GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 7, 2021

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

RE: License #: AS630378443
Investigation #: 2021A0991020
Meadowood

Dear Ms. 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 (248) 975-5053.

Sincerely,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630378443
Investigation #:	2021A0991020
Complaint Receipt Date:	04/15/2021
Investigation Initiation Date:	04/15/2021
Report Due Date:	06/14/2021
Licensee Name:	Quest, Inc
Licensee Address:	36141 Schoolcraft Road Livonia, MI 48150-1216
Licensee Telephone #:	(734) 838-3400
Licensee Designee:	Patricia Thomas
Name of Facility:	Meadowood
Facility Address:	15904 Meadowood Ave Southfield, MI 48076
Facility Telephone #:	(248) 559-7077
Original Issuance Date:	10/01/2015
License Status:	REGULAR
Effective Date:	03/31/2020
Expiration Date:	03/30/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
On 04/09/21, staff LaRena Effinger was giving Resident A a shower when the shower chair tilted forward and Resident A fell, hitting his head. Resident A had a laceration to his forehead that required stitches.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/15/2021	Special Investigation Intake 2021A0991020
04/15/2021	Special Investigation Initiated - Telephone To Office of Recipient Rights (ORR) worker, Darlita Paulding
04/15/2021	Referral - Recipient Rights Received from ORR
04/16/2021	Contact - Telephone call made To home manager, Shenita Grissom
04/16/2021	Contact - Telephone call made To direct care worker, LaRena Effinger
04/16/2021	Contact - Telephone call made Left message for staff, Marqueta Arnold
04/16/2021	Contact - Document Received Individual plan of service (IPOS) and crisis plan
04/22/2021	Inspection Completed On-site Unannounced onsite inspection
04/22/2021	Contact - Document Received Discharge paperwork, assessment plan
04/22/2021	Contact - Telephone call made To Darlita Paulding, ORR worker

06/02/2021	Contact - Telephone call received From Darlita Paulding, ORR worker
6/07/2021	Exit Conference Via telephone with licensee designee, Patricia Thomas

ALLEGATION:

On 04/09/21, staff LaRena Effinger was giving Resident A a shower when the shower chair tilted forward and Resident A fell, hitting his head. Resident A had a laceration to his forehead that required stitches.

INVESTIGATION:

On 04/15/21, I received a complaint alleging that Resident A fell out of his shower chair and sustained a laceration to his forehead. I initiated my investigation on 04/15/21 by contacting the assigned Office of Recipient Rights (ORR) worker, Darlita Paulding. Ms. Paulding provided copies of the incident report, as well as copies of Resident A's individual plan of service (IPOS) and crisis plan.

On 04/16/21, I interviewed the home manager, Shenita Grissom, via telephone. Ms. Grissom indicated that she was not working when Resident A fell. On 04/09/21, she received a FaceTime call from staff, LaRena Effinger, who told her that she asked Resident A to scoot back in the shower chair and the chair tipped over, causing Resident A to fall. Resident A's forehead was bleeding and Ms. Grissom instructed Ms. Effinger to take Resident A to the hospital. Ms. Grissom indicated that Resident A is a short individual and his feet do not touch the ground when he is in the shower chair. It is difficult for Resident A to scoot back in the chair, so staff must assist him. Resident A has a history of seizures and falls, and he requires staff assistance at all times when in the shower. The left side of Resident A's body is weaker, and he frequently leans to the left. Ms. Grissom stated that the shower chair has wheels with a lock on one of the front and back wheels. She was not sure if the wheels were locked when Resident A fell. Ms. Grissom indicated that she felt the fall could have been prevented if staff had been holding onto the chair and guiding Resident A back into the seat. She stated that Resident A's plan might need to be updated to indicate that he needs two people to assist with showers.

On 04/16/21, I interviewed direct care worker, LaRena Effinger, via telephone. Ms. Effinger indicated that on 04/09/21, she was assisting Resident A in the bathroom with another staff person, Marqueta Arnold. After Resident A used the toilet, Ms. Effinger decided to give him a shower. Resident A sat on the edge of the shower chair. When he tried to scoot back, the shower chair tipped forward. Resident A fell to the right and hit his head on the floor of the shower. The chair fell forward on top of him. Ms. Effinger sat Resident A up and noticed he had a cut above his right eye. She put a compress on the cut to stop the bleeding and called the home manager. Ms. Effinger took Resident A to

the hospital and he received three stitches. Ms. Effinger stated that when Resident A fell, she was standing on the left side of him, as he usually leans to the left side. He fell in the opposite direction from where she was standing, and she was unable to prevent the fall. Ms. Effinger indicated that Ms. Arnold was in the bathroom when Resident A fell, but she was cleaning up by the toilet and was not assisting with bathing Resident A. She stated that the brakes were engaged on the shower chair and the footrest was up so that Resident A could scoot back in the chair. Ms. Effinger stated that Resident A requires one staff person to assist him with showers. She was trained on how to shower the residents when she first started working in the home two years ago. She did not receive specific instructions for bathing Resident A. Ms. Effinger indicated that if she had known the chair would tip, she would have stood in front of the chair to prevent Resident A from falling. After the fall, Ms. Effinger received instructions from the home manager about the proper way to shower Resident A. She should apply pressure to the back of the chair so that it does not tip forward, and she should stand in front of Resident A and not on the side of him.

