GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 22, 2022

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

RE: License #: AM250309137
Investigation #: 2022A0580059
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250309137
Investigation #:	2022A0580059
Complaint Receipt Date:	09/28/2022
Investigation Initiation Date:	09/29/2022
Report Due Date:	11/27/2022
Licensee Name:	Woodland Park Assisted Living LLC
Licensee Address:	2363 E. Coldwater Rd. Flint, MI 48505
Licensee Telephone #:	(812) 202-9149
Administrator:	Ponnammal 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 B was sent to her room due to behaviors by Ms. Pam Rinoldo-Dikos. She indicated that from now on she would be using a timer and time out when Resident B is having behavior issues.	No
Complaints that Resident A was not receiving the pain medication from the facility and was in severe pain.	No
Additional Findings	Yes

III. METHODOLOGY

09/28/2022	Special Investigation Intake 2022A0580059
09/28/2022	APS Referral This complaint was denied by APS for investigation.
09/29/2022	Special Investigation Initiated - On Site An onsite inspection was conducted.
09/29/2022	Contact - Face to Face An interview was conducted with Resident A
09/29/2022	Contact - Face to Face An observation of Resident B was conducted.
10/06/2022	Comment Intake # 190765 was received and combined with this investigation.
10/062022	APS Referral A referral was made to APS sharing the allegations.
10/06/2022	Contact - Telephone call made Spoke with Heather Roca, VAAA Case Manager for Resident B.
10/06/2022	Contact - Telephone call made Spoke with Ms. Pam Rinoldo-Dikos of All American Hospice. .
10/06/2022	Contact - Telephone call made Spoke with Ms. Aisha Pettigrew, home manager.

10/06/2022	Contact - Document Received A faxed copy of documents requested was received.
11/03/2022	Contact - Telephone call made A call was made to Mr. Subbiah, Licensee Designee.
11/10/2022	Inspection Completed On-site A follow-up onsite inspection was conducted.
11/16/2022	Contact - Telephone call made Call made to Relative A.
11/16/2022	Contact - Telephone call made A call was made to Relative B.
11/17/2022	Contact - Telephone call made A call was made to Mr. Subbiah.
11/18/2022	Contact - Telephone call made A follow-up call was made to Ms. Heather Roca.
11/18/2022	Contact - Telephone call made A follow-up call was made to Relative Guardian A.
11/22/2022	Exit Conference An exit conference was held with the licensee designee, Mr. Subbiah.

ALLEGATION:

Resident B was sent to her room due to behaviors by Ms. Pam Rinoldo-Dikos. She indicated that from now on she would be using a timer and time out when Resident B is having behavior issues.

INVESTIGATION:

On 10/06/2022, I received an additional complaint via BCAL online complaints.
A referral was made to APS sharing the allegations.

On 10/06/2022, I spoke with Ms. Heather Rocca, assigned Valley Area on Aging (VAAA) Case Manager for Resident B. She shared that she has been speaking with Ms. Pam Rinoldo-Dikos, who has been assisting the staff at the facility while the licensee is out of the county. To her knowledge, she is not an employee at the facility. She expressed concerns regarding a conversation held with Ms. Rinoldo-Dikos

regarding Resident B's behavior. She shared that while speaking on the phone with Rinoldo-Dikos, she indicated that she sent her to her room. Ms. Rinoldo-Dikos stated from now on she is going to use a timer and time out when Resident B is having behavioral issues. Resident B does not have a behavior plan allowing such interventions. Ms. Roca shared a copy of the AFC Assessment Plan given to her by the facility.

The AFC Assessment Plan for Resident B indicates that Resident B does not move independently in the community due to being imbalanced. Resident B also lacks verbal skills to communicate her needs. It also indicates that her aggressive behaviors are controlled with medications. The plan states that Resident A requires assistance with toileting, walking and mobility, however, it does not address how the need will be met. The assessment was completed by the home manager, Ms. Aisha Pettigrew, and Ms. Pam Rinoldo-Dikos of All American Hospice. The plan was not signed by the licensee designee or the resident's designated representative.

On 10/06/2022, I spoke with Ms. Pam Rinoldo-Dikos of All American Hospice. She indicated that she is not employed by the facility, she is just assisting the staff with anchoring down, so to speak, while the licensee is out of the county. She adds that she has been going to the facility each evening to assist the manager, Ms. Aisha Pettigrew as needed. She adds that Ms. Pettigrew has since hired new employees. She shared that she does provide hospice services to 2 of the residents in the home.

