GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 7, 2025

Anita Anderson
4791 E Mt Garfield Rd
Fruitport, MI 49417

RE: License #: AS610419002
Investigation #: 2025A0340012
Woodland Gardens Whitehall

Dear Ms. Anderson:

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 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 (616) 356-0183.

Sincerely,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610419002
Investigation #:	2025A0340012
Complaint Receipt Date:	12/10/2024
Investigation Initiation Date:	12/10/2024
Report Due Date:	02/08/2025
Licensee Name:	Anita Anderson
Licensee Address:	2189 S 86th Ave Shelby, MI 49455
Licensee Telephone #:	(231) 571-8642
Administrator:	Stefan Bullerman
Licensee Designee:	Anita Anderson
Name of Facility:	Woodland Gardens Whitehall
Facility Address:	1023 Alice Street Whitehall, MI 49461
Facility Telephone #:	(231) 893-0322
Original Issuance Date:	N/A
License Status:	NONE
Effective Date:	N/A
Expiration Date:	N/A
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The proposed Administrator and former member of the household/direct care worker, Stefan Bullerman, is not suitable to provide care in an AFC.	Yes

III. METHODOLOGY

12/10/2024	Special Investigation Intake 2025A0340012
12/10/2024	Special Investigation Initiated - Telephone Det. Tyler Kempema-OCSD
12/10/2024	Contact - Telephone call made Relative 1-daughter of resident
12/10/2024	Contact - Telephone call made APS by Liz Elliott
01/06/2025	Inspection Completed On-site
01/06/2025	Contact – Whitehall Police Department
02/07/2025	Exit Conference Designee Anita Anderson

ALLEGATION: The proposed Administrator and former member of the household/direct care worker, Stefan Bullerman, is not suitable to meet the needs of the occupants of this home.

INVESTIGATION: This home is not currently licensed, but an application has been received with Stefan Bullerman identified as the Administrator. An unlicensed investigation was previously substantiated in November 2024 where Mr. Bullerman was found to be the live in staff working at the home.

On December 10, 2024, after consulting with Adult Foster Care Licensing Supervisor, Jerry Hendrick, a complaint was opened due to the concerns reported by AFC Licensing Consultant Elizabeth Elliott, and it being reported to me by family of a resident at Woodland Gardens Whitehall that Mr. Bullerman was found intoxicated while caring for vulnerable adults in this still unlicensed home.

On December 10, 2024, I contacted Detective Tyler Kempema from the Ottawa County Sheriff's Department to obtain the police report involving Mr. Bullerman at the Woodland Gardens Zeeland home where he was charged on 6/18/24 with Assault and Vulnerable Adult Abuse 4th Degree. I informed him of the concerns regarding Mr. Bullerman continuing to provide care at the Woodland Gardens Whitehall home. Det. Kempema confirmed that the charges he submitted against Mr. Bullerman were pleaded down to a "disturbing the peace" charge with four months of probation on 9/25/24.

On December 10, 2024, I received and reviewed the report, videos, and photos from Det. Kempema. I also forwarded this to Area Manager Jerry Hendrick and Consultant Elizabeth Elliott.

On December 10, 2024, I was contacted by Relative 1 whose mother resides at the Woodland Gardens Whitehall home. She had previously expressed concern that Mr. Bullerman was intoxicated while providing care for residents. She called 911 when discovering Mr. Bullerman's state. She explained that the Whitehall Police Officer informed her that because Mr. Bullerman resided in the home, they were unable to take action. Relative 1 stated she was very upset that Mr. Bullerman was allowed to provide care in such a state of intoxication. Relative 1 stated there was a bottle of whiskey on the counter and Mr. Bullerman had difficulty standing and was slurring his words.

Relative 1 further reported that there have been multiple times in which she found her mother to be left in urine-soaked briefs, still in her clothes from the day before, bedding not washed, food left out and the home unkempt and dirty. She then expressed concern as to Mr. Bullerman's sobriety in the past and his ability to adequately provide care.

