GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 13, 2023

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

RE: License #: AS820014227
Investigation #: 2023A0778012
Notre Dame Group 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:

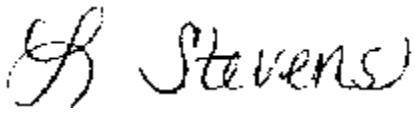
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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.

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,



LaKeitha Stevens, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3055

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820014227
Investigation #:	2023A0778012
Complaint Receipt Date:	01/24/2023
Investigation Initiation Date:	01/26/2023
Report Due Date:	03/25/2023
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:	Notre Dame Group Home
Facility Address:	25530 Notre Dame Dearborn Heights, MI 48127
Facility Telephone #:	(313) 791-2482
Original Issuance Date:	10/02/1989
License Status:	REGULAR
Effective Date:	06/20/2021
Expiration Date:	06/19/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident passed away. On 1/16/23 during a transport by DCW Kenyetta Webb, Resident fell out of her wheelchair. Please investigate to determine if the home aided in Resident's death.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/24/2023	Special Investigation Intake 2023A0778012
01/26/2023	Special Investigation Initiated - Telephone Telephone call made to home manager Nakol Bullard
01/26/2023	Referral - Recipient Rights Referral received
01/26/2023	Referral- Recipient Rights Referral Received
02/07/2023	Contact - Telephone call made. Telephone interviews conducted with Staff Kenyatta Webb and Mukala Broome
02/07/2023	Contact - Telephone call made. Telephone call made to home manager to request paperwork.
02/07/2023	Contact - Document Received Received a copy of Resident A's death certificate.
03/06/2023	Exit Conference Attempted exit conference on 03/06/2023 and 03/08/2023.

03/08/2023	Inspection Completed-BCAL Sub. Non-Compliance
03/13/2023	Exit Conference Telephone exit conference with Patricia Thomas, licensee designee.

ALLEGATION: Resident passed away. On 1/16/23 during a transport by DCW Kenyetta Webb, Resident fell out of her wheelchair. Please investigate to determine if the home aided in Resident's death.

INVESTIGATION: On 01/26/2023, I made a telephone call to Nakol Bullard, home manager. She stated she was informed Resident A fell out of her wheelchair in the company vehicle. She stated staff told her she did not do the tie downs because she became distracted. When asked about the tie downs, Ms. Bullard stated Resident A was not secured with the strap that goes across her lap and chest. Ms. Bullard stated she has received no confirmation of cause of death.

I made a telephone call to the sister of Resident A. She stated she was informed staff did not buckle her sister in properly while on a transport. In addition, she stated she was informed her sister was also transported back to the facility before being transported to ER. Upon arrival to ER her sister was admitted to the hospital. She stated the ER doctor called her and stated her sister had bruising, hematoma to the right frontal lobe, lacerations to her left frontal lobe. She stated she was informed the bleeding was controlled on the lacerations, but they could not control the bleeding to the inside of the large hematoma. Resident A's sister stated she would forward a copy of the death certificate once it's received.

On 02/07/2023, I completed a telephone interview with staff Kenyatta Webb. Ms. Webb stated she was transporting Resident A for an appointment and forgot to put the tie down seatbelt on her. She stated she became distracted but does not recall what distracted her. According to Ms. Webb, she drove down the street and was stopping at a light when Resident A fell and hit her head on the tie down based on the floor. Ms. Webb stated she called the facility and requested one of her co-workers to come and assist her with Resident A. Ms. Webb stated after receiving assistance, she took Resident A back to the facility. When asked about bruising, Ms. Webb stated she noticed 2 cuts in Resident A's head. According to Ms. Webb, while at the facility she cleaned Resident A's scalp, called her home manager and upon direction of her home manager, she took Resident A to Henry Ford Emergency Room. According to Ms. Webb she has been employed with the agency since August 2018. She again stated she's not sure what happened. She stated she remembers being distracted while putting Resident A in the van but cannot recall what the distraction was.

On 02/07/2023, I completed a telephone interview with staff Mukala Broome. Ms. Broome stated she arrived at the van and saw Resident A sitting with her back to the inside of the van and her wheelchair was a few inches away from her. She stated she helped to get her back in her chair and secure her. According to Ms. Broome Resident A was awake/alert and speaking. However, she noticed cuts in the top of her head that looked deep. She stated staff Kenyatta Webb was panicking and stated she fell because she didn't have the strap around her to prevent her from falling.

I received a copy of Resident A's death certificate. The cause of death was listed as acute subdural hematoma and fall. The manner of death was listed as an accident.

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:	Resident A's protection and safety was not adhered too while being transported. Staff Kenyatta Webb was transporting Resident A without properly securing her. As a result of not being secure, Resident A fell out of her wheelchair during transport. Resident A's cause of death was acute subdural hematoma and fall.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: During my interview with staff Kenyatta Webb, she indicated Resident A fell out of wheelchair because of not being properly secured. Ms. Webb called staff from the facility to come and assist her with Resident A. Ms. Webb stated she observed cuts to the head of Resident A. However, she took Resident A back to the facility and contacted the home manager for direction prior to seeking emergency treatment for Resident A.

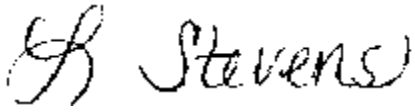
APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**

ANALYSIS:	Staff Kenyatta Webb did not demonstrate the capability to appropriately handle the emergency with Resident A. According to staff Mukala Broome, Ms. Webb was panicking when she arrived to assist her. Despite seeing the cuts to the head of Resident A, Ms. Webb took her back to the facility and contacted the home manager who then told her to take Resident A for emergency treatment and evaluation.
CONCLUSION:	**VIOLATION ESTABLISHED**

I've attempted a telephone exit conference with Ms. Patricia Thomas, licensee designee. I left a detailed voice message for her on 03/06/2023 and 03/08/2023. I was informed Ms. Thomas is out of the office. On 03/13/2023, I completed a telephone exit conference with Ms. Thomas. She stated she is saddened with the death of Resident A; she understood my recommendation and will work on submitting a corrective action plan upon receipt of the report.

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan, I recommend the status of the license is changed to provisional.



03/13/2023

LaKeitha Stevens Date
Licensing Consultant

Approved By:

03/13/2023

Ardra Hunter Date
Area Manager