GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 10, 2025

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

RE: License #: AL330280995
Investigation #: 2025A0466009
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,

Julie Elkins

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL330280995 |
| | |
| **Investigation #:** | 2025A0466009 |
| | |
| **Complaint Receipt Date:** | 11/21/2024 |
| | |
| **Investigation Initiation Date:** | 11/21/2024 |
| | |
| **Report Due Date:** | 01/20/2025 |
| | |
| **Licensee Name:** | Walnut Ridge Country Estate, LLC |
| | |
| **Licensee Address:** | 4077 Oakley Rd.<br>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.<br>Stockbridge, MI 49285 |
| | |
| **Facility Telephone #:** | (517) 851-7501 |
| | |
| **Original Issuance Date:** | 12/27/2007 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 12/30/2023 |
| | |
| **Expiration Date:** | 12/29/2025 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>AGED |

## II. ALLEGATION

| | **Violation Established**? |
|---|---|
| On 11/16/2024, direct care worker (DCW) in training gave Resident A the wrong medications. | Yes |
| On 11/15/2024 DCW Tisha Weirauch put Resident C on the toilet and left him there for an hour because she stated he was difficult. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 11/21/2024 | Special Investigation Intake 2025A0466009. |
| 11/21/2024 | Special Investigation Initiated – Telephone call Complainant interviewed. |
| 12/06/2024 | Inspection Completed On-site. |
| 12/06/2024 | Exit conference with licensee designee Jeffrey Shepard. |
| 01/02/2025 | Contact- email sent to licensee designee Jeffrey Shepard requested documents. |
| 01/06/2025 | Contact- telephone call to DCW Victoria Mullins, interviewed. |
| 01/07/2025 | Contact- email received from licensee designee Jeffrey Shepard. |
| 01/08/2025 | APS referral- not required no suspected abuse/neglect. |

**ALLEGATION: On 11/16/2024, direct care worker (DCW) in training gave Resident A the wrong medications.**

**INVESTIGATION:**
On 11/21/2024 Complainant reported that on 11/16/2024, DCW Rita Welch was being trained in medication administration by DCW Victoria Mullins. At that time, DCW Welch gave Resident A, Resident B's prescribed medications. Complainant reported that Resident B was not administered any medications on 11/16/2024 since they were administered to Resident A. Complainant reported that she was not aware of any adverse side effects that impacted Resident A after taking medications that he was not prescribed. Complainant reported that an incident report (IR) was written.

On 12/06/2024 an unannounced investigation was conducted and I interviewed licensee designee Shepard who reported being aware of a medication error involving DCW Mullins while she was training DCW Welch. Licensee designee Shepard reported DCW Mullins was training DCW Welch and DCW Mullins was supposed to administer medications, not DCW Welch however DCW Welch administered Resident A's medications to Resident B. Licensee designee Shepard reported Resident B was administered his prescribed medications on 11/16/2024. Licensee designee Shepard reported that he did not contact Resident A's physician nor a pharmacist about the medication error that occurred with Resident A. Licensee designee Shepard reported he did not contact Resident A's guardian. Licensee designee Shepard reported DCW Welch was being trained in medication administration and was not competent to administer medications herself. Licensee designee Shepard reported that an IR was completed but was unable to locate it at the time of the investigation. Licensee designee Shepard reported DCW Welch is no longer employed at the facility.

Administrator, Jennifer Flores reported being aware of a medication error involving DCW Mullins while she was training DCW Welch. Administrator Flores reported licensee designee Shepard handles all the medications therefore she did not contact Resident A's physician, pharmacist or guardian about the medication error. Administrator Flores reported that an IR was completed but she was unable to locate it at the time of the investigation. Administrator Flores reported that DCW Welch is no longer employed at the facility.

I reviewed Resident A's record in its entirety and there was no documentation that anyone contacted Resident A's physician and/or pharmacist after the medication occurred on 11/16/2024. I did not locate an IR in the resident record.

I reviewed Resident B's medication administration record (MAR) which was signed and documented that Resident B's medications were administered on 11/16/2024.

