GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 1, 2025

Kenneth Jordan
Samaritan Homes, Inc.
22610 Rosewood
Oak Park, MI 48237

RE: License #: AS820068075
Investigation #: 2025A0116017
Vreeland Home

Dear Mr. Jordan:

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.

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.

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,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820068075
Investigation #:	2025A0116017
Complaint Receipt Date:	03/05/2025
Investigation Initiation Date:	03/07/2025
Report Due Date:	05/04/2025
Licensee Name:	Samaritan Homes, Inc.
Licensee Address:	22610 Rosewood Oak Park, MI 48237
Licensee Telephone #:	(248) 399-8115
Administrator:	Kenneth Jordan
Licensee Designee:	Kenneth Jordan
Name of Facility:	Vreeland Home
Facility Address:	17090 Ray Riverview, MI 48194
Facility Telephone #:	(734) 282-0230
Original Issuance Date:	10/01/1995
License Status:	REGULAR
Effective Date:	05/15/2024
Expiration Date:	05/14/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A had shallow breathing and then stopped breathing. Resident A was choking on food, and staff did not know what to do. This is the second incident of a resident choking on food and staff didn't know what to do.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/05/2025	Special Investigation Intake 2025A0116017
03/05/2025	APS Referral Received.
03/06/2025	Referral - Recipient Rights Made.
03/07/2025	Special Investigation Initiated - On Site Interviewed home manager, Tamekia LaShore, staff, Erin Stovall, visually observed Residents B-D, and reviewed Ms. Stovall's employee record and Resident A's records.
03/11/2025	Contact - Telephone call made Resident A's independent supports coordinator, Melanie O'Dell.
03/12/2025	Contact - Telephone call made Resident A's independent supports coordinator mentor (supervisor), Lesa Wilson.
03/13/2025	Contact - Telephone call-made APS investigator, Monique King.
03/13/2025	Contact - Telephone call made Recipient rights investigator, Lexus Davis.
03/18/2025	Contact - Telephone call made Guardian A1.

03/18/2025	Contact - Document Received Death certificate received from Guardian A1.
03/18/2025	Contact - Telephone made Speech language pathologist, John Dubois, with Future Healthcare.
03/25/2025	Contact - Telephone call made Recipient rights investigator, Ms. Davis.
03/25/2025	Inspection Completed-BCAL Sub. Non-Compliance
03/27/2025	Exit Conference With licensee designee, Kenneth Jordan.
04/21/2025	Contact-Telephone call made American Red Cross instructor support agent, Thomas Hunt.
04/23/2025	Exit Conference With licensee designee, Kenneth Jordan.

ALLEGATION:

Resident A had shallow breathing and then stopped breathing. Resident A was choking on food, and staff did not know what to do. This is the second incident of a resident choking on food and staff didn't know what to do.

INVESTIGATION:

On 03/07/25, I conducted an unscheduled on-site inspection and interviewed home manager, Tamekia LaShore, staff, Erin Stovall, visually observed Residents B-D, and reviewed Resident A's records and Erin Stovall's employee record.

Ms. LaShore reported on 02/28/25, she was out of the home on an outing with Resident D and received a call from Ms. Stovall. Ms. Stovall informed her that she had to call 911 because Resident A appeared to be choking and was going in and out of consciousness. She immediately returned to the home and emergency medical services (EMS) were preparing to rush Resident A to the hospital. The emergency medical technician (EMT) reported that Resident A still had a faint pulse. Ms. Stovall explained to her that she did not start CPR as Resident A was still conscious at times and was coughing. Ms. Stovall followed the instructions of the 911 operator until the police and EMS arrived.

Ms. LaShore denied any knowledge of any resident choking in the past and reported she was assigned to this home in June of 2024. Since that time, there had not been

any instances of Resident A or any of the other residents choking and 911 being called.

Ms. Stovall reported that on 02/28/25, she was the staff on shift when the incident occurred and was responsible for the care of Resident A and B. Ms. Stovall stated Resident C was at school, and Resident D was on an outing with Ms. LaShore.

