GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 14, 2020

Patricia Thomas
Quest, Inc
36141 Schoolcraft Road
Livonia, MI 48150-1216

RE: License #: AS820014032
Investigation #: 2020A0116027
Belair Home

Dear Mrs. Thomas:

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,

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 #:	AS820014032
Investigation #:	2020A0116027
Complaint Receipt Date:	07/06/2020
Investigation Initiation Date:	07/09/2020
Report Due Date:	09/04/2020
Licensee Name:	Quest, Inc
Licensee Address:	36141 Schoolcraft Road Livonia, MI 48150-1216
Licensee Telephone #:	(734) 838-3400
Administrator:	Patricia Thomas

Licensee Designee:	Patricia Thomas
Name of Facility:	Belair Home
Facility Address:	279 Church Belleville, MI 48111
Facility Telephone #:	(734) 699-3808
Original Issuance Date:	03/11/1988
License Status:	REGULAR
Effective Date:	09/18/2018
Expiration Date:	09/17/2020
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The home is often understaffed.	No
The home manager Chelsea Holdbird told Resident A to hold her bowel movements for 2nd shift. The same day the other four residents were left in urine-soaked briefs.	No
Resident A was called a liar and troublemaker by Ms. Holdbird.	Yes

All allegations were not addressed as they were not rule related.

III. METHODOLOGY

07/06/2020	Special Investigation Intake 2020A0116027
07/09/2020	Special Investigation Initiated - Telephone

	Interviewed assigned Adult Protective Services Worker (APS) Ciera Lewis.
07/09/2020	Contact - Telephone call made Interviewed home manager Chelsea Holdbird
07/13/2020	Contact - Telephone call made Interviewed Resident A and staff Laura Blair.
07/21/2020	Contact - Telephone call made Interviewed Relative (1).
07/22/2020	Contact - Telephone call made Case manager for Resident A, voice mail full no message could be left.
07/22/2020	Contact - Telephone call made Left a message for area supervisor Renea Smith requesting a return call.
07/28/2020	Contact - Document Sent Email sent to licensee designee Patricia Thomas requesting staff schedules and resident assessment plans.
07/30/2020	Contact - Telephone call received Spoke with area supervisor Renea Smith.
07/31/2020	Contact - Document Received Received staff schedules and resident assessment plans.
08/03/2020	Contact - Telephone call made Interviewed support's coordinator Dawne Hemphill-Williams
08/03/2020	Contact - Telephone call made Interviewed Residents B and C.
08/03/2020	Inspection Completed-BCAL Sub. Compliance Onsite Inspection not completed due to Covid-19 pandemic
08/07/2020	Exit Conference With licensee designee Patricia Thomas.

ALLEGATION:

The home is understaffed.

INVESTIGATION:

I interviewed home manager Chelsea Holdbird on 07/09/20 and she reported that all five residents in the home require the regular use of a wheelchair. Ms. Holdbird reported that the home always schedules two staff per shift as residents are dependent on staff for most of their needs. Ms. Holdbird reported that staffing has been an issue especially since the Covid-19 pandemic. She reported that staff were calling off work at the last minute, others were scared to return to work due to fear of the virus, and others wanted to stay home to collect the enhanced unemployment benefit. Ms. Holdbird reported that the company has been constantly trying to hire but reports it has been difficult. Ms. Holdbird reported that due to all of the aforementioned they have had to have staff from some of their other licensed homes work shifts at the home to ensure coverage. Ms. Holdbird reported that there were about three days in the month of June that she worked her shift alone due to staff shortages and call offs. She was unable to remember the dates. Ms. Holdbird reported that she was busy and was constantly working on those days but reported she was able to ensure all of the resident's needs were met.

I interviewed staff Laura Blair and Resident A on 07/13/20. Ms. Blair reported that she has worked for the company over a year, however, volunteered to come over to work at the home effective June 1, 2020 due to the staffing shortages. Ms. Blair reported she is not aware of what occurred with staffing prior to her coming to the home in June. Ms. Blair reported that since she has been working in the home there have been two staff per shift. Ms. Blair admitted that the home is still working with a limited amount of staff but reported staff from other homes are chipping in and covering shifts until they can get enough staff hired specifically for the home. Ms. Blair reported that the Covid-19 pandemic is making things even more challenging, however, reported that they will do what they have to do to ensure that the needs of the residents remain the priority.

I interviewed Resident A and she reported that to her recollection there is always two staff working each shift. Resident A reported she did not remember a time that there was only one staff working.

