GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 23, 2026

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

RE: License #: AS630085648
Investigation #: 2026A0626026
Greenberg Shiffman Stein

Dear Jasmine 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.

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) 972-9136.

Sincerely,

Sara Shaughnessy, Licensing Consultant
Bureau of Community and Health Systems
3044 West Grand Boulevard
2nd Floor Annex, Suite 2-730
Detroit, MI 48202
(248) 320-3721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630085648
Investigation #:	2026A0626026
Complaint Receipt Date:	06/01/2026
Investigation Initiation Date:	06/01/2026
Report Due Date:	07/31/2026
Licensee Name:	JARC
Licensee Address:	6735 Telegraph Rd Suite 100 Bloomfield Hills, MI 48301
Licensee Telephone #:	(248) 940-9617
Licensee Designee/Administrator:	Jasmine Boss
Name of Facility:	Greenberg Shiffman Stein
Facility Address:	28773 Village Lane Farmington Hills, MI 48334
Facility Telephone #:	(248) 539-1762
Original Issuance Date:	07/02/1999
License Status:	REGULAR
Effective Date:	07/04/2025
Expiration Date:	07/03/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A choked on her breakfast and required hospitalization. There is concern that she was not fed according to her prescribed mechanical soft diet.	No
Additional Findings	Yes

III. METHODOLOGY

06/01/2026	Special Investigation Intake 2026A0626026
06/01/2026	APS Referral I did not make a referral to Adult Protective Services (APS), as it was already reported and denied for investigation.
06/01/2026	Special Investigation Initiated - Telephone I initiated the special investigation by completing a telephone interview with recipient rights specialist, Rachel Moore.
06/04/2026	Contact - Face to Face I completed an unannounced onsite investigation at Greenberg Shiffman Stein. I completed interviews with home manager, Stella Swift, and licensee designee, Jasmine Boss.
06/23/2026	Contact - Document Received I received, via email, videos from recipient rights specialist, Rachel Moore. The videos were of Resident A's food preparation.
06/24/2026	Contact - Telephone call made I completed a telephone interview with Relative A1.
06/25/2026	Contact - Face to Face I completed an unannounced onsite investigation at Greenberg Shiffman Stein, along with recipient rights specialist, Rachel Moore. We completed interviews with home manager, Stella Swift, district manager, Brandie Whelan, and licensee designee, Jasmine Boss. I also completed an in person interview with direct care staff member, Delois Martin.
06/25/2026	Contact - Face to Face I completed a face to face case conference with recipient rights specialist, Rachel Moore.

06/26/2026	Contact - Document Sent I emailed a request to Oakland County 911 Dispatch, requesting the audio recording of the 911 call.
07/08/2026	Contact - Document Received I received, via email, a recording of the 911 call.
07/08/2026	Contact - Telephone call received I completed a telephone interview with direct care staff member, Nishon Donaldson.
07/15/2026	Contact - Document Received I received an email from ORR specialist, Rachel Moore, indicating she is not substantiating her investigation.
07/17/2026	Contact – Telephone call made I completed a telephone interview with direct care staff member, Kelly Miller.
07/22/2026	Exit Conference I completed an exit conference, via telephone, with licensee designee, Jasmine Boss.

ALLEGATION:

Resident A choked on her breakfast and required hospitalization. There is concern that she was not fed according to her prescribed mechanical soft diet.

INVESTIGATION:

On 06/01/2026, I received a complaint, via email, indicating Resident A had choked on her food. The complaint indicated that staff had to perform CPR until paramedics arrived and she was hospitalized. The complaint also indicated that Resident A is to be on a mechanical soft diet, food cut or broken up into pieces, with thin liquids and staff monitoring.

On 06/01/2026, I initiated the special investigation by completing a telephone interview with Rachel Moore, from recipient rights. Ms. Moore stated Resident A is on a mechanical soft with liquids diet and requires someone to watch her consume her food. She stated Resident A is a food hoarder, and she almost passed away from the incident. The emergency services report indicated that they had to clear her airway. She was in the hospital, being treated for possible cardiac issues and stroke.

On 06/04/2026, I completed an unannounced onsite investigation at Greenberg Shiffman Stein. I completed an interview with home manager, Stella Swift. Ms. Swift stated that she received a phone call while she was on her way to work on 05/26/2026 informing her that EMTs (emergency medical technicians) were at the home because Resident A was choking. She was informed that staff performed the Heimlich maneuver and followed instructions given by 911 dispatch, which was to proceed to perform CPR. The EMTs arrived and took Resident A to the hospital. After Resident A was transported to the hospital, Ms. Swift spoke with staff and was informed that Resident A was eating breakfast and aspirated her food. She stated they have now changed Resident A to a 1:1 staff for meals. Prior to the choking incident, she was supposed to be supervised with a direct care staff member within arm's reach. Ms. Swift showed me the guides that are kept in the kitchen, along with photographs, so that staff are aware of how to prepare Resident A's food. She then showed me the tools they use to make her food appropriately, including a blender and a Ninja food processor. Ms. Swift created a set up to show where everyone was when Resident A was choking. There was a staff member standing next to her and one about six feet away, at the counter. I took photographs of the set up.

