GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 10, 2021

Nozmi Elder
Cedar Woods Assisted Living
44401 I-94 S Service Dr
Belleville, MI 48111

RE: License #: AH820304947
Investigation #: 2022A1019011
Cedar Woods Assisted Living

Dear Mr. Elder:

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.

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) 284-9730.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820304947
Investigation #:	2022A1019011
Complaint Receipt Date:	11/05/2021
Investigation Initiation Date:	11/08/2021
Report Due Date:	01/05/2022
Licensee Name:	Willow Commons, LLC
Licensee Address:	44401 I-94 S. Service Dr. Belleville, MI 48111
Licensee Telephone #:	(734) 699-2900
Administrator:	Robin Wojtowicz
Authorized Representative:	Nozmi Elder
Name of Facility:	Cedar Woods Assisted Living
Facility Address:	44401 I-94 S Service Dr Belleville, MI 48111
Facility Telephone #:	(734) 699-2900
Original Issuance Date:	05/21/2010
License Status:	REGULAR
Effective Date:	07/30/2021
Expiration Date:	07/29/2022
Capacity:	210
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had a black eye.	No
Resident A's injury was not reported.	Yes
Additional Findings	No

III. METHODOLOGY

11/05/2021	Special Investigation Intake 2022A1019011
11/05/2021	Comment Complaint was forwarded to LARA from APS. APS denied the referral and did not assign it for investigation.
11/08/2021	Special Investigation Initiated - On Site
11/08/2021	Inspection Completed On-site
11/08/2021	Inspection Completed-BCAL Sub. Compliance
11/10/2021	Exit Conference

ALLEGATION:

Resident A had a black eye.

INVESTIGATION:

On 11/5/21, the department received a complaint alleging that Resident A sustained a black eye of unknown origin. The complaint read that facility staff had no documentation surrounding the incident and could not provide an explanation for the resident's injury.

On 11/8/21, I conducted an onsite inspection. I interviewed executive director Tammy Murdock at the facility. Ms. Murdock stated that on 11/1/21, she was informed by the facility's director of resident care Lasonia Peterson that Resident A

had “discoloration” to one of her eyes. Ms. Murdock stated that Resident A’s guardian had questioned Ms. Peterson about the injury during her visit earlier that day. Ms. Murdock stated she and Ms. Peterson went to examine the resident. Ms. Murdock stated that upon assessing Resident A, a scabbed area was observed on one of her arms, had some abrasions to her elbow and an open area above one of her eyebrows and a purple and yellow discoloration under the same eye. Ms. Murdock stated that Resident A told her that she had fallen “a few days ago” when attempting to get up out of bed because she fell. Ms. Murdock stated that Resident A said that staff helped her up but could recall who the staff was or provide any additional detail about the event. Ms. Murdock stated that the resident was not in any pain at the time and did not require any medical treatment. Ms. Murdock stated that she instructed Ms. Peterson to complete and incident report for the event and notify Resident A’s guardian. Ms. Murdock stated that some staff were questioned about the incident but that at this time, all deny knowledge of a fall. Ms. Murdock stated that staff “Rachel” worked second shift on 10/29/21 and did not see a bruise and then returned to work second shift on 10/30/21 and noticed the bruise, so it is believed that the injury occurred during third shift on 10/29/21 or first shift on 10/30/21.

On 11/8/21, I interviewed Ms. Peterson at the facility. Ms. Peterson stated that she was informed by Resident A’s guardian on 11/1/21 that Resident A had a black eye and she wanted to know what happened. Ms. Peterson stated that at the time, she was unaware that Resident A had an injury. Ms. Peterson stated that she assisted Resident A with bathing during first shift on 10/29/21 and affirmed that the discoloration was not present at that time. Ms. Peterson stated that when she and Ms. Murdock went to check on Resident A after her guardian left, Resident A informed her that she had fallen and that “the girls” picked her up. Ms. Peterson stated that she has attempted to reach out to numerous staff who worked with Resident A after first shift on 10/29/21 and before first shift on 11/1/21 but no one acknowledged that Resident A fell and all denied helping her up. Ms. Peterson stated that she completed an incident report but forgot to notify the guardian at the time. Ms. Peterson reported that she called Resident A’s guardian on 11/4/21 and left a voicemail.

