GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 4, 2025

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

RE: License #: AM250309137
Investigation #: 2025A0580011
Woodland Park Assisted Living

Dear Subbu 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 #:	2025A0580011
Complaint Receipt Date:	12/13/2024
Investigation Initiation Date:	12/13/2024
Report Due Date:	02/11/2025
Licensee Name:	Woodland Park Assisted Living LLC
Licensee Address:	2363 E. Coldwater Rd. Flint, MI 48505
Licensee Telephone #:	(812) 202-9149
Administrator:	Ponnomal 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:	12/13/2023
Expiration Date:	12/12/2025
Capacity:	12
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was found wandering outside in single digit temperature for longer than 10 minutes without care or supervision.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/13/2024	Special Investigation Intake 2025A0580011
12/13/2024	APS Referral Call to Michael Grant, APS, Genesee County.
12/13/2024	Special Investigation Initiated - Telephone Call to the complainant.
12/16/2024	Contact - Telephone call made Call to Julie Bird, Owner.
12/16/2024	Contact - Telephone call received Call from Hurley Social Worker-Haley Weimer.
12/17/2024	Inspection Completed On-site Unannounced onsite. Contact with Vincent Bird, Owner.
12/17/2024	Contact - Face to Face Interview with Felise Wilford, Staff.
12/18/2024	Contact - Document Received Documents received via email.
01/07/2025	Contact - Telephone call made Call to SW Weimer.
01/08/2025	Contact - Telephone call received Call from Michael Grant, APS Investigator.
01/08/2025	Contact - Document Received

	Email from Michael Grant.
01/10/2025	Contact - Document Received Hurley Medical Center medical records for Resident A received.
01/29/2025	Contact - Telephone call made Call to staff, Diane Stokes.
01/30/2025	Contact - Document Received Documents received.
02/03/2025	Exit Conference Exit with the Licensee Designee, Subbu Subbiah.
02/03/2025	Contact - Telephone call made Call to Relative A.

ALLEGATION:

Resident A was found wandering outside in single digit temperature for longer than 10 minutes without care or supervision.

INVESTIGATION:

On 12/13/2024, I received a complaint via LARA-BCHS-Complaints. This complaint was opened by Adult Protective Services (APS) for investigation. On 12/13/2024, I placed a call to Michael Grant of Genesee County APS. A voice mail message was left requesting a return call.

On 12/13/2024, I spoke with the complainant who shared that staff at the home were unaware that Resident A was missing and for how long. Staff initially reported 10 minutes, however, because the tips of Resident A's fingertips were black and frostbitten, it had to be an estimated 30 minutes or more.

On 12/16/2024, I spoke with one of the two new owners of the facility, Julie Bird, who is operating the home under the current license. Owner, Julie Bird stated that she was in route to the facility to cover the shift of a staff person who called in when she was informed by staff, Diane Stokes that Resident A was missing. Owner Bird stated that staff Stokes was working alone due to the staff call-in and the other staff that was on duty, Felise Wilford, having to leave for the day, due to having another job. Owner Bird stated that upon review of the camera, it appears as if while staff Stokes was in the back assisting another resident, Resident A threw a coat over her shoulder and went out the front door and locked it behind herself. Staff Stokes looked all around the house and went outside to look for Resident A. Staff Stokes did not see any footprints in the

snow, however, once she walked around the property, she eventually found Resident A outside in the backyard playing in the snow. Owner Bird added that Resident A has been declining in her mental ability and becoming combative.

On 12/16/2024, I spoke with Hailey Weimer, assigned Social Worker (SW) for Resident A at Hurley Hospital. SW Weimer confirmed that Resident A is diagnosed as having frostbite. Resident A did not lose any extremities as a result. SW Weimer is not sure if Resident A will return to the AFC, however, she is assigned to the patient and will be able to provide any updates.

