GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 6, 2024

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

RE: License #: AS820405972
Investigation #: 2024A0116038
Troy

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,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820405972
Investigation #:	2024A0116038
Complaint Receipt Date:	07/12/2024
Investigation Initiation Date:	07/16/2024
Report Due Date:	09/10/2024
Licensee Name:	Quest, Inc
Licensee Address:	36141 Schoolcraft Road Livonia, MI 48150-1216
Licensee Telephone #:	(734) 838-3400
Administrator:	Michelle Smith
Licensee Designee:	Patricia Thomas
Name of Facility:	Troy
Facility Address:	15149 Troy St. Taylor, MI 48180
Facility Telephone #:	(734) 946-4971
Original Issuance Date:	11/08/2021
License Status:	REGULAR
Effective Date:	05/08/2024
Expiration Date:	05/07/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
On 07/08/2024, Resident A choked while eating. The concern is that the staff did not adhere to his feeding guidelines.	Yes

III. METHODOLOGY

07/12/2024	Special Investigation Intake 2024A0116038
07/12/2024	APS Referral Received.
07/12/2024	Referral - Recipient Rights Made by APS reporting source.
07/16/2024	Special Investigation Initiated - On Site Interviewed area supervisor, Michelle Smith, visually observed Resident A, interviewed Residents B and C, and reviewed Resident A's Individual Plan of Service (IPOS) and eating guidelines.
07/17/2024	Contact - Document Received Staff, Mildred Dunagan, training and in-service training on Resident A’s IPOS and eating guidelines.
07/26/2024	Contact - Telephone call made Interviewed staff, Mildred Dunagan.
07/26/2024	Contact - Telephone call made Interviewed Resident A's support coordinator, Hanna Martens.
07/26/2024	Contact - Telephone call made Interviewed staff, Joshua Shamly.
07/26/2024	Inspection Completed-BCAL Sub Compliance
07/30/2024	Exit Conference With licensee designee, Patricia Thomas.

ALLEGATION:

On 07/08/2024, Resident A choked while eating. The concern is that the staff did not adhere to his feeding guidelines.

INVESTIGATION:

On 07/16/24, I conducted an unscheduled on-site inspection and interviewed area supervisor, Michelle Smith, visually observed Resident A, and interviewed Residents B and C. Ms. Smith reported that she was not at the facility at the time of the incident, however, reported that staff, Joshua Shamly, called and informed her of what occurred. Ms. Smith reported that on 07/08/24, while eating dinner, Resident A choked and staff, Joshua Shamly, performed the Heimlich maneuver. Ms. Smith reported the food came up and Resident A was fine. Ms. Smith reported that Mr. Shamly called 911, however, when emergency medical services (EMS) arrived Resident A was okay, so they assessed him and determined he did not require any further treatment.

Ms. Smith reported that during the internal investigation, she found out that staff, Joshua Shamly, was outside on a call and staff, Mildred Dunagan, was in the kitchen. She reported based on Resident A's IPOS and eating guidelines staff is required to be at the table with him, reminding him to chew and swallow each bite before taking another. Ms. Smith reported that staff, Joshua Shamly, should have been aware of the eating guidelines for Resident A and he was in-serviced on Resident A's IPOS, which references the eating guidelines, on 06/13/24 when Resident A was admitted into the facility. Ms. Smith reported that Ms. Dunagan is a new staff, so she may not have been fully aware as she is still in training and is shadowing trained staff.

Ms. Smith reported that recipient rights has been to the facility and are investigating the matter. Ms. Smith reported that she submitted verification of the recent in-service she conducted with staff, of Resident A's eating guidelines, on 07/11/24 to the recipient rights investigator and reported she will also forward to me.

I visually observed Resident A as he could not be interviewed due to his developmental disability. Resident A was neatly dressed and groomed.

I interviewed Resident B and he reported that he observed Resident A choking at the table. Resident B reported they were eating spareribs, macaroni and cheese and vegetables. Resident B reported Resident A choked on the meat. Resident B reported that he does not recall where either staff were in the house at the time, and reported that staff, Joshua Shamly, ended up helping Resident A. Resident B reported that EMS came to the facility and looked at Resident A, but did not take him to the hospital because he was okay. Resident B reported that since this incident staff has been sitting at the table next to Resident A at every meal.

I interviewed Resident C and he reported that he was at the table eating dinner and saw Resident A gagging. He reported that staff, Joshua Shamly, was outside on the porch, and does not know where staff, Mildred Dunagan was in the facility. Resident C reported that he knew Resident A was going to regurgitate, so he left the table and went to his bedroom. Resident C reported that he heard that staff, Joshua Shamly,

helped Resident A and reported that he is glad he is okay. Resident C reported that staff sit at the table next to Resident A at every meal now and there has not been any other issues.

