GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 11, 2022

Geri Turner
Quality Living, Inc.
PO Box 9
Holly, MI 48442

RE: License #: AS630015369
Investigation #: 2022A0465039
Hidden Lane Home

Dear Ms. Turner:

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,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-514-9391
Fax: 517-763-0204

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630015369
Investigation #:	2022A0465039
Complaint Receipt Date:	06/21/2022
Investigation Initiation Date:	06/22/2022
Report Due Date:	08/20/2022
Licensee Name:	Quality Living, Inc.
Licensee Address:	10947 Erindale Ct. Holly, MI 48442
Licensee Telephone #:	(248) 634-3140
Administrator:	Geri Turner
Licensee Designee:	Geri Turner
Name of Facility:	Hidden Lane Home
Facility Address:	5710 Hidden Lane White Lake, MI 48383
Facility Telephone #:	(248) 887-9863
Original Issuance Date:	10/25/1994
License Status:	REGULAR
Effective Date:	07/11/2020
Expiration Date:	07/10/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 6/19/2022, Resident A sustained second degree burns to her hand when direct care staff, Debra Allen served her a plate of hot food.	Yes

III. METHODOLOGY

06/21/2022	Special Investigation Intake 2022A0465039
06/22/2022	Special Investigation Initiated - Telephone Telephone call to Complainant completed by Cindy Berry
07/13/2022	Contact - Document Received Received an email from Sabrina Ramirez, stating this special investigation has been transferred to me effective today from a consultant on leave.
08/01/2022	Inspection Completed On-site I conducted an onsite investigation, observed Resident A, reviewed Resident A's record, and interviewed direct care staff, Heather Parks
08/01/2022	Contact – Telephone call made I left a voice message for direct care staff, Debra Allen
08/04/2022	Contact – Telephone call made I left a voice message for direct care staff, Debra Allen
08/04/2022	Contact – Telephone call made I spoke to Guardian A1 via telephone
08/04/2022	Exit Conference Conducted an exit conference with licensee, Geri Turner, via telephone
08/11/2022	APS referral Adult Protective Services (APS) referral made

ALLEGATION:

On 6/19/2022, Resident A sustained second degree burns to her hand when direct care staff, Debra Allen served her a plate of hot food.

INVESTIGATION:

On 6/21/2022, an *Incident/Accident Report* was received from the facility, indicating that on 06/19/2022, Resident A's safety needs were not attended to. The incident report indicated that on this date, direct care staff, Debra Allen, served Resident A a hot plate of food. Resident A placed her left hand into the plate and burned her hand. Subsequently, Resident A sustained second degree burns and required medical attention.

On 6/22/2022, AFC Licensing Consultant, Cindy Berry, spoke to Complainant via telephone. Complainant confirmed that the information contained in the complaint is accurate.

On 8/1/2022, I conducted an onsite investigation at the facility. I observed Resident A, reviewed Resident A's record, and interviewed direct care staff, Heather Parks. Resident A was sitting at the kitchen table, eating lunch. Resident A appeared to be adequately dressed and well-groomed.

I reviewed the *Face Sheet* which indicated that Resident A was admitted to the facility on 9/18/2020 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Mental Disability. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, has limited communication skills, requires assistance with personal care tasks and uses a wheelchair for mobility. I reviewed the *Incident/Accident Report,* dated 6/19/2022, which indicated the following:

> On 6/19/2022 at 2:00pm; completed by Debra Allen: Resident A was at the table. Resident A usually starts with utensils and then starts to use her fingers. Food was hot. Resident A put her left hand in the hot food. I put cold water on it, wrapped it up and took her to the ER. Doctor checked her out and sent her home. Will make sure the food it at a safe temperature for clients. Manager was notified.

I reviewed the *McLaren Clarkston Emergency Department Discharge Summary,* dated 6/19/2022, which stated that Resident A was treated for second degree burns of her left hand and discharged back to the facility on the same day.

I interviewed home manager and direct care staff, Heather Parks, who stated that she has worked at the facility for 25 years. Ms. Parks stated, "Resident A eats with her hands primarily. As the home manager, I interviewed Ms. Allen regarding this incident. Ms. Allen informed me that on 6/19/2022, she served Resident A food and forgot to

check the temperature of the food first. Ms. Allen stated that Resident A put her hand into the food and sustained burns. Ms. Allen immediately notified management and transported Resident A to the emergency room. While at the hospital, medical staff applied ointment to Resident A's hand and wrapped it. Resident A's hand is now completely healed. This has never happened before and in order to prevent this from happening again, staff now make sure to check the temperature of all food items, including taking the temperature of the middle of the food, prior to serving the food to Resident A, as well as the other residents."

On 8/1/2022 and 8/4/2022, I attempted to interview Ms. Allen via telephone. I left several voice messages and have not received a return call as of the date of this report.

On 8/4/2022, I spoke to Guardian A1 via telephone. Guardian A1 stated, "I believe this was an honest mistake and it could have happened to anyone. I don't feel staff intentionally did anything wrong." Guardian A1 did not vocalize any concerns related to the personal care, supervision and protection that direct care staff are providing to Resident A.

On 8/4/2022, I conducted an exit conference with licensee designee and administrator, Geri Turner. Ms. Turner stated that Ms. Allen resigned on 8/3/2022, for reasons unrelated to this investigation and is no longer employed by the facility. Ms. Turner is in agreement with the findings of this report.

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:	According to Ms. Parks and the I*ncident/Accident Report,* on 6/19/2022, Ms. Allen served Resident A a plate of food prior to checking the temperature. Subsequently, Resident A placed her hand into the food and sustained second degree burns, which required medical attention. Based on the information above, Ms. Allen did not attend to Resident A's protection and safety needs on 6/19/2022 by failing to ensure that the temperature of the food was a safe temperature prior to serving.
CONCLUSION:	**VIOLATION ESTABLISHED**

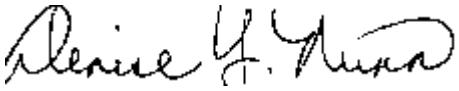
IV. RECOMMENDATION

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

8/11/2022

Stephanie Gonzalez Date
Licensing Consultant

Approved By:



08/11/2022

Denise Y. Nunn Date
Area Manager