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 #: 2024A0992015
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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS820407565
Investigation #:	2024A0992015
Complaint Receipt Date:	01/02/2024
Investigation Initiation Date:	01/02/2024
Report Due Date:	03/02/2024
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 12/28/2023 direct care staff Christine Pace said to Resident A “bitch get up" and yanked her up. Christine Pace shoved her back towards her room.	Yes

III. METHODOLOGY

01/02/2024	Special Investigation Intake 2024A0992015
01/02/2024	Special Investigation Initiated - Telephone Tina King, home manager
01/02/2024	Contact - Telephone call made Staff 1, direct care staff (DCS)
01/02/2024	Contact - Telephone call made Patricia Thomas, licensee designee
01/02/2024	Contact - Telephone call made Lakeitha Cobb, Resident A’s Supports Coordinator with Community Living Services. Ms. Cobb was not available, message left.
01/05/2024	Referral - Recipient Rights
01/05/2024	Contact - Telephone call made Staff 3, DCS
01/05/2024	Contact - Telephone call made Staff 4, former DCS
01/05/2024	Contact - Telephone call made Staff 7, DCS
01/05/2024	Contact - Telephone call made Relative A, Resident A's guardian.
01/05/2024	Contact - Telephone call made Ms. King

01/05/2024	Contact - Telephone call made Staff 2, DCS
01/11/2024	Exit Conference Ms. Thomas

ALLEGATION: On 12/28/2023 direct care staff Christine Pace said to Resident A “bitch get up" and yanked her up. Christine Pace shoved her back towards her room.

INVESTIGATION: On 01/02/2024, I contacted Tina King, home manager and interviewed her regarding the allegation. Ms. King stated she received a call from direct care staff (DCS), Staff 7 (who was recently hired), stating she witnessed DCS, Staff 3 being very inappropriate with Resident A. She said Staff 3 said, “Bitch get up," to Resident A and yanked her up. She said Staff 3 shoved Resident A back towards her bedroom. I asked Ms. King if there were any other staff on shift and she said yes. She said at the time Staff 3, Ms. Garrett, and Staff 1 were on shift. I asked if Resident A was injured, and Ms. King said there was a scratch on Resident A’s neck. Ms. King provided a picture of Resident A’s neck. I observed two faint red marks in the crease of Resident A’s neck. Ms. King said Resident A is nonverbal and unable to be interviewed. Ms. King said Resident A has a guardian and she agreed to provide me her guardians contact information; as well as the contact information for the DCS that were on shift at the time.

On 01/02/2024, I contacted Staff 1, and interviewed her regarding the allegation. Staff 1 stated she did not witness Staff 3 being inappropriate with Resident A. Staff 1 said she observed Resident A walking up to the dinner table and Staff 3 said, “No [Resident A] it is not time to eat.” Staff 1 said Resident A is blind, so she typically sits at the dinner table when she smells food. Staff 1 said Resident A also sits at the table for “bean therapy.” Staff 1 said she told Staff 3 maybe Resident A wants to do bean therapy. Staff 1 said at that time she received a telephone call, so she walked out to the garage to take the call. She said when she came back in, Resident A was in her bedroom. Staff 1 said it was the end of her shift, so she grabbed her belongings and left. Staff 1 said she has never observed Staff 3 using vulgar language or being physically inappropriate with the residents. Staff 1 said she does not typically work the same shift as Staff 3. She said sometimes they see each other in passing unless she is covering a shift for someone else.

On 01/02/2024, I contacted Patricia Thomas, licensee designee, and interviewed her regarding the allegation. Ms. Thomas said Ms. King previously made her aware of the allegation. Ms. Thomas said Staff 3 is suspended and will not be returning to the home. 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 3, and interviewed her regarding the allegation. Staff 3 said, “Hell no, I did not do that.” She said she worked a double from 12:00 a.m. to 8:00 a.m. and from 8:00 a.m. to 4:00 p.m. She said during the day shift she worked along with Staff 4, Staff 5 and Staff 6. Staff 3 said Resident A was being aggressive. She said Staff 4, Staff 5 and Staff 6 kept telling Resident A to sit down. Staff 3 said she observed Resident A sitting at the dinner table, but she did not say “bitch get up" or yank her up. Staff 3 said she did not shove Resident A or push her back towards her bedroom. Staff 3 said, “Fuck no, that did not happen.” Throughout this interview Staff 3 constantly used vulgar language. I had to remind her that this is a professional interview and to refrain from using such language. Staff 3 apologized and said she has been with the company for over 20 years and Ms. King is trying to taint her character because they does not always agree with one another. Staff 3 said she would never use such language towards the residents or physically assault them.

On 01/05/2024, I contacted Staff 4, former DCS and interviewed her regarding the allegation. Staff 4 said she never really worked the same shift as Staff 3. Staff 4 said she did not witness the reported behavior. Staff 4 said Staff 5 has been on medical since the first or second week in November and Staff 6 left the company right after Thanksgiving so it is unlikely that DCS would have worked alongside Staff 3 at the time of the reported incident.