Ms. Stovall reported that Resident A is non-verbal, however, is able to communicate his wants with non-verbal cues. Resident A finished his lunch and made it known to her, by gesturing, that he wanted a cupcake. She cut the cupcake into bite size pieces and Resident A ate it and got up from the table. Ms. Stovall reported being in the kitchen washing dishes. Resident A collapsed in the living room on his side. She saw him from the kitchen and went to his side and noticed pieces of cupcake coming out of his mouth. She observed Resident A going in and out of consciousness. She called 911, explained what happened, and the 911 operator instructed her to continuously pat/hit Resident A on his back to see if whatever food may have been stuck, would dislodge. She had Resident A sitting in an upright position on the floor and was sitting behind him, while patting him on his back as instructed, by the 911 operator. Resident A would go silent and then start coughing and making gurgling noises. The police arrived within 5-8 minutes, and they engaged in CPR, even after stating that Resident A still had a faint pulse. Officers asked if she had attempted the heimlich maneuver, and she admitted that she was not aware of what it is, or how to do it and had followed the instructions given to her by the 911 operator. Shortly after the police arrived, EMS arrived and took over. EMTs used a CPR device that manually gives chest compressions and then loaded Resident A into the ambulance.

Ms. Stovall denied that anything like this had happened since she began working at the home in July 2024.

I reviewed Ms. Stovall's employee record and confirmed that she is fully trained in all required areas. Ms. Stovall completed adult and pediatric first aid, cardiopulmonary resuscitation, and automatic external defibrillator (FA/CPR/AED) training 11/30/22 through the American Red Cross.

On 03/13/25, I interviewed assigned APS investigator, Monique King, and she reported that she was able to verify the wellbeing of the remaining residents who reside in the home. They are all non-verbal, however, they presented neat and nicely groomed. The APS case will be closing as the victim is deceased.

On 03/13/2025, I interviewed recipient rights investigator, Lexus Davis. Ms. Davis reported that she is currently still investigating and trying to determine what occurred.

On 03/18/25, I interviewed Guardian A1. Guardian A1 reported that home manager, Tamekia LaShore, notified him of the incident when it occurred and reported that the family had remained by Resident A’s side until his passing.

Guardian A1 reported that in all the time Resident A lived in the home, he didn't have many concerns, as the staff provided good care to Resident A, and he believed that they really cared for him. He never observed any signs of abuse and Resident A was happy there. He still really does not know what happened, other than what the staff shared about Resident A choking on a cupcake. He is hopeful that the staff did what they were supposed to do for Resident A.

On 03/25/25, I interviewed recipient rights investigator, Lexus Davis. Ms. Davis reported that she is substantiating Neglect I. She reported during her interview with Ms. Stovall on 03/13/25, she reported only patting Resident A on his back and calling 911. She denied attempting to clear Resident A's mouth of food, checking his pulse, performing the Heimlich maneuver, or engaging in CPR.

On 04/21/25, I interviewed American Red Cross instructor support agent, Thomas Hunt. Mr. Hunt reported that a portion of all American Red Cross adult and pediatric FA/CPR/AED class curriculum includes instruction on what to do when a person is choking. This includes instructions on how and when to start abdominal thrusts, formerly known as the Heimlich maneuver, and back blows. The instructions given include alternating five abdominal thrusts and five back blows to expel the obstruction. Class participants are also taught when and how to transition from abdominal thrusts and back blows to administering CPR if the person goes unconscious.

On 04/23/25, I conducted the exit conference with licensee designee, Kenneth Jordan, and informed him of the findings of the investigation. Mr. Jordan reported an understanding. Mr. Jordan reported that staff, Erin Stovall, told him she had followed proper protocols, and he is learning through this investigation that she has told different accounts of what her actions were on the day of the incident. Ms. Stovall received a written reprimand and remains employed. She will be retrained.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**

