GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 17, 2024

Jasmine Boss
JARC
Suite 100
6735 Telegraph Rd
Bloomfield Hills, MI 48301

RE: License #: AS630095511
Investigation #: 2024A0465035
Pitt

Dear Ms. Boss:

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 (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: 248-308-6012
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 #:	AS630095511
Investigation #:	2024A0465035
Complaint Receipt Date:	08/08/2024
Investigation Initiation Date:	08/14/2024
Report Due Date:	10/07/2024
Licensee Name:	JARC
Licensee Address:	Suite 100 6735 Telegraph Rd Bloomfield Hills, MI 48301
Licensee Telephone #:	(248) 940-9617
Administrator:	Jasmine Boss
Licensee Designee:	Jasmine Boss
Name of Facility:	Pitt
Facility Address:	5920 Indianwood Tr Bloomfield Twp, MI 48301
Facility Telephone #:	(248) 865-7862
Original Issuance Date:	11/20/2001
License Status:	REGULAR
Effective Date:	11/15/2022
Expiration Date:	11/14/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 2/27/2204, direct care staff, Dorothy Harris and Kahra-Lyn Cobbler, failed to obtain needed medical care for Resident A. Resident A was pronounced deceased at 3:00am.	Yes

III. METHODOLOGY

08/08/2024	Special Investigation Intake 2024A0465035
08/08/2024	APS Referral Adult Protective Services Referral denied
08/14/2024	Special Investigation Initiated - Telephone I spoke to Complainant via telephone
08/19/2024	Inspection Completed On-site I conducted an onsite investigation; Home is vacant and under renovations
08/21/2024	Contact - Telephone call made I spoke to Office of Recipient Rights Officer, Amanda Clasman, via telephone
08/21/2024	Contact - Document Received Documents received via email from Amanda Clasman
08/23/2024	Contact - Document Received Facility documents received via email from Shula Kantrowitz
08/29/2024	Contact - Document Received Documents received from ORR Specialist, Amanda Clasman, via email
09/10/2024	Contact - Telephone call made I attempted to speak to direct care staff, Dorothy Harris; Requested a return call
09/16/2024	Contact - Telephone call made I attempted to interview direct care staff, Kahra-Lyn Cobbler; no voicemail set up.

09/18/2024	Contact - Document Sent Email exchange with Detective David VanKerckhove
09/20/2024	Contact - Telephone call made Email exchange with Guardian A1
09/26/2024	Contact - Telephone call made I spoke to Detective David VanKerckhove, via telephone
09/30/2024	Contact - Telephone call made Attempted to call Kahra-Lyn Cobbler; Phone number is not in working service
10/01/2024	Contact - Document Received Document received from Amanda Clasman via email
10/03/2024	Contact - Telephone call made I spoke to direct care staff, Dorothy Harris, via telephone
10/03/2024	Contact - Telephone call made I spoke to direct care staff, Kahra-Lyn Cobbler, via telephone
10/03/2024	Contact - Telephone call made I spoke to Dr. Daniel Spitz, medical examiner/coroner, via telephone
10/03/2024	Contact - Telephone call made I spoke to Guardian A1 via telephone
10/03/2204	Contact – Document sent Email exchange with Detective David VanKerckhove
10/03/2024	Exit Conference I conducted an exit conference with licensee designee/ administrator, Jasmine Bell, via telephone

ALLEGATION:

On 2/27/2204, direct care staff, Dorothy Harris and Kahra-Lyn Cobbler, failed to obtain needed medical care for Resident A. Resident A was pronounced deceased at 3:00am.

INVESTIGATION:

On 8/8/2024, a complaint was received, alleging that on 2/27/2024, direct care staff, Dorothy Harris and Kahra-Lyn Cobbler, failed to obtain needed medical care for Resident A. The complaint stated the following: Resident A had a history of Down Syndrome and obesity. Resident A's cause of death on 2/27/2024 was pneumonia and asphyxiation. At the time of Resident A's death, direct care staff, Dorothy Harris, was on duty. An autopsy was completed, and it was determined that there was a delay in obtaining medical care for Resident A, which resulted in her death.

On 8/14/2024, I spoke to Complainant, who confirmed the information contained in this complaint is accurate.

On 8/19/2024, I conducted an onsite investigation at the facility. However, upon arrival, the home was vacant due to renovations being completed.

