GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 15, 2022

Nidhal Ghraib
Quality Care of Howell LLC
Suite #139
17197 N. Laurel Park Dr.
Livonia, MI 48152

RE: License #: AL470397950
Investigation #: 2022A1029029
Quality Care Of Howell 2

Dear Mr. Ghraib:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL470397950
Investigation #:	2022A1029029
Complaint Receipt Date:	02/15/2022
Investigation Initiation Date:	02/17/2022
Report Due Date:	04/16/2022
Licensee Name:	Quality Care of Howell LLC
Licensee Address:	Suite #139 17197 N. Laurel Park Dr. Livonia, MI 48152
Licensee Telephone #:	(517) 579-2019
Administrator:	Nidhal Ghraib
Licensee Designee:	Nidhal Ghraib
Name of Facility:	Quality Care Of Howell 2
Facility Address:	2820 N Burkhart Rd. Howell, MI 48855
Facility Telephone #:	(517) 579-2019
Original Issuance Date:	02/07/2020
License Status:	REGULAR
Effective Date:	08/07/2020
Expiration Date:	08/06/2022
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident D was yelled at by direct care staff member Ms. Grigg.	No
Quality Care of Howell 2 did not follow Resident C's prescribed diet because they allowed her to eat in her bedroom which caused her to choke on her food.	No
Resident A and Resident B are not receiving weekly showers.	No

III. METHODOLOGY

02/15/2022	Special Investigation Intake 2022A1029029
02/15/2022	Contact - Document Sent Email to complainant
02/17/2022	Special Investigation Initiated – Telephone to complainant for APS referral
03/08/2022	Contact - Telephone call made to Katrina, Hospice bath aide. Left a message
03/08/2022	Contact - Telephone call made to RN Shelly Conrad from American Hospice and Home Care
03/14/2022	Contact - Face to Face with Nidhal Ghraib, direct care staff member Janice Grigg, Resident A and B
04/13/2022	Contact – Telephone call to direct care staff member Florence Woodcock.
04/13/2022	Contact – Telephone call to former direct care staff member Amber Eckardt
04/13/2022	Contact – Telephone call to direct care staff member Breanna VanRiper
04/14/2022	Exit conference with Licensee designee Nidhal Ghraib

ALLEGATION:

Resident D was yelled at by direct care staff member Ms. Grigg.

INVESTIGATION:

On February 15, 2022 a referral was received from adult protective services alleging that direct care staff member Janice Grigg was heard yelling at Resident D.

On February 17, 2022, I interviewed Complainant from the adult protective services referral. Complainant reported Resident D passed away on January 23, 2022. Complainant stated she heard Ms. Grigg screaming at Resident D however Complainant did not have a date that this incident happened or any other details described what Ms. Grigg yelled to Resident D.

On March 8, 2022 I contacted Registered Nurse Shelly Conrad from American Hospice and Home Care. RN Conrad stated she was not familiar with Resident D who passed away but she was familiar with the direct care staff member Janice Grigg. RN Conrad described Ms. Grigg as "one of the people that she really trusts to be her eyes and ears." RN Conrad stated she will frequently talk to her about the residents to make sure that orders are followed through. RN Conrad stated she has never heard concerns regarding Ms. Grigg's interactions with residents. RN Conrad stated Ms. Grigg will go sit in patients' room when she works nights and talk to them if they are having a hard time. RN Conrad stated Ms. Grigg has a lot of experience and does a nice job. RN Conrad stated she has never heard her screaming or being inappropriate with the residents or the staff.

On March 14, 2022, I conducted an unannounced onsite investigation at Quality Care of Howell 2 and I interviewed licensee designee, Nidhal Ghraib. He denied that he has ever witnessed or heard reports of direct care staff member Janice Grigg yelling at a resident including Resident D. He described her as one of the best direct care staff members at the facility.