ANALYSIS:	Based on the findings of the investigation, which included interviews of staff, Erin Stovall, recipient rights investigator, Lexus Davis, and American Red Cross instructor support agent, Thomas Hunt, I am able to corroborate the allegations. Ms. Stovall reported that when Resident A collapsed in the living room, she immediately went to his aid. Ms. Stovall admitted that she was not aware of what the Heimlich maneuver is or how to perform it. Ms. Stovall reported that she called 911, positioned Resident A upright, and followed the instructions of the 911 operator. Ms. Stovall reported that Resident A was going in and out of consciousness when law enforcement and EMS arrived and took over the care of Resident A. Ms. Stovall reported that CPR was initiated by the police and then EMS upon their arrival. Ms. Davis reported that she is substantiating Neglect I as Ms. Stovall reported only patting Resident A on his back and calling 911. She admitted that she did not attempt to clear Resident A's mouth of food, check his pulse, perform the Heimlich maneuver, or engage in CPR. Mr. Hunt reported that American Red Cross adult and pediatric FA/CPR/AED class curriculum includes instruction on what to do when a person is choking. This includes instructions on how and when to start abdominal thrusts, formerly known as the Heimlich maneuver, and back blows. This violation is established as staff, Erin Stovall, did not appropriately handle this emergency situation. Ms. Stovall did not follow or implement her FA/CPR/AED training, which instructs participants to provide alternating abdominal thrusts and back blows to dislodge food/objects and clear the obstruction.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 03/07/25, I conducted an unscheduled on-site inspection and interviewed home manager, Tamekia LaShore and staff, Erin Stovall.

Ms. LaShore acknowledged that Resident A had eating guidelines, and his food is required to be chopped/bite size and staff are required to prompt Resident A to drink fluids every couple bites due to his oral dysplasia and risk of aspiration/choking. Ms. LaShore reported that Resident A could feed himself, but required reminders from staff to slow down, to chew, and not to stuff his mouth. Ms. LaShore provided me a copy of Resident A's eating guidelines and most recent individualized plan of service (IPOS).

Ms. LaShore reported that Resident A passed away on 03/02/25, after his family took him off the ventilator. Resident A's guardian informed her that Resident A coded on the way to the hospital and again while at the hospital and consequently had to be placed on a ventilator. The doctors informed the family if Resident A survived, he would be in a vegetative state, so they made the decision to have him removed from the ventilator.

Ms. Stovall reported that she was the staff on shift when Resident A choked and was responsible for the care of Resident A and B. Ms. Stovall acknowledged that Resident A had eating guidelines and that she had been trained on them and his IPOS. She reported that the consistency of Resident A's food is chopped/bite sized. Staff are not required to sit at the table with Resident A while he is eating, and reported, "You just have to be in the kitchen area to make sure he is not eating too fast." Resident A is able to feed himself. Ms. Stovall was in the kitchen washing dishes while Resident A was at the kitchen table eating. Resident A finished eating and wanted a cupcake. Ms. Stovall cut the cupcake into bite-sized pieces and Resident A ate it, got up from the table and collapsed in the living room. Ms. Stovall was in the kitchen and observed Resident A collapse.

Ms. Stovall reported that she has worked with the company, at another home, for about 3 years prior to being moved to this home in July of 2024.

I reviewed Resident A's records and obtained a copy of his most recent IPOS dated 09/16/24 and eating guidelines dated 03/25/24. While reviewing the IPOS, I observed that the plan documents the following:

- *When it comes to eating, Resident A has eating guidelines with aspiration precautions due to oral dysphagia, so his food has to be prepared to the specifications of his eating guidelines.*
- *Resident A needs physical assistance to be fed and monitoring for risk of choking due to chewing and swallowing issues.*
- *Staff should sit at the table with Resident A while he is eating.*

Verbally remind Resident A to chew and swallow each bite before taking another.

- *Remind Resident A to take a dink after every 3-4 bites.*
- *Use a two-cup method-give him 1-2 ounces of liquid at a time and refill his cup as desired.*
- *Monitor for signs and symptoms of aspiration including but not limited to coughing, gagging, wet/gurgly vocal quality, increased temperature, watery eyes or runny nose.*
- *Notify supports coordinator and speech language pathologist if signs/symptoms of aspiration are present or if there are any changes in Resident A's ability to eat.*

I reviewed Resident A's eating guidelines and the recommendations are as follows:

- *Food texture consistency: ground, liquid consistency: regular.*
- *Supervision: fed by staff*
- *Body position: upright in chair*
- *Place setting: regular*
- *Food presented via: dish/utensils*
- *Liquids presented via: cup*
- *Cues to chew and swallow, alternate liquids and solids*