On 8/21/2024, 8/29/2024 and 10/1/2024, I spoke to Office of Recipient Rights Specialist, Amanda Clasman, via email exchange. Ms. Clasman stated that she has completed an investigation of this complaint. Ms. Clasman found sufficient information to confirm this allegation is true. Ms. Clasman stated that she substantiated Ms. Harris for Neglect Class I.

On 8/23/2024, I received facility documents via email from Chief Administrative Officer, Shula Kantrowitz.

The *Face Sheet* indicated that Resident A resided at the facility from 4/28/2021 – 2/27/2024, and had a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Developmental Disability, Bipolar and Seizure Disorder.

I reviewed the *Easter Seals MORC Clinical Progress Notes*, which indicated the following:

- *1/24/2024 at 4:30pm; Completed by Bethany Shay: Face to face encounter with*
- *Resident A (at the facility). Resident A appeared to be in good hygiene, but staff (Qweenie Guy) reported Resident A has been sick with a cold, which has led to decreased activity.*
- *2/23/2024 at 1:00pm; Completed by Laysha Cooks: The purpose of the meeting was to conduct monthly monitoring. Present at the meeting were Resident A and home*

manager, Theresa Saunders). Theresa mentioned that Resident A has been doing ok, but unfortunately, she has been unwell with a cold.

The *Staff Log Notes* indicated the following:

- *2/23/2024 between 8:00am – 9:00am; Completed by Theresa Saunders: Taken to living room. Resident A given medication. Noticed slight cough.*
- *2/23/2024 at 8:00am – 10:00am; Completed by Kahra-Lyn Cobbler: Came in to check on house. Prepping for the move next week. Theresa Saunders mentioned Resident A's cough; said she will be calling doctor.*
- *2/23/2024 between 8:30am – 9:00am; Completed by Detrice McBride: Noticed Resident A's had a cough.*
- *2/23/2024 between 9:00am – 12:00pm; Completed by Theresa Saunders: {Resident A's} cough progressed. Called Dr. Yashinsky (he was out sick; his nurse sent him a message and he could get back to us). Continued to monitor.*
- *2/23/2024 at 12:58pm; Completed by Theresa Saunders: Dr. Yashinsky called back; left message. Instructions followed.*
- *2/23/2024 between 12:00pm – 2:00pm; Completed by Kahra-Lyn Cobbler: Theresa Saunders called the doctor and told me the instructions given. Asked if Theresa called the family. She said she was going to.*
- *2/23/2024 between 1:00pm – 3:30pm; Completed by Theresa Saunders: Guardian A2 was contacted; Told Resident A had a cough. Made aware Dr. Yashinsky was called. Informed her we are to give fluids and cough medicine. Guardian A2 said, "ok, thank you for letting me know, just want to know what's going on with Resident A."*
- *2/26/2024 between 7:00am – 8:00am; Completed by Theresa Saunders: Was told that Resident A threw up by staff; Resident A was in bed. Did bed check.*
- *2/26/2024 between 9:00am – 12:00pm; Completed by Theresa Saunders: No significant change. {Resident A} did not appear any better or any worse. Called Dr. Yashinsky (still out sick). Nothing alarming, waited for doctor to call back.*
- *2/26/2024 between 12:00pm – 4:00pm; Completed by Theresa Saunders: Kept monitoring {Resident A} and giving fluids.*
- *2/26/2024 between 3:35pm and 7:05am; Completed by Dorothy Harris: Resident A was sitting in her chair when I arrived at the home. So, I gave her 4:00 meds and then about a half hour late direct care staff Lisa Rutland fixed her dinner and then I feed her and she ate and drank 1/25 of her drink and then she was sitting in her chair wheezing and coughing so I gave her 1 dose (cough medication) on her prn and waited for reaction, her vitals were 120,102/117 and while I waited, I passed her 8:00pm meds and she took them then I watched her after last prn and I changed her at 10:20pm. She fell asleep, and she was talking and moving yet so I kept on monitoring her for health and safety. 120/102/117 then around 1:40am I checked her again and heart rate slow.*

I read the email exchange between Ms. Saunders and Christine McClue (JARC Staff) on 2/26/2024 between 11:05am – 11:39am, which indicated the following:

