RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

June 21, 2017

Robert Russell Jr.
Superior Woods Healthcare Center
8380 Geddes Rd.
Ypsilanti, MI 48198

RE: License #: AH810287412
Investigation #: 2017A1013017
Superior Woods Healthcare Center

Dear Mr. Russell Jr.:

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,

Loma M Campbell

Loma M Campbell, Licensing Staff
Bureau of Community and Health Systems
51111 Woodward Avenue 4th Floor, Suite 4B
Pontiac, MI 48342
(248) 860-3110
Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH810287412
Investigation #:	2017A1013017
Complaint Receipt Date:	01/13/2017
Investigation Initiation Date:	01/13/2017
Report Due Date:	02/12/2017
Licensee Name:	SSC Superior Township Operating Company, LLC
Licensee Address:	Suite 1400 One Ravinia Dr. Atlanta, GA 30346
Licensee Telephone #:	(770) 829-5100
Administrator:	Catherine Jackson
Authorized Representative:	Robert Russell Jr.
Name of Facility:	Superior Woods Healthcare Center
Facility Address:	8380 Geddes Rd. Ypsilanti, MI 48198
Facility Telephone #:	(734) 547-7644
Original Issuance Date:	01/19/2007
License Status:	REGULAR
Effective Date:	08/16/2015
Expiration Date:	08/15/2016
Capacity:	26
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established
A Resident fell on 5/14/16 fracturing her hip and requiring a titanium rod. There was no explanation provided regarding the cause of the fall.	Yes
The facility was understaffed.	Yes
ADDITIONAL FINIDNGS	Yes

III. METHODOLOGY

01/13/2017	Special Investigation Intake 2017A1013017
01/13/2017	Special Investigation Initiated - Telephone Provided allegations to Adult Protective Services Centralized Intake worker Jackie - she refused to provide her last name.
01/13/2017	APS Referral Provided allegations to Adult Protective Services Centralized Intake worker Jackie - she refused to provide her last name.
01/19/2017	Contact - Document Received As I initiated the investigation for Loma Campbell by notifying APS - I have now rec'd a letter from Washtenaw Co APS Complaint Coordinator indicating my APS referral was not assigned for investigation. I will forward the letter to L. Campbell via ID mail.
02/02/2017	Contact - Telephone call made Telephoned complainant
03/16/2017	Inspection Completed On-site On-site inspection included interviewing staff members, reviewing record, and observing environment
06/15/2017	Exit Conference Conducted with the authorized representative of Superior Woods Healthcare Center, Robert Russell, by telephone

ALLEGATION:

A Resident fell on 5/14/16 fracturing her hip and requiring a titanium rod. There was no explanation provided regarding the cause of the fall.

INVESTIGATION:

On 1/13/17, the department received the allegation in this report.

On 1/13/17, Andrea Krausmann, licensing staff, made a referral to Adult Protective Services (APS) Centralized Intake to notify APS of the allegation written in this report.

On 2/2/17, I interviewed the complainant by telephone. The complainant stated that Resident A had lived in the facility for about three weeks when the incident occurred. She stated that Resident A fallen on 5/13/16 and it was initially believed she did not suffer any injury. However, on the morning of 5/14/16, Resident A was transported to the hospital and was found to have a broken tibia. The complainant said she was not told how the injury.

On 3/16/17, I reviewed Resident A's record at the facility. According to the record, Resident A moved to the facility on 4/15/16 and was discharged to a skilled nursing facility on 5/14/16. An incident report nor any documentation of the 5/14/16 incident was not located within the record.

On 3/16/17, I interviewed administrator Catherine Jackson at the facility. Ms. Jackson stated that she began working at the facility in January 2017 and was not familiar with Resident A. Ms. Jackson was unable to locate any incident report concerning Resident A's 5/13 or 5/14 events detailing she suffered harm.

