GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 7, 2021

Madiha Zeeshan
Grand Blanc Assisted Living, LLC
219 Church St.
Auburn, MI 48611

RE: License #: AL250390289
Investigation #: 2021A0580026
Grand Blanc Fields Assisted Living

Dear Mr. Zeeshan:

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 (810) 787-7031.

Sincerely,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250390289
Investigation #:	2021A0580026
Complaint Receipt Date:	05/18/2021
Investigation Initiation Date:	05/19/2021
Report Due Date:	07/17/2021
Licensee Name:	Grand Blanc Assisted Living, LLC
Licensee Address:	12628 Pagels Drive Grand Blanc, MI 48439
Licensee Telephone #:	(810) 606-0823
Administrator:	Madiha Zeeshan
Licensee Designee:	Madiha Zeeshan
Name of Facility:	Grand Blanc Fields Assisted Living
Facility Address:	12628 Pagels Drive Grand Blanc, MI 48439
Facility Telephone #:	(810) 606-0823
Original Issuance Date:	08/03/2018
License Status:	REGULAR
Effective Date:	02/03/2021
Expiration Date:	02/02/2023
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was taken outside on 4/30/2021 during a fire drill. Staff left her outside in her wheelchair unlocked. She rolled across the parking lot and when it hit the curb she flew out of the chair. She received a broken arm as the result and was not taken for medical treatment until the next day. Staff lied to family regarding the injury and told them she fell out of a chair in the sunroom.	Yes

III. METHODOLOGY

05/18/2021	Special Investigation Intake 2021A0580026
05/19/2021	Special Investigation Initiated - Telephone A call was made to Guardian A.
05/26/2021	Inspection Completed On-site An onsite inspection was conducted at Grand Blanc Fields Assisted Living. Contact was made with the manager, Mr. Robert Woolley.
05/26/2021	Contact - Face to Face An interview was conducted with direct staff, Ms. Alissa Dowd.
06/04/2021	Contact - Telephone call made A call was made to direct staff, Ms. Avery Ketterer.
06/07/2021	Exit Conference An exit conference was held with the licensee.

ALLEGATION:

Resident A was taken outside on 4/30/2021 during a fire drill. Staff left her outside in her wheelchair. She rolled across the parking lot and when it hit the curb she flew out of the chair. She received a broken arm as the result and was not taken for medical treatment until the next day.

INVESTIGATION:

On 05/18/2021, I received a complaint via BCAL Online complaints. This complaint was denied by APS for investigation.

On 05/19/2021, I made a call to Guardian A. The indicated that on 04/30/2021, staff, Mr. Robert Woolley contacted her indicating that Resident A fell while in the sunroom during the fire drill. Upon visiting with Resident A later that evening, Resident A could not tell her what occurred. Resident A is diagnosed with Dementia. Resident A's arm appeared swollen. Guardian A requested ice for Resident A's arm. Guardian A then inquired about taking Resident A to the emergency room. Staff then informed Guardian A that an X-Ray had been requested and a technician should be arriving shortly. Staff also mentioned that Resident A fell outside and there was a video recording of the fall. Guardian A indicated that this was not the information initially reported. Guardian A indicated that she waited for 2 hours and the technician did not show. Guardian A left, requesting that staff contact her as soon as the technician arrived, regardless of the time.

When Guardian A had not heard from the facility the following morning, 05/01/21, she called them. Guardian A indicated that she called the facility all morning, at least 3-4 times and did not receive an answer until sometime between 11:30-12noon. At that time, she was informed that the X-Ray technician never showed. Guardian A requested that Resident A immediately be transported to McLaren Hospital via ambulance. Resident A was diagnosed as having a fractured left shoulder.

Resident A returned to the facility later that evening. Guardian A and her siblings requested a meeting with the owners due to hearing 2 different versions of how Resident A received her injuries. At the meeting held on 05/12/2021 Guardian A indicated that Mr. Woolley did verify that Resident A had fallen in her wheelchair while outside as a result of undoing her brakes. The facility denied her access to the video. The facility did admit that Resident A was left outside while the staff went in for other residents. However, the facility refuses acknowledge any wrongdoing on their part, even though they left a dementia patient alone.