- 2/26/2024 at 11:05am; From Ms. Saunders to Ms. McClue: Good morning, Christine. I just got a call from Dr. Goldman's office stating that they had to cancel Resident A's appt until April 11th at 10:00am. I am wondering is this too far out? Should I call Dr. Yashinsky and ask to make it urgent? HELP?
- 2/26/2024 at 11:30am; From Ms. McClue to Ms. Saunders: Please notify Dr. Yashinsky, when the reschedule appointment is scheduled. He can direct what to do.
- 2/26/2024 at 11:39am; From Ms. Saunders to Ms. McClue: Ok. Called the office and doctor is still out sick but they did leave him a message about this situation. Last time they did this, he did call me back and left me a message, so I am hoping for the same response.

I listened to the voicemail from Dr. Yashinksy to the facility, on 2/23/2024 at 12:58pm, regarding Resident A's cough, which stated the following:

> "Hi. Dr. Yashinksy returning your call about {Resident A}. You could try just some Robitussin DM. I assume her cough is sort of dry and irritating and not productive. I assume she's not sick with fever and in which case, I would just try to treat the cough with more fluid and Robitussin. Call me on Monday if she needs more help or needs to be seen."

The *Incident/Accident Reports*, which indicated the following:

> *2/27/2024 at 1:40am; Completed by Dorothy Harris: Resident A was acting different, so I went and check her vital and it was 120 – 102 BP, normal for her when she sleep so I called on-call because she was moving different. So, when I went to talk to her. When we came back into the room, she wasn't moving at all so ask. {Ms. Cobbler} did CPR. I called 911 and waited.*
>
> *2/27/2024 at 2:30am; Completed by Kahra-Lyn Cobbler: I received a call from Ms. Harris on the on-call phone. Resident A was not acting herself. Ms. Harris checked her vitals. They were in the normal range but wanted to let me know she seemed off. Because vitals were good, I decided to come in myself to check on Resident A. I arrived just after 2:30am. As soon as I saw Resident A, I started with checks and yelled her name. She did not react. Immediately I started CPR and instructed Ms. Harris to call 911. I continued CPR until help showed up.*

The *Bloomfield Township Fire Department Incident Report #240000965*, dated 2/27/2024, stated the following:

> *2/27/2204 at 2:46am: BTFD Station 3 dispatched emergent to a group home for Resident A in cardiac arrest. Found Resident A on ground in living room, pale and*

cold to the touch. Staff stated Resident A hadn't been feeling well for last week, but around 1:30am this morning, Resident A was found on the ground. Staff states that Resident A wasn't responding normally but they did not call EMS. At 2:40am, they called EMS because she was not breathing. Assessment finds Resident A asystole and cold to the touch, rigor mortis set in on the jaw and EMS was unable to get jaw open. Mechanical CPR initiated by EMS. Resident A never left asystole on monitor. Staff states downtime was at least an hour. Dr. Taqi notified of situation and gave time of death of 3:00am. CPR halted.

The *Bloomfield Township Police Department Case Report #240004040*, dated 2/27/2204, stated the following:

2/27/2024 at 2:40am; Completed by Officer Tyler Retford and Officer Cody Denison: I was dispatched the facility for a CPR in progress. I arrived on scene with BTFD where JARC group home district manager Kahra-Lyn Cobbler was giving CPR to Resident A on the living room floor. At this time, BTFD took over and began providing life saving measures to Resident A. BTFD later contacted Trinity Health Oakland Hospital and Dr. Taqi pronounced Resident A deceased at 0300 (3:00am) hours. Resident A's medical history included dementia, intellectual disability, bipolar, and down syndrome. I observed the body and there were no signs of trauma. {Interview with Dorothy Harris} Dorothy Harris advised that Resident A had a cold which had spread to various residents of the group home. Resident A was sleeping in a living room chair as she did not want to go to bed. Dorothy Harris struggled to remember exact times, stating Resident A had begun to slide out of the chair at 2300 hours (11:00pm) and then at 0045 hours (12:45am). Dorothy Harris continued to mix up her timeline throughout our interaction, leaving times of events unclear. Once Resident A began to slide out of the chair Dorothy Harris assisted her to the floor and put a pillow under her head. Dorothy Harris stated Resident A felt comfortable and had slept on the floor in the same manner previously. While Resident A was on the floor, Dorothy Harris continued to check her vitals and believed that Resident A was sleeping. At some point, Resident A began gagging after being moved to the floor, but Dorothy Harris had checked her vitals which were normal and at this time she was still moving. Dorothy Harris believed Resident A was ok at this time. At some point between the time Resident A was moved to the floor and emergency services arriving on scene Dorothy Harris had realized something was wrong and had given Resident A CPR and called other JARC staff to make the location. Dorothy Harris stated Resident A's vitals checked regular at 0130 hours (1:30am). Dorothy Harris stated her last check occurred around 0220-0225 hours (2:20am – 2:25am) when "everything had stopped" referring to Resident A's vitals. When asked why she did not call emergency services immediately, Dorothy Harris stated she needed to get another employee at the residence for the other residents in the home. Dorothy Harris later stated she "wasn't thinking." {Interview with Kahra-Lyn Cobbler} While speaking with Kahra-Lyn Cobbler, she advised she received a call from Dorothy Harris that Resident A was not doing well as she had previously been sick. At the time of the call Kahra-Lyn Cobbler was informed that Resident A's vitals were fine but was not doing ok from the cold she had over the

