GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 13, 2022

Subbu Subbiah
Woodland Park Assisted Living LLC
2585 Stanton St.
Canton, MI. 48188

RE: License #: AM250309137
Investigation #: 2022A0779049
Woodland Park Assisted Living

Dear Mr. Subbiah:

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) 643-7960.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250309137
Investigation #:	2022A0779049
Complaint Receipt Date:	07/27/2022
Investigation Initiation Date:	07/28/2022
Report Due Date:	09/25/2022
Licensee Name:	Woodland Park Assisted Living LLC
Licensee Address:	2363 E. Coldwater Rd. Flint, MI 48505
Licensee Telephone #:	(812) 202-9149
Administrator:	Ponnammai Subbiah
Licensee Designee:	Subbu Subbiah
Name of Facility:	Woodland Park Assisted Living
Facility Address:	2363 E. Coldwater Road Flint, MI 48505
Facility Telephone #:	(812) 202-9149
Original Issuance Date:	09/22/2011
License **Status:**	REGULAR
Effective Date:	12/13/2021
Expiration Date:	12/12/2023
Capacity:	12
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A got up unassisted and had a fall on Sunday in the bathroom. She was not taken to the hospital until Monday and found to have a broken pelvis.	Yes

III. METHODOLOGY

07/27/2022	Special Investigation Intake 2022A0779049
07/28/2022	APS Referral Complaint was referred to APS centralized intake.
07/28/2022	Special Investigation Initiated - Telephone Spoke to Complainant.
07/28/2022	Contact - Telephone call made Spoke to family member of Resident A.
07/28/2022	Contact - Telephone call made Spoke to hospice nurse.
08/01/2022	Inspection Completed On-site
08/02/2022	Inspection Completed On-site
08/22/2022	Contact - Telephone call made Interview conducted with staff person, Ashia Pettigrew.
08/22/2022	Contact - Telephone call made Interview conducted with staff person, Diamond Johnson.
09/13/2022	Exit Conference Conducted with licensee designee Subbu Subbiah.

ALLEGATION:

Resident A got up unassisted and had a fall on Sunday in the bathroom. She was not taken to the hospital until Monday and found to have a broken pelvis.

INVESTIGATION:

On 7/28/22, a phone conversation took place with Complainant. She stated that Resident A had a fall on Sunday 7/24/22 and did not receive medical treatment until the next day, when a relative went to the home and found Resident A in significant pain. Complainant reported that the staff did call Relative 1 to report the fall and then only gave Resident A some Tylenol and an ice pack. Complainant stated that Resident A utilizes a walker but was able to transfer and ambulate independently.

On 7/28/22, a phone conversation took place with Relative 1. She confirmed that staff called her right after the fall on 7/24/22, so Relative 2 went to the home later the same day to see Resident A. Relative 1 reported that Relative 2 witnessed Resident A to be eating dinner at the dining room table and Resident A appeared to be doing fine. She stated that Relative 2 noticed that Resident A had a small bruise on her right temple area. Relative 1 stated that Resident A has a history of mental illness and now has dementia. Relative 1 does not feel that Resident A would be able to answer any questions regarding the fall or her care there. She stated that Resident A was able to get out of bed on her own but was a fall risk and required supervision when walking. She stated that she made that clear to the licensee designee, Subbu Subbiah, when Resident A first arrived at this home. Relative 1 reported that she received a call from Hospice nurse on 7/25/22, asking her to meet her at the home. Relative 1 stated that when she got to the home staff told her that Resident A appeared to be having pain and would not get up out of bed or eat breakfast that morning. She stated that she and the Hospice nurse decided to have Resident A sent to the hospital to get looked at. Relative 1 reported that Resident 1 is a Genesys hospital with a broken pelvis and will be going to a rehab facility. She stated that she is not sure if Resident A will be returning to this home.

On 7/28/22, a phone conversation took place with Hospice nurse, Pam Rinaldo-Dikos. She stated that she has been working with the licensee designee, Mr. Subbiah, to evaluate the residents of this home for Hospice and/or getting them set up with an appropriate visiting primary care physician. Ms. Rinaldo-Dikos stated that Mr. Subbiah called her the morning of 7/25/22 and asked her to come look at Resident A, so she called Relative 1 and asked her to meet her at the home. She reported that staff could not get Resident A up out of bed and could barely move her. She stated that her assessment showed that Resident A could not ambulate and was in significant pain, so they determined to send Resident A to the hospital.

On 8/1/22, a visit was made to the home and staff person, Lisa Willingham was interviewed. Ms. Willingham confirmed that she worked 1st shift on 7/25/22 and that Resident A was having significant pain that morning. She stated that Resident A would

not get out of bed or eat breakfast. Ms. Willingham stated that she called Mr. Subbiah and that nurse Ms. Rinaldo-Dikos and Relative 1 came to the home and had Resident A sent to the hospital. Ms. Willingham reported that Resident A was able to walk independently with her walker, but Resident A would sometimes forget to use her walker.

