GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 11, 2022

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

RE: License #: AS500015318
Investigation #: 2022A0604015
Fisher Estates Clf

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 (248) 975-5053.

Sincerely,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W Grand Blvd, Suite 9-100
Detroit, MI 48202
2
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500015318
Investigation #:	2022A0604015
Complaint Receipt Date:	03/09/2022
Investigation Initiation Date:	03/09/2022
Report Due Date:	05/08/2022
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:	Fisher Estates Clf
Facility Address:	4464 Fisher Estates Lane Romeo, MI 48065
Facility Telephone #:	(586) 752-1583
Original Issuance Date:	04/01/1994
License Status:	REGULAR
Effective Date:	11/04/2020
Expiration Date:	11/03/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A is not receiving adequate protection and supervision. Resident A is kept in his bedroom with the shut and TV on. Staff are playing video games with head set on.	Yes

III. METHODOLOGY

03/09/2022	Special Investigation Intake 2022A0604015
03/09/2022	APS Referral Made referral to Adult Protective Services (APS)
03/09/2022	Special Investigation Initiated – Telephone TC to APS
03/10/2022	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Home Manager, Jessica O'Berry and observed Resident A.
03/10/2022	Contact - Document Received Email received from Patricia Thomas. Response from request for placement update.
03/10/2022	Contact - Document Received Email from Online Complaints. APS referral was denied. APS previously investigated the sexual assault allegations ID #710949-7.
03/18/2022	Contact - Document Received Email from Patricia Thomas. She has started emergency discharge process.
03/18/2022	Contact - Document Sent Email to Patricia Thomas
04/01/2022	Contact - Document Received Email from Patricia Thomas. MORC disagrees with emergency discharge.

05/02/2022	Contact- Document Sent Email to Patricia Thomas requesting placement update.
05/04/2022	Contact- Telephone call made Left message for MORC Supports Coordinator, Christina Hill. Received return call.
05/04/2022	Contact- Document Received Email from Patricia Thomas
05/05/2022	Contact- Document Sent Email to and from Nicole Hagood
05/05/2022	Inspection Completed On-site Completed onsite investigation. Interviewed Home Manager, Jessica O'Berry, Edith Bakewell, Resident B and Resident C. Observed Resident A, Resident D, Resident E and Resident F.
05/06/2022	Contact- Document Sent Email to and from Nicole Hagood. Received copies of staff schedules.
05/09/2022	Contact- Document Sent Email to Nicole Hagood. Received return email.
05/09/2022	Contact- Telephone call made Left message for Christina Hill
05/09/2022	Contact- Document Received Email from Licensee Designee, Patricia Thomas. Resident A has been moved to new home.
05/10/2022	Contact- Telephone call made TC to Staff, Jared Vernatter
05/11/2022	Exit Conference I completed an exit conference with Licensee Designee, Patricia Thomas.

ALLEGATION:

Resident A is not receiving adequate protection and supervision. Resident A is kept in bedroom with door shut and TV on. Staff are playing video games with head set on.

INVESTIGATION:

I received a complaint regarding Fisher Estates Clf on 03/09/2022. It was alleged that an unannounced visit was made to the home. There was a portable video game with a screen and headset on the kitchen counter closest to kitchen table. The office chair of which is a gaming chair was in front of the video game. Complainant has never seen resident use it. Visit lasted about an hour and there was only one staff member to six residents. Resident B sexually violated Resident A last July 2022. Resident A was in his room and was brought out for the visit. Resident A was sleepy so was taken back to his room. The bed was at this highest height. In the past, he got the medical bed so it could be lowered because Resident A was getting out of the bed. The staff member said Resident A does roll when he sleeps. Staff turned on the TV set for Resident A but it probably wasn't necessary since Resident A looked like he was going to sleep. Staff left it on anyway. The door was shut by staff. Complainant also noticed in the dining area a portable baby crib, it appeared to be the same crib that was in the den the previous week. Resident B's room is across the hallway. Resident A's roommate was in the front den. Complainant is concerned that Resident A is not receiving adequate protection and care. With the room door shut and TV set on it would be hard to hear Resident A fall out of bed. Also, the den TV was on and if staff was playing video games with a headset on and his back to all of the residents, he receives zero supervision including Resident B whose room is across the hallway. In addition, last week the room key was in the doorknob itself.

