GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 6, 2024

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

RE: License #: AS820407565
Investigation #: 2024A0992014
Gulley II

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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820407565
Investigation #:	2024A0992014
Complaint Receipt Date:	12/21/2023
Investigation Initiation Date:	12/26/2023
Report Due Date:	02/19/2024
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:	Gulley II
Facility Address:	34396 Parkgrove Westland, MI 48185
Facility Telephone #:	(734) 762-0338
Original Issuance Date:	10/11/2021
License Status:	REGULAR
Effective Date:	04/11/2022
Expiration Date:	04/10/2024
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 12/15/2023, Staff 3 was sleeping on the couch during her shift. Medications were not passed, and the residents were soiled.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/21/2023	Special Investigation Intake 2024A0992014
12/21/2023	APS Referral
12/26/2023	Special Investigation Initiated - Telephone Complainant not available, message left.
12/27/2023	Inspection Completed On-site Staff 1 and Staff 2, direct care staff
12/27/2023	Contact - Telephone call made Tina King, home manager
01/02/2024	Contact - Telephone call made Patricia Thomas, licensee designee was not available. Message left.
01/02/2024	Contact - Telephone call received Ms. Thomas
01/05/2024	Contact - Telephone call made Staff 4, former direct care staff.
01/05/2024	Contact - Telephone call made Staff 3, direct care staff
01/05/2024	Referral - Recipient Rights
01/05/2024	Contact - Telephone call made Relative D, Resident D's guardian
01/10/2024	Exit Conference

	Ms. Thomas was not available, message left.
01/11/2024	Exit Conference Ms. Thomas
02/02/2024	Contact - Telephone call made Relative A, Resident A's guardian
02/02/2024	Contact - Telephone call made Patricia Habibi, Resident C's guardian with Faith Connections.
02/02/2024	Contact - Telephone call made Relative B, Resident B's guardian

ALLEGATION: On 12/15/2023, Staff 3 was sleeping on the couch during her shift. Medications were not passed, and the residents were soiled.

INVESTIGATION: On 12/27/2023, I completed an unannounced onsite inspection Staff 1 and Staff 2, were on shift. Staff 1 and Staff 2 denied having knowledge of the allegation; both stated they were not shift on 12/15/2023. While onsite Staff 1 contacted Tina King, home manager, and I interviewed her regarding the allegation. Ms. King confirmed the allegation. She said she received a telephone call from Staff 4 on 12/15/2023 stating when she arrived on shift Staff 3 was asleep in the recliner and she did not administer medications, complete progress notes and the residents were soiled. Ms. King said the medications were immediately administered by Staff 4 so, they were given timely. However, the residents were soiled. Ms. King said from what she understands, Staff 3 was not feeling well and failed to do her job. Ms. King said she has not had a chance to address the allegations with Staff 3 because she was previously scheduled off for a week of vacation time. Ms. King said the allegation will be addressed as soon as she returns. As far as the residents, Ms. King said Resident A is nonverbal and Residents B, C, and D have limited verbal skills Ms. King agreed to provide me contact information for Staff 3, and Staff 4.

I requested to review the medication administration records (MARs); I reviewed three months of MARs. No discrepancies were noted for Residents A, B, and D. As it pertains to Resident C, the following medications were not initialed:

DOK CAP100MG LTC; take one capsule by mouth twice a day, was not initialed on 11/22/2023, 11/23/2023 at 8:00 a.m.

SIMVASTATIN TAB 40MG; take 1 tablet by mouth once daily, was not initialed on 11/23/2023 at 8:00 a.m.

MULTIVITAMIN WITH IRON; take 1 tablet by mouth once daily, was not initialed on 11/23/2023 at 8:00 a.m.

LORATADINE TAB 10MG; take 1 tablet by mouth daily, was not initialed on 11/23/2023 at 8:00 a.m.

BETHANECHOL TAB 25MG; take 1 tablet by mouth 4 times daily, was not initialed on 11/23/2023 at 8:00 a.m. or on 11/30/2023 at 4:00 p.m.