I interviewed area supervisor Renea Smith on 07/30/20 and she reported that she recently took over the home and is working to address the staffing issues. Ms. Smith reported that although it has been challenging the home has had two staff per shift and other staff from their other licensed homes have been picking up shifts to ensure proper coverage. Ms. Smith reported being unaware that Ms. Holdbird had allegedly worked 3 shifts in June alone. I requested the staff schedule for the months of April-July for review as well as the current resident assessment plans for each resident.

I received and reviewed staff schedules on 07/31/20. The schedules were from the months of April through July. Although it was evident that there were call off's and no shows it appears that the home was able to cover those shifts based on the schedule. I also reviewed the resident assessment plans for Residents A-E and

based on those assessments and the needs of the residents at minimum the home should have two staff per shift.

I interviewed Residents B and C on 08/03/20 and they both reported that there is always two staff on each shift and reported they do not recall a time where there was only one person working.

I conducted the exit conference with licensee designee, Patricia Thomas, on 08/03/20. Ms. Thomas reported that staffing has been an issue especially during the pandemic, however, as a company staff from other licensed homes have chipped in, volunteered, and helped ensure adequate coverage at the home during these difficult times. I informed Ms. Thomas of the findings of the investigation and she agreed with the findings.

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:	Based on the findings of the investigation, which included interviews of Ms. Holdbird, Ms. Blair, Resident's A-C, Ms. Smith and consultant review of staff schedules and resident assessment plans, I am unable to corroborate the allegations. Although Ms. Holdbird admitted that during the month of June, she worked alone on her shift for a period of three days, she was unable to provide specific dates and review of the June schedule did not reflect this. Ms. Smith also reported she was not aware of anytime that Ms. Holdbird or any other staff at the home worked a shift alone, as the company was sending other staff to cover shifts. Residents A-C reported that there is always two staff on each shift and they could not recall a time where any staff worked alone. Ms. Blair reported that since June 1st when she began working at the home, she has not had to work a shift alone and reported that all shifts have been covered. This violation is not established as the home has sufficient direct care staff on duty at all times for the supervision, personal care, and protection of the residents and are providing the services specified in the resident's assessment plan.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The home manager Chelsea Holdbird told Resident A to hold her bowel movements for 2nd shift. The same day the other four residents were left in urine-soaked briefs.

INVESTIGATION:

I interviewed assigned APS worker Ciera Lewis on 07/09/20. Ms. Lewis reported that she is currently investigating the allegations, however, reported has been unable to interview Resident A outside of the presence of Ms. Holdbird as she has been present in the home each time she has called the home. Ms. Lewis reported she hopes to interview Resident A this week.

I interviewed Ms. Holdbird on 07/09/20 and she denied the allegation. Ms. Holdbird reported that although Resident A wears incontinent briefs she is capable of informing staff when she needs to use the bathroom. Ms. Holdbird reported if/when she uses it in her brief she can, and most times will inform staff and she is immediately toileted. Ms. Holdbird reported that she never told Resident A to hold her bowel movement until second shift and reported that was ridiculous. Ms. Holdbird reported that she does remind Resident A to let her know when she needs to be toileted and reported that she will also ask her at minimum every two hours in an attempt to catch her before she urinates or defecates in her brief. Ms. Holdbird also denied that any of the residents are left sitting in urine-soaked briefs. Ms. Holdbird reported that each resident is toileted at least every 2-3 hours and more often if needed.

I interviewed Resident A on 07/13/20 and she reported that Ms. Holdbird never told her to hold her bowel movements for 2nd shift and reported this was all a misunderstanding. Resident A reported staff are good about toileting her and the other residents in the home. Resident A denied that she is left sitting in soiled briefs and reported that when she has an accident, she tells the staff and they change and clean her up immediately.

I interviewed Ms. Blair on 07/13/20 and she reported that she was unaware of the allegation and had not heard anything about it. Ms. Blair reported that she can only speak for what happens during her shifts. Ms. Blair reported that all of the residents are checked and/or toileted every two hours or more often if needed. Ms. Blair also reported that she has also never come on shift and found the residents sitting in soiled briefs.

I interviewed Relative (1) on 07/21/20 and she reported that she is not aware if any of the other residents are left sitting in soiled briefs as reported, however, reported that Resident A told her that she was told to hold her bowel movements by Ms. Holdbird or her girlfriend. Relative (1) reported she believed it when Resident A shared the information with her.

I interviewed supports coordinator Ms. Hemphill-Williams on 08/03/20 and she reported that she is new to the home and is the supports coordinator for all five of the residents. Ms. Hemphill-Williams reported not being aware of the allegation or if it occurred, however, reported that at Resident A's plan meeting her plan was updated to include her becoming a little more independent by doing a better job of

informing staff when she needs to use the restroom instead of just using it in her brief during the times she can control it. Ms. Hemphill-Williams reported that she would review the case notes to see if there were issues prior, regarding residents not being toileted regularly. Ms. Hemphill-Williams reported she would contact me if she found anything in the notes to suggest that this has been an issue in the past.

