GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 28, 2026

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

RE: License #: AS820410264
Investigation #: 2026A0993022
Donna

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,

DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820410264
Investigation #:	2026A0993022
Complaint Receipt Date:	07/14/2026
Investigation Initiation Date:	07/16/2026
Report Due Date:	09/12/2026
Licensee Name:	Quest, Inc
Licensee Address:	36141 Schoolcraft Road Livonia, MI 48150-1216
Licensee Telephone #:	(734) 838-3400
Administrator:	Michele Smith
Licensee Designee:	Patricia Thomas
Name of Facility:	Donna
Facility Address:	19414 Donna Livonia, MI 48157
Facility Telephone #:	(734) 469-4182
Original Issuance Date:	06/29/2022
License Status:	REGULAR
Effective Date:	12/29/2024
Expiration Date:	12/28/2026
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On July 12, 2026, staff Tamara Rich, left three residents unsupervised in the facility.	Yes

III. METHODOLOGY

07/14/2026	Special Investigation Intake 2026A0993022
07/14/2026	APS Referral Received allegations from Adult Protective Services (APS). APS denied the intake.
07/14/2026	Referral - Recipient Rights Received allegations from Detroit Wayne Integrated Health Network (DWIHN)
07/14/2026	Contact - Telephone call made Telephone call made to Guardian A1, Guardian B1 and Guardian D1. Received a message that the number was changed, disconnected or no longer in service. Called the office and was informed that number was the only available number. Another number or email address was not provided.
07/16/2026	Special Investigation Initiated - Telephone Telephone call made to DWIHN recipient rights investigator Kailin Mack
07/16/2026	Contact - Telephone call made Telephone call made to Guardian A1, Guardian B1 and Guardian D1. Received a message that the number was changed, disconnected or no longer in service.
07/20/2026	Inspection Completed On-site Conducted an unannounced onsite investigation. I interviewed home manager, Michele Smith. I observed Resident A, Resident B, Resident C, and Resident D. I was unable to interview them due to their limited cognitive abilities.
07/20/2026	Contact - Telephone call made

	Telephone call made to Guardian A1, Guardian B1, and Guardian D1. Received a message that the number was changed, disconnected or no longer in service.
07/20/2026	Contact - Telephone call made Telephone call made to supports coordinator, Krupa Mahta. Left a message.
07/20/2026	Contact - Telephone call made Telephone call made to staff, Tamara Rich
07/20/2026	Contact - Telephone call made Telephone call made to Guardian C1. Left a message.
07/20/2026	Contact - Telephone call made Telephone call made to supervisor, Kimberly Davis
07/20/2026	Contact - Document Received Received a copy of Resident A's, Resident B's and Resident D's Individual Plan of Service (IPOS)
07/21/2026	Contact - Telephone call made Telephone call made to Guardian C1
07/22/2026	Contact - Telephone call made Telephone call made to supports coordinator, Krupa Mahta
07/22/2026	Contact - Telephone call made Telephone call made to Guardian A1, Guardian B1 and Guardian D1. Received a message that the number was changed, disconnected or no longer in service.
07/22/2026	Exit Conference Attempted to hold with licensee designee, Patricia Thomas. Left a message.
07/23/2026	Exit Conference Attempted to hold with licensee designee, Patricia Thomas. Left a message.
07/24/2026	Exit Conference Held with licensee designee, Patricia Thomas

ALLEGATION:

On July 12, 2026, staff, Tamara Rich, left three residents unsupervised in the facility.

INVESTIGATION:

On 07/14/2026, I received allegations from Adult Protective Services (APS). APS denied the intake.

On 07/4/2026, I received allegations from Detroit Wayne Integrated Health Network (DWIHN).

On 07/16/2026, I conducted a telephone interview with DWIHN recipient rights investigator, Kailin Mack. She stated she is also investigating the allegations.

On 07/20/2026, I conducted an unannounced onsite investigation. I interviewed home manager, Michele Smith. I observed Resident A, Resident B, Resident C, and Resident D. I was unable to interview them due to their limited cognitive abilities.