On March 14, 2022, I interviewed Janice Grigg at Quality Care of Howell 2. Ms. Grigg denied she has ever spoken in a disrespectful tone to the residents including Resident D. Ms. Grigg stated that she is at the facility a lot and feels very close to the residents. She stated as a manager, she has zero tolerance for the direct care staff member being disrespectful to a resident.

On April 13, 2022, I interviewed direct care staff member Florence Woodcock. She stated Janice Grigg is an employee there and she has never heard her talking to the residents in an inappropriate tone or being disrespectful.

On April 13, 2022, I interviewed former direct care staff member, Amber Eckardt who stopped working there about a month ago. Ms. Eckardt stated she worked with Ms. Grigg often because they were the two main midnight people. She stated Resident D

was ignored by Ms. Grigg and that sometimes Ms. Grigg talked disrespectfully to Resident D. Ms. Eckardt stated that Resident D fell or needed her adult incontinence brief changed Ms. Grigg acted annoyed because she thought she was overworked. Ms. Eckardt was unable to provide details of specific incidents of direct care staff member Janice Grigg acting as Ms. Eckardt described above. According to Ms. Eckardt, Ms. Grigg is the one that is called in when someone is needed at the facility.

On April 13, 2022, I interviewed former direct care staff member Breanna VanRiper who stated she has never heard of a situation when Ms. Grigg nor any other direct care staff member was disrespectful to a resident. She has never heard anyone swear or yell at the residents. Ms. VanRiper stated the direct care staff members at the facility treat the residents well.

APPLICABLE RULE	
R 400.15305	**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:	There is no indication that Resident D was not treated with respect and dignity while living at Quality Care of Howell. Although former direct care staff member, Ms. Eckardt felt that Ms. Grigg was overworked and seemed annoyed with Resident D, she was unable to provide details or further information of what occurred. Direct care staff members, Ms. Woodcock and RN Shelly Conrad from American Hospice and Home Care all denied concerns regarding how direct care staff member Janice Eckardt treated residents including Resident D. Licensee designee Mr. Ghraib described Ms. Grigg as one of the best direct care staff members at the facility. RN Conrad described Ms. Grigg as “one of the people that she really trusts to be her eyes and ears.”
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Quality Care of Howell 2 did not follow Resident C’s prescribed diet because they allowed her to eat in her bedroom which caused her to choke on her food.

INVESTIGATION:

On February 15, 2022 a referral was received from adult protective services alleging that direct care staff member Janice Grigg was involved in Resident C’s death.

On February 17, 2022, I interviewed Complainant documented in the adult protective services referral. She stated Resident C was on Hospice through American Hospice

and Home Care. Complainant alleged Resident C was eating in her bed when direct care staff member Janice Grigg's went to check on her after twenty minutes and found Resident C was deceased on November 30, 2021. Complainant was concerned that Ms. Grigg was scooping food out of Resident C's mouth at the time of her death so Complainant thought this meant Resident C had choked on her food and the facility was trying to conceal this. Complainant reported direct care staff member Florence Woodcock saw Ms. Grigg taking food out of Resident C's mouth. Complainant believed Resident C was supposed to be eating at the table not in bed with the tray of food. Complaint also voiced concern Resident C did not receive soft foods.

On March 8, 2022 I interviewed RN Shelly Conrad from American Hospice and Home Care. She stated that this facility has always followed medical orders and she did not have any concerns regarding Resident C's passing. RN Conrad did not have any concerns that the medical orders were not followed for Resident C and believed the facility was following the order for soft food for Resident C.

An *AFC Licensing Division – Incident / Accident Report* was reviewed regarding Resident C's passing and there was documentation that she was "deceased – notified hospice. Protocol followed" with no additional information. This was completed by Florence Woodcock and Janice Grigg.

On March 14, 2022, I conducted unannounced onsite investigation at Quality Care of Howell 2 and I interviewed licensee designee Nidhal Ghraib. Mr. Ghraib stated that direct care staff member Janice Grigg has been employed at Quality Care of Howell 1 and 2 for 3 years and has 30 years of direct care experience. She has never been written up or disciplined, there are no concerns regarding her work performance, is shift lead for the overnight shift, and works more hours than any other direct care staff member.