I reviewed Resident A's IPOS dated 11/08/23 and his eating guidelines dated 08/02/22. The IPOS documents:

> *Staff are to follow the most recent eating guidelines, completed by John DuBois of Futures, as well as all subsequent reports and guidelines, being implemented to address Resident A's tendency to choke. SLP to monitor guidelines annually and revise as needed. Resident A's eating guidelines are not current. The prescription was recently obtained. Supports coordinator will authorize SLP services.*

Resident A's eating guidelines document:

1. *Staff should be seated at the table with Resident A when he is eating.*
2. *Verbally remind Resident A to chew and swallow each bite before taking another one.*
3. *Remind Resident A to take a drink after every few bites of food.*
4. *Monitor for signs and symptoms of aspiration including but not limited to coughing, gagging, wet/gurgly vocal quality, increased temperature, watery eyes, or a runny nose.*
5. *Notify PA and SLP if signs/symptoms of aspiration are present or if there are any changes in Resident A's ability to eat.*

On 07/17/24, I received and reviewed staff, Mildred Dunagan, direct care training. I also received and reviewed verification of in-service training on Resident A's eating guidelines dated 07/11/24 for all staff. I also received and reviewed verification of in-service training on Resident A's IPOS dated 06/14/24 for five staff and 07/12/14 for the remaining five staff. The verification documents that staff, Joshua Shamly, was in-serviced on Resident A's IPOS on 06/13/24 and the eating guidelines on 07/11/24. Staff, Mildred Dunagan, was not in-serviced on Resident A's eating guidelines until 07/11/24 and his IPOS on 07/12/24. Resident A was admitted into the facility on 06/14/24.

On 07/26/24, I interviewed staff, Mildred Dunagan, and she reported that she has worked at the facility for almost two months and only needs to complete cardiopulmonary resuscitation, first aid and medication training and she will be fully trained. Ms. Dunagan reported that she has been shadowing trained staff and learning the residents. Ms. Dunagan reported that she worked the afternoon shift (4:00 p.m. -12:00 a.m.) on 07/08/24, with staff, Joshua Shamly. Ms. Dunagan reported that during dinner, the residents were all at the table eating. She reported that she was in the kitchen putting the dishes up, and staff, Joshua Shamly, had stepped outside on the porch. Ms. Dunagan reported that all of a sudden, she heard Resident A start to choke and she yelled for Mr. Shamly, who immediately came

inside, called 911 and preformed the Heimlich maneuver on Resident A. Ms. Dunagan reported that Resident A regurgitated and once the lodged food came out, he was fine. She reported that EMS arrived and assessed Resident A and left.

Ms. Dunagan reported that when she started working in the facility Resident A had not been admitted. She reported that she had been trained on the IPOSs of all of the other residents and was aware of their needs. Ms. Dunagan reported that she had not been trained on Resident A's IPOS and was not aware that he had eating guidelines. Ms. Dunagan reported that all she was told was to cut Resident A's food into bite-size pieces. Ms. Dunagan reported that none of the staff she had previously worked with told her that staff was supposed to be sitting at the table with Resident A every time he is eating or that staff had to remind him to chew his food good and to take a drink after every few bites. Ms. Dunagan reported that since the incident she has been in-serviced on Resident A's IPOS and eating guidelines. Ms. Dunagan also reported that Resident A's eating guidelines are now posted on the refrigerator.

On 07/26/24, I interviewed supports coordinator, Hanna Martens, and she reported that prior to Resident A moving into the facility, she in-serviced the then facility manager, Ashley Smith, on Resident A's IPOS. Ms. Martens reported that the facility manager no longer works for the company. Ms. Martens reported that the IPOS documents Resident A's tendency to choke and for staff to follow Resident A's eating guidelines, which were also provided. Ms. Martens reported that it is the responsibility of the facility manager to in-service all staff, which she reported appears to not have happened. Ms. Martens reported that she has received the prescription for an updated swallow test for Resident A as well as updated eating guidelines. Ms. Martens reported that the staff are still required to follow the eating guidelines that were in place at the time of Resident A's admission into the facility, until the new ones are received. Ms. Martens reported that since Resident A is in a licensed facility, the eating guidelines will now be updated annually.

On 07/26/24, I interviewed staff, Joshua Shamly, and he reported that on 07/08/24, he worked the afternoon shift with staff, Mildred Dunagan. Mr. Shamly reported that he stepped out onto the porch to take an emergency phone call pertaining to his daughter. He reported that while on the call staff, Mildred Dunagan, was calling for him and told him that Resident A was chocking. Mr. Shamly reported that he called 911 and his training kicked in. Mr. Shamly reported he performed the Heimlich maneuver and the food that Resident A was choking on, dislodged and came up. He reported by the time EMS arrived Resident A was fine. Mr. Shamly reported that EMS conducted a medical assessment of Resident A, determined he was okay, and left.

Ms. Shamly reported that although he was in-serviced on Resident A's IPOS prior to his admission, he reported that the IPOS did not provide the specific steps that staff should take to ensure Resident A does not choke while eating. Mr. Shamly reported that the then facility manager, Ashley Smith, only told him that Resident A's food should be cut into bite size pieces. Mr. Shamly reported that since the incident all

staff have been in-serviced on Resident A's eating guidelines and reported that they are also posted on the refrigerator. Mr. Shamly reported that he is sitting at the table next to Resident A, every time he eats, during his shifts.

On 07/30/24, I conducted the exit conference with licensee designee, Patricia Thomas, and informed her of the findings of the investigation. Ms. Thomas reported an understanding of the rule cited and reported that she would submit an acceptable corrective action plan.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.
ANALYSIS:	Based on the findings of the investigation, which included interviews of area supervisor, Michelle Smith, Residents B and C, staff, Mildred Dunagan, Joshua Shamly, supports coordinator, Hanna Martens, and my review of Resident A's IPOS and eating guidelines, I am able to corroborate that Resident A's IPOS and eating guidelines were not implemented.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Parchea Robinson

_ 08/06/24

Pandrea Robinson
Licensing Consultant

Date

Approved By:

08/06/24

_____

Ardra Hunter
Area Manager

Date