Ms. Smith confirmed that staff, Tamara Rich, left Resident A, Resident B, and Resident D in the facility unsupervised on 07/12/2026. She learned that the residents were unsupervised when Guardian C1 returned Resident C to the facility. There were no staff present so he contacted her. Ms. Smith stated Ms. Rich is suspended the outcome of the investigation.

On 07/20/2026, I conducted a telephone interview with staff, Tamara Rich. She confirmed she left Resident A, Resident B, and Resident D unsupervised in the facility on 07/12/2026. Per Ms. Rich, when the afternoon shift did not arrive at the facility by 4:30pm, she contacted Ms. Smith and supervisor Kimberly Davis via telephone to inform them that the afternoon shift staff had not arrived. She explained to them that she needed to leave to pick up her kids. Per Ms. Rich, Ms. Smith instructed her to try to find someone to come in to relieve her. Ms. Rich stated she informed Ms. Smith that she could not stay. She also informed Ms. Smith that she needed to come in to relieve her. Ms. Rich stated she made dinner and ensured the residents were okay. She waited in the facility for Ms. Smith until about 6pm. When she did not arrive, she left the residents alone in the facility.

On 07/20/2026, I conducted a telephone interview with supervisor, Kimberly Davis. She confirmed that Ms. Rich left Resident A, Resident B, and Resident D in the facility unsupervised on 07/12/2026. Ms. Davis did not know how long the residents were left alone in the facility. She stated the residents were not injured.

On 07/20/2026, I reviewed Resident A's, Resident B's, and Resident D's Individual Plan of Service (IPOS). I read the following:

- Resident A's "requires monitoring throughout the day as he is non-verbal, blind, and has an unsteady gait. Supports monitor him every 15 minutes during daytime hours and every 30 minutes during the night."
- Resident B "is mostly non-verbal and communicates her wants and needs using sounds and gestures for communication. She relies on staff to assist with identifying safety hazards and universal precautions."
- Resident D "is blind and is monitored every 15 minutes during waking hours and 30 minutes throughout the night."

On 07/21/2026, I conducted an interview with Guardian C1. He confirmed when he dropped Resident C off at the facility on 07/12/2026, there were no staff present. Guardian C1 stated he called out to staff, but no one answered. He did not go into the facility. He contacted Ms. Smith to let her know what was going on. He remained on the front porch until Ms. Smith arrived at the facility. Due to the incident, he discharged Resident C from the facility today.

On 07/22/2026, I conducted a telephone interview with supports coordinator, Krupa Mahta. She confirmed she was informed that Ms. Rich left Resident A, Resident B, and Resident D in the facility unsupervised on 07/12/2026. Per Ms. Mahta, Resident A and Resident D are legally blind. Resident B is hearing impaired. The residents require 24-hour supervision.

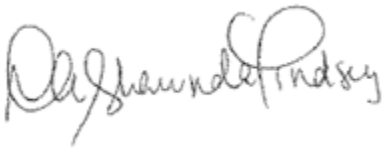
On 07/24/2026, I contacted licensee designee Patricia Thomas to conduct the exit conference. I informed her of the findings. She agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(b) 12 residents for small group and family homes.**
ANALYSIS:	On 07/12/2026, Ms. Rich left Resident A, Resident B, and Resident D unsupervised in the facility. There were no staff in the facility until Ms. Smith arrived after being contacted by Guardian C1. The residents were not injured. Resident A's "requires monitoring throughout the day as he is non-verbal, blind, and has an unsteady gait. Supports monitor

	him every 15 minutes during daytime hours and every 30 minutes during the night." Resident B "is mostly non-verbal and communicates her wants and needs using sounds and gestures for communication. She relies on staff to assist with identifying safety hazards and universal precautions." Resident D "is blind and is monitored every 15 minutes during waking hours and 30 minutes throughout the night." Evidence supports that was not sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. Reference the SIR 2026A0993006, dated 04/20/2026. CAP, dated 04/22/2026.**

IV. RECOMMENDATION

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



07/24/2026

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DaShawnda Lindsey Date
Licensing Consultant

Approved By:

07/28/2026

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Ardra Hunter Date
Area Manager