GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 23, 2023

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

RE: License #: AM250309137
Investigation #: 2023A0580014
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 add 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,

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 #:	2023A0580014
Complaint Receipt Date:	12/29/2022
Investigation Initiation Date:	01/03/2023
Report Due Date:	02/27/2023
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell a couple of weeks ago. He hurt his shoulder as a result. His hands are swollen as a result and unable to physically use his hands. Staff did not provide medical attention.	Yes
Resident A is not receiving a diet that is proper for a diabetic.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/29/2022	Special Investigation Intake 2023A0580014
12/29/2022	APS Referral This complaint was opened by APS for investigation.
01/03/2023	Special Investigation Initiated - Telephone A call was made to Ms. Tiffany Williams of Genesee Co. APS.
01/18/2023	Inspection Completed On-site An onsite inspection was conducted. Contact was made with Ms. Nicole Spencer, Facility Manager.
01/18/2023	Contact - Face to Face Interview with Resident A.
02/17/2023	Contact - Telephone call made A call was made to Relative A.
02/23/2023	Exit Conference An exit conference was held with the licensee designee, Mr. Subbu Subbiah.

ALLEGATION:

Resident A fell a couple of weeks ago. He hurt his shoulder as a result. His hands are swollen as a result and unable to physically use his hands. Staff did not provide medical attention.

INVESTIGATION:

On 12/29/2022, I received a complaint via BCAL Online Complaints. This complaint was opened by APS for investigation.

On 01/03/2023, I spoke with assigned Genesee County APS worker, Ms. Tiffany Williams. She shared that she visited with Resident A at the facility on 12/28/2022. He reported to her that he has fallen several times. She received copies of 4 incident reports in which he has fallen beginning in July of 2022 to the present. While onsite she observed that Resident A's bedrail was broken, resting on the opposite wall. Both the licensee, Mr. Subbu Subbiah and staff, Ms. Asia Pettigrew stated that they are in the process of trying to obtain a new hospital bed for Resident A via his insurance. They deny that he was not provided with medical care.

On 01/18/2023, I conducted an onsite inspection at Woodland Park Assisted Living. Contact was made with Ms. Nicole Spencer, former employee who just recently returned to working at the facility as the new manager. She shared that she began working again on 01/09/2023 and has no current information related to Resident A's falls. Copies of the AFC Assessment plan for Resident A, current health care appraisal, incident reports related to his falls and a copy of the current facility menu were obtained.

While onsite I interviewed Resident A. Resident A indicated that he has fallen at least 4 times, with his most recent fall taking place a week or so ago. He is unsure of the date. He recalls that he was sitting on the edge of the bed with his water, next thing he knows his walker fell on top of him, hurting his arm. He stated that he saw the doctor who took an Xray and said it was not broken, however, she would not give him any pain pills, only Tylenol, and continues to be in pain. He does not like the physician being used by the AFC home and wants to go back to utilizing his previous physician. He received his new bed a few days ago. The bed was observed as a new hospital bed, with rails.

The AFC Assessment plan for Resident A indicates that Resident A uses assistive device for mobility and walking. The AFC plan does not identify what devices are used for mobility. The plan does state that Resident A has physical limitations and uses a walker as an assistive device.

The AFC Licensing Division - Accident/ Incident Report (IR) dated 07/11/22 states that Resident A slid out of bed while trying to sit up on the edge. Staff action was assisting Resident A off the floor. Staff moved Resident A to the middle of the bed as a corrective measure. No injuries were noted.

IR dated 08/03/2022 states that Resident A fell out of bed while attempting to go to the bathroom. Staff actions were to assist him up and to the bathroom. Corrective measures included reminding Resident A to use his call button when he needs assistance. No serious injury was noted.

IR dated 10/11/22 states that Resident A fell out of bed. Actions taken by staff consisted of assisting Resident A to his chair. Staff assisted Resident A in his wheelchair as a corrective measure.

IR dated 11/03/22 states that Resident A was trying to get his soda top from the floor and fell. Staff actions included picking Resident A up from the floor. Staff inquired if he was hurt, and Resident A indicated that his right arm hurt. Resident A was given 2 Tylenol. Management was contacted. Management in turn contacted the facility physician. Staff reminded Resident A to use his call button for assistance to get things from the floor as a corrective measure.

