RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

July 5, 2018

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

RE: License #: AS820014032
Investigation #: **2018A0116026**
Belair Home

Dear Ms. 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.

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,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820014032
Investigation #:	2018A0116026
Complaint Receipt Date:	05/03/2018
Investigation Initiation Date:	05/04/2018
Report Due Date:	07/02/2018
Licensee Name:	Quest, Inc
Licensee Address:	36141 Schoolcraft Road Livonia, MI 48150-1216
Licensee Telephone #:	(734) 458-8140
Administrator:	Patricia Thomas

Licensee Designee:	Patricia Thomas
Name of Facility:	Belair Home
Facility Address:	279 Church Belleville, MI 48111
Facility Telephone #:	(734) 699-3808
Original Issuance Date:	03/11/1988
License Status:	REGULAR
Effective Date:	09/18/2016
Expiration Date:	09/17/2018
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was pushed in the chest on 4/30/18 by staff Gaye Mahone, causing her to almost fall. Staff was also swearing at resident.	Yes

III. METHODOLOGY

05/03/2018	Special Investigation Intake 2018A0116026
05/04/2018	Special Investigation Initiated - Telephone Left a message with staff requesting a return call from the home manager Ramonda.
05/04/2018	APS Referral received Complaint denied for investigation

05/10/2018	Contact - Telephone call made Interviewed home manager Ramonda Bonarge.
05/15/2018	Contact - Telephone call made Interviewed staff Gaye Mahone.
05/16/2018	Inspection Completed On-site Interviewed Resident A.
05/29/2018	Contact - Telephone call made Interviewed Guardian (1)
06/06/2018	Contact - Telephone call made Interviewed Area Supervisor Michelle Smith
06/06/2018	Inspection Completed-BCAL Sub. Compliance
06/27/2018	Exit Conference With licensee designee Patricia Thomas

ALLEGATION:

Resident A was pushed in the chest on 4/30/18 by staff Gaye Mahone, causing her to almost fall. Staff was also swearing at resident.

INVESTIGATION:

On 05/10/18, I interviewed Ms. Bonarge and she reported not being present in the home when the incident occurred. Ms. Bonarge reported she was out of the home at the time but received a call from Ms. Mahone. Ms. Bonarge reported hearing noise and static in the background but could not make out the voices. Ms. Bonarge reported she headed back to the home when she arrived she observed Resident A outside pacing. Ms. Bonarge reported she asked Resident A what was wrong, and she told her she did not want to go back inside, but she did not tell her why. Ms. Bonarge reported later that day Resident A was interviewed at the company's main office by Ms. Smith and disclosed what had occurred. Ms. Bonarge reported that Resident A disclosed that Ms. Mahone pushed her causing her to trip and almost fall. Ms. Bonarge reported based on Resident A's disclosure, Ms. Mahone was immediately removed from the schedule pending investigation and to date remains off work. Ms. Bonarge reported speaking with Ms. Mahone regarding the allegations and reported that Ms. Mahone admitted putting her hands on Resident A, but only to guide her to her room while she finished an interview of a prospective employee. Ms.

Bonarge reported that Resident A is fully ambulatory and stated that verbal re-direction only, should have been used to re-direct her.

On 05/15/18, I interviewed Ms. Mahone and she reported on 04/30/18 she was interviewing a prospective employee when Resident A came into the hallway yelling and cussing about wanting her clothes washed. Ms. Mahone reported she told Resident A that she would finish washing her clothes once she was finished with the interview. Ms. Mahone reported Resident A continued cussing and yelling so she got up put her hands on Resident A's shoulders, guided her to her bedroom and asked her to remain in her bedroom for the next five minutes while she concluded the interview. I inquired with Ms. Mahone when is it appropriate to use crisis/physical intervention on a resident, and Ms. Mahone responded correctly. Ms. Mahone admitted that this situation did not warrant use of any physical contact.

Ms. Mahone reported she called her manager, Ms. Bonarge who reported she was on her way back to the house. Ms. Mahone reported she finished the interview and by that time Ms. Bonarge had returned and was speaking to Resident A outside. Ms. Mahone reported about an hour or so later she was informed that she was suspended pending investigation and reported she has not been back to work since 04/30/18. Ms. Mahone denied pushing Resident A. I asked Ms. Mahone did she yell or use profanity towards Resident A and she reported that she did not. Ms. Mahone reported that she did tell Resident A that if she keeps cussing and mistreating staff that the staff would not want to continue working at the home.

