GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 2, 2021

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

RE: License #: AS500015318
Investigation #: 2021A0604016
Fisher Estates Clf

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 (248) 975-5053.

Sincerely,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500015318
Investigation #:	2021A0604016
Complaint Receipt Date:	09/28/2021
Investigation Initiation Date:	09/29/2021
Report Due Date:	11/27/2021
Licensee Name:	Quest, Inc
Licensee Address:	36141 Schoolcraft Road Livonia, MI 48150-1216
Licensee Telephone #:	(734) 838-3400
Administrator:	Nicole Hagood
Licensee Designee:	Patricia Thomas
Name of Facility:	Fisher Estates Clf
Facility Address:	4464 Fisher Estates Lane Romeo, MI 48065
Facility Telephone #:	(586) 752-1583
Original Issuance Date:	04/01/1994
License Status:	REGULAR
Effective Date:	11/04/2020
Expiration Date:	11/03/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was sexually abused by Resident B.	Yes

III. METHODOLOGY

09/28/2021	Special Investigation Intake 2021A0604016
09/29/2021	Special Investigation Initiated - Letter Email to Patricia Thomas and Nicole Hagood
09/29/2021	Contact - Document Received Received email from Nicole Hagood with Individual Plans of Service, safety plan and incident reports.
10/01/2021	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Home Manager, Jessica O'Berry and observed Resident A.
10/01/2021	Contact - Document Received Email from Nicole Hagood. Sent return email. Received two incident reports by email. Resident A was taken to hospital and police came to home to interview Resident B today.
10/05/2021	APS Referral Received second intake. Email to Adult Protective Services (APS) Worker, Emily Poley.
10/05/2021	Contact - Document Sent Email to APS Worker, Emily Poley
10/06/2021	Contact - Document Received Received additional information from Online Complaints
10/07/2021	Contact - Document Received Email to and from Emily Poley.
10/28/2021	Contact - Document Received Email from Emily Poley. Sent return email. APS will be substantiating complaint.

10/28/2021	Contact - Document Sent Email to Nicole Hagood.
10/29/2021	Contact - Document Received Email from Nicole Hagood. Sent return email.
10/29/2021	Contact - Document Sent Email to and from Emily Poley
10/29/2021	Contact - Telephone call received Returned TC from Trooper Fayhe, Michigan State Police
11/01/2021	Contact - Document Received Email from Emily Poley. Sent return email.
11/02/2021	Exit Conference Completed exit conference by email with Licensee Designee, Patricia Thomas and Administrator, Nicole Hagood.

ALLEGATION:

Resident A was sexually abused by Resident B.

INVESTIGATION:

On 09/28/2021, I received a complaint regarding Fisher Estates. Resident A is developmentally delayed and non-verbal. It was alleged that on 07/27/2021, Resident B took off Resident B's diaper and performed oral sex on him. The incident occurred at the group home. Resident A is unable to take his diaper off himself and was found later that day with it off. The facility has been made aware of the situation, a safety plan is being developed, and Resident B will also receive additional services to address the incident. There is no surveillance in the group home and law enforcement has not been contacted.

On 09/29/2021, I received an email from Administrator, Nicole Hagood with Resident A and Resident B's Individual Plans of Service, safety plan and incident reports.

On 10/01/2021, I completed an unannounced onsite investigation. I interviewed Home Manager, Jessica O'Berry and observed Resident A. Resident A was observed in his bedroom sitting in his wheelchair. I was unable to interview Resident A as he is non-verbal. Ms. O'Berry stated that she found out about the incident on Monday, 09/27/2021. Resident B had his first appointment with the counselor at the home and he told her that he performed oral sex on Resident A. Ms. O'Berry heard him tell the counselor about the incident. Resident B stated that it only occurred one time. Ms. O'Berry stated that Resident A is non-verbal and in a wheelchair. He is not able to move

much and does not have the ability to take his diaper off himself. Ms. O'Berry stated that on 07/27/2021, her son was working at the home. He had laid Resident A down in bed after giving him a shower and getting him dressed. Ms. O'Berry stated that he stepped outside and when he came back to Resident A's room his diaper was undone and his blanket was pulled up to his chin. Resident A had nothing on from the bottom down. Staff did not know that a sexual act had occurred, however, were concerned and contacted her. Ms. O'Berry notified her boss and it was suggested to put Resident A in a bedroom with a verbal roommate. Resident A previously had his own bedroom. Ms. O'Berry stated that there are currently six residents in the home. Resident A and Resident C are both non-verbal and in wheelchairs. Ms. O'Berry stated that they typically have two staff per shift and do bed checks every 30 minutes. Resident A's mother requested that he be moved to another home prior to the investigation. Resident A was placed in the home on 01/26/2016. Resident B was placed in the home on 09/27/2003.