On 06/02/21, I spoke to the ORR worker, Darlita Paulding. Ms. Paulding indicated that she interviewed direct care worker, Marqueta Arnold on 04/28/21. Ms. Arnold stated that on 04/09/21 she assisted Resident A with using the toilet. She undressed Resident A and guided him to LaRena Effinger so that Ms. Effinger could give him a shower. Ms. Arnold stated that she left the bathroom and did not see Ms. Effinger put Resident A on the shower chair. She was only out of the bathroom for a minute or two when Ms. Effinger called out to her and stated that Resident A fell. Ms. Arnold came back into the bathroom and observed Resident A on the floor and the shower chair tipped over. They got Resident A up and sat him back in the chair. Ms. Arnold could not recall if the wheels were locked on the chair. Resident A's forehead was bleeding above his eyebrow. Ms. Arnold indicated that when she showers Resident A, she pulls the chair out of the shower and pushes it against the wall, so it won't move. She does not put Resident A into the chair in the shower, because the floor could be wet.

On 04/22/21, I conducted an unannounced onsite inspection at Meadowood. I observed Resident A sitting in a chair in the living room. He had stitches above his right eyebrow. Resident A was unable to answer any questions due to his limited cognitive and verbal abilities. The home manager, Shenita Grissom, and direct care worker, LaRena Effinger, were on shift during my unannounced onsite inspection. Ms. Effinger showed me the shower chair and demonstrated how the chair tipped forward. The shower chair was made of PVC piping and was very lightweight. It tipped forward very easily when pressure was applied to the footrest. I observed that the chair had locks on the front right and left rear wheels. The chair could still be moved and tipped when it was locked. Ms. Effinger again indicated that she was standing on the left side of Resident A and he fell towards the right side. The chair tipped over as well. Ms. Effinger was unable to provide a clear answer as to why she was not able to break Resident A's fall before he hit his head on the floor or why she could not prevent the chair from falling on top of

him. Ms. Effinger and Ms. Grissom both indicated that the shower chair belongs to the home and was there before Resident A moved into the home. When Resident A moved into the home, his guardian indicated that he needed a shower chair. Resident A did not have his own shower chair, so they used the chair that was in the home.

During the onsite inspection, I reviewed Resident A's file. There was no authorization from a physician for the use of a shower chair. Resident A's adult foster care licensing assessment plan dated 02/22/21 indicated that he needs one on one assistance for showers. It did not note the use of a shower chair for bathing or as an assistive device.

I reviewed a copy of Resident A's IPOS and crisis plan completed by Macomb Oakland Regional Center (MORC) dated 02/22/21. The plans note that Resident A has a history of falls. Resident A has an increased fall risk when he removes his clothing to use the restroom, gets seated on the toilet, and while cleaning up after using the restroom. Staff are to assist Resident A while he uses the restroom. A caregiver must assist Resident A by providing hands-on assistance during bathing, drying, and dressing. The plan notes that a caregiver should ensure that Resident A is not at risk of falling while assisting in bathing. Resident A's IPOS and crisis plan do not note that a shower chair should be used while showering Resident A.

I reviewed a copy of the incident report dated 04/09/21, which notes the same information provided by Ms. Effinger. I reviewed a copy of the discharge paperwork from the Beaumont Royal Oak Emergency Department dated 04/09/21, which notes that Resident A was treated for a laceration of the forehead, which was repaired with stitches.

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:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not attend to Resident A's safety and protection on 04/09/21 when the shower chair tipped over and Resident A sustained a laceration to his forehead. Staff did not ensure that the chair was stable and did not provide proper assistance in guiding Resident A onto the shower chair to prevent him from falling.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my unannounced onsite inspection, Ms. Effinger and Ms. Grissom both indicated that the shower chair Resident A was using belongs to the home and was there before Resident A moved into the home. When Resident A moved into the home, his guardian indicated that he needed a shower chair. Resident A did not have his own shower chair, so they used the chair that was available in the home.

During the onsite inspection, I reviewed Resident A's file. There was no authorization from a physician for the use of a shower chair. Resident A's adult foster care licensing assessment plan dated 02/22/21 indicated that he needs one on one assistance for showers. It did not note the use of a shower chair for bathing or as an assistive device.

I reviewed a copy of Resident A's IPOS and crisis plan completed by MORC dated 02/22/21. The plans note that a caregiver should ensure that Resident A is not at risk of falling while assisting in bathing. Resident A's IPOS and crisis plan do not note that a shower chair should be used while showering Resident A.

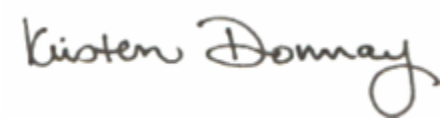
On 06/07/21, I conducted an exit conference via telephone with the licensee designee, Patricia Thomas. Ms. Thomas did not have any additional information to share regarding the investigation. She indicated that she would submit a corrective action plan to address the violations that were identified.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A's written assessment plans did not specify the use of a shower chair for bathing.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A's file did not contain authorization from a physician for the use of a shower chair.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



06/07/2021

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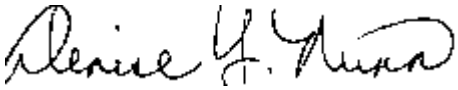
Kristen Donnay Date
Licensing Consultant

Approved By:



06/07/2021

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Denise Y. Nunn Date
Area Manager