On 01/06/2025, I interviewed DCW Mullins who reported that she worked with DCW Welch on the day DCW Welch administered Resident A the wrong medications. DCW Mullins reported that was DCW Welch's sixth or seventh day in training, so she was more hands on with tasks and medication administration. DCW Mullins reported she put the medications into a medication cup and had DCW Welch give the medications to the resident. DCW Mullins reported that since DCW Welch had worked at the facility at least six times she knew the residents but out of caution she asked the Resident A to raise his hand to be sure that DCW Welch knew to whom to administer the medications. DCW Mullins reported that she turned her back for a minute and DCW Welch reported to her that she thought she administered the medications to the wrong resident. DCW Mullins reported that she had DCW Welch show her who she administered the medications to and DCW Mullins reported that it was Resident B and not Resident A. DCW Mullins stated therefore DCW Welch gave Resident A's medications to the wrong resident. DCW Mullins reported she contacted licensee designee Shepard and went over the medications with him by

phone. DCW Mullins reported that Resident A was a little sleepy but other than that he did not act any differently. DCW Mullins reported that she did not contact Resident A's physician, pharmacist or guardian about the medication error. DCW Mullins reported she completed an IR and provided it to licensee designee Shepard. DCW Mullins reported DCW Welch did not contact Resident A's physician, pharmacist or guardian about the medication error either. DCW Mullins reported that Resident B was administered his prescribed medications on 11/16/2024. DCW Mullins reported that DCW Welch is no longer employed at the facility.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15312** | **Resident medications.** |
| | **(2) Medication shall be given, taken, or applied pursuant to label instructions.**<br><br>**(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:**<br>**(a) Be trained in the proper handling and administration of medication.**<br>**(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**<br><br>**(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.** |
| **ANALYSIS:** | Licensee designee Shepard and DCW Mullins both reported that DCW Welch was not fully trained in medication administration when she passed Resident B's medications to Resident A. Licensee designee Shepard and DCW Mullins reported that neither Resident A's physician nor pharmacist were not contacted after the medication error occurred. Reasonable precautions to insure that medication is not used by a person other than for whom the medication is prescribed was not achieved therefore a violation has been established. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION: On 11/15/2024 DCW Tisha Weirauch put Resident C on the toilet and left him there for an hour because she stated he was difficult.**

**INVESTIGATION:**
On 11/21/2024, Complainant reported on 11/15/2024 DCW Tisha Weirauch put Resident C on the toilet and left him there for an hour. Complainant reported that

Resident C only has one leg and cannot ambulate/transfer himself from the toilet to the wheelchair. Complainant reported DCWs make sure that the wheelchair is far enough away from Resident C that he cannot access it from the toilet. Complainant reported DCW Weirauch stated Resident C was difficult, so she was just going to leave him on the toilet for a while.

On 12/06/2024 I conducted an unannounced investigation and I interviewed administrator Flores who reported that DCW Weirauch treats Resident C with dignity and respect. Administrator Flores reported that no other resident or DCW has ever made any complaints about how DCW Weirauch interacts with Resident C. Administrator Flores reported she has no knowledge that DCW Weirauch ever left Resident C on the toilet for an hour for any reason including because Resident C was being difficult. Administrator Flores reported that on 11/15/2024, DCW Weirauch did not work. Administrator Flores reported that between 11/11/2024 and 11/17/2024, DCW Weirauch worked one shift, and it was on 11/14/2024 from 2pm-4pm to train DCW Welch. Administrator Flores reported that DCW Welch never reported this incident or any concern to her regarding DCW Weirauch.

I interviewed licensee designee Shepard who reported that Resident C requires full assistance with everything. Licensee designee Shepard reported Resident C requires cues for dressing and full assistance with washing and wiping. Licensee designee Shepard reported Resident C can be difficult due to his confusion. Licensee designee Shepard reported Resident C uses the main toilet by the living room that is shared by other residents and there is no way that he could be left there for an hour as other residents would complain to DCWs so they could use the restroom. Licensee designee Shepard reported that Resident C wears briefs but is also toileted during the day and in between meals. Licensee designee Shepard reported that Resident C can transfer himself. Licensee designee Shepard reported DCWs do frequent checks on Resident C while he is in the bathroom as he has transferred himself from the toilet to the wheelchair without pulling his pants up and has come out of the bathroom that way. Licensee designee Shepard reported that Resident C is not very verbal and is typically confused. Licensee designee Shepard reported he has always observed DCW Weirauch treat Resident C with dignity and respect. Licensee designee Shepard reported that no other resident or DCW has ever made any complaints about how DCW Weirauch interacts with Resident C. Licensee designee Shepard reported he has no knowledge that DCW Weirauch ever left Resident C on the toilet for an hour for any reason or stated that Resident C is difficult.

I reviewed Resident C's written *Assessment Plan for Adult Foster Care (AFC) Residents* which was dated 9/12/2024. In the "toileting" section of the report it stated, "full assist." In the "communicate needs" section of the report it stated, "due to altered mental status, may confuse needs."

I interviewed Resident C who reported that he receives good care at the facility. Resident C reported that he can toilet himself and that he gets on and off the toilet

independently.  Resident C denied that he was ever left in the bathroom for an hour by any DCW.  Resident C reported that he likes and gets along with all the DCWs including DCW Weirauch.