On 10/06/2022, I spoke with Aisha Pettigrew, the home manager at Woodland Park Assisted Living. A copy of any Incident Reports (IR) involving Resident B were requested.

An incident report dated 09/30/2022 indicates that on 09/29/2022, Resident B cried all night and all morning. She also came out of her room naked and urinated on another resident's floor. Actions taken by staff were to redirect her to her room and attempting to give her snacks to calm her down. As corrective measures, staff called VAAA and Rinoldo-Dikos. Ms. Rinoldo-Dikos then sent a text message to United Medical Services asking for a mental evaluation.

The incident report dated 10/04/22 states that Resident B went into another resident's room, sat in his wheelchair, and indicated that it was hers and she would not get up. She was also crying most of the day, sneaking pie from the kitchen cabinets, and punching the wall. Actions taken were to redirect her to the living room couch or to her room. Corrective measures included calling Ms. Rinoldo-Dikos, who then sent a text message to United Medical Services.

The incident report dated 10/05/22 states that Resident B came out of her room with no underwear or pants on. Actions taken were to redirect her to her room. Corrective measures included calling Ms. Rinoldo-Dikos. United Medical Service medication change visit scheduled.

The incident report dated 10/07/22 states that Resident B was angry, hitting the wall, throwing, refusing to go to bed. She kept going in other residents' rooms, taking their things, and slamming their doors. Resident B was also taking food from the kitchen and fighting with staff. Staff contacted the home manager, Ms. Aisha Pettigrew, Ms. Rinoldo-Dikos, and United Medical Service and was told to send Resident A to the ER. Resident A was sent to Hurley for a psychiatric evaluation. Resident B did not return to the facility after this incident.

On 11/03/2022, I spoke with Mr. Subbiah. He denied that Ms. Rinoldo-Dikos works at the facility in any capacity other than as a medical professional. Ms. Rinoldo-Dikos is also clinician at United Medical Services, where he contracts medical services for the residents in the home. She currently provided hospice care for 2 of the residents at the facility.

On 11/10/2022, I conducted a follow-up onsite at Woodland Park. Contact was made with the licensee, Mr. Subbiah, home manager Ms. Aisha Pettigrew and Ms. Rinoldo-Dikos.

Ms. Rinoldo-Dikos indicated that Resident A's case manager misunderstood her when she indicated Resident A was being sent to her room. She indicated that due to Resident A's behaviors, a room in the facility was created for her to deescalate by coloring, lay down on the couch, or other activities. She denies using a timer for timeouts indicating that there is no timer in the facility. An observation of the room was made. The room is a sitting area in the facility complete with a sofa couch, an end table and a television sitting atop a bureau/TV stand.

On 11/18/2022, I conducted a follow-up call to Ms. Heather Roca. She shared that Resident B's last day of stay was on 10/13/2022. The morning of 10/14, Resident B was at an appointment with GHS when she began complaining of chest pain. Resident A does have a Pacemaker, therefore she was transferred to the emergency department where she began having behaviors. Resident A was placed on a psychiatric hold for 7 days and placed at Cranberry Park AFC effective 10/21/2022. She is awaiting information from the hospital's legal team regarding the status to petition a public guardian for Resident B. As it stands currently, Resident B is her own guardian.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or

	obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Based on my investigation, which included interviews with licensee designee Subbu Subbiah, Ms. Pam Rinoldo-Dikos direct staff, case manager, Ms. Heather Roca, and a review of the documents provided, other than what was indicated in the written complaint, there is no evidence to substantiate the allegation that a timer and time out was used as a behavior intervention for Resident B.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Complaints that resident was not receiving the pain medication from the facility and was in severe pain.

INVESTIGATION:

On 09/28/2022, I received a complaint via BCAL Online complaints. This complaint was denied by APS for investigation.

On 09/29/2022, I conducted an onsite inspection at Woodland Park AFC. Contact was made with direct staff, Ms. Destiny Jackson, and Ms. Kirsten Auburn. Both indicated that they were not working when Resident A was sent back to the hospital.

On 9/29/2022, Resident A was interviewed. Upon observing and interviewing Resident A, he indicated that since his 2nd hospital visit, he has been receiving his medication and is doing well.

On 9/29/2022, Resident B was observed while onsite at the facility. Resident B was having behaviors and continuously being redirected by staff. She has limited verbal skills and is unable to participate in an interview.