On 12/17/2024, I conducted an unannounced onsite inspection at Woodland Park Assisted Living. Contact was made with Vincent Bird, co-owner of the facility, who confirmed that there are currently 9 residents in the home. Resident B is the only occupant that requires a 2-person Hoyer Lift. While onsite I observed 5 residents who were finishing up their meal while sitting at the dining room table. There were also 2 residents observed in the living room watching television. Resident B and another resident were observed lying in their rooms. The residents were all adequately cleaned and groomed. No immediate concerns regarding their care were noted. There were 2 staff were on duty at the time of the unannounced onsite inspection.

While onsite I received a copy of the Incident Report, which states that on 12/12/2024, Resident A was in the chair while staff was cleaning. When staff got done cleaning, staff did not see Resident A. Upon going through the house staff was unable to locate Resident A. Staff then went outside and checked grounds. Resident A was located on the side of the shed, playing with the snow. Staff helped Resident A inside and contacted management and EMT. As a corrective measure, Resident A was sent to ER for evaluation from the cold.

On 12/17/2024, while onsite, I interviewed direct staff Felise Wilford, who stated that she has worked for the home an estimated 6 months. Staff Wilford stated that on the day in question, she was scheduled to work 9am-5pm, however, she continued working until 6pm, however, she had to leave due to a second job she has in Midland, MI. Staff Wilford recalled that Resident A was sitting in the living room in the recliner chair when she left. Staff Wilford added that Resident A had been talking about going home all week, often having been redirected back into the common area.

On 12/18/2024, I received a copy of the AFC Assessment Plan, signed and dated by the license administrator, Ponnamal Subbia, effective 02/03/2024. The plan indicates that Resident A is not able to move independently while in the community and does not leave without a visitor or staff. Resident A did not have a history of eloping; however, she did have some recent cognitive decline.

On 01/08/2025, APS Grant provided a copy of Resident A's most recent assessment plan. An updated AFC Assessment Plan for Resident A was completed by Owner Julie Bird, on 11/02/2024. Noted as comments/special instructions, the plan notes that Resident A was discharged from Ascension Genesys with a decline in physical and

orientation abilities. It notes that Resident A requires constant supervision, is an elopement risk, and now combative. Resident A AOX 1-2 at times, but mostly AOX 1. Resident A's medications have changed to reflect this decline as well as her dementia worsening. Resident A's level of care has increased exponentially. No increased rounds or line of sight requirement were added to the assessment plan.

On 01/07/2025, I placed a follow-up phone call to SW Weimer who shared that Resident A passed away on 12/21/2024. Comfort measures for Resident A were provided.

On 01/08/2025, I spoke with Michael Grant of APS, who stated that although it appears that Resident A got out of the home by accident, APS will be substantiating for neglect. In addition, Michael Grant shared email communication between himself and the Keith Rumbold, Administrator at the Genesee Couty Medical Examiner's Office as well as documents provided to him by the AFC.

On 01/08/2025, I received a copy of the email communication between APS Investigator Michael Grant and Genesee Couty Medical Examiner's Office Administrator, Keith Rumbold. Admin Rumbold identifies Dr. John Bechinski as the Medical Examiner who completed the death certificate for Resident A based on her medical history and listed the cause of death to be: Hypertensive and Atherosclerotic Cardiovascular Disease, with other significant conditions as: Dementia; Frostbite of hands; Retroperitoneal Hematoma. The manner of death is listed as accident.

On 01/10/2025, I received a copy of the medical records for Resident A were received from Hurley Medical Center. The medical records indicate that Resident A was admitted on 12/12/2024 and was diagnosed with Hypothermia, initial encounter, Frostbite of both hands, Frostbite of finger.

