GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 11, 2024

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

RE: License #: AS820014227
Investigation #: 2024A0101025
Notre Dame Group Home

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,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820014227
Investigation #:	2024A0101025
Complaint Receipt Date:	04/12/2024
Investigation Initiation Date:	04/19/2024
Report Due Date:	06/11/2024
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:	Notre Dame Group Home
Facility Address:	25530 Notre Dame Dearborn Heights, MI 48127
Facility Telephone #:	(313) 791-2482
Original Issuance Date:	10/02/1989
License **Status:**	REGULAR
Effective Date:	09/28/2023
Expiration Date:	09/27/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Direct care staff, LaKiea Patton, forcefully turned Resident A over causing her to hit her head on the wall.	Yes

III. METHODOLOGY

04/12/2024	Special Investigation Intake 2024A0101025
04/12/2024	Referral received from Office of Recipient Rights (ORR) Referral faxed to Adult Protective Services (APS)
04/19/2024	Special Investigation Initiated - Telephone Home Manager, Na'kol Bullard
05/15/2024	Contact - Telephone call made Ms. Bullard
05/31/2024	Contact - Telephone call made Licensee designee Patrica Thomas. Regarding requested documentation
06/04/2024	Contact - Document Received Incident report LaKiea Patton termination documentation Ms. Patton's training, reference check, acknowledgement of personnel policies and fingerprints. Telephone numbers
06/12/2024	Contact - Telephone call made Direct Care Staff (DCS) La Kiea Patton Keadura Haythorne Jasmine Foutain
06/14/2024	Onsite completed Observed Resident A Reviewed Resident A's assessment plan.
06/20/2024	Contact - Telephone call made

	Licensee designee, exit conference

ALLEGATION: Direct care staff, LaKiea Patton forcefully turned Resident A over causing her to hit her head on the wall.

INVESTIGATION: On 04/19/2024, I spoke with the home manager, Na'kol Bullard. Ms. Bullard stated Resident A is nonverbal and dependent on staff for all activities of daily living. Ms. Bullard stated on 03/26/2024, direct care staff, Keadura Haythorne and Jasmine Fountain were changing Resident A's diaper in her bed. DCS LaKiea Patton entered the room and forcefully turned Resident A over causing her to hit her head. According to Ms. Bullard, Ms. Patton contended it was an accident. On 03/26/2024, Resident A was taken to the Emergency Department at Beaumont Hospital. Ms. Bullard further stated Ms. Patton was terminated for forcefully turning Resident A over and causing Resident A to hit her head.

On 05/15/2024, I contacted Ms. Bullard to schedule interviews with Ms. Haythorne and Ms. Fountain. Ms. Bullard informed me that they both had been terminated due to poor attendance.

On 06/12/2024, I made numerous calls to Ms. Haythorne and Ms. Fountain. To date they have not returned my calls.

On 06/14/2024, I conducted an onsite investigation. Resident A is non-verbal and is dependent on a wheelchair for mobility. According to Resident A's assessment plan she requires assistance with eating, toileting, bathing, grooming, dressing, personal hygiene, and mobility. I also reviewed the incident report which is consistent with the information Ms. Bullard provided.

On 06/20/2024, I received and reviewed a copy of Resident A's discharge summary from Beaumont Hospital dated 03/26/2024. Resident A was admitted to the Emergency Department. Resident A was treated for head and spine trauma. A CT scan of the head and spine were completed. According to the discharge summary Resident A did not have any visual bruising. Resident A was discharged and sent home.

On 06/20/2024, I telephoned the licensee designee to conduct had an exit conference with the licensee designee. I left a message regarding my finding. I also requested that she return my call if needed to discuss this matter. To date, Ms. Thomas has not called.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	According to the incident report, Ms. Haythorne and Ms. Foutain witnessed Ms. Patton forcefully turned Resident A over which caused her to hit her head on the wall. According to Ms. Bullard, Ms. Patton contended it was an accident when she forcefully turned Resident A over causing her to hit her head. Therefore, it is concluded Ms. Patton mistreated Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan I recommend the status of the license remains unchanged.

07/09/2024

Edith Richardson
Licensing Consultant
Date

Approved By:

07/11/2024

Ardra Hunter
Area Manager
Date