On 10/06/2022, I spoke with Ms. Aisha Pettigrew, home manager. She indicated that Resident A received his surgery on Thursday 09/22/2022 and was discharged the same day. Resident A was not sent home a prescription after his outpatient surgery. The following day when he complained of pain, a call was made to his physician's office for medication, and he was provided with a pain medication and an antibiotic. Resident A's prescription was filled by his Relative A, who typically tends to his needs as Guardian A is often difficult to reach. He did not have it filled immediately. Once the prescription was received, they began administering the medication.
The AFC Plan observed for Resident A indicates that he takes medication. It does not identify how this need will be met.

On 11/03/2022, I spoke with Mr. Subbiah. He denied that Resident A's script was not filled. He stated that the guardian was responsible for filling the script. Once it was filled Resident A was given his medication.

On 11/09/2022, I received a copy of the hospital discharge instructions for Resident A. The After Visit Summary indicates that Resident A received an outpatient Cystoscopy, due to a urethral narrowing. Aftercare instructions were provided related to Foley Catheter Placement Care and How to Change a Catheter Drainage Bag. The instructions indicated that he is to continue his current medication, with a discontinuation of Oxybutynin-5mg tablet. The discharge instructions also indicate to call for an appointment on Monday 09/26/2022 to have the Foley Catheter removed. It does not indicate that any new prescriptions were given to the resident.

An additional set of discharge papers for Resident A were also received. The After Visit Summary, dated 09/27/2022 indicates that Resident A was seen again at the hospital due to penis pain/irritation from the Foley Catheter. Resident A was prescribed Acetaminophen, 325 mg tablet, take 2 tablets by mouth every 6 hours as needed for mild pain. He was also prescribed Cephalexin, 500mg capsule, take 1 capsule by mouth 3 times a day, for 5 days.

A faxed copy of the September 2022 medication log for Resident A was received. Resident A began taking the medications Acetaminophen, 325 mg tablet and Cephalexin, 500mg capsule on 09/28/2022. The medication, Oxybutynin 5mg, continued to be administered throughout the month of September after the 09/22/2022 discontinuation date.

On 11/16/2022, I made a call Relative A. He was unable to participate in an interview at that time. A call back was requested.

On 11/16/2022, I spoke with Relative B. She indicated that she is not Resident A's guardian, however, she is a concerned relative. She stated that Resident A is not receiving the best care in this home. He constantly calls her to complain about the phone and the fact there is nothing there to do. She alleges that the facility took a week to fill Resident A's prescription. Guardian A is his legal guardian; however, she does not visit or tend to Resident A's needs while in the home, She and other family members often visit and make sure he has the things he needs.

On 11/17/2022, I placed a call to the licensee designee informing him that according to the hospital discharge paperwork for Resident A, he should no longer be taking the medication, Oxybutynin 5mg. He indicated that he would check with the manager, Ms. Aisha Pettigrew. Mr. Subbiah agreed to ensure staff rear discharge instructions more carefully.

Mr. Subbiah followed up later this same day and indicated that the medication has been discontinued for Resident A.

11/18/2022, I spoke with Relative Guardian A. She shared that anything that her husband needs, she obtains for him and ensures it gets to the facility. She indicated that she and Relative A usually pick up his prescriptions and take them to the facility. They only administer the medication. She has no concerns with the facility.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation, which included interviews with licensee designee Subbu Subbiah, multiple direct staff members, Resident A, and Relative Guardian A, Relative A, Relative B, and the documents reviewed, other than what was indicated in the written complaint, there is no evidence to substantiate the allegation that Resident A was not receiving the pain medication from the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

The 09/22/2022 Hurley Hospital discharge instructions indicated that Resident A should discontinue the medication of Oxybutynin-5mg tablet. The September 2022 medication log indicates that staff continued to give the medication past the discontinuation date of 09/22/2022.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Per the September 2022 Medication Longs, Resident A's medication was not given as prescribed by the licensed physician. There is evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11//22/2022, an exit conference was conducted with Mr. Subbiah. Mr. Subbiah was informed of the findings of this investigation.

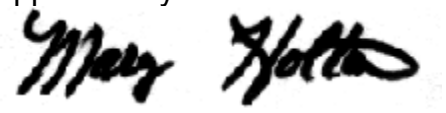
IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of correction, no change to the status of the license is recommended.

November 22, 2022

Sabrina McGowan Date
Licensing Consultant

Approved By:



November 22, 2022

Mary E. Holton Date
Area Manager