GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 17, 2024

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

RE: License #: AS820383337
Investigation #: 2024A0121028
Riverdale

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 was required. On 06/07/24, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS EXPLICIT LANGUAGE

I. IDENTIFYING INFORMATION

License #:	AS820383337
Investigation #:	2024A0121028
Complaint Receipt Date:	04/10/2024
Investigation Initiation Date:	04/12/2024
Report Due Date:	06/09/2024
Licensee Name:	Quest, Inc
Licensee Address:	36141 Schoolcraft Road Livonia, MI 48150-1216
Licensee Telephone #:	(734) 838-3400
Licensee Designee:	Patricia Thomas
Name of Facility:	Riverdale
Facility Address:	9188 Riverdale Redford, MI 48239
Facility Telephone #:	(313) 286-3016
Original Issuance Date:	08/05/2016
License **Status:**	REGULAR
Effective Date:	02/05/2023
Expiration Date:	02/04/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On an unknown date, an unknown staff member punched Resident A.	No
On an unknown date and time, it is alleged that direct care worker, Ag'e Shackleford told Resident A to "shut the fuck up."	Yes
On an unknown date, Resident A fell and bust his head, and staff did nothing about it.	No

III. METHODOLOGY

04/10/2024	Special Investigation Intake 2024A0121028
04/10/2024	Referral - Recipient Rights Matthew Schneider, Recipient Rights Investigator (RRI)
04/10/2024	APS Referral Alexa Fisher, Services Specialist
04/12/2024	Special Investigation Initiated - Telephone Home Manager, Delisa Wideman
04/17/2024	Inspection Completed On-site Interviewed Home Manager, Delisa Wideman, direct care worker, Rhonda Davis, and Resident B. Observed Resident A.
05/01/2024	Inspection Completed-BCAL Sub. Compliance Interviewed Ms. Wideman. Observed Resident A.
05/08/2024	Contact - Telephone call received. Alexa Fisher with Adult Protective Services
05/09/2024	Contact - Telephone call made. Area Manager, Keyanna McIver
05/09/2024	Contact - Telephone call made. Matthew Schneider with Recipient Rights
05/15/2024	Inspection Completed On-site

	Unannounced. Observed Resident A. Interviewed Ms. Wideman and Assistant Home Manager, Tiara Walker.
05/23/2024	Contact - Telephone call made. Direct care worker, Catherine Dockery
05/23/2024	Contact - Telephone call made. Ms. McIver
05/23/2024	Contact - Telephone call made. Direct Care Worker, Ag'e Shackelford
05/24/2024	Contact - Telephone call made. Follow up call to Ms. Fisher
05/24/2024	Contact - Telephone call made. Attempted call to former direct care worker, Marchelle Matthews
06/05/2024	Contact - Telephone call made. Ms. McIver
06/05/2024	Contact - Document Sent Email to Patricia Thomas to schedule the Exit Conference
06/05/2024	Contact - Telephone call made. Relative 1A
06/05/2024	Contact - Telephone call made. Left message for Betty George with CLS
06/05/2024	Contact - Telephone call made. Left message for Relative 2A.
06/06/2024	Contact - Telephone call made. Direct care worker, Dorian Burkes
06/06/2024	Contact - Telephone call received. Return call from Relative 2A.
06/06/2024	Contact - Telephone call received. Return call from Betty George
06/06/2024	Exit Conference Patricia Thomas, licensee designee.

06/07/2024	Contact - Telephone call made. Completed phone interview with Dorian Burkes
06/07/2024	Contact - Telephone call made. Phone interview with Ms. George

ALLEGATION: On an unknown date, an unknown staff member punched Resident A.

INVESTIGATION: On 4/12/24, I initiated the complaint with a phone call to Home Manager, Delisa Wideman. Ms. Wideman reported that there are currently 4 residents in care with only 1 person being verbal. Ms. Wideman indicated that direct care worker, Catherine Dockery was recently fired for threatening to do bodily harm to her to the extent that police encouraged Ms. Wideman to file a personal order of protection against Ms. Dockery. As a result, Ms. Wideman reported Ms. Dockery threatened to get the group home "shut down!" Since that time, Ms. Wideman stated, the home has been under investigation by multiple governing agencies.

On 4/17/24, I completed an onsite inspection at the facility. Ms. Wideman denied residents are punched or beaten by staff. Ms. Wideman insisted the allegations are bogus and they only appeared after Ms. Dockery was transferred to another home for attendance problems at Riverdale. Direct care worker, Rhonda Davis denied having ever seen or been involved in resident abuse at the facility.

