GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 9, 2023

Alicia Mitchell
Hancock Residential Center Inc
801 W Willis
Detroit, MI 48226

RE: License #: AL820007519
Investigation #: 2022A0121038
Hancock Residential Center

Dear Ms. Mitchell:

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 (313) 456-0380.

Sincerely,

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820007519
Investigation #:	2022A0121038
Complaint Receipt Date:	08/26/2022
Investigation Initiation Date:	08/26/2022
Report Due Date:	10/25/2022
Licensee Name:	Hancock Residential Center Inc
Licensee Address:	801 W Willis Detroit, MI 48226
Licensee Telephone #:	(313) 283-4725
Administrator:	Alicia Mitchell, Designee
Licensee Designee:	Alicia Mitchell, Designee
Name of Facility:	Hancock Residential Center
Facility Address:	801 W Willis Detroit, MI 48201
Facility Telephone #:	(313) 831-8641
Original Issuance Date:	04/04/1994
License **Status:**	REGULAR
Effective Date:	02/05/2021
Expiration Date:	02/04/2023
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On or around 7/31/22, a female resident choked on a meatball during mealtime at the group home. She remains unconscious with no cognitive awareness or response to stimuli.	Yes

III. METHODOLOGY

08/26/2022	Special Investigation Intake 2022A0121038
08/26/2022	Special Investigation Initiated - Telephone Call to Relative 1
09/01/2022	Inspection Completed On-site Reviewed Resident A's closed file. Interviewed direct care workers, Jacketa Stephens and Paul Nilson, and Resident B and C.
09/01/2022	Contact - Telephone call received Alicia Mitchell, licensee designee
09/01/2022	APS Referral Denied
09/01/2022	Referral - Recipient Rights Assigned to Lawrence Caldwell
10/12/2022	Contact - Telephone call made Left message for Relative 1
10/18/2022	Contact - Telephone call received Return call from Relative 1
10/21/2022	Contact - Telephone call made Relative 1
11/01/2022	Contact - Telephone call made Follow up call to Relative 1
11/01/2022	Contact - Document Received Resident A's death certificate

11/18/2022	Contact - Telephone call made Alicia Mitchell
11/18/2022	Contact - Telephone call made RRI, Lawrence Caldwell
11/20/2022	Contact - Document Sent Copy of Resident A's eating guidelines, progress notes, and Staff training records
01/05/2023	Contact – Telephone made Left message for DCW, Denise Janke
01/06/2023	Contact – Telephone call received Denise Janke
01/06/2023	Exit Conference Alicia Mitchell

ALLEGATION: On or around 7/31/22, a female resident choked on a meatball during mealtime at the group home. She remains unconscious with no cognitive awareness or response to stimuli.

INVESTIGATION: On 8/26/22, I initiated the complaint with a call to Relative 1. Relative 1 reported she spoke to Resident A's guardian, Marcella Harris with Faith Connections regarding the circumstances surrounding her death. Relative 1 reported Ms. Harris told her Resident A was reprimanded by direct care worker, Denise Janke for eating as they blessed the food. Relative 1 expressed concern Ms. Janke "startled" Resident A causing her to choke. According to Relative 1, Resident A's injury was so severe, she was placed on life support. Relative 1 stated the family has since chosen to remove Resident A from life support in hopes of donating her organs to others awaiting transplant. Per Relative 1, Resident A was taken off life support on 8/20/22.

On 9/1/22, I made an unannounced onsite inspection at the facility. I reviewed Resident A's records, interviewed Staff and residents. Direct care worker, Jacketa Stephens was on duty. Ms. Stephens had little information about the choking incident, but she did describe Resident A as "aggressive with her food." According to Ms. Stephens, Resident A would get so excited about food that she would "start shaking." Ms. Stephens also described Resident A as someone who would "pack her mouth and not chew properly if you don't watch her." Direct care worker, Paul Nilson was also on duty on the day of inspection. Mr. Nilson was working when Resident A choked on meatballs. Mr. Nilson said he tried to assist Resident A as

she choked by performing CPR to no avail. Mr. Nilson indicated he prepared the food that day. Mr. Nilson said he does remember cutting Resident A's food into bite size pieces in accordance with her eating guidelines. Mr. Nilson explained Resident A "sucks food down if you don't watch her … she has to be monitored, it's in her plan." Resident B reported Resident A was "eating while everybody was praying." Resident B said Mr. Nilson, Ms. Janke, and licensee designee, Alicia Mitchell tried to assist Resident A when she was in distress. Resident C said he simply remembers Resident A "choked on some meat." Resident C had little information to add to the investigation. I attempted to interview Ms. Janke, but she was off work ill for almost one month. Upon her return to work, I interviewed Ms. Janke by phone. Ms. Janke acknowledged she was the first to notice Resident A choking. According to Ms. Janke, on 7/31/22 at approximately 4:00 p.m., she along with Ms. Mitchell and all residents were in the dining room with heads bowed blessing the food. Ms. Janke said she heard a noise, so she looked up and saw Resident A eating food from the plate placed in front of her. Per Ms. Janke, each resident had their own separate plate of meatballs and cheese sticks as an appetizer. Ms. Janke admitted she initially instructed Resident A to stop eating prematurely and that's when Resident A began to choke. Ms. Janke said she immediately began to administer CPR, then Mr. Nilson took over when she wasn't having any success getting the food dislodged.