Ms. Murdock and Ms. Peterson both stated that Resident A requires assistance with mobility and transferring. Ms. Peterson and Ms. Murdock stated that they do not believe Resident A would be able to get herself up if she fell.

Resident A’s service plan identified Resident A as being a fall risk. The plan read that Resident A has a hospital bed with a concave mattress, a floor mat and geri chair as part of her fall prevention program. The plan also read that Resident A cannot ambulate even with assistance and that staff must perform all transfers.

The incident report authored by Ms. Peterson read:

A red area was noted on her left arm and a scab on her right arm. While we were investigating what may have occurred. [Resident A] starting [sic] to talk to us once we stopped & listen [sic] [Resident A] was telling us how she received the injury to of [sic] her arms. She stated she was wet and wanted to be change and fell out of bed hurting her arm and face.

Ms. Peterson also completed a progress note outlining the incident. The progress note contained the same information as the incident report but added the following:

She said she couldn't remember who got her up. She also stated it happened a day or two ago. I showered her on Friday at noon and there was no noted scrapes or discolorations noted at that time. Therefore, we recorded an unreported fall that occurred between 2:30pm Friday and 2:30pm Sat (due to afternoons reporting no noted injury Friday but noted on Sat at 2:30pm).

Following my onsite, Ms. Murdock compiled a list of all staff who worked during the estimated timeframe that the injury occurred, and attempts made to contact all staff. Below are the results of those contacts:

Afternoon Shift 10/29/21
Jordan Fouty- Supervisor- Doesn't know anything about [Resident A's] eye.
Rachel Rigdon-Smith-MC- Wasn't like that on Friday
Maria Fountain- MC- Didn't know anything about it
Asia Redman- Didn't work MC this day, didn't know anything about her
LaJaychanae Minter- Didn't work MC this day, didn't know anything about her.
Cherri Smith-Monk- Didn't work MC this day, didn't know anything about her.

Midnight Shift 10/29/21
Lorna Pascual-Gallera -(Supervisor) Doesn't know anything about [Resident A's] Discoloration of her eye; nothing reported to her on the shift.
Aisha Idrissa - MC-Hasn't returned our phone calls. (Scheduled tonight 11-9 will attempt contact then)
Patricia McGee- MC-Stated that she doesn't know anything about [Resident A's] discoloration of her eye.
Wesley Curtis- Hasn't returned our phone calls or texts; he is contingent now from a previous FT position, goes to school all day most days.

Day Shift 10/30/21
Lisa McGee- Supervisor- No staff reported any discoloration of [Resident A's] eye.
Ebon McAllister-MC- Hasn't returned our phone calls or texts. RCA walked off shift on 10/31/21 and has not returned nor take calls re: the walk off.
Kennedy Allen-MC- Called numerous times and no call back. RCA walked off shift on 11/5/21.
Cherri Smith-Monk- Didn't work MC and doesn't know anything about.
Desiree Heningberg- Didn't work MC and doesn't know anything about.

Harmony Jones - Didn't work MC and doesn't know anything about it. (RCA trained with Desiree)
Kierra Goldston- Didn't work MC and doesn't know anything about.
Leah Coates- Didn't work MC, called numerous times and no call back RCA was also terminated on 11/2/21.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Resident A had an unwitnessed fall estimated to have occurred sometime on 10/29 or 10/30. Staff interviewed denied knowledge of the fall, including helping her up off the floor. Resident A does have a history of falls with active fall prevention protocol in place. Given the information available, the injury cannot be attributed to staff wrongdoing.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's injury was not reported.

INVESTIGATION:

Ms. Murdock and Ms. Peterson stated that staff have not come forward with knowledge of Resident A's fall and had no documentation from when it occurred. Ms. Peterson stated during interviews, staff "Rachel" and staff "Alex" both stated that they saw the bruising but assumed that it was already properly reported. Ms. Peterson admitted to calling Resident A's guardian days after learning of what occurred. Additionally, the incident was not reported to licensing.

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.
ANALYSIS:	Facility staff did provide timely notification of Resident A's injury.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/10/21, I shared the findings of this report with authorized representative Nozmi Elder. Mr. Elder verbalized understanding of the citation and did not have any additional questions.

IV. RECOMMENDATION

Contingent upon receipt an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

11/10/21

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

11/10/21

Russell B. Misiak Date
Area Manager