On 01/05/2024, I contacted Staff 7, and interviewed her regarding the allegation, which she confirmed. Staff 7 said she was on shift on 12/28/2023 along with Staff 1, Staff 2 and Staff 3. Staff 7 said this was only her second day on the job. She said Staff 3 came in and introduced herself. She said she started telling her about the residents and the roles and responsibilities of the home. Staff 7 said it was between 7:00 a.m. and 7:30 a.m. when Resident A was walking towards the dinner table, and she reached her hand towards the chair. Staff 7 said Resident A is blind, so she feels her way around the house. She said as Resident A reached for the chair; Staff 3 grabbed Resident A’s wrist to prevent her from grabbing the chair. She said Staff 3 started pushing Resident A back, towards her bedroom. She said Staff 3 said, “Bitch you got me fucked up,” to Resident A. Staff 7 said Staff 3 shoved Resident A towards her bedroom and put her in the bed. Staff 7 said Resident A is nonverbal, but she was making noises as Staff 3 was shoving her. She said when Staff 3 returned to the table area, she said, “I damn near had to wrestle with her.” Staff 7 said Staff 3 kept referring to Resident A as a “Bitch.” She said Staff 3 said “Bitch” at least fifty times, no exaggeration. Staff 7 said Staff 3 wreaked of alcohol and probably do not even remember what occurred. Staff 7 said she is not sure if this is normal behavior for Staff 3, but she seemed very comfortable interacting with Resident A like that. Staff 7 reiterated that it was only her second day on the job. Staff 7 said she felt very uncomfortable and called Ms. King to report the behavior. Staff 7 denied Staff 5 or Staff 6 were on shift. She said to her knowledge Staff 5 has been on medical for a while and Staff 6 and Staff 4 no longer work for the company.

On 01/05/2024, I contacted Relative A, Resident A's guardian and interviewed her regarding the allegation. Relative A denied she was aware of the allegation. She said she was previously hospitalized and is not sure if the DCS attempted to contact her or not. As it pertains to the allegation, I explained that the DCS took immediate action and Staff 3 was removed from the schedule. Relative A said she is relieved to know that immediate action was taken, but she is disturbed that she was not notified. Relative A further stated that Resident A is relatively new to the home and that she previously lived in another one of the corporation's facilities. Relative A denied having any concerns at this time, but said she will follow-up with the home to check on Resident A.

On 01/05/2024, I contacted Ms. King to clarify if Staff 5 and Staff 6 were on schedule on or about 12/28/2023, and Ms. King said no. She said Staff 5 has been on medical leave since around 12/17/2023. As for Staff 6, Ms. King said she no longer works for the company and her last day was on 12/12/2023. Ms. King said Staff 1 and Staff 2 were on shift.

On 01/05/2024, I contacted Staff 2, and interviewed her regarding the allegation. Staff 2 explained that she is relatively new to the company, and she does not work on shift with Staff 3. I asked if she was present on 12/28/2023 when the reported incident occurred, which she confirmed. I asked Staff 2 if she witnessed and/or overheard Staff 3 using vulgar language towards Resident A, and she said yes. I asked her what she heard, and she said she heard Staff 3 say "Bitch" several times when talking to Resident A.

On 01/11/2024, I contacted Ms. Thomas and conducted an exit conference. I made her aware based on the investigative findings there is evidence to support the allegation. I explained that based on my interviews, staff witnessed Staff 3 using vulgar language when speaking to Resident A and physically shoving her. I also made Ms. Thomas aware that Relative A was not aware of the incident. Ms. Thomas explained that efforts were made to contact Relative A by Ms. King but were unsuccessful. She stated Ms. King did contact Jackie Johnson, Resident A's Supports Coordinator with Community Living Services and made her aware. She said Ms. Jonhson was aware Relative A was hospitalized and agreed to follow-up with her. Ms. Thomas said attempts were made. I made Ms. Thomas aware, due to the violations, a written corrective action plan is required, which she agreed to provide.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment.**

	(b) Use any form of physical force other than physical restraint as defined in these rules. **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.** **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.** **(e) Withhold food, water, clothing, rest, or toilet use.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.** **(g) Refuse the resident entrance to the home.** **(h) Isolation of a resident as defined in R 400.14102(1)(m).** **(i) Any electrical shock device.**
ANALYSIS:	During this investigation, I interviewed Patricia Thomas, licensee designee; Tina King, home manager; Staff 1, Staff 2, Staff 3, Staff 4, and Staff 7, and Relative A; regarding the allegations. Although Staff 3 denied the allegation, Staff 2 and Staff 7 overheard Staff 3 using vulgar language towards Resident A. Staff 7 witnessed Staff 3 physically grab and shove Resident A. Resident A is nonverbal and unable to be interviewed. I observed two faint red marks in the crease of Resident A's neck, but I am unable to determine the redness was caused during the reported incident. Based on the investigative findings, there is sufficient evidence that Resident A was subjected to verbal abuse by Staff 3. The allegation is substantiated.
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:	During this investigation, I interviewed Patricia Thomas, licensee designee; Tina King, home manager; Staff 1, Staff 2, Staff 3, Staff 4, and Staff 7, and Relative A; regarding the allegations. Although Staff 3 denied the allegation, Staff 2 and Staff 7 overheard Staff 3 using vulgar language towards Resident A. Staff 7 witnessed Staff 3 physically grab and shove Resident A. Resident A is nonverbal and unable to be interviewed. Based on the investigative findings, there is sufficient evidence that Resident A was not treated with dignity and her personal needs, including protection and safety, was not attended to at all times. The allegation is substantiated.
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

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Ardra Hunter Date
Area Manager