GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 2, 2022

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

RE: License #: AS820383337
Investigation #: 2022A0901021
Riverdale

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,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820383337
Investigation #:	2022A0901021
Complaint Receipt Date:	03/31/2022
Investigation Initiation Date:	03/31/2022
Report Due Date:	05/30/2022
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:	Riverdale
Facility Address:	9188 Riverdale Redford, MI 48239
Facility Telephone #:	(313) 286-3016
Original Issuance Date:	08/05/2016
License Status:	REGULAR
Effective Date:	02/05/2021
Expiration Date:	02/04/2023
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A seemed different on 3/29/2022. He felt jittery and could not open his mouth all the way. Hospital stated he had consumed the wrong medication.	Yes

III. METHODOLOGY

03/31/2022	Special Investigation Intake 2022A0901021
03/31/2022	Special Investigation Initiated - Telephone Home Manager, Delisa Wideman
03/31/2022	APS Referral
03/31/2022	Referral - Recipient Rights
04/05/2022	Contact - Telephone call made Staff, Victoria Fraiser
04/05/2022	Contact - Telephone call made Staff, Lashanda Williams
04/05/2022	Contact - Telephone call made Resident A
04/05/2022	Contact - Telephone call made Supervisor, Kenyanna McIver
04/05/2022	Contact - Telephone call made Resident A's Guardian
04/07/2022	Inspection Completed On-site Resident A
05/13/2022	Contact - Telephone call made Case Manager, Lauren Konowski

05/13/2022	Inspection Completed-BCAL Sub. Compliance
05/26/2022	Exit Conference Licensee Designee, Patricia Thomas

ALLEGATION:

Resident A seemed different on 3/29/2022. He felt jittery and could not open his mouth all the way. Hospital stated he had consumed the wrong medication.

INVESTIGATION:

On 03/31/2022, I received a copy of Resident A's discharge summary along with the complaint. He was seen at Garden City Hospital emergency department on 03/29/2022. The reason for visit was documented as "patient consumed wrong medication at group home" and his diagnosis was "medication reaction." He was given Benadryl.

On 03/31/2022, I made a telephone call the home manger, Delisa Wideman. She explained that she was currently on maternity leave but was informed about the incident. Based on what she knew, the midnight staff, Victoria Fraiser, gave Resident A the wrong medication. The mishap was discovered when he told the day shift staff person, Lashanda Williams. She also stated the area supervisor, Kenyanna McIver, was filling in for her in her absence and that I could call her for additional information.

On 04/05/2022, I made a telephone call to staff, Victoria Fraiser. She confirmed she gave Resident A his medications the morning of 03/29/2022 and stated she did not believe she gave him the wrong medication. Ms. Fraiser stated she was later informed, after her shift was complete, that Resident A was taken to the hospital and that he accused her of giving him an extra pill. She explained that Resident A gets 4 white pills in the morning, but he believes she gave him and extra white pill or the wrong pill. She further stated that she was almost certain she did not make an error and if she did, Resident A never mentioned anything to her.

On 04/05/2022, I made a telephone call to staff, Lashanda Williams. She stated she works day shift and when she arrived to work on 03/29/2022, Resident A looked "off." He was not his normal self and was complaining that he had the shakes. When asked what was wrong, Resident A stated he was given the wrong medication. His words were mumbled, but she understood him. Ms. Williams explained that they normally have some difficulty understanding him, but on this day, his speech was more off. She called poison control and was advised to take him to

the hospital. She further stated it is unknown what he was given, but the symptoms he was displaying on 03/29/2022 was not his normal reaction from taking his daily medications.

On 04/05/2022, I made a telephone call to the facility and attempted to interview Resident A. It was difficult understanding him, but he repeatedly said, “Wrong med,” and “Got sick.”

On 04/05/2022, I made a telephone call to the home supervisor, Keyanna McIver. She stated it was unknown what medication Resident A was given or if he was given the wrong medication. She further stated that sometimes when his sugar levels are off, it could cause slurred speech and he is not his normal self. In such a case, they would give him a snack. They did not check his sugar level on 03/29/2022 and Ms. McIver stated he had just eaten when given his medication. She also stated that it was very rare for his sugar to be off.

On 04/05/2022, I made a telephone to Resident A’s guardian, who is also his sister. She was aware of the incident. She stated she was told by Ms. McIver that he was given the wrong medication. He felt weird and his tongue was swelling. He was taken to the hospital and was diagnosed as having an allergic reaction. She stated this was not normal behavior for Resident A. He does not have food allergies and his regular medications have not been causing this reaction. Therefore, she felt he must have been given something different. She further stated Resident A was diagnosed as being pre-diabetic many years ago. Since then, his diet was changed and he lost weight. It has never been an issue again and he has never needed insulin, so she doubted if the reaction had anything to do with his sugar. She also suggested that I try interviewing him in person. She explained that he has Cerebral Palsy and it is normally difficult to understand him. His speech is slurred and he has a hearing impairment. She felt I would understand him better if I met with him face to face.

On 04/07/2022, I conducted an onsite inspection at the facility and interviewed Resident A. He again said he was given the wrong medication. He did not know what he took. When asked how he know it was wrong, he said because he got sick.

On 05/13/2022, I made a telephone call to Resident A’s case manager from Community Living Services, Lauren Konowski. She stated Ms. McIver informed her of the incident and told her that Resident A was given the wrong medication. She did know that Resident A also said he was given the wrong medication and stated she would talk to him. She further stated that he has been in the home almost a year and this was the first incident. There had been no other issues with the home.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	Based on the information obtained during this investigation, the allegations are confirmed. Resident A's medications were modified in that he was likely given a medication other that what was prescribed to him. Although Ms. Fraiser did not recall making a medication error, Resident A stated he was given the wrong medication. Staff and his guardian confirmed that the reaction he had was not the normal reaction from taking his regular medications. In addition to this the hospital paperwork conformed that he was brought there due to being given the wrong medication and he was diagnosed as having a medication reaction.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

_____05/26/2022
Regina Buchanan Date
Licensing Consultant

Approved By:

_____06/02/2022
Ardra Hunter Date
Area Manager