I also reviewed the Detroit Wayne Integrated Health Network treatment plan training log. The log was dated 07/19/24 and is signed by Ms. LaShore acknowledging she was trained/in-serviced on Resident A's IPOS, and eating guidelines by independent supports coordinator, Melanie O'Dell. Ms. Stovall signed and dated the log on 09/30/24. I also reviewed the Samaritan Homes in-service record, dated 09/27/24, that contained the signatures of the staff who were in-serviced on Resident A's IPOS and eating guidelines, by Ms. LaShore. Ms. Stovall signed the in-service record on 09/30/24

On 03/11/25, I interviewed Resident A's independent supports coordinator, Melanie O'Dell. Ms. O'Dell reported that she works with her independent supports coordinator mentor (supervisor), Lesa Wilson, who authored Resident A's IPOS. Ms. O'Dell reported that she, along with Ms. Wilson, staff and family members develop the plan as a team and once completed all responsible parties implement their parts of the plan. Ms. O'Dell reported that any specific questions regarding the plan would best be answered by Ms. Wilson.

On 03/12/25, I interviewed independent supports coordinator mentor, Lesa Wilson, and she reported that she authored Resident A's IPOS dated 09/15/24, and facilitated the meeting with Resident A's family, home manager, Tamekia LaShore, and area manager, Stacy Washington.

I informed Ms. Wilson that Ms. LaShore and Ms. Stovall reported that Resident A's food consistency is bite-sized/chopped, although the IPOS documents ground. Ms. Wilson reported that the plan documents what the most recent eating guidelines

require and confirmed that as of 03/25/24, Resident A's food is required to have a ground consistency. If the staff felt that Resident A was not tolerating ground food and would do better with chopped/bite sized, they should have brought it to her attention and the process of requesting another dysphagia evaluation could have been initiated. Until that happens, staff are required to continue to follow all current guidelines. This is a team approach and as a supports coordinator, she relies on the staff, who spend more time with the residents, to inform her or Ms. O'Dell of any changes/recommendations, that would benefit the resident. At the plan meeting no changes regarding eating guidelines/food consistency was brought up or the plan would have reflected that.

Ms. Wilson added that she takes the dysphagia evaluation recommendations and includes them in the IPOS as they are written.

On 03/13/25, I interviewed assigned APS investigator, Monique King, and she reported that she was able to verify the wellbeing of the remaining residents who reside in the home and did not have any concerns. Ms. King reported that Ms. Stovall reported that Resident A had finished his lunch and was eating a cupcake and collapsed in the living room. Ms. King did not ask Ms. Stovall about how the cupcake was prepared before giving it to Resident A, as she was not aware of any eating guidelines at that time.

On 03/13/2025, I interviewed recipient rights investigator, Lexus Davis. She is currently still investigating. If she determines that Resident A's eating guidelines were not followed, and that contributed to his death, she will be substantiating Neglect I. Ms. Davis has requested Resident A's death certificate.

On 03/18/25, I interviewed Guardian A1, and he reported that he was aware that Resident A's IPOS documents that his food should be ground, because Resident A did not have any teeth, and ground consistency was easier for him to chew. Resident A would try to stuff his mouth and reported you really had to watch him. On the day of the incident, the doctor told him that Resident A coded in the ambulance while on the way to the hospital and once while there. Resident A also sustained a perforated bowel, which the doctor reported was likely from the use of the machine used by EMTs when doing CPR. The doctor informed him that if Resident A survived, he would be in a vegetative state, coupled with Resident A's severe developmental disability, it would be best to remove him from the ventilator. Guardian A1 reported that Resident A passed immediately after he was taken off.

Guardian A1 reported that he has the death certificate, and the manner of death was aspiration pneumonia and acute hypoxic respiratory failure.

On 03/18/25, I interviewed John DuBois, the speech language pathologist who completed Resident A's dysphagia evaluation and authored the eating guidelines. He confirmed that the most recent eating guidelines were completed 03/25/24, and he had not made any changes or updates to them

On 03/18/25, I received and reviewed a copy of Resident A's death certificate. Resident A was pronounced on 03/02/25, due to aspiration pneumonia and acute hypoxic respiratory failure.