Guardian A indicated that Mr. Woolley seemed to only care about the fact that the fire drill only took 4 minutes. Resident A was moved from the facility effective 05/13/2021.

On 05/26/2021, I conducted an onsite inspection at Grand Blanc Fields Assisted Living. Contact was made with the manager, Mr. Robert Woolley. Mr. Woolley was informed of

the allegations. Mr. Woolley shared that on the date of the fire drill, there were 18 residents in the home. While he was present, he oversaw, but did not assist staff with evacuating the residents. Ms. Alissa Dowd and Ms. Avery Keltner were the 2 staff present during fire drill. He shared that Ms. Kelter was to take residents out of one door while Ms. Dowd assisted residents out the other door. As staff were heading back outside with the last batch of residents, Resident A was found lying on her left side, in the parking lot. Mr. Woolley indicated that the owner/licensee, does have a video of the incident in which Resident A was observed unlocking her wheelchair.

While onsite I observed the residents of the facility. They appeared to be receiving adequate care. While onsite I also observed the sidewalk and the parking lot where the drill was held. The sidewalk is an estimated 30 feet from the parking lot, which slopes due to the facility being on a hill. There is also a curb that separates the sidewalk from the parking lot. There is another curb on the other side of the parking lot. Mr. Woolley indicated that Resident A was left what was an estimated 8-10 feet from the door, on the sidewalk in her wheelchair while staff went back inside to retrieve other retrieve other residents. Resident A landed on the other side of the parking lot after rolling off the sidewalk, across the parking lot, and landing on her left side.

A copy of the AFC Care Agreement, assessment plan, incident report and the medical treatment report from McLaren Hospital were received. The care agreement was signed and dated by the guardian effective 03/09/2021. The assessment plan indicates that Resident A requires the use of a wheelchair for mobility, requiring a 2-person transfer to the chair. The assessment plan also indicates that Resident A is unable to move independently while in the community. In addition, the plan also indicates that Resident A cannot walk, stand, or pivot. A 2-person assist is required to transfer to wheelchair. Resident A also requires full assistance with bathing, grooming, eating, dressing and personal hygiene.

The incident report dated 04/30/2021 indicates that Resident A unlocked her wheelchair during a fire drill and moved herself from the sidewalk to the grass. Her wheelchair tipped forward and she landed face first in the grass. The report indicates that Resident A had a small bruise on her left hand. No other injury. The AFC took the residents vitals, called the family and the physician, Dr. Hardman. As a corrective measure, the home indicated that they would make sure someone stays with the resident once outside, during the next fire drill. The Fire drill log indicates that staff Ms. Avery Keltner, Ms. Alissa Down and Mr. Robert Woolley were present. This drill occurred on 04/30/2021 and listed 17 resident names, including Resident A. Discharge papers from McLaren Hospital, dated 05/01/2021 indicated that Resident A was found to have a fractured left shoulder. Resident A was placed in a sling and prescribed pain medication as needed. A follow-up appointment should be made with Family Orthopedic Associates, located in Flint.

On 05/26/2021, I spoke with direct staff, Ms. Alissa Dowd. Ms. Dowd verified that she, along with another staff were working on the day of the fire drill, which was pre-planned. Although it was pre-planned, she recalled it being very chaotic. She indicated that she

took some residents out of one exit, while the other staff took residents out of the other exit, located at the end of the other hall. She recalls assisting at least 4 residents that required extra assistance. She did not transport Resident A outside during the drill. While she is aware that Resident A fell while outside, she did not observe how Resident A fell or ended up across the parking lot. It is her understanding that there is a video which shows that Resident A unlocked the wheels on her wheelchair, causing herself to roll across the parking lot. She did not see the video.