Relative 1 stated she was informed by Ron Langford, who is the owner of the home, that Mr. Bullerman was moving out of the home due to this incident and staff from the previous owner was moving in. Relative 1 expressed relief that Mr. Bullerman would not be providing direct care for her mother.

On December 10, 2024, I contacted Licensing Consultant Elizabeth Elliott and discussed with her the events which occurred at the home which she is licensing (Woodland Gardens Zeeland) and the details which can be found in her report AS700415341_SIR_2025A0356014. We viewed the pictures and videos that were sent by Det. Kempema, which showed the resident at Woodland Gardens Zeeland (WGZ) getting yelled at with profanity by Mr. Bullerman.

There were photos of the occupant at WGZ with bruising on his upper arm and left elbow as well as a scabbed cut and redness surrounding it on the top part of his arm at the wrist. I viewed a picture of his right knee with some bruising on his left calf and a picture of his left arm showing the same scabbed cut on the lower arm close

to the wrist. Another picture was of the occupant's face and a bruise above and around his right eyebrow and swelling on the corner and around his right eye.

The first video I observed showed the occupant walking around his room, talking in a mumbling voice and then the noise of a door opening and a voice that I know to be Mr. Bullerman's can be heard saying; "get in bed, I'm not fucking dealing with you all night." The occupant is fully dressed and not in pajamas. Mr. Bullerman's speech is slurred and sounds different than the times I have talked to him, as though he is inebriated.

The second video I observed showed the occupant standing on the inside of his room at the door. All of a sudden, the door opens quickly, and the occupant is jolted back and says, "Oh!" and then a voice that I know to be Mr. Bullerman can be heard saying; "What'd I tell you? Stay in your fucking room" and the occupant responds; "OK" and sits down in his chair. The occupant is fully dressed in different clothes from the previous video. Mr. Bullerman's speech is slurred and sounds as though he is inebriated.

The third video I observed an empty room. The door opens, and a voice I know to be Mr. Bullerman can be heard saying; "I'm fucking tired of your shit" and the same occupant stumbles into the room, and stumbles around a bit near the doorway. Mr. Bullerman can then be heard saying; "go to bed, go to bed" and the occupant says, "I will, I have to find the bed." Mr. Bullerman then says; "straight fucking ahead," the occupant replies, "Ok" and Mr. Bullerman said, "I swear to God (occupant)," the occupant says; "boy, I tell ya," Mr. Bullerman said; "you and I will have a completely different" and the video ends before Mr. Bullerman's sentence is finished. The occupant is dressed in the same clothes as the second video. Mr. Bullerman's speech is slurred, and he repeats the word "different" a couple of times because he cannot pronounce it clearly. Mr. Bullerman's speech is different and sounds as though he is inebriated.

In the fourth video I observed the same occupant, dressed in the same clothes as the 2nd and 3rd videos. He is standing in his room, pulls up his pants and straightens out his jacket and then he walks to the door of his room. The door opens and an arm reaches in around the back of his neck and pulls him out of the room. I heard the occupant say, "OK" and then a thud, bang, and commotion takes place out in the hall and Mr. Bullerman can be heard saying; "I'm done" and the occupant responds, "OK" and the video ends.

On January 6, 2025, I conducted an unannounced home inspection. Staff Melissa Cavanaugh was working at the time of my inspection. Ms. Cavanaugh was familiar with me from having worked with the previous owner of the home. I asked Ms. Cavanaugh how things have been going. She stated she has now moved into the home as live-in staff. She was contacted by Ron Langford and informed that the previous live-in staff was moving out and he asked if she wanted the position, which she did.

Ms. Cavanaugh stated Mr. Bullerman no longer works at the home. She stated she did not know firsthand what had happened but had heard from Relative 1. Ms. Cavanaugh stated she has never seen Mr. Bullerman drinking but she has seen him behave in a concerning manner. She explained this to mean that she observed him failing to provide care to the residents. Ms. Cavanaugh also stated she had observed a lack of cleanliness in the home, garbage overflowing, residents left in soaking wet briefs, residents putting themselves to bed, food all over their clothes, and lots of cigarette butts left by the front door. She had previously brought it to the attention of Ron Langford.