On 03/25/25, I interviewed recipient rights investigator, Lexus Davis. Ms. Davis reported that she is nearing completion of her investigation. During her interview with staff, Erin Stovall, on 03/13/25, she provided a different account of what occurred, than what was previously told to me during my interview with her on 03/07/25. Ms. Stovall reported to her that she was sitting at the table with Resident A while he was eating his food and cupcake. Ms. Davis reported when she asked Ms. Stovall how she prepared the cupcake for Resident A she reported that Ms. Stovall's response was, "I gave it to him, and he began eating it." Then reported, "I cut it up in about four to five pieces, it was not ground". Ms. Davis will be substantiating Neglect I, as Ms. Stovall's negligence resulted in Resident A's death.

On 03/27/2025, I conducted an exit conference with licensee designee, Kenneth Jordan, and informed him of the findings of the investigation and the specific rule cited. Mr. Jordan reported that he was surprised that there was a rule violation because when he spoke with his home manager, Tamekia LaShore, she reported that Resident A's eating guidelines and IPOS were followed. Mr. Jordan did not conduct an internal investigation into the matter because he did not want it to appear as if he was coaching Ms. Stovall, as he was aware of the rights and licensing investigations. Mr. Jordan reported that Ms. Stovall was fully trained in all required areas as well as on Resident A's eating guidelines and IPOS. He reported, "You can't teach common sense." He cannot understand why Ms. Stovall did not follow the eating guidelines and IPOS. I informed Mr. Jordan of my recommendation to modify the license to provisional and he reported that it was Ms. Stovall who was in error, and did not believe he should be responsible or liable for what Ms. Stovall did or did not do.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.

ANALYSIS:	Based on the findings of the investigation, which included, interviews of home manager, Tamekia LaShore, staff, Erin Stovall, independent supports coordinator, Melanie O'Dell, independent supports coordinator mentor, Lesa Williams, Guardian A1, speech language pathologist, John DuBois, recipient rights investigator, Lexus Davis, and review of Resident A's records, I am able to corroborate that on 02/28/25, staff, Erin Stovall, did not implement Resident A's plan of service, subsequently Resident A choked and collapsed. Resident A passed away on 03/02/25. Ms. Lashore, although not present in the home, at the time of the incident, reported during my interview, that Resident A's food consistency is chopped/bite sized, and that he is able to feed himself. Ms. Stovall reported that Resident A's food consistency is chopped/bite sized, that he can feed himself and that staff is not required to sit at the table with him while eating. Ms. Stovall further reported that on 02/28/25, she gave Resident A a cupcake and reported that she chopped it in bite-sized pieces. Ms. Odell and Ms. Wilson reported working together with Resident A's team of supports and developing the IPOS and upon completion, each responsible party is required to implement the plan. Ms. Wilson reported the plan dated 09/16/24, is the most recent plan and is what the staff should be following. Guardian A1 reported that he was aware of Resident A's eating guidelines and knew that the consistency of his food was ground. Guardian A1 reported that Resident A did not have any teeth, and that ground consistency was easier for Resident A to eat. Mr. Dubois reported that he authored Resident A's eating guidelines and that the 03/25/24 report is the most recent and should have been the ones followed by staff. Ms. Davis reported that there are inconsistencies in Ms. Stovall's story, however, reported that she admitted to her that she gave Resident A the cupcake, and then reported she cut in four to five bite sized pieces. She admitted it was not ground consistency prior to giving it to him.

	I reviewed Resident A's IPOS dated 09/16/24 and his eating guidelines dated 03/25/24, in summation, both document that Resident A's food consistency is ground, staff should be sitting at the table, Resident A should be fed by staff while eating, and staff should give verbal reminders to Resident A to drink liquids after three to four bites. Ms. Stovall did not adhere to either and Resident A subsequently choked, collapsed and later passed away.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the license is modified to provisional.

Pandrea Robinson
Licensing Consultant

04/23/25
Date

Approved By:

05/01/25

_____

Ardra Hunter
Area Manager

Date