I interviewed Residents B and C on 08/03/20 and they both reported that they never heard Ms. Holdbird, or any staff tell Resident A to hold her bowel movement for the 2nd shift. Resident B denied that she is ever left sitting in a soiled or urine-soaked briefs and reported that she is able to change herself with staff assistance. Resident C reported that staff check them often and change them when they need to be changed. Resident C reported that if she is wet, she does not hesitate to inform the staff. Resident C also reported that Residents D and E are non-verbal and cannot tell staff when their brief is soiled, however reported that when staff toilet one they toilet them all.

I conducted the exit conference on 08/03/20 with Ms. Thomas and informed her of the findings of the investigation. Ms. Thomas agreed with the findings.

APPLICABLE RULE	
R 400.14303	**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:	Based on the findings of the investigation, which included interviews of Ms. Holdbird, Ms. Blair, and Residents A-C I am unable to corroborate the allegations. Ms. Holdbird denied the allegations as reported and reported that all the residents are toileted every two hours or more often if necessary. Residents A denied that Ms. Holdbird told her to hold her bowel movement until 2nd shift and reported that she is toileted regularly and is not left sitting in soiled briefs. Residents C and D reported that all of the ladies in the home are toileted regularly and denied that they are left to sit in urine-soaked briefs. This violation is not established as the licensee is providing supervision, protection and personal care as specified in the resident's assessment plan.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was called a liar and troublemaker by Ms. Holdbird.

INVESTIGATION:

I interviewed Ms. Holdbird on 07/09/20 and she denied that she called Resident A a liar and a troublemaker. Ms. Holdbird reported that she may have made mention of people getting in trouble based on something Resident A reported, however, denies calling Resident A troublemaker.

I interviewed Resident A on 07/13/20 and she reported that Ms. Holdbird was upset after finding out that a rights investigation was open based on some information she shared. Resident A reported that Ms. Holdbird came directly to her and said, “You are a troublemaker and a liar and you are going to get people in trouble.” Resident A reported that Ms. Holdbird was really mad at her. Resident A reported that this was the first time that Ms. Holdbird had been mean to her or used harsh language with her.

I interviewed Ms. Blair on 07/13/20 and she reported that she did not hear Ms. Holdbird call Resident A a liar or troublemaker and this was her first time hearing about it.

I interviewed Relative (1) on 07/21/20 and she reported that Resident A called her and told her that Ms. Holdbird was mad about an investigation and called her a liar and a troublemaker. Relative (1) reported that when it was addressed with Ms. Holdbird, she denied it, however, she reported that Resident A is very credible and does not make up things or lie about events. Relative (1) reported that Resident A loves living in the home and would be devastated if she had to leave or be moved. Relative (1) reported that regardless, Resident A will speak out if and when she believes she is being mistreated.

I interviewed Ms. Hemphill-Williams on 08/03/20 and she reported that she was aware of the allegation and reported during Resident A’s plan meeting, she asked her about it. Ms. Hemphill-Williams reported that Resident A denied it but reported that could have been because other staff in the home were present and she may have been uncomfortable sharing in that setting.

I conducted the exit conference on 08/03/20 with Ms. Thomas and informed her of the findings. Ms. Thomas was not aware of the allegations but reported that they would definitely be addressed with Ms. Holdbird. Ms. Thomas also reported that Ms. Holdbird was no longer the manager at the home and reported that another staff person had been assigned.

I informed Ms. Thomas that the report was forthcoming and that it would include a request for a corrective action plan. Ms. Thomas reported upon receipt of the report she would submit the plan to address the rule violation.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**
ANALYSIS:	Based on the findings of the investigation, which included interviews with Ms. Holdbird, Resident A, Ms. Hemphill-Williams and Relative (1) I am able to corroborate the allegation. Although Ms. Holdbird denied the allegation, after interviewing Resident A and listening to her provide details of what Ms. Holdbird said to her, coupled with her credibility, there is sufficient evidence to substantiate this allegation. Relative (1) also reported that Resident A called and told her the same account of events and reported she was upset about it. Relative (1) reported she believes Ms. Holdbird said it as Resident A had nothing to gain by telling her truth.
CONCLUSION:	**VIOLATION ESTABLISHED**

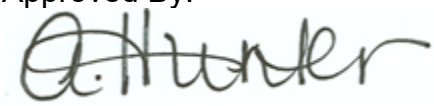
IV. RECOMMENDATION

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

08/11/20

Pandrea Robinson — Date
Licensing Consultant

Approved By:



08/14/2020

Ardra Hunter — Date
Area Manager