The patient care summary plan for Resident A states that he was seen on 12/09/2022 by United Health Care Group as a follow-up to pain in his right shoulder for 2 weeks, indicating that he'd fallen and landed on his walker. The summary also indicates that a hospital bed was ordered for Resident A. The plan summary for Resident A indicates to continue present management, medications were reviewed. Advised to monitor BP regularly, follow low salt, bland, diabetic diet recommended. Follow up 1 month, sooner as needed. An Xray of Resident A's right shoulder was ordered.

A copy of the Radiology report conducted on 12/11/2022, by Trident Care Imaging, states that Resident A received an Xray on this date. No fractures were noted.

IR dated 01/03/2023 states that Resident A complained of chest and arm pain around 4:30am, believing he was having a heart attack. Staff actions indicate that Resident A was sat up in bed for comfort. Staff then contacted EMS, management and Resident A's spouse. Resident A was checked out by the ambulance, however, he refused to go to the hospital as the pain had subsided. Staff actions were to keep an eye on him following the incident.

IR dated 01/15/2023 states that while doing room checks Resident A was found on the floor. Resident A said he'd fallen asleep in his wheelchair and when he tried to get into bed he fell. Staff actions were to pick him up from the floor. Staff inquired if he was hurt, and Resident A indicated that his right arm hurt. Resident A was given 2 Tylenol. Staff actions were to remind him to pull his call button when he needs help.

The patient care summary plan for Resident A states that he was seen on 01/23/2023 by United Health Care Group as a follow up. Still complains of stiffness in right hand. The swelling has come down but still has some. Denies any further trauma. He had a fall and landed on his walker 2 months ago. He fell on his right arm. He complains of pain at rest and increases with movement. The plan summary for Resident A indicates to continue present management. US right arm and MRI of cervical spine ordered.

Continue PT for right arm. Advised to keep exercising the hand with exercise ball. Advised to keep hand and arm elevated above level of heart. Advised to monitor BP regularly, follow low salt, bland, diabetic diet recommended. Advised staff to monitor BS regularly. Follow up 1 month, sooner as needed.

On 02/17/2023, I spoke with Relative A who stated that she had been aware of Resident A having falls at the facility recently. The home recently got him a new bed with rails to keep him from falling from bed. She adds that Resident A likes to remain independent, often trying to do things for himself. Staff encourage him to use his call button. To her knowledge, Resident A has also received Xray's indicating that his arm is not broken. She has no other concerns.

Special Investigation Report # 2022A0779049 dated 09/13/2022 substantiated violation to R 400.14310(4) due to evidence found to prove that a resident had an accident that caused an adverse change in her physical condition and medical coverage was not provided until the next day. The corrective action plan dated September 2022, signed by the licensee designee, Mr. Subbu Subbiah, stated that staff would be trained in proper incident action and reporting procedures to address any risks of falling and taking immediate action based on an evaluation of the resident.

On 02/23/2023, I conducted an exit conference with the licensee designee, Mr. Subbu Subbiah. Mr. Subbiah was informed that appropriate safety measures need to be implemented immediately to prevent Resident A from additional falls. He stated that measures have been put in place, however, they were not documented on the incident reports. Mr. Subbiah was informed of the findings of this investigation. A corrective action plan is due within 15 days.

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 alleged that Resident A fell and hurt his shoulder a couple of weeks ago and staff did not provide medical attention. Both the licensee, Mr. Subbu Subbiah and staff, Ms. Asia Pettigrew deny that he was not provided with medical care. Resident A indicated that he has fallen at least 4 times, with his most recent fall taking place a week or so ago. Incident Reports for Resident A dated 7/11/22, 8/3/22, 10/11/22, 11/03/22, 1/3/23 and 1/15/2023 related to Resident A's falls were reviewed.

	The AFC Licensing Division Accident/Incident Report dated 11/03/22, reported Resident A fell and had pain to his right arm. The patient care summary plan for Resident A states that he was seen on 12/09/2022 by United Health Care Group. Medical care was not sought immediately. The AFC Licensing Division Accident/Incident Report dated 1/15/23, reported Resident A fell and reported injury to his right arm. The patient care summary plan for Resident A states that he was seen on 01/23/2023 by United Health Care Group as a follow up. Medical care was not sought immediately. Relative A who stated that the AFC home recently got Resident A a new bed with rails to keep him from falling. Resident A has also received Xray's indicating that his arm is not broken. She has no other concerns. Based on the information obtained throughout the course of this investigation, there is substantial evidence to establish the rule violation that the home did not seek immediate care.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED SIR#2022A0779049 Dated 09/13/2022**

ALLEGATION:

Resident A is not receiving a diet that is proper for a diabetic.