I spoke with Resident A during my inspection. It was evident that she suffered from a limited cognitive level and was unable to be interviewed.

Resident B and C were sitting together, and I began to talk with them and it was apparent they too suffer from dementia or other cognitive delay and were unable to be interviewed. Both residents repeatedly stated they "just wanna go home".

Resident D was interviewed in his room. He did present as cognitively able to be interviewed. Resident D was informed of the reason for my visit. I asked him to tell me about the staff at the home. When asked about Mr. Bullerman, Resident D stated he had on several occasions witnessed Mr. Bullerman "passed out" at the desk so Resident D made food for himself. He has also reportedly witnessed Mr. Bullerman "passed out" on the couch and in a chair. I asked Resident D if there were any other concerns he had about Mr. Bullerman. He stated that he had asked Mr. Bullerman to fix the window blinds in his room and he would not fix them. Eventually Ms. Cavanaugh fixed it. Resident D also stated that Mr. Bullerman spends a lot of time sitting on the porch smoking and he did not feel that was something he should be doing if he was there to work.

On January 6, 2025, I went to the Whitehall Police Department. I requested and received a copy of the report regarding the incident which occurred at the Woodland Gardens Whitehall home involving Mr. Bullerman.

The police report written by Officer Fernando Hernandez regarding the incident on 11/11/24 at 8:30 PM states the following: *'Complainant contacted CD after she saw that an employee at the facility exhibited behaviors which led her to believe he was intoxicated. The employee was checked on and the facility owner was contacted.*

CONTACT WITH (RELATIVE 1)

I met with (Relative 1) outside of the home where she stated her mom is a resident at this home. (Relative 1) stated she saw a bottle of "McMasters Canadian" whiskey on the desk of the home manager which she took a picture of and showed me. (Relative 1) stated she noticed the manager, Ronald (this is an error in the report where the officer mixed up Mr. Bullerman's name and Mr. Langford, the owner) had

slurred speech and was walking as if he was intoxicated. She asked him if he was ok and he told her he was fine.

CONTACT WITH STEFAN BULLERMAN:

I met with Stefan who was at his desk entering information into the laptop. I asked Stefan if he was fine and he indicated he was though, I did notice some slurred speech and he could not stay focused on the conversation he and I were having. I did request he take a PBT so we could see where he was at impaired wise. He blew a .20.

CONTACT WITH RONALD LANDFORD:

Ronald is the owner of the facility. He had already been contacted by (Relative 1). I spoke to him over the phone and advised him of the situation. Ronald advised he had another aide on her way to the facility who would be reliving (sic) Stefan. Ronald stated he would be meeting with Stefan in the morning.

No criminal action taken. Owner of facility to address the situation.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(9) A licensee and the administrator shall possess all of the following qualifications: (a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.
ANALYSIS:	Based on investigative finds, there is a preponderance of evidence to show that Mr. Bullerman is not suitable to provide care to vulnerable adults or to serve as the administrator of an adult foster care home as proposed on the current application. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**

	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.
ANALYSIS:	Based on investigative finds, there is a preponderance of evidence to show that Mr. Bullerman is not suitable to provide care to vulnerable adults or to serve as the administrator of an adult foster care home as proposed on the current application. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

On February 07, 2025, an exit conference was conducted with Designee Anita Anderson. The allegations were explained to Ms. Anderson to which she agreed that the situation warranted a violation, and that Mr. Bullerman was not suitable to be Administrator, or direct care staff in AFC homes. Ms. Anderson was asked for a Corrective Action Plan (CAP) which she agreed to send.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend moving forward with the AFC licensing application.

Rebecca Piccard February 7, 2025

Rebecca Piccard Date
Licensing Consultant

Approved By:

Jerry Hendrick

February 7, 2025

Jerry Hendrick Date
Area Manager