At the onsite investigation, Ms. Swift provided me with Resident A's diet sheet from her individual plan of service (IPOS), dated 04/10/2026. Resident A is supposed to receive a mechanical diet, soft, cut/broken into 1/2-inch pieces, with thin liquids. She is to have supervision, within arm's reach, due to impulsive self-feeding.

Ms. Swift provided me with two separate incident reports. The incident report dated 05/27/2026, completed by direct care staff Delois Martin, indicates that Ms. Martin arrived to work around 6:45 am. When she arrived, direct care staff members told her that Resident A was choking. She observed another direct care staff member performing the Heimlich maneuver. She checked Resident A's pulse and she was not breathing. They lowered her to the floor and began CPR. They continued until EMS arrived and they were able to get her breathing.

The incident report dated 05/26/2026, completed by direct care staff Kelly Miller, indicates that Ms. Miller was in the kitchen, passing medication, when she heard Resident A make a coughing sound. She went over to check on her and noticed Resident A was choking. She grabbed the phone and called 911, then called for the other direct care staff member. She followed directions provided by the 911 operator until EMS arrived.

Ms. Swift also provided me with Resident A's discharge paperwork. The paperwork indicates she was admitted to Corewell Health Farmington Hills Hospital on 05/27/2026 and was discharged on 05/29/2026. She was admitted due to choking. The discharge paperwork states that Resident A's discharge diet is dysphagia diet, one-to-one feed, and that she is high risk for recurrent aspiration.

On 06/04/2026, I completed an in-person interview with licensee designee, Jasmine Boss. Ms. Boss stated she was told that around breakfast time, Resident A had

distress and direct care staff members responded immediately and appropriately. Staff contacted 911, performed the Heimlich maneuver, and then performed CPR. Ms. Boss is not sure if there was food that became dislodged. Resident A was hospitalized for three days. She denied having concerns regarding the staff member, Nishon Donaldson, who was feeding Resident A. She is a solid staff member and has been there for years. She informed me that Resident A's diet is now minced, since the choking episode.

On 06/04/2026, during the onsite investigation, I attempted to interview Resident A, but she was curled up in a bean bag chair and did not interact with me.

On 06/23/2026, I received a video, via email, from recipient rights worker, Rachel Moore. She wrote that the video was of the direct care staff members showing how they prepare meals for Resident A. Ms. Moore verified that the food prepared in the video was prepared correctly according to Resident A’s IPOS.

On 06/24/2026, I completed a telephone interview with Relative A1, mother and guardian to Resident A. She denied any concerns regarding the care of Resident A in the home. She does not believe the direct care staff members did anything wrong to lead to the choking incident. She explained that Resident A has a genetic abnormality called Partial Trisomy 9, which is an abnormality of the X chromosome. She stated that it is a rare diagnosis that comes with increased swallowing difficulty as the individual ages. She is concerned that it is progressing with Resident A and that it might have caused the choking incident. She stated Resident A often chokes on liquids as well.

On 06/25/2026, I completed an unannounced, onsite investigation at Greenberg Shiffman Stein. I completed a face-to-face interview with licensee designee, Jasmine Boss, district manager, Brandie Whelan, and home manager, Stella Swift. They stated that Resident A is doing well and they had a dietician come to the home to help them with feeding Resident A. Ms. Swift confirmed that Relative A1 told her about the Partial Trisomy 9 diagnosis, but there is nothing about it in her official medical records.

On 06/25/2026, I completed an in-person interview with direct care staff member, Delois Martin. Ms. Martin came on shift while Resident A was choking. She came in at 6:45 am and another direct care staff member opened the door and told her that Resident A was choking. She observed direct care staff member, Nishon Donaldson, performing the Heimlich maneuver on Resident A. She noticed Resident A was turning purple, so they laid her down. She instructed Ms. Donaldson to contact 911 as they began performing CPR. She stated Resident A was not breathing and things became hectic, but they kept on following the instructions from 911. She did not notice any specific piece of food come out when the Heimlich maneuver was performed, but Resident A did throw up. She stated Resident A also threw up blood. They all played their part and the EMTs told her that if they had not worked the way that they did, Resident A probably would not have survived.

On 06/25/2026, I had a conference with recipient rights specialist, Rachel Moore. Ms. Moore informed me that she does not have enough evidence to determine that anyone did anything wrong regarding Resident A.

On 07/08/2026, I received a recording of the 911 call from Oakland County 911 Dispatch for the incident with Resident A. The caller did not identify herself, but is heard telling 911 that her resident was choking. The dispatch operator asked what the resident was choking on and the caller stated, "Her breakfast." The caller informed 911 dispatch that the food was out of her mouth, but Resident A was turning purple. The dispatch operator proceeded to provide instructions for CPR, and the caller could be heard begging for them to please hurry.