The Hospital Course report is as follows: Patient is an 84 y/o female with a history of dementia who residents at Woodland Park AFC home, who presented to Emergency Department (ED) on 12/12 for cold exposure. Patient was found wandering and crawling on ground outside and EMS was called. Upon arrival in ED, patient A&O x 1 with GCS 15. Hypothermic to 34.6 C and placed on Bair Hugger. Bilateral hands with wounds consistent with frostbite. Laboratory work-up significant for AKI with BUN 36, Cr 1.4, CK 521, lactate 3.8. X-rays of bilateral knees, hands, and pelvis with no acute process. TACS consulted and patient was admitted to 5E for treatment of frostbite and AKI on IVF. Patient developed hypotension and bradycardia, thought to be 2/2 polypharmacy and improved with IVF and holding anti-hypertensive medications. Patient complaining of chest pain, EKG showed old anterior wall MI. Troponin elevated and peaked at 5.120. Cardiology consulted, echo done with EF 40-45% grade 1 DD, severe aortic stenosis. Unfortunately, patient unable to have further ischemic work-up due to no NOK/guardian. Neuropsych consulted and deemed patient unable to make medical decisions. CM consulted and legal guardianship paperwork sent. Patient developed urinary retention and has gross hematuria with foley placement. Patient developed increasing agitation and requiring precede gtt. Complaining of abdominal pain with associated tachycardia. CTA obtained with no PE, 1cm intermediate density right renal lesion partial visualized.

Due to CT findings and hematuria, urology was consulted and recommended bladder irrigation every shift and outpatient cystoscopy. Patient subsequently developed Afib with RVR, started on Cardizem gtt and heparin gtt with transfer orders placed to CCU on 12/17. Patient converted to NSR, cardizem discontinued. Patient transferred from CCU to ICCU the following day pending legal guardianship for consent for further cardiac ischemic work-up.

Patient transferred back to CCU on 12/19 due to hypotension and new retroperitoneal hematoma noted on CT chest abdomen and pelvis. Patient noted to have hemoglobin of 4.2 on 12/19 in ICCU and was hypotensive. Patient given 2g of TXA, 10mg of vitamin K, 3 units of PRBC's and 3 units of FFP during mass transfusion protocol. Pt required vapotherm overnight for hypoxia, since back to wall high flow. Pt's nephew further updated regarding clinical decline today. Patient will be transferred to ICU step down for further care while guardianship process remains ongoing. 12/20 pt was made DNR/DNI with no escalation of care. Pt's nephew was updated regarding the change in code status and agrees. Nephew working on emergency guardianship. Patient ultimately became bradycardic and hypotensive and passed. Resident A was discharged as deceased on 12/22/2024.

On 01/29/2025, I spoke with Diane Stokes, staff at Woodland Park Assisted Living. Staff Stokes recalled that she'd just finished feeding a resident, heading towards the kitchen to dishes when she observed Resident A sitting in the chair in the living room. Once staff Stokes finished cleaning the kitchen and walked back towards the living room, she did not see Resident A. Staff Stokes stated that she went through the house twice and looked in the basement for Resident A. Staff Stokes stated that she went outside and did not see any footprints, however, she continued looking and calling Resident A's name until she found her outside in the backyard making circles with her hands in the snow. Staff Stokes brought Resident A inside to get warm. Staff Stokes contacted EMS, the owner Julie Bird, and other staff members informing them of what occurred.

02/03/2025, I spoke with Licensee Designee Subbu Subbia who stated that he understands the seriousness of the violations that were issued and will provide the corrective action plan and provisional acceptance letter as requested.

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:	It was alleged that Resident A was found wandering outside in single digit temps for longer than 10 minutes without care or supervision.

	Owner, Julie Bird stated that Resident A has been declining in her mental ability and becoming combative. Staff, Felise Wilford, recalled Resident A had been talking about going home all week, often having been redirected back into the common area. Staff, Diane Stokes, recalled observing Resident A sitting in the chair in the living room, then disappearing. Resident A was found outside in the backyard making circles with her hands in the snow. Staff Stokes brought Resident A inside to get warm. The Incident Report dated 12/12/2024 was reviewed. The AFC Assessment plan for Resident A, revised on 11/02/2024 notes that Resident A requires constant supervision, is an elopement risk, and now combative. Resident A's level of care has increased exponentially. No increased rounds or line of sight requirement were added to the assessment plan. Medical records received from Hurley Medical Center were reviewed. Resident A did require medical care due to frostbite from being out in the cold. APS Investigator, Michael Grant, stated that APS will be substantiating for neglect. Based on the interviews conducted and the documents reviewed, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 12/16/2024, Owner, Julie Bird confirmed that staff Diane Stokes was working alone due to a staff call-in.