On 05/16/18, I made a scheduled onsite investigation at the home and interviewed Resident A. Resident A reported that a couple weeks ago Ms. Mahone told her that it was her fault that all of the staff is leaving and no longer wants to work in the home. Resident A denied that Ms. Mahone was cussing at her. Resident A reported that Ms. Mahone also pushed her in the chest causing her to trip and almost fall. Resident A reported that Ms. Mahone was mad at her because she was bothering her about washing her clothes. Resident A reported she just wanted her clothes washed and stated she did not deserve to be pushed in her chest. Resident A reported she went outside and called her father and told him what happened. Resident A reported Ms. Bonarge returned home and asked her what happened but reported she was so upset she did not tell her. Resident A reported she went on transport with Ms. Shay and then to the office. Resident A reported when she was at the office she told Ms. Smith what happened. Resident A reported that this is the first time any staff had ever pushed her. Resident A reported that Ms. Mahone has not been back in the home since the incident occurred.

On 05/29/18, I interviewed Guardian (1). Guardian (1) reported that he was aware of the incident and reported that he knows that Resident A agitates staff at time, but reported that does not give them the right to put their hands on Resident A. Guardian (1) reported that Resident A called and told him that Ms. Mahone pushed her in the chest causing her to trip and almost fall, all because she was asking about getting her clothes washed. Guardian (1) reported that he believes the incident

happened as reported. Guardian (1) reported that Resident A is placed in an AFC home because of her mental and developmental issues and reported that staff is aware of her limitation and is supposed to be trained and able to deal with these types of things appropriately Guardian (1) reported that prior to this incident he has not had any major concerns regarding the care or the staff at the home.

On 06/06/18, I interviewed Ms. Smith and she reported interviewing Resident A regarding the allegations. Ms. Smith reported Resident A has been consistent when disclosing the details of what occurred on 04/30/18 between her and Ms. Mahone. Ms. Smith reported that Resident A told her that Ms. Mahone pushed her in her chest/stomach area because she kept asking her to finish washing her clothes. Ms. Smith reported that Resident A denied falling, however, reported she lost her balance and almost fell. Ms. Smith reported Ms. Mahone was immediately suspended and to date has not returned to work. Ms. Smith reported that the Office of Recipient Rights (ORR) is also investigating, and they are cooperating with their investigation as well.

On 06/27/8, I conducted the exit conference with Ms. Thomas and she reported that she was made aware of the incident shortly after it occurred and reported Ms. Mahone was initially removed from the schedule pending investigation. Ms. Thomas reported Ms. Mahone has since been terminated. Ms. Thomas reported that it is not appropriate for staff to put their hands on residents when verbal re-direction was the appropriate action that should have been taken. I informed Ms. Thomas of the findings of the investigation and informed her that the report was forthcoming.

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:	Based on the findings of my investigation, which included interviews with Ms. Bonarge, Resident A, Ms. Mahone, Guardian (1) and Ms. Smith, this violation is established. Resident A reported that she was pushed in the chest by Ms. Mahone after asking her to finish washing her clothes. Ms. Mahone denied pushing Resident A but admitted to putting her hands on Resident A's shoulders and guiding her back to her bedroom. Ms. Mahone reported being aware of the instances where it may be appropriate to use crisis/physical intervention on a resident and admitted that this was not one of those instances. Guardian (1) and Ms. Smith also reported that Resident A gave the same account to them regarding Ms. Mahone pushing her in the chest. Ms. Mahone was terminated as a result of the internal and ORR investigations. Resident A was not treated with dignity and respect and her personal needs, including protection and safety were not attended to in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

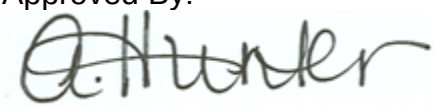
IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

07/02/2018

Pandrea Robinson — Date
Licensing Consultant

Approved By:



07/05/2018

Ardra Hunter — Date
Area Manager