On 8/2/22, a second visit was made to the home and several residents were viewed. All residents were viewed to be clean, well groomed and doing well. Staff person, Shacrai Johnson, was interviewed. She confirmed that Resident A could transfer herself out of bed and could walk fine using her walker. Ms. Johnson reported that she once did find Resident A walking down the hallway without her walker.

During the on-site inspection on 8/2/22, licensee designee, Mr. Subbiah, was interviewed. He stated that staff person, Ashia Pettigrew, called him right after Resident A's fall on 7/24/22 and that he told her to check for visible injuries and/or pain. Mr. Subbiah reported that he was told that Resident A was okay, was not in any visible pain, ate dinner and went to bed. He stated that Resident A had a call button/alarm but did not use it. Mr. Subbiah stated that staff called him the next morning to report that Resident A was having significant pain, so he contacted Hospice nurse, Ms. Rinaldo-Dikos, and asked her to go to the home and evaluate Resident A. He stated that an assessment was done and it was decided that Resident A be sent to the hospital.

Resident A's *Assessment Plan for AFC Residents* was reviewed. The plan confirmed that Resident A was mobile when utilizing a walker. It indicated that Resident A was a stand-by assist for toileting and required staff assistance for all other activities of daily living.

On 8/22/22, a phone interview was conducted with staff person, Ashia Pettigrew, who confirmed that she was working 2nd shift on 7/24/22 when Resident A had her fall. Ms. Pettigrew stated that she had seen Resident A sleeping in her bedroom right before she went to prepare for dinner. She stated that while preparing dinner, she heard a big boom sound and then went and found Resident A laying the bathroom floor. She stated that Resident A did not have her walker with her in the bathroom. Ms. Pettigrew reported that she did an assessment and touched Resident A all over and Resident A said that nothing was hurting. She reported that Resident A did get a bruise on her right thigh and right temple area and that she called Relative 1 to let her know of the fall. Ms. Pettigrew stated that after dinner, Resident A said that her leg hurting a little, so she gave her some Tylenol and an ice pack and sat her in a chair. She stated that later Resident A was in visible pain and needed help getting up out of the chair. Ms. Pettigrew stated that Resident A was put in her bed for the night at the end of her shift.

An *AFC Licensing Division- Incident/Accident Report* (IR) regarding Resident A's fall was reviewed. The IR was completed by staff person, Ms. Pettigrew and confirmed the fall took place at approximately 5:00 pm on 7/24/22. The information on the IR matched the information that was obtained during Ms. Pettigrew's interview. It stated that Resident A was found on the bathroom floor, had a bruise on her right thigh and right

temple area, and was given Tylenol and an ice pack. The IR stated that Resident A was sent out the hospital on 7/25/22. The corrective measures listed on the IR was for staff to take Resident A to the bathroom at least every two hours during the day so she does not feel the need to walk to the bathroom on her own.

On 8/22/22, a phone interview was conducted with staff person, Diamond Johnson, who confirmed that she worked 3rd shift on 7/24/22 and that she started at 11:00 pm. Ms. Johnson stated that Resident A was sitting in a living room chair when she arrived at work. Ms. Johnson reported that it took her and one other staff to help get Resident A up out of the chair, which was unusual for Resident A. She stated that she could tell that Resident A was in pain and that it hurt to move her. Ms. Johnson stated that Resident A was put in her bed for the night and that she did not have to do anything for Resident A the rest of the night.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	It was confirmed that Resident A had a fall in the bathroom of the home on 7/24/22 and that she received a bruise to her right thigh and right temple area. Although Resident A initially appeared to be fine, she was observed by two separate staff later that same night to be in pain and she required assistance from those two staff to get up and out of a chair. Resident A was then placed in her bed for the night. The next morning, Resident A would not eat breakfast, get out of bed, could not be moved and was visibly in significant pain. During the same night as her fall, Resident A was observed to be in pain and required assistance from staff that was not normal for her to need. Resident A was then placed in her bed for the night without being provided any medical services or evaluation. There was sufficient evidence found to prove that Resident A had an accident that caused an adverse change in her physical condition and that immediate medical care should have been provided. Such care was not provided until the next day, at which time Resident A was in significant pain and could not move.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/13/22, an exit conference was held with licensee designee, Subbu Subbiah. He was informed that the result of this investigation warranted a licensing rule violation and that a written corrective action plan was required.

IV. RECOMMENDATION

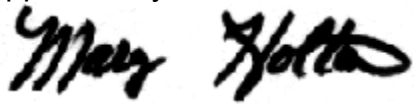
Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

9/13/2022

_____

Christopher Holvey Date
Licensing Consultant

Approved By:



9/13/2022

_____

Mary E. Holton Date
Area Manager