According to Mr. Ghraib, Resident C did have a special diet consisting of soft foods. Licensee designee Nadal Ghraib stated Resident C was never left unattended in her room while eating. He said that there was always a direct care staff member present when she was eating. Mr. Ghraib also denied that direct care staff member Janice Grigg was found scooping food out of her mouth. Mr. Ghraib stated that Resident C was diagnosed with Alzheimer's which was her cause of death and at the time of her death Resident C was "bed bound" so she would eat often in her resident bedroom. Resident C was also under Hospice care at the time of her death. He stated typically they serve breakfast between 8-9:00 a.m. and she passed away at 10:01 a.m.

Resident C's resident record was reviewed during the onsite investigation. I noted there was a physician's order from November 9, 2021 requiring her to have soft food signed by Dr. Paul Musson. There was no special diet listed on resident C's *Healthcare Appraisal*. According to her *Assessment Plan for AFC Residents*, there were no special diets or limitations listed regarding her eating in her resident bedroom.

On March 14, 2022, I interviewed Janice Grigg at Quality Care of Howell 2. She has worked there for three years. Ms. Grigg stated there is a former employee who is upset with her and she talked to Adult Protective Services about this earlier. She stated she completed an incident report when Resident C passed away. Ms. Grigg stated Resident C ate in her room at times and was receiving care from Hospice. Ms. Grigg stated there was always a staff member who would stay with Resident C while she was eating. Ms. Grigg stated she was working the day that Resident C passed away. Ms. Grigg stated direct care staff member, Florence Woodcock came to her upset that Resident C was not breathing and when Ms. Grigg went into Resident C's resident room to check on her, she stated she found her deceased. She stated because it was after breakfast, she did scoop Resident C's mouth to make sure there was no food and to rule out choking. Ms. Grigg denied that there was any food in her mouth at that time. She stated Resident C had a fractured hip at the time, so she was spending a lot of time in bed however she was not feeling sick. Ms. Grigg stated when she contacted Resident C's family, they both stated that the death was not unexpected. Ms. Grigg stated Resident C also had some ankle swelling and leg pain which she mentioned the night before so that could have been another reason why Resident C she did not want to leave her room. Ms. Grigg stated when she went into the room, there was no signs Resident C threw up or gagged on food rather Ms. Grigg stated Resident C looked peaceful when she was found.

During the onsite inspection, I toured the kitchen area and spoke with kitchen staff member, Cody Bruno. He stated all resident special diets are listed on the whiteboard in the kitchen area, as well as discuss amongst the kitchen staff. Mr. Bruno stated there are three people who primarily work in the kitchen and they are all aware of what each resident receives. I noted Resident C did not have information in the kitchen area because she passed before the on-site investigation however there was a list of other special diets for current residents.

On April 13, 2022, I interviewed direct care staff member Florence Woodcock who stated on the day of Resident C's death she was calling Resident C's name and talking to her but Resident C she was not responding. Ms. Woodcock stated when she got closer to Resident C, she realized that she was not breathing. Ms. Woodcock stated Resident C was not eating at the time she went in to check on Resident C as it was after breakfast. Although Resident C was not "bed bound," Ms. Woodcock stated Resident C spent a lot of time in bed due to a recent surgery and coming back from rehabilitation. Ms. Woodcock also stated Resident C did not want to get up that morning. Ms. Woodcock stated Resident C was prescribed a soft food diet which was followed at each meal. Ms. Woodcock stated she did not know what Resident C passed from but she knew that she had dementia.

APPLICABLE RULE	
R 400.15313	**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:	There is no indication that the soft food diet prescribed to Resident C was not followed. There was no physicians order in her file that she could not eat in her room, only that she was prescribed a soft food diet. There was no documentation of either restriction on her *Assessment Plan for AFC Residents*. Neither the *AFC Licensing Division – Incident / Accident Report* or the Hospice Notes from their final visit indicating Resident C passed from choking or that her being in the bedroom during her breakfast meal contributed to her death.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A and Resident B are not receiving weekly showers.