INVESTIGATION:

On 01/03/2023, I spoke with assigned Genesee County APS worker, Ms. Tiffany Williams. She shared that Resident A is a diabetic whose blood sugar constantly runs high. In her investigation, Ms. Pettigrew stated that Resident A is not provided with a specific diabetic diet. To control his blood sugar, the facility tries to cut back on certain foods and monitors what he eats.

On 01/18/2023, Ms. Nicole Spencer stated that since returning to work at the facility was not providing Resident A with a diabetic diet.

A copy of the Health Care Appraisal for Resident A, completed on 09/22/2022, states that Resident A requires a DM (diabetic) Diet.

On 01/18/2023, Resident A stated the food in the facility is not up to par and breakfast is the only meal that is good. He stated that they provide minimal tablespoon sized portions for grown adults. He often has his sister bring in items that he likes.

While onsite I observed the current menu posted. It was last dated on 01/14/2023. No special diet menu for Resident A was available.

The Health Care Appraisal for Resident A, completed on 09/22/2022, states that Resident A requires a DM (diabetic) Diet.
On 01/25/2023, I spoke with Ms. Williams of APS who indicated that she will be substantiating against the facility for neglect as a result of the repeated falls and the broken bed rails observed while onsite, as well as the lack of a diabetic diet.

On 02/17/2023, I spoke with Relative A who stated that to her knowledge, the facility tries to provide Resident A with low sodium food to help control his blood sugar. She is not aware if he is being provided with a special diet.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	It was alleged that Resident A is not getting a diet that is proper for a diabetic. Staff, Ms. Asia Pettigrew and Ms. Nicole Spencer report no special diet menu for Resident A. The Health Care Appraisal for Resident A, completed on 09/22/2022, states that Resident A requires a DM (diabetic) Diet. The menu posted in the facility does not provide a special DM diet for Resident A. Resident A stated the food in the facility is not up to par and breakfast is the only meal that is good. Relative A who stated that to her knowledge, the facility tries to provide Resident A with low sodium food to help control his blood sugar. Ms. Tiffany Williams of APS stated that she will be substantiating against the facility for neglect. Based on the interviews with direct staff, Resident A, Relative A, APS, a review of the current Health Care Appraisal for Resident

	A and the facility menu, there is enough evidence to support the rule violation that Resident A is not being provided with a DM diet.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 01/18/2023, while onsite at Woodland Park Assisted Living, the menu visibly posted was last dated on 01/14/2023. No current menu was available or visibly posted.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	The facility did not have menus of regular diets written and posted at least 1 week in advance and posted at least 1 week in advance, supporting the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

The AFC Licensing Division - Accident/ Incident Report (IR) dated 07/11/22 states that Resident A slid out of bed while trying to sit up on the edge. Staff action was assisting Resident A off the floor. Staff moved Resident A to the middle of the bed as a corrective measure. No injuries were noted.

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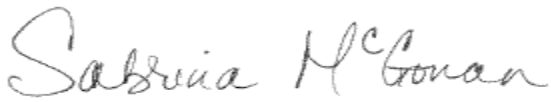
On 02/23/2023, I conducted an exit conference with the licensee designee, Mr. Subbu Subbiah. Mr. Subbiah was informed that appropriate safety measures need to be implemented immediately to prevent Resident A from additional falls. He stated that measures have been put in place, however, they were not documented on the incident reports. Mr. Subbiah was informed of the findings of this investigation. A corrective action plan is due within 15 days.

APPLICABLE RULE	
R 400.14305	**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:	IR's dated 7/11/22, 8/3/22, 10/11/22, 11/03/22 and 1/15/2023 indicate that Resident A had multiple falls while at the facility. No appropriate corrective measures were put in place to prevent future falls or injury to Resident A, failing to ensure Resident A's safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/23/2023, I conducted an exit conference with the licensee designee, Mr. Subbu Subbiah. Mr. Subbiah was informed of the findings of this investigation. A corrective action plan is due within 15 days.

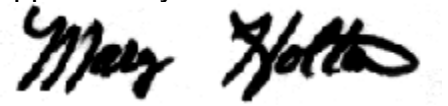
IV. RECOMMENDATION

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

 February 23, 2023

Sabrina McGowan — Date
Licensing Consultant

Approved By:

 February 23, 2023

Mary E. Holton — Date
Area Manager