LISINOPRIL 10MG TABS; take 1 tablet by mouth once daily, was not initialed on 11/23/2023, 11/25/2023, 11/26/2023 at 8:00 a.m.

On 01/02/2024, I contacted Patricia Thomas, licensee designee, and interviewed her regarding the allegation. Ms. Thomas said she was previously made aware of the allegations by Ms. King. She said based on the information she received; medications were passed timely by Staff 4. Ms. Thomas said this situation will also be addressed with Staff 3. I made Ms. Thomas aware that while onsite I reviewed the MARs and although there were no discrepancies noted for Residents A, B, and D; there were several medications that were not initialed for Resident C. Ms.

Thomas agreed to investigate the medication issues. I made Ms. Thomas aware that I will contact her for an exit conference upon completion of the investigation.

On 01/05/2024, I contacted Staff 4 and interviewed her regarding the allegation, which she confirmed. She said on 12/15/2023, she arrived onsite at approximately 7:45 a.m. for shift. Staff 4 said it was very dark, and the shades were closed. She said Staff 3 was balled up in the chair and she stated she did not feel well. Staff 4 said she asked Staff 3 if she checked on the residents and she said no. Staff 4 said she went to check on the residents and they were all soiled. She said Residents A and D are ambulatory but need reminders for toileting, she said it was obvious they were not toileted throughout the night. Staff 4 said she had to change Resident C and B's bedsheets because they were so soiled. Staff 4 said she proceeded to administer the morning medications for all the residents. She said Staff 3 said she had to go because she was not feeling well. Staff 4 said she asked Staff 3 if she had notified Ms. King that she was not feeling well, and she said no. Staff 4 said it is normal protocol to contact the manager for situations like this so that she can find coverage for the shift. Staff 4 said Staff 1 did come in an hour and a half later to assist her. I asked Staff 4 about the staffing ratio, she said for the last month or so, it has been 1:4. She said there has been issues with being short staffed. Staff 4 said she had previously retired from the company but returned to help as a direct care worker. She said as of 12/20/2023, she resigned because it became too stressful.

On 01/05/2024, I contacted Staff 3 and interviewed her regarding the allegation. Staff 3 denied the allegation, but confirmed she was not feeling well. She said she made Ms. King aware that she was not feeling well prior to her shift (she was uncertain about the date, but stated she had previous conversation with Ms. King about not feeling well). Staff 3 said due to the home being short staff, she agreed to work anyway. Staff 3 confirmed she worked the midnight shift on 12/14/2023. I asked if she administered morning medications on 12/15/2023, and she said no. She said she was not feeling well, and Staff 4 administered the resident's medications when she arrived. I asked Staff 3 if she normally administer morning medications before her shift ends when she work midnights, and she said yes. However, she said sometimes the day shift (8:00 a.m. to 4:00 p.m.) staff will come in and assist the midnight staff by administering medications, which is what Staff 4 did. Staff 3 said as a team they help each other out if needed. She said Staff 4 noticed she was not feeling well and told her to go ahead and go home. I asked Staff 3 if she toileted the residents as required during her shift and she said, she was not feeling well. I asked Staff 3 if she toileted the residents as required during her shift, and she said she toileted Residents A and D; and Staff 4 tended to Residents B and C when she arrived for her shift. She said she changed Residents B and C through the night so they should not have been soiled. I asked if she called Ms. King during her shift to let her know she was not feeling well, and she said no. Throughout the interview, Staff 3 repeatedly said she did not feel well, she said she had influenza (Flu) like symptoms and a urinary tract infection (UTI) and could not perform her work duties including complete case notes, administer medications and/or toilet Residents B and C. Staff 3 said Ms. King was fully aware she was not feeling well because they

discussed it the day before when Staff 6 had called off and she asked her to cover her shift.

On 01/05/2024, I contacted Relative D, Resident D's guardian, and made her aware of the allegation. Relative D denied she was aware of the allegation. She said Resident D is relatively new to the home and that she previously lived in another one of the corporation's facilities. Relative D denied having any concerns at this time.