On 9/1/22, I received a phone call from Ms. Mitchell. Ms. Mitchell acknowledged Resident A had eating guidelines in place requiring that she be monitored while eating. Ms. Mitchell also reported Resident A had a 1:1 staffing assignment approved 3 days a week, 8 hours per day. However, Ms. Mitchell stated Resident A did not have the 1:1 assignment on the day of the incident. I asked Ms. Mitchell if Resident A was known to steal food. Ms. Mitchell replied, "Yes, but she had gotten better with it." Ms. Mitchell witnessed the choking incident on 7/31/22; she said Staff tried to administer CPR to no avail. Ms. Mitchell expressed frustration that 911 had her on hold 3-4 minutes before someone answered. Although there is a fire station 2 blocks away from the group home, Mr. Nilson expressed frustration that it took 20-30 minutes for help to arrive. Ms. Mitchell suggested the lapse in response time contributed to Resident A's poor recovery. Additionally, Mr. Nilson reported EMS used forceps to successfully dislodge the food in Resident A's throat. Mr. Nilson said when EMS left, he cleaned the floor where Resident A laid; he noticed multiple pieces of meatballs remaining on the floor that had been removed from her mouth. Both Ms. Mitchell and Mr. Nilson indicated Resident A was not alert, but she was alive when she left the home with EMS to be taken to the nearest hospital.

I reviewed staff training records. Ms. Janke, Mr. Nilson, and a third Staff Bruce Mitchell attempted CPR to get the food dislodged from Resident A's throat. It should be noted that Bruce Mitchell was not on duty. Mr. Mitchell arrived early to start a new shift and he jumped in to help. Ms. Janke, Mr. Nilson, and Mr. Mitchell all successfully completed a CPR refresher course on 5/7/22. Proof of training is placed in their respective employee records.

Upon review of Resident A's records, I determined it was repeatedly documented she required close supervision while eating. Resident A's Wayne Center Functional Behavior Assessment/Positive Behavior Support Plan dated 7/5/21 gives specific instructions for caregivers to store food "in a manner which prevents her from visually focusing on them, as this increases the potential of engaging in food seeking behaviors." The plan further states food should "never be left unattended" and warns Resident A "may engage in rapid consumption of food during meals, which presents a risk of choking." Resident A's most recent AFC Assessment Plan dated 7/8/21 also documents she "needs to be monitored while eating." This plan is signed by Ms. Mitchell, the guardian, Ms. Harris, and Resident A's case manager, Loretta Nesti with Wayne Center.

On 11/1/22, I received a copy of Resident A's death certificate. The cause of death is listed as "Anoxic brain injury", "Cardiac arrest", "Aspiration", and "Choking".

On 1/6/23, I completed an exit conference with Ms. Mitchell. Ms. Mitchell reported the home has a longstanding history with the department with minimal violations. Ms. Mitchell insisted Resident A's death was a tragic accident that sadly impacted both residents and Staff. Ms. Mitchell became emotional when discussing the case. She expressed anger that Resident A's brother had no contact with Resident A in the last 20 years. Ms. Mitchell indicated she believes the complaint and pending litigation is based on greed. Ms. Mitchell demonstrated a clear understanding of the department's findings and recommendation. Ms. Mitchell wants to assure the department that a plan of correction will be implemented to prevent serious injury to residents in the future.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	- Resident A was a known choking risk; therefore, all recent assessment plans required she be monitored while eating or in the presence of food. - Both Ms. Mitchell and Ms. Janke were supervising residents at dinner on 7/31/22. They acknowledged Resident A took meatballs off a plate prepared before her while everyone had their heads bowed in prayer. - Because Mr. Nilson observed multiple meatballs that had been dislodged from Resident A's throat, it is safe to assume, Resident A gained access to enough food to cause her to choke while Staff was present. - Based on these findings, the department has determined Ms. Mitchell failed to provide supervision and protection as outlined in Resident A's written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend the status of this license remain unchanged.

01/06/23

Kara Robinson — Date
Licensing Consultant

Approved By:

01/09/23

Ardra Hunter — Date
Area Manager