weekend. When Kahra-Lyn Cobbler arrived, she noticed something was wrong, began CPR, and had emergency services called.

I reviewed the *Office of Recipient Rights Report of Investigative Findings,* completed by Ms. Clasman, which stated, in part, the following:

On 7/26/24, Oakland Community Health Network (OCHN) Registered Nurse (OCHN Nurse) was consulted by the ORR Specialist. OCHN Nurse reported Ms. Harris could have caused or contributed Neglect Class 1, non-compliance with standard of care due to not calling EMS sooner as Ms. Harris noted Resident A was not breathing normally. In a follow up consult OCHN Nurse explained that Resident A's 120 heart rate, was very high, and she should have gone to the hospital. The blood pressure of 102/117 is not normal either, and the 117 is high diastolic. It should have been retaken to verify and if it remained at that level she needed to be seen by a doctor.

The *Autopsy Report,* completed by Dr. Werner U. Spitz and Dr. Daniel J. Spitz, stated the following:

Resident A died as a result of aspiration pneumonia. Both lungs showed acute pneumonia with associated bacterial colonies and aspirated food material. The right lung showed fibrinous pleuritis. The autopsy did not show evidence of a food bolus airway obstruction. Additional autopsy findings included cerebral atrophy, uterine fibroid, obesity and a patent foramen ovale. A clinical history of Down Syndrome is noted.

The *State of Michigan Certificate of Death*, dated 3/25/2204, stated that Resident A's cause of death was atherosclerotic heart disease.

On 9/18/2024, 9/26/2024, and 10/3/2024, I spoke to Detective David VanKerckhove, from the West Bloomfield Police Department. Detective VanKerckhove stated that his investigation is still pending and it is unknown at this time if criminal charges will be filed.

On 10/3/2024, I spoke to direct care staff, Dorothy Harris, via telephone. Ms. Harris stated, "Prior to the day of the incident, Resident A had been sick with a cough for about four weeks. I had been complaining to management that Resident A needed t be taken to the doctors. She was sick for a while and eventually she got all of the other residents' sick too. But the other residents got better, and Resident A never seemed to shake the cough and cold. She wasn't really eating or holding down pills. On 2/26/2024, I came into work at 3:43pm and worked a double shift (16 hours straight) and did not get off work until the next morning at 7:41am. That day, when I got to work, Resident A seemed worse. I asked management why they hadn't taken Resident A to the doctors, and I was told that the doctor didn't have any openings yet. I was told to give her couch medicine. I gave Resident A her medications at 8:00pm and I gave her Robitussin cough medicine at 10:00pm. I checked her blood pressure before I gave her the cough