On 07/09/2026, I completed a telephone interview with direct care staff member, Nishon Donaldson. Ms. Donaldson prepared Resident A's breakfast the day she choked. Ms. Donaldson made waffles for Resident A, and she informed me that recipient rights asked her to send a video of her preparing the food and she did. She was in the kitchen, grabbing drinks for everyone and another direct care staff member was starting to pass medications as she was getting the drinks. She stated she performed the Heimlich maneuver on Resident A. She does not remember seeing food come out, only the blood Resident A vomited. She believes the food that was observed on the floor was knocked over during the chaos. It was not the first time she prepared food for Resident A, and she never had issues before. Ms. Donaldson informed me that Resident A has been moved to pureed food and that she probably should have been prior to this, but it was not in her IPOS.

On 07/17/2026, I completed a telephone interview with direct care staff member, Kelly Miller. Ms. Miller was working the midnight shift when the choking incident occurred. Ms. Miller stated that it is the responsibility of the midnight shift staff to pass morning medications and to feed the residents breakfast. On 05/26/2026, she was working with Nishon Donaldson. The residents were eating breakfast, and Ms. Miller started the medication pass, which is done at the kitchen counter, on the opposite side of the kitchen table. The table is still in view. Ms. Donaldson had to do something for another resident and was in the other room. Ms. Miller heard Resident A coughing, which is normal for her, and then she saw her color changing and heard her gasping. She ran over, opened her mouth, and did not see any food. She yelled for Ms. Donaldson, laid Resident A down on the floor, and started CPR. They called 911 and another staff member came in for her shift and began helping them. I asked if anyone was within arm’s reach of Resident A and she stated they were not.

On 07/22/2026, I completed an exit conference, via telephone, with licensee designee, Jasmine Boss. Ms. Boss was informed of the findings and indicated an understanding regarding the findings. Ms. Boss stated that they have a dietician working with them to ensure that Resident A is being fed properly and safely.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(5) A resident who has a prescribed diet by an appropriately licensed health care professional shall be provided that diet.
ANALYSIS:	Based on the information obtained during the special investigation, there is not enough evidence to conclude that the direct care staff members did not follow the prescribed diet for Resident A. Direct care staff member, Nishon Donaldson prepared Resident A's breakfast that morning and sent a video of how she prepares the food to ORR specialist, Rachel Moore, who verified it was made correctly. Resident A's mother stated Resident A has a diagnosis that creates difficulty with swallowing and becomes progressively worse. She believes that is why Resident A choked. Ms. Donaldson stated she made the food correctly and was there, with Resident A, when she began choking. She performed the Heimlich maneuver and contacted 911, then began CPR. Resident A now has a newly prescribed diet calling for minced food and a one-to-one staff while eating to prevent this from happening again.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/04/2026, I completed an unannounced onsite investigation at Greenberg Shiffman Stein. I completed an interview with home manager, Stella Swift. Ms. Swift provided me with a copy of Resident A's IPOS, dated 04/10/2026. The IPOS indicates that Resident A is to be supervised, within arm's reach, due to impulsive feeding. Ms. Swift also provided me with an incident report, completed by Kelly Miler. The report indicates that Ms. Miller was in the kitchen, passing medication and heard Resident A make a coughing sound, so she went over to check on her and noticed she was choking. She grabbed the phone and called 911, then called for the other direct care staff member. She followed directions provided by the 911 operator until EMS arrived.

On 07/09/2026, I completed a telephone interview with direct care staff member, Nishon Donaldson. She stated she was in the kitchen, grabbing drinks for everyone and another direct care staff member was starting to pass medications as she was getting the drinks.

On 07/17/2026, I completed a telephone interview with direct care staff member, Kelly Miller. She stated the residents were eating breakfast, and she started the medication pass, which is done at the kitchen counter, on the opposite side of the kitchen table with the table is still in view. Ms. Donaldson had to do something for another resident and was in the other room. I asked if anyone was within arm's reach of Resident A, and she stated they were not.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based upon the information obtained during the special investigation, it has been determined that there is enough evidence to support that Resident A did not receive supervision, protection, and personal care as specified in her assessment plan. Resident A's IPOS dated 04/10/2026, states that Resident A needs to be "within arm's reach supervision due to impulsive self-feeding." Ms. Donaldson stated she was getting drinks for the residents and Ms. Miller was passing medications while Resident A was eating and subsequently choked. Ms. Miller stated she was passing medications and Ms. Donaldson was helping another resident in another room. Neither staff stated they were within arm's reach of Resident A when she began to choke.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

07/23/2026

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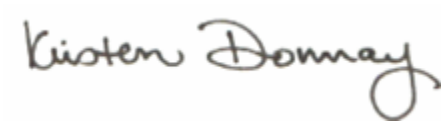
Sara Shaughnessy Date
Licensing Consultant

Approved By:



WOC Area Manager for 07/23/2026

_____

Denise Y. Nunn Date
Area Manager