On 3/16/17, I interviewed staff members LaShauna Smith, Lori Weaver, Tamia Patton, and Alana Armstead at the facility. Ms. Smith, Ms. Weaver, Ms. Patton, and Ms. Armstead stated that they have been working in the facility for two months or less and were not familiar with Resident A.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
For Reference: R 325.1901	**Definitions.**

	(17) “Reportable incident/accident” means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	The complainant stated that Resident A was transported to the hospital on 5/14/16 and was found to have a broken tibia. It is reasonable to believe an event occurred in the facility that led to staff sending Resident A to the hospital for medical care. A review of the licensing file did not reveal any reported incident for Resident A occurring on 5/14/16. Staff members at the time of the incident did not document in the resident’s record or complete an incident report regarding Resident A suffering harm.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

The facility was understaffed.

INVESTIGATION:

The complainant said two staff members worked in the facility and felt the facility was understaffed because fourteen residents were in the unit. The complainant said she and another relative were in the facility at about 8:30 pm (could not recall the exact date) and could not find a staff member to assist with care of the resident.

Ms. Jackson stated that fourteen residents are residing in the facility (eight residents living on 500 hall and six residents living on 600 hall). Ms. Jackson stated that Resident B on 500 hall has required two staff members to transfer to and from a wheelchair, bed, and toilet because of a gradual decline in physical health. From 7:00 am until 6:00 pm, Ms. Jackson stated she will assist the two staff members scheduled to work in the provision of care to the residents and from 6:00 pm until 7:00 am two staff members are working in the facility providing care to residents.

Ms. Smith, Ms. Weaver, Ms. Patton, and Ms. Armstead stated that Resident B and Resident C required two staff members to transfer to and from a wheelchair, bed, and toilet. They also stated that Resident D needed to be fed during the breakfast and dinner meals which required a staff member provide this type of assistance.

I reviewed the service plan of seven of the fourteen residents. Two residents wore a Wanderguard, one resident was independent in areas of personal care, three

residents required assistance in personal care, and one resident required stand-by assistance in personal care.

Resident B's service updated 12/24/15 read under a section titled *Transfers* "[Resident A] requires assistance with transfers from one person. She will then pull her call light for staff to assist her with transferring back to her wheelchair. She will ask for assistance from staff with all other transfers. *chair alarm added. Resident and family have been educated on importance of having assistance [with] all transfers."

Resident C's service plan dated 2/22/17 read under a section titled *Mobility* "Wheelchair Requires assist X 2 bed mobility…", under a section titled *Transfers* "Requires Mod assist X 2", and under a section titled *Bathing* "Supervision Mod assist X2…"

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	The complainant stated that the facility was understaffed and could not find a staff member when visiting Resident A on one occasion. Staff members stated that Resident B and Resident C required two staff members to assist with transferring to and from a wheelchair, bed, and toilet. The facility is staffed with two staff members from 6:00 pm until 7:00 am. Staffing with two staff members from 6:00 pm until 7:00 am would not ensure that staffing is available to the other thirteen residents when either Resident B or Resident C required two staff members to assist them with care. Therefore, staffing was not adequate to meet the needs of the residents.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDING

INVESTIGATION:

Resident B's service plan updated 12/24/15 did not include Resident B's need to have two staff members transfer her to and from a wheelchair, bed, and toilet.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Resident B's service plan was not updated to include Resident B's need to have two staff members to transfer to and from a wheelchair, bed, or toilet.
CONCLUSION:	VIOLATION ESTABLISHED

On 6/15/2017, I conducted an exit conference with the authorized representative of the facility, Robert Russell Jr. by telephone. Mr. Russell had no comments.

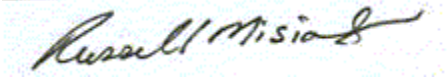
IV. RECOMMENDATION

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

6/20/2017

Loma M Campbell Date
Licensing Staff

Approved By:



6/20/17

Russell B. Misiak Date
Area Manager