medicine and it was normal. Resident A was then sitting in a reclining chair in the living room, and I was sitting there watching her because she was sick. Resident A fell asleep and then the next thing I knew, she was hanging from the chair. I thought she was hanging from the chair because she was sleepy from the cough medicine. I moved her to the floor because she didn't want to get up and go to her room. I put a pillow under her head, and I kept an eye on her. She looked like she was sleeping, and I didn't want to wake her, so I left her on the floor. At 1:00am, I noticed she was double breathing, like having a hard time breathing with heavy breathing. I had never seen Resident A breath like that before, and I thought I heard her make a gagging sound. So, I called the on-call manager, Kahra-Lyn Cobbler. I called Ms. Cobbler around 1:30am and asked her to come in, in case I had to take Resident A to the hospital, I needed another staff to be here for the other residents. When Ms. Cobbler arrived, Resident A was slightly breathing, and I think she was still alive. She spoke to Ms. Cobbler when she first arrived and then stopped breathing right away." When I informed Ms. Harris that Ms. Cobbler reported that Resident A was non-responsive and not breathing when she arrived at the facility, Ms. Harris changed her story. She then stated, "Oh, I thought she spoke to Ms. Cobbler but she was also knocked out from the medicine so I can't explain it. I am not sure. I did check Resident A's vitals at 12:15am or sometime around the time I called Ms. Cobbler at 1:30am. I checked Resident A's vitals right before I called Ms. Cobbler, and Resident A's heart rate was slow. I don't remember exact times." When asked why she did not immediately call 911 anytime between 10:00pm and 2:30am, Ms. Harris stated, "I have always been told to call the on-call manager first, then call 911 as a last option. I didn't call 911 because I did that before for another resident at a different home and I was told that I should have called the on-call manager first. I thought I did the right thing by calling the on-call manager."

On 10/3/2024, I spoke to direct care staff, Ms. Cobbler, via telephone. Ms. Cobbler stated, "Resident A did have a cough for a while. She wasn't eating much or participating in her normal activities. We had called the doctors office the Friday prior to her passing to see if we could get her in to be seen but that doctor was out sick. I was on-call on the night of the incident. At about 1:45am, I received a call from Ms. Harris. Ms. Harris stated that Resident A was acting off and didn't want to get up and go to her bedroom. Ms. Harris told me that Resident A was not acting like herself and that her breathing was funny and sounded weird, but that her vitals were fine. Ms. Harris just kept saying that Resident A wasn't acting normal and that she was worried. I told Ms. Harris that I would come into the facility to help her with Resident A and to help move her to the bedroom. I clocked into work at 2:38am and that is time that I had pulled into the driveway of the facility. When I walked into the facility, I saw Resident A laying on the living room floor. I called her name, and she didn't respond. I didn't check her vitals or touch her skin, but I touched the top of shirt and could tell her chest wasn't moving up and down, so I figured she wasn't breathing. I immediately began chest compressions and told Ms. Harris to call 911." When asked if she performed CPR that included mouth-to-mouth/rescue breaths, Ms. Cobbler stated, "No, I did not perform rescue breaths. I didn't have the plastic piece on me. It was in another part of the home, and I didn't get it. I didn't feel comfortable doing mouth-to-mouth, so I only did chest compressions until EMS arrived and took over." When asked why she did not advise Ms. Harris to call 911

immediately when she called her at 1:30am, Ms. Cobbler stated, “I didn’t tell Ms. Harris to call 911 because nothing made me think it was emergent because Ms. Harris said her vitals were fine. And staff don’t have to ask permission before calling 911. Ms. Harris did tell me that Resident A’s breathing was off, but she also said her vitals were fine.” Ms. Cobbler acknowledged that she did not specifically ask Ms. Harris for Resident A’s vitals information.

On 10/3/2024, I spoke to medical examiner, Dr. Daniel Spitz, via telephone. Dr. Spitz stated, “I assisted with the autopsy {report} for Resident A. The findings of the report are accurate. If rigor mortis of the jaw was observed and had already set in at 2:46am when EMS arrived, then Resident A likely passed away two to three hours prior to their arrival (estimated time of death is 11:46pm – 12:46am). A minimum of at least two hours is needed for rigor mortis to set in to the extent that was observed of Resident A’s condition by EMS.”

On 10/3/2204, I spoke to Guardian A1 via telephone. Guardian A1 stated, “This was a horrible, unnecessary death of Resident A. They need to be held accountable. The facility called us at 3:00am to notify us of her passing and we demanded an autopsy because the something didn’t seem right, and I am glad we did. The staff did not obtain medical care immediately and they should have. They killed my sister.”

On 10/3/2204, I conducted an exit conference with licensee designee/administrator, Jasmine Bell, via telephone. Ms. Bell stated that she is aware of this incident. Ms. Bell stated that she is in agreement with the findings of this report and stated she plans to accept the recommendation of a six-month provisional license.

