact - Document Received Email from APS Worker, Jose Garcia. APS substantiated for emotional abuse.
07/14/2023	Contact - Document Sent Email to APS Worker, Jose Garcia

07/17/2023	Contact - Document Sent Email to Lijo Antony. Received return email.
07/18/2023	Contact - Document Received Email from Lijo Antony with current staff list.
07/26/2023	Contact - Document Received Email from APS Worker, Jose Garcia. Staff reported to be emotionally abusive is Stephanie Hill. Licensee did not have contact information for Ms. Hill.
07/26/2023	Contact - Document Sent Email to Jose Garcia
08/08/2023	Contact - Document Sent Email to Lijo Antony
08/09/2023	Contact- Telephone call made TC to Brittny Taylor
08/09/2023	Contact- Document Sent Email to Lijo Antony. Requested Stephanie Hill's employee file by 08/11/2023. Email from Lijo Antony
08/14/2023	Contact- Document Sent Email to Lijo Antony re: employee file and contact. Received Stephanie Hill file from Lijo Antony by email.
08/14/2023	Contact- Telephone call made TC to Stephanie Santos
08/14/2023	Exit Conference Completed exit conference with Lijo Antony. Left message.

ALLEGATION:

Resident A is being verbally abused by staff at home. He denies physical abuse but states he was pushed down on to bed.

INVESTIGATION:

I received a licensing complaint regarding Walnut Creek Life, LLC on 06/20/2023. It was alleged that Resident A is being verbally abused and staff are being mean towards him at the group home. He denied any physical abuse; however, he reported that he was pushed down onto the bed instead of them slowly laying him down. Also, when Resident A asks for assistance with his activities of daily living (ADLs), he is told, "wash

your own ass!". Resident A refuses to provide the name of the staff members that are verbally abusing him.

On 06/21/2023, I completed an unannounced onsite investigation. I interviewed Staff, Stephanie Santos, and Resident A, Resident B, Resident C and Resident D.

On 06/21/2023, I interviewed Staff, Stephanie Santos. Ms. Santos stated that they have one staff per shift at the home. Staff assist residents with bathing, toileting, brief changes and administer medication. Ms. Santos stated that residents are never told to bath themselves. Resident B and Resident C typically receive bed baths. Resident A receives sponge baths, and he also has someone from hospice come to the home to bathe him. Ms. Santos stated that she never yells at residents and has never heard another staff yell at residents. She stated that Resident D is hard of hearing, so you must talk loud to him. She also stated that Resident C wears hearing aids. Ms. Santos did not report any concerns regarding the home.

On 06/21/2023, I interviewed Resident A. He stated that he has lived at the home for three weeks and is stuck here for the rest of his life which he described as “rough”. He stated that the staff that yelled at him and stated, "Wash your own ass!", is gone. He stated that staff have raised their voice, however, he does not want to mention names because he may have to work with them again. He also has had to wait to go to the bathroom. Resident A stated that he is getting pain pills he does not need, and they make him hallucinate. He stated that a hospice worker comes two times per week and helps him with bathing. He also sees a nurse and a case worker.

On 06/21/2023, I interviewed Resident B. He stated that he has lived at home for about a year. He stated that it is going “ok”. Resident B stated that staff help him with everything that he cannot do himself. Staff assist him with bathing, dressing and medication. Resident B stated that he was mistreated by a staff about a year ago, however, she was fired. He described staff as “mouthy”. He did not report staff’s name. Resident B stated that he is currently doing good at home and all the current staff are good.

On 06/21/2023, I interviewed Resident C. She stated that she has lived at home for about six weeks. She had a recent surgery and is going to start occupational therapy. Resident C stated that staff are helping her with bathing, toileting and giving her all her medications. Resident C stated that some staff have, “a little attitude problem”. She described the staff currently working, Ms. Santos, as “kind”. Resident C stated that there is no abuse or anything by staff, just attitudes. Resident C did not name specific staff.

On 06/21/2023, I interviewed Resident D. There was some difficulty interviewing Resident D due to his hearing. Resident D stated that he has lived in home since February. He indicated that there has been a lot of turnover. He stated that things at the home are improving. Resident D stated that some staff are too strict and more concerned with rules. He did not name any specific staff. Staff help him with bathing and taking his medication.