On 06/04/2021, I spoke with direct staff, Ms. Avery Ketterer. She verified that she was working on the date of the fire drill. Ms. Ketterer states that when the alarm went off, she and the other staff working first took the residents out that were in the living room. These residents were able to ambulate themselves out of the building. They then went in to retrieve the residents who require assistance. Ms. Ketterer indicated that there were at least 3 residents that needed to be assisted. Resident A was amongst the last of the residents to exit as she requires extra assistance and is sometimes impulsive. Upon getting Resident A outside on the sidewalk, she left her outside with the manager, Mr. Woolley while she went back in to retrieve other residents. Ms. Ketterer indicated that she assumed that Mr. Woolley would remain outside, however, he went back inside for a final check. At some point, Resident A was left outside without staff supervision. When she came back out, Mr. Woolley informed her that Resident A had fallen. While she did not see Resident A fall, however, she did see the video. Ms. Ketterer reports that Resident A was immediately taken back to her room for observation. Staff also checked the residents' vitals, as well as contact both the guardian and assigned physician.

On 06/07/2021, I conducted an exit conference with the license designee, Dr. Madiha Zeeshan. Dr. Zeeshan was informed that the results of the investigation determined a violation of the licensing rule. A corrective action plan addressing how this matter will be handled differently was requested within 15 days.

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:	It was alleged that Resident A was taken outside on 4/30/2021 during a fire drill. Staff left her outside in her wheelchair. She received a broken arm as the result.

	The care agreement and AFC Assessment Plan were signed and dated by the guardian effective 03/09/2021. The assessment plan indicates that Resident A requires the use of a wheelchair for mobility, requiring a 2-person transfer to the chair. The assessment plan also indicates that Resident A is unable to move independently while in the community. In addition, the plan also indicates that Resident A cannot walk, stand, or pivot. A 2-person assist is required to transfer to wheelchair. Resident A also requires full assistance with bathing, grooming, eating, dressing and personal hygiene. The incident report dated 04/30/2021 indicates that Resident A unlocked her wheelchair during a fire drill and moved herself from the sidewalk to the grass. Her wheelchair tipped forward and she landed face first in the grass. The report indicates that Resident A had a small bruise on her left hand. No other injury. The AFC took the residents vitals, called the family and the physician, Dr. Hardman. The Fire drill log indicates that staff Ms. Avery Keltner, Ms. Alissa Down and Mr. Robert Woolley were present. This drill occurred on 04/30/2021 and listed 17 resident names, including Resident A. Discharge papers from McLaren Hospital, dated 05/01/2021 indicated that Resident A was found to have a fractured left shoulder. Resident A was placed in a sling and prescribed pain medication as needed. A follow-up appointment should be made with Family Orthopedic Associates, located in Flint. Direct staff, Ms. Alissa Dowd, verified that she, along with another staff were working on the day of the fire drill. Although it was pre-planned, she recalled it being very chaotic. She recalls assisting at least 4 residents that required extra assistance. She did not transport Resident A outside during the drill. Direct staff, Ms. Avery Ketterer, verified that she was working on the date of the fire drill. Ms. Ketterer indicated that there were at least 3 residents that needed to be assisted and Resident A was amongst the last of the residents to exit, as she requires extra assistance and is sometimes impulsive. Upon getting Resident A outside on the sidewalk, she left her outside with the manager, Mr. Woolley while she went back in to retrieve other residents. Ms. Ketterer indicated that she assumed that Mr. Woolley would remain outside, however, he went back inside for

	a final check and Resident A was left alone. When she came back out, Mr. Woolley informed her that Resident A had fallen. Based on the information gathered throughout the course of this investigation, there is sufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

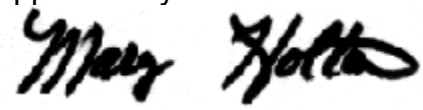
IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no changes to the status of the license is recommended.

June 7, 2021

Sabrina McGowan — Date
Licensing Consultant

Approved By:



June 7, 2021

Mary E Holton — Date
Area Manager