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:	According to the *Staff Log Notes*, on 2/23/2024, Ms. Saunders, Ms. Cobbler, Ms. McBride and Ms. Harris, all noted that Resident A had a cough. Ms. Saunders contacted Dr. Yashinsky to schedule an appointment but was advised that no appointments were available on this day. On the morning of 2/26/2024, Resident A was still sick with a cough and had vomited. Around 5:00pm, Ms. Harris noted that Resident A was observed wheezing and coughing.

	According to Ms. Harris, Resident A had been sick with a cough for four weeks and had a decreased appetite and trouble holding down medications. Ms. Harris acknowledged that she was concerned about Resident A's health and had vocalized this concern to management on multiple occasions. Ms. Harris stated that Resident A appeared "more sick/worse" when she arrived to work on 2/26/2024 at 4:00pm. Ms. Harris acknowledged that between the hours of 10:00pm and 2:30am, she observed Resident A hanging from the reclining chair, slide off of the reclining chair at least two times onto the floor, make gagging noises at last once, have heavy/labored breathing, wheezing, slow heart rate, and move around on the floor in an unusual manner. Ms. Harris acknowledged that during this 4½ hour occurrence, at no time did she call 911 to obtain medical care for Resident A. Ms. Harris did not call 911 until 2:40am, after Ms. Cobbler arrived at the facility. According to Ms. Cobbler, Resident A did have a cough for a several weeks, wasn't eating much, nor participating in her normal activities. Ms. Cobbler stated that Resident A had not been taken to the doctors for follow-up due to scheduling issues with the doctor's office. Ms. Cobbler acknowledged that she received a call from Ms. Harris on 2/27/2024 at 1:45am, stating that Resident A was not acting herself, was breathing funny, breathing was off, and was not acting normal. Ms. Cobbler acknowledged that she informed Ms. Harris that she would come to the facility to check on Resident A but did not advise Ms. Harris to call 911 at any time during that phone call. Ms. Cobbler arrived at the facility at 2:38am and immediately began compressions on Resident A without touching Resident A's body or checking for a pulse or vitals. Ms. Cobbler stated she did not attempt rescue breathes because she was not comfortable doing so without a plastic piece, which she stated was in another part of the facility. According to the *Bloomfield Township Fire Department Incident Report, dated 2/27/2204,* EMS arrived at the facility at 2:46am, and found Resident A pale, cold to the touch with rigor mortis set in on the jaw. Resident A was pronounced deceased at 3:00am.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	According to the *Autopsy Report* and Dr. Daniel Spitz, Resident A died as a result of aspiration pneumonia. Dr. Spitz further stated that Resident A's estimated time of death is between 11:46pm and 12:46am, due to the progressed onset of rigor mortis of the jaw observed by EMS at 2:46am. Resident A displayed an ongoing change in her physical condition, including cough, decrease appetite, difficulty holding down medication and vomiting, between the dates of 1/24/2024 and 2/26/2024, which is referenced in multiple documents by MORC and direct care staff at the facility. Despite ongoing scheduling difficulties with the primary care physician, the facility failed to seek needed care for Resident A. On 2/26/2024 – 2/27/2024, Ms. Harris failed to obtain needed medical care for Resident A for approximately 4½ hours. During this time, Ms. Harris documented vitals for Resident A that were abnormal and warranted immediate medical attention. Ms. Harris also provided inconsistent information that does not match the timeline for when Resident A passed away. Additionally, Ms. Cobbler failed to obtain needed medical care for Resident A when she did not advise Ms. Harris to call 911 immediately when she spoke to her via telephone at 1:45am. Ms. Cobbler also did not make efforts to check Resident A's vitals nor attempt rescue breathes due to feeling uncomfortable performing CPR. Based on the information above, the facility, including Ms. Cobbler and Ms. Harris, failed to obtain needed medical care for Resident A between 1/24/2024 and 2/27/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

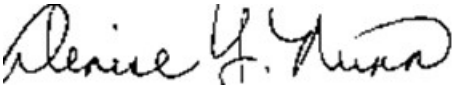
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that a six-month provisional license be issued.

10/17/2024

Stephanie Gonzalez — Date
Licensing Consultant

Approved By:



10/17/2024

Denise Y. Nunn — Date
Area Manager