On 06/22/2023, I received email from Lijo Antony. Mr. Antony indicated that he believed this was a false allegation from hospice employee that was terminated. He stated that no one has been terminated due to abuse allegations.

On 07/12/2023, I received email from APS Worker, Jose Garcia. He indicated that he substantiated on staff, Stephanie Hill, for emotional abuse. He indicated that Ms. Hill no longer works at the home and licensee did not have a working phone number or current address for her. On 07/26/2023, I received an email from APS Worker, Jose Garcia. He indicated that Staff, Stephanie Hill, was named by Resident A during his investigation as being staff that was emotionally abusive.

On 08/08/2023, I received email from Lijo Antony. He stated that Stephanie Hill was a new hire who was only at home for four days training. She quit without notice and walked out on 06/12/2023.

On 08/09/2023, I interviewed Staff, Brittney Taylor, by phone. Ms. Taylor stated that she is no longer working at home as of last week. She stated that she was not working with Stephanie Hill when alleged incident occurred. She stated that Ms. Hill was working by herself. She stated that Ms. Hill had prior experience working at a home and then quit and came back. Ms. Taylor stated that she has not witnessed any staff being verbally or physically abusive to any residents.

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 substantiate that residents' personal needs are not being met in the home. All the residents interviewed stated that they receive assistance from staff including help with bathing, dressing, toileting and medication administration.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of **(f) Subject a resident to any of the following:** **(ii) Verbal abuse.**

ANALYSIS:	Resident A indicated that he was yelled at by staff and told to “wash your own ass!". He stated that staff was not physically abusive but did not slowly lay him down. On 06/21/2023, during the onsite investigation Resident A did not name staff, however, stated that they were gone. APS Worker, Jose Garcia, indicated that staff was identified as Stephanie Hill, who no longer works at the home. APS substantiated for emotional abuse. None of the residents interviewed reported physical abuse in home, however, all the residents did indicate there was verbal mistreatment by staff. Resident B stated that he was mistreated by a staff about a year ago, however, she was fired. He described staff as “mouthy”. Resident C stated that some staff have, “a little attitude problem”. Resident D stated that some staff are too strict and more concerned with rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 08/14/2023, I received a copy of Stephanie Hill’s employee file from Lijo Antony by email. Mr. Antony indicated that Ms. Hill only worked for four days and was still under the process of hiring and training. Mr. Antony indicated that Stephanie Santos handles all the training and was in the process of training Ms. Hill. Mr. Antony provided a copy of Ms. Hill’s application, references, driver’s license, social security card, consent to background check, tax forms, verification of personnel polices/job description, and personal care, supervision and protection training. Ms. Hill did not have verification of a TB test, which should be obtained at time of hire. Ms. Hill was still within 30 days of employment for medical statement to be obtained. Ms. Hill did not have verification of fingerprinting clearance.

On 08/14/2023, I interviewed Stephanie Santos by phone. She stated that she is responsible for training and trained Ms. Hill for four days. She stated that they worked together from 7:00 am-7:00 pm. Ms. Santos stated that she never observed Ms. Hill being abusive or inappropriate towards residents. She indicated that Resident A does hallucinate. Ms. Santos stated that Ms. Hill never worked by herself. She does not know why Ms. Hill quit.

I completed an exit conference with Licensee Designee, Lijo Antony, by phone on 08/14/2023. I left Mr. Antony a message regarding the violations found and that a copy of the special investigation would be provided. I requested that Mr. Antony contact me with any questions.

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.
ANALYSIS:	On 08/14/2023, I received copy of Stephanie Hill's employee file from Licensee Designee, Lijo Antony. Ms. Hill did not have verification of TB test in employee file.
CONCLUSION:	**VIOLATION ESTABLISHED**

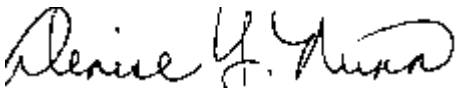
IV. RECOMMENDATION

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

08/14/2023

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



09/15/2023

Denise Y. Nunn — Date
Area Manager