On 5/8/24, Alexa Fisher with Adult Protective Services (APS) informed me that Resident A was identified as the person who was allegedly punched by an unknown Staff.

On 5/9/24, I spoke to Area Manager, Keyanna McIver. Ms. McIver expressed concern that the complaint wasn't made until after several direct care workers were placed on leave or suspension. Ms. McIver indicated the workers are disgruntled. Based on the sequence of events, Ms. McIver suspects the disgruntled employees had no intention of reporting any previous acts of abuse or neglect. Ms. McIver reasoned, "Why would they wait until they were mad to come forward?" Therefore, Ms. McIver is inclined to believe the allegations are false in nature and that the complaints are being made out of spite.

On 5/15/24, I completed an unannounced onsite inspection at the facility. Resident A was sitting at the table watching TV with Ms. Wideman upon my arrival. Resident A appeared safe and content. Resident A had no physical signs of injury. Resident A is non-verbal, so he could not comment.

On 5/23/24, I contacted Ms. Dockery for an interview. Ms. Dockery reported hearing a loud screeching sound coming from Resident A's bedroom back in January or

February of this year. Ms. Dockery stated she does not know the exact time or day the incident happened. However, Ms. Dockery is certain that something terrible happened to Resident A. According to Ms. Dockery, she walked to Resident A's bedroom to see what was going on and that's when she observed Resident A with a "knot on his head." Ms. Dockery said direct care worker, Dorian Burkes was in the room with Resident A and that Mr. Burkes informed her "[Resident A] slipped and fell running." Ms. Dockery admitted she did not see Mr. Burkes "punch" Resident A; however, she suspects he did assault the resident on this day based on the resident's injury.

On 6/5/24, I contacted Relative 1A and 2A. Relative 1A reported he goes to the facility "every weekend" to visit Resident A. Relative 1A stated he does not believe Resident A is being mistreated or neglected by group home workers. Relative 2A reported she goes to the home "every couple months" to visit Resident A. Relative 2A stated she does not have any concerns over Resident A's safety or overall well-being at the facility. Both Relative 1A and 2A reported they like Ms. Wideman and they are comfortable with the care provided to residents at the facility.

On 6/7/24, I interviewed Mr. Burkes by phone. Mr. Burkes laughed when I explained the nature of my call and the allegation made against him. Mr. Burkes is adamant that he would "never" physically harm a resident. Mr. Burkes denied having ever punched Resident A. Mr. Burkes described his relationship with Resident A as "pretty good." Mr. Burkes explained there are some people that work or worked at the facility that are jealous of the relationship he formed with Ms. Wideman. According to Mr. Burkes, he was Ms. Wideman's "right hand man" because he was reliable and worked well with residents. Mr. Burkes said he believes the allegation was made out of spite to sabotage his potential for promotion.

I completed an exit conference with licensee designee, Patricia Thomas on 6/6/24. Mrs. Thomas indicated she does not know Mr. Burkes well since her primary focus is on the administrative side of the business, however, Mrs. Thomas is aware of the allegation made against Mr. Burkes. Mrs. Thomas reported Mr. Burkes was transferred to a different home pending the outcome of this investigation.

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: **(b) Use any form of physical force other than physical restraint as defined in these rules.**

ANALYSIS:	• There are no specifics (date or time) provided about when Resident A was punched. • Ms. Dockery acknowledged she did not actually witness Mr. Burkes punch Resident A. • Mr. Burkes denied punching Resident A. • Therefore, there is insufficient evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On an unknown date and time, it is alleged that direct care worker, Ag'e Shackleford told Resident A to "shut the fuck up."

INVESTIGATION: On 4/17/24, I interviewed Ms. Wideman, Ms. Davis, and Resident B. Both Ms. Wideman and Ms. Davis denied having ever witnessed direct care worker, Ag'e Shackleford act inappropriate or aggressive towards residents in the home. However, Resident B reported he has witnessed Ms. Shackleford get upset with Resident A and yell or curse at him. It should be noted that Resident B has cerebral palsy, so it's very difficult to understand him. Therefore, I was only able to gather minimal information about Ms. Shackleford's conduct at work. Resident B is the only resident in the home that can speak.

On 5/8/24, Ms. Fisher with APS confirmed Resident A is the resident involved in the allegation made against Ms. Shackleford. Ms. Fisher reported she substantiated emotional abuse did occur with respect to the interaction between Resident A and Ms. Shackleford.