I interviewed DCW Weirauch who reported that Resident C is full care and that he requires assistance with dressing, washing, wiping, etc.  DCW Weirauch denied working on 11/15/2024. DCW Weirauch reported that she worked with DCW Welch on 11/14/2024 and had to intervene on a situation that she overheard between DCW Welch and Resident C. DCW Weirauch reported she was in the staff office which shares a wall with the bathroom. DCW Weirauch reported that she heard DCW Welch raising her voice and being short with Resident C. DCW Weirauch reported that Resident C can be slow, confused or resistant to help with transfers. DCW Weirauch reported that when she heard DCW Welch use a swear word, she went into the bathroom to take over helping Resident C. DCW Weirauch reported that DCW Welch appeared relieved that she came in to assist. DCW Weirauch reported she assisted Resident C with his toileting needs and assisted Resident C back to the living room where he could enjoy the company of other residents. DCW Weirauch reported that to assist Resident C while he is on the toilet Resident C's wheelchair has to be moved to another part of the bathroom as there is not enough room for the wheelchair, Resident C and a DCW. DCW Weirauch reported Resident C is given some privacy when he needs to have a bowel movement as that can take a while. DCW Weirauch reported if Resident C is left alone in the bathroom, he needs to be checked on frequently as he can become confused and want to get up before he is finished. DCW Weirauch reported that Resident C requires assistance with wiping and pulling his pants up so that is another reason why frequent checks are required. DCW Weirauch reported that Resident C can transfer himself to and from the wheelchair and that when a DCW is not in the bathroom with him, he does have access to the wheelchair, it is just moved while they provide direct care. DCW Weirauch denied ever leaving Resident C on the toilet for an hour at any time and denied saying that Resident C was difficult, so she was just going to leave him on the toilet for a while.

On 01/06/2025, I interviewed DCW Mullins who reported that Resident C is full care and that he requires assistance with dressing, washing, wiping, etc.  DCW Mullins reported Resident C is often confused and not very verbal.  DCW Mullins reported Resident C has access to his wheelchair when he is in the bathroom independently. DCW Mullins reported that she has no knowledge that DCW Weirauch ever left Resident C on the toilet for an hour because Resident C was being difficult. DCW Mullins reported that that no other resident or DCW has ever made any complaints about to her about how DCW Weirauch interacts with Resident C. DCW Mullins reported that she has always observed DCW Weirauch treat Resident C with dignity and respect.

| 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:** | Complainant reported DCW Weirauch left Resident C on the toilet for an hour because he was being difficult. Licensee designee Shepard, administrator Flores and DCW Mullins all reported that they have always observed DCW Weirauch treating Resident C with dignity and respect. Licensee designee Shepard, administrator Flores and DCW Mullins all reported that no other resident or DCW has ever made any complaints about how DCW Weirauch interacts with Resident C. Licensee designee Shepard, administrator Flores and DCW Mullins all reported having no knowledge that DCW Weirauch ever left Resident C on the toilet for an hour or stated that Resident C was difficult. DCW Weirauch denied this allegation. There is not enough evidence to establish a violation. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**
On 12/06/2024 I conducted an unannounced investigation and I reviewed the medication cart which had medications that were not kept in the original pharmacy-supplied container.

I interviewed licensee designee Shepard who reported that because of the volume of residents and the number of medications prescribed and passed to each resident, it is more efficient to have the medications in blister packs. Licensee designee Shepard reported that residents affiliated with PACE and veterans' affairs (VA) are required to get prescribed medications from a pharmacy that does not offer blister packing therefore when the medications are delivered, he counts them and puts them into blister packaging himself to ensure that the medications are set up correctly. Licensee designee Shepard reported he is aware that resident medications are required to remain in the pharmacy prescribed containers however he reported concern with the number of residents served along with the volume of medications administered that medication errors will occur if all medication is left in the pharmacy prescribed containers and not combined in blister packages.

| APPLICABLE RULE | |
|---|---|
| **R 400.15312** | **Resident medications.** |
| | **(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.** |
| **ANALYSIS:** | While inspecting the medication cart I observed that resident medications had been taken out of the pharmacy supplied container and put into blister packs. Licensee designee Shepard confirmed that he takes prescribed resident medications out of the pharmacy supplied container and putting them into blister packs. Therefore, a violation has been established as prescribed resident medications are required to be kept in the original pharmacy-supplied container. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

Julie Elkins

1/09/2025

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Julie Elkins Date
Licensing Consultant

Approved By:

Dawn Timm

01/10/2025

_____

Dawn N. Timm Date
Area Manager