INVESTIGATION:

On February 17, 2022, I interviewed the Complainant documented on the adult protective services referral who indicated that Resident A and Resident B were not receiving weekly showers at the facility. She stated both residents will sometimes refuse showers but sometimes they just will not get them.

On March 14, 2022, I conducted an unannounced onsite investigation at Quality Care of Howell 2 and I interviewed licensee designee Nidhal Ghraib and direct care staff member Ms. Grigg. Mr. Ghraib stated all residents receive showers two times per week. Ms. Grigg stated that many residents refuse to shower on a certain day and the direct care staff members are instructed to ask them later if they need assistance. Resident showers are documented in their individual medication administration records (MARs) which were reviewed for the period of February 14, 2022 – March 14, 2022. Resident A did not receive a shower during the week period of February 14-February 20, 2022. She did receive a shower on February 21, 2022. There was one notation on February 14 from Ms. Grigg which stated, “unable to provide – not enough staff” and there was a notation on February 17 that “Resident Refused.” Resident A gets her shower between 5:00 and 6:00 am Monday and Thursday and often refuses to shower. Mr. Ghraib stated that he thinks this was recently resolved with assistance from family members.

According to Mr. Ghraib, Resident B needs complete assistance to shower and showers on Wednesday and Saturday. According to Resident B’s MAR documentation, she received at least one shower per week during the time period reviewed. I observed the

shower schedules are listed on each resident MAR, posted in the office, resident bedrooms, and the breakroom.

On April 13, 2022, I interviewed former direct care staff member Amber Eckardt who stated while she worked at the facility Resident A received her showers before first shift came in because she liked them earlier in the day because Resident A got up early. Ms. Eckardt stated Resident A was showered twice per week and residents had shower schedules on the wall by their door. When she was leaving, they were switching her days around for her showers. She was not sure about other residents because that was the only resident that showered that early during third shift.

On April 13, 2022, I interviewed direct care staff member, Florence Woodcock who stated residents are showered two days per week. Ms. Woodcock stated some residents have Wednesday and Saturday and some are Monday and Friday if they are on Hospice. Ms. Woodcock stated that sometimes Hospice staff will also shower residents at different times. She stated there were no concerns of residents not receiving a shower on a regular basis. Ms. Woodcock stated if a resident refuses a shower, then direct care staff members will come back and ask them later. If the resident keeps refusing the shower, then direct care staff members will mark it in the MAR that they refused and then offer it another day. She stated that Resident A and Resident B will typically shower when it's time according to their schedule and do not usually refuse. Ms. Woodcock stated she has not experienced a time there was not enough staff to take a shower but sometimes they will change the time of day so there is more coverage to safely provide showers and care for the remaining residents.

On April 13, 2022, I interviewed former direct care staff member, Breanna VanRiper. She stated all residents showered on a schedule and it was usually between two and four times / week. The resident would typically be on the same schedule. She stated that all of the residents received at least one shower per week. Sometimes if they were busy, the next shift would have to pick up her shift. She stated there were a couple male residents that would decline showers but most of the women were okay with showering regularly. She did not recall if Resident A or Resident B ever refused to shower.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.

ANALYSIS:	The completed showers were reviewed for Resident A for the period of February 14, 2022 – March 14, 2022. During one week, Resident A refused to shower but was offered the opportunity and on a second time there were not enough staff to safely shower Resident A. Resident B received at least one or two showers each week during the time frame reviewed. Consequently, both residents were afforded the opportunity to shower at least once per week during the time frame reviewed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend no change in the license status.

Jennifer Browning _____4/14/2022_____

Jennifer Browning
Licensing Consultant
Date

Approved By:

Dawn Timm 04/15/2022

_____

Dawn N. Timm
Area Manager
Date