On 5/23/24, Ms. Dockery reported she worked the afternoon shift with Ag'e Shackleford many times. Ms. Dockery stated she witnessed Ms. Shackleford curse at Resident A at least "5-7 times." Ms. Dockery also stated she reported the abuse to Ms. Wideman and Ms. Wideman did nothing to intervene. Ms. Dockery indicated Ms. Wideman ignored Ms. Shackleford's bad behavior because the two women are friends.

On 5/23/24, I interviewed Ms. Shackleford by phone. Ms. Shackleford's demeanor was micro-aggressive as she stated, "Make it, make sense! … How can you yell at someone who can't hear?" Ms. Shackleford denied yelling at or causing emotional distress to Resident A and the others.

On 6/6/24, I completed an exit conference with Mrs. Thomas. Mrs. Thomas stated prior to this incident, she had not been made aware of any incidents of abuse involving Ms. Shackleford. Mrs. Thomas said she was "shocked" when she learned of the allegation. On 6/7/24, Mrs. Thomas submitted an approved plan of correction. Ms. Shackleford's employment with the licensee has since been terminated.

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: **(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.**

ANALYSIS:	• Ms. Dockery reported witnessing Ms. Shackleford curse at Resident A at least 5-7 times when the two worked on shift together. • Resident B reported witnessing Ms. Shackleford yell at and curse Resident A when she gets frustrated with the resident. • Ms. Shackleford denied yelling at or cursing Resident A. • Based on Ms. Dockery's and Resident B's witness statements, the department determined the allegation is more likely than not true that Ms. Shackleford did subject Resident A to verbal abuse.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On an unknown date, Resident A fell and bust his head, and staff did nothing about it.

INVESTIGATION: Ms. Wideman acknowledged Resident A did fall and injured his head; however, the incident happened last year. I reviewed an incident report dated 5/19/24 authored by Ms. Wideman that states, "Staff called and informed manager that [Resident A] came out his room running up the hallway and fell." Resident A was taken to Garden City Hospital for emergency medical treatment. I reviewed Resident A's hospital discharge summary; he was admitted to the hospital 5/19/23 through 5/23/23. Resident A was diagnosed with a laceration on the right side of his forehead. I reviewed Resident A's resident record. It is well documented that Resident A has an unsteady gait. Resident A is a fall risk. As a result, Resident A is ordered to wear a protective helmet. However, Ms. Wideman explained Resident A can and will take the helmet off at times as it is not permanently fastened or secured. Staff have been trained on Resident A's ambulation guidelines.

On 5/9/24, I contacted Recipient Rights Investigator, Matthew Schneider. Mr. Schneider reported, "The home did everything they were supposed to do" in relation to the fall based on the medical evidence provided.

On 6/5/24, Relative 1A and 2A confirmed Resident A was injured during a fall last year. Both Relative 1A and 2A explained Resident A tends to lean forward when walking causing him to lose balance at times. Relative 2A stated it is plausible that Resident A fell and hit his head causing the injury. Relative 1A and 2A stated they have not observed Resident A with repeated injuries to his face or body. Relative 1A and 2A are comfortable leaving Resident A in the home. Relative 2A emphasized it is not uncommon for Resident A to get injured because of his gait. Relative 2A reported Resident A broke his foot at his previous placement, so the family isn't too alarmed about the fall. Relative 2A confirmed Resident A will take his

helmet off, so plans are being made to obtain a newer, more secure helmet for him to wear in the near future.

On 6/6/24, I completed an exit conference with Mrs. Thomas. Mrs. Thomas confirmed Resident A did fall last year while walking. Mrs. Thomas reported Resident A was immediately taken to the hospital for medical treatment. The situation was resolved without incident. According to Mrs. Thomas, she does not believe an outside investigation was commenced considering the incident was accidental in nature.

On 6/7/24, I interviewed Resident A's Supports Coordinator, Betty George with Community Living Services. Ms. George reported she's been managing Resident A's care for the past 2-3 years. Ms. George stated she goes to the home to visit Resident A at least 1 time monthly. Ms. George reported she has not observed Resident A with any marks, bruises, or other physical injuries, nor does he show signs of anxiety or stress around staff. Per Ms. George, Resident A presents as "comfortable" in his current home environment.

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:	• Resident A is a known fall risk. • On 5/19/23, Resident A suffered from a bad fall and injured his head causing laceration. • Resident A was taken to the hospital on the same day, and he was admitted. • Resident A received proper medical treatment to address his wound. • Therefore, the department determined Resident A received the needed care immediately following the accidental fall.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain unchanged.

06/12/24

Kara Robinson Date
Licensing Consultant

Approved By:

06/17/24

Ardra Hunter Date
Area Manager