I reviewed an incident report dated 07/27/2021. The report indicates that Staff Bryan O'Berry told Jessica O'Berry that Resident B told him that Resident A was taking off his diaper. Mr. O'Berry went into Resident A's room and the blanket was up to his neck. Mr. O'Berry pulled the blanket down and looked to see his diaper was off. He put the brief back on. Nicole Hagood was notified and a decision was made to change bedroom.

I reviewed an incident report dated 09/27/2021 completed by Nicole Hagood. The report indicates that Ms. Hagood received a call from Counseling and Behavioral Support stating that Resident B admitted that, "He put (Resident A's) penis in his mouth". Adult Protective Services (APS) and recipient rights were being notified.

I reviewed an incident reported dated 10/01/2021 completed by Nicole Hagood. The report indicates that Resident A was taken to Crittenton Hospital to have his anus examined per the request of his guardian. The hospital did an exam and did not find any tears. The hospital indicated that they would be contacting the police per their protocol. The police arrived at the home to conduct interviews.

I reviewed Resident B's Individual Plan of Service dated 09/07/2021. Resident B has been diagnosed with Major Depressive Disorder, Mixed Disturbance of Conduct/ Emotion and Pedophilia. The plan indicates that Resident A requires indirect supervision while in his home as long as his caregivers know his whereabouts and activities at all times. This is based on his history of eloping as well as inappropriate sexual behaviors. He requires monitoring at all times when in the community due to his history of behavioral challenges including inappropriate sexual behavior towards small children and less capable peers, as well as limited safety skills in the community.

On 10/28/2021, I received an email from APS worker, Emily Poley. Ms. Poley stated that APS would be substantiating the complaint.

On 10/29/2021, I received telephone call from Trooper Fayhe with the Michigan State Police. Trooper Fayhe indicated that he did not believe Resident A and Resident B

being placed in the same home was appropriate. He stated that there would not be any criminal charges due to resident's disability. Trooper Fayhe stated that he would be issuing a civil infraction for the home failing to make a report when the incident occurred. This will result in a fine.

I completed an exit conference on 11/02/2021 with Licensee Designee, Patricia Thomas and Administrator, Nicole Hagood. I informed them of the violations found and that a copy of the special investigation report would be mailed once approved. I also informed them that a corrective action plan would be requested.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	Resident B is not compatible with other residents in the home. Resident B's Individual Plan of Service dated 09/07/2021 indicates that he is diagnosed with Major Depressive Disorder, Mixed Disturbance of Conduct/Emotion and Pedophilia. He requires monitoring at all times when in the community due to his history of behavioral challenges including inappropriate sexual behavior towards small children and less capable peers. Despite Resident B's history he was placed in the home with two resident's that are non-verbal, and wheelchair bound. The placement of Resident A and Resident B together resulted in Resident A being sexually abused by Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 need for protection and safety was not met in the home. Resident B's Individual Plan of Service dated 09/07/2021 indicates that Resident B requires indirect supervision while in his home as long as his caregivers know his whereabouts and activities at all times. This is based on his history of eloping as well as inappropriate sexual behaviors. On 07/27/2021, Resident B was able to enter Resident A's bedroom, remove his diaper and perform oral sex without being seen by staff. Resident B admitted sexually abusing Resident A to his counselor. Resident A was unable to report or stop the abuse as he is non-verbal and has little mobility.
CONCLUSION:	**VIOLATION ESTABLISHED**

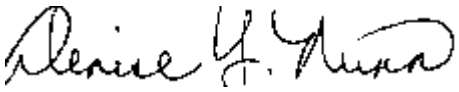
IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change in the license status.

11/02/2021

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



11/02/2021

Denise Y. Nunn — Date
Area Manager