On 12/17/2024, while onsite, Vincent Bird, co-owner of the facility, confirmed that Resident B requires a 2-person Hoyer Lift for mobility.

On 12/18/2024, I received a copy of the staff schedule for December 2024. The schedule reflects that on December 12, 2024, there was 1 staff scheduled for 7am, 1

staff scheduled for 9am, 1 staff scheduled for 7pm and 1 staff scheduled for 11pm. Owner, Julie Bird, clarified that staff are scheduled for 12 hours shifts. According to the schedule, there is a period of time between 9pm and 11 pm when there is only 1 staff on duty.

On 12/17/2024, while onsite, staff Wilford confirmed that Resident B requires the use of a 2-person Hoyer lift for mobility.

On 01/29/2025, staff Stokes confirmed that Resident B requires the use of a 2-person Hoyer lift for mobility.

On 01/30/2025, I received a copy of the AFC Assessment Plan for Resident B, which states that Resident B requires the use of a Hoyer lift for mobility.

The AFC Assessment plan for Resident A, revised on 11/02/2024 notes that Resident A requires constant supervision, is an elopement risk, and now combative. Resident A's level of care has increased exponentially. No increased rounds or line of sight requirement were added to the assessment plan.

Special Investigation Report #2022A0580023 dated March 25, 2022, cited violation to R 400.14206(4) due to short staffing. The corrective action plan dated 04/06/2022 and signed by the licensee designee, Mr. Subbiah states that he has hired enough employees to handle the workload of the residents. All shifts to be covered with 2-person coverage and a full-time manager and on call-support.

Special Investigation Report #2022A0580057 dated November 22, 2022, cited R 400.14206(4) due to short staffing. The corrective action plan dated 12/09/2022 and signed by the licensee designee, Mr. Subbiah states that an additional direct care staff will be scheduled for 3rd shift going forward.

02/03/2025, I spoke with Licensee Designee Subbu Subbia who stated that he understands the seriousness of the violations that were issued and will provide the corrective action plan and provisional acceptance letter as requested.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Owner, Julie Bird confirmed that staff Diane Stokes was working alone due to a staff call-in.

	The December 2024 staff schedule reflects that on December 12, 2024, there was 1 staff scheduled for 7am, 1 staff scheduled for 9am, 1 staff scheduled for 7pm and 1 staff scheduled for 11pm. Owner, Julie Bird, stated that staff are scheduled for 12 hours shifts. According to the schedule, there is a period of time between 9pm and 11 pm when there is only 1 staff on duty. Owner, Vincent Bird, confirmed that Resident B requires Hoyer Lift for mobility. Staff Wilford confirmed that Resident B requires the use of a 2-person Hoyer lift for mobility. Staff Stokes confirmed that Resident B requires the use of a 2-person Hoyer lift for mobility. The assessment plan reviewed for Resident B indicates that Resident B requires the use of a person Hoyer Lift for mobility. The assessment plan for Resident A indicated she was an elopement risk. Based on the interviews conducted and the documents reviewed, there is enough evidence to support the rule violation.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR2022A0580057, dated November 22, 2022.** **SIR2024A0580023, dated March 25, 2022.**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend a modification of the license to provisional status due to willful and substantial quality of care violations.

Sabrina McGowan — February 4, 2025

Sabrina McGowan
Licensing Consultant

Date

Approved By:

Mary Holton — February 4, 2025

Mary E. Holton
Area Manager

Date