On 01/11/2024, I completed an exit conference with Ms. Thomas. I made her aware based on the investigative findings there is sufficient evidence to support the allegations. I explained that based on my interview with Staff 3, she knowingly came to work sick and was unable to meet the physical needs of the residents. In addition, I made her aware that upon review of the MARs, Resident C's medications were not initialed, and no explanation was provided. Due to the violations, I made Ms. Thomas aware that a written corrective action plan is required, which she agreed to provide.

On 02/02/2024, I contacted Relative A, Resident A's guardian, and interviewed her regarding the allegation. Relative A denied having any knowledge of the allegation. She said Relative A seems to be well taken care of and the staff seem to love her. She said Relative A is non-verbal, so she visits as often as she can, and she calls regularly to check on her. Relative A went on to say she last visited with Resident A two weeks ago and there were no concerns. She said Resident A is always well-groomed, the home is always clean and cozy. Relative A denied having any concerns.

On 02/02/2024, I contacted Patricia Habibi, Resident C's guardian with Faith Connections; I interviewed her regarding the allegation. Ms. Habibi said she was made aware of the allegation by Ms. King. She said Ms. King made her aware that the staff that neglected her duties is no longer employed with the company. Ms. Habibi said on another note, the reported facility is one of her better facilities and the residents are always well-groomed and well-nourished. She said although her main concern is Resident C, she observes the other residents as well. Ms. Habibi said the home is always clean and well-maintained. Ms. Habibi denied having any concerns.

On 02/02/2024, I contacted Relative B, Resident B's guardian, and interviewed her regarding the allegation. Relative B said she is actively involved in Resident B's care; she said she visited with her last Saturday. Relative B said Resident B has been in the home for over 30 years and she has never received a call or complaint on the home. Relative B said Ms. King is "no nonsense" and she takes great care of the residents. Relative B denied having any concerns.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	During this investigation, I interviewed Patricia Thomas, licensee designee; Tina King, home manager; Staff 1, Staff 2, Staff 3, Staff 4, Relative A, Resident A's guardian; Relative B, Resident B's guardian; Relative D; Resident D's guardian and Patricia Habibi, Resident C's guardian with Faith Connections. Throughout the interview Staff 3 repeatedly stated on 12/15/2023, she did not feel well, she said she had Flu like symptoms, a urinary tract infection (UTI) and could not perform her work duties including complete case notes, administer medications and/or toilet Residents B and C. Staff 4 also stated on 12/15/2023, when she arrived onsite that morning medications had not been administered and the residents were soiled. Based on the investigative findings, there is sufficient evidence that Staff 3 was not suitable to meet the physical, needs of each resident. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION: On 12/27/2023, I reviewed three months of MARs. The following medications were not initialed for Resident C:

DOK CAP100MG LTC; take one capsule by mouth twice a day, was not initialed on 11/22/2023, 11/23/2023 at 8:00 a.m.

SIMVASTATIN TAB 40MG; take 1 tablet by mouth once daily, was not initialed on 11/23/2023 at 8:00 a.m.

MULTIVITAMIN WITH IRON; take 1 tablet by mouth once daily, was not initialed on 11/23/2023 at 8:00 a.m.

LORATADINE TAB 10MG; take 1 tablet by mouth daily, was not initialed on 11/23/2023 at 8:00 a.m.

BETHANECHOL TAB 25MG; take 1 tablet by mouth 4 times daily, was not initialed on 11/23/2023 at 8:00 a.m. or on 11/30/2023 at 4:00 p.m.

LISINOPRIL 10MG TABS; take 1 tablet by mouth once daily, was not initialed on 11/23/2023, 11/25/2023, 11/26/2023 at 8:00 a.m.

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: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	At the time of inspection, I reviewed Resident C MARs. I observed several medications that were not initialed by the person who administered the medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

02/02/2024

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Denasha Walker Date
Licensing Consultant

Approved By:

02/06/2024

_____

Ardra Hunter Date
Area Manager