NOTE: I completed Special Investigation Report #2021A0604016 dated 11/02/2021 due to a complaint that Resident A was sexually abused by Resident B. The home was cited for R14301(2)(c) as it was found that Resident B was not compatible with other residents in the home. The placement of Resident A and Resident B together resulted in Resident A being sexually abused by Resident B. The home was also cited for R14305(3) as Resident A's need for protection and safety was not met in the home. On 07/27/2021, Resident B was able to enter Resident A's bedroom, remove his diaper and perform oral sex without being seen by staff. Resident B admitted sexually abusing Resident A to his counselor. Resident A was unable to report or stop the abuse as he is non-verbal and has little mobility. Licensee Designee, Patricia Thomas submitted a corrective action plan dated 11/11/2021. The CAP indicated that Resident B was given a 30-day notice on 11/08/2021. The plan also indicated that alarms were placed on bedroom doors and Resident B was moved to his own bedroom.

I completed an unannounced onsite investigation at Fisher Estates on 03/10/2022 at approximately 2:00 pm. I interviewed Home Manager, Jessica O'Berry and observed Resident A. Ms. O'Berry stated that Relative 1 has been trying to move Resident A out of home and has been mistreating her staff. She stated that Relative 1 tried to feed Resident A cookies that did not meet his eating guidelines. Ms. O'Berry stated that there was a gaming system in the home. I observed a gaming system and headphones on the kitchen counter along with chair. Ms. O'Berry stated there are residents in the home who like to play video games and they talk to other people through the system. When

staff play games with residents, they keep one headphone on and one off. Ms. O'Berry stated that Resident A was laying down in his bedroom. He lays down in the afternoons after lunch. I observed Resident A in his bed with the TV on. Ms. O'Berry stated that they were getting ready to lower his bed. It is typically lowered when he sleeps. She stated that they do take Resident A out of his bedroom and he will sit in the front room or in a bean bag. I also observed the lock on Resident A's door. The door had the appropriate non-locking-against-egress hardware. Ms. O'Berry stated that they typically have one staff working the day shift and two staff on afternoon and night shift.

Ms. O'Berry stated that staff brought in a play pen because they were giving it away to a coworker. The play pen isn't being used for children at the home.

On 03/18/2022, I received an email from Licensee Designee, Patricia Thomas. Ms. Thomas stated, "I have started the emergency discharge process. Today, I sent the responsible agency an email and a fax requesting that they call me or respond to me so that we may confer about the emergency discharge R14302(5)(b). I have not gotten any response from them yet. Additionally, I updated our attorney, hoping that he may have an avenue I can research to get the attention of the responsible agency. They have been unresponsive to the initial 30-day notice and any other attempts to converse with them regarding this matter. Concerning the complaint, you received regarding Fisher Estates. I am not surprised. (Relative 1) has announced on Facebook that she has made some calls and complaints to bring us down and solve all her problems regarding (Resident A). Additionally, please note: (Relative 1) was coming into Fisher and feeding (Resident A) whole food, which is entirely against his eating guidelines in his Individual Plan of Service (IPOS). She was attacking and mean to our staff. I asked the Supports Coordinator (SC) to talk to her and ask her to follow the IPOS and be nice to my staff. She retorted with a litany of issues and is now retaliating against us. Concerning the crib at the home. It is a Pack and Play and was there for 24-48 hours. One staff member donated it to another staff member, and it was brought into the home to see if it would work for the staff's baby. It is now gone. Concerning the accusation of staff playing video games and wearing headphones. Yes, that does occur. Two of the residents love playing video games, and staff donated the system and headphones to the home. They all play together. Concerning the accusation, 'resident is kept in his room in bed with the door shut in place of supervision,' (Resident A) takes a nap after receiving his medications. On at least two occasions, (Relative 1) has come to the home at precisely that time. Regarding the door being shut. Please note that (Resident A) shares a room with another resident who likes the door shut. Additionally, the door alarms were put on the doors to keep (Resident A) safe from (Resident B), and to work, the door must be shut. At no time is (Resident A) put into his bed with the door shut in place of supervision. Please see the attached addendum to the IPOS about the door alarms. Finally, the SC notified the home today that they need to take (Resident A) to another home next week to visit as a potential new home for him"

On 04/01/2022, I received an email from Patricia Thomas. She stated that she started the emergency discharge process for Resident B. MORC disagrees with the emergency discharge, so they cannot discharge him at this time. Ms. Thomas also stated that Relative 1 has identified another placement for Resident A and they anticipate he will be moving soon. Ms. Thomas has left Resident A on the list with MORC for alternative placement and will continue to push for them to find another home. On 05/04/2022, Ms. Thomas indicated that she is not aware of any placement efforts made for Resident B, once MORC stated that they disagreed with discharge. She stated that they are not responding to her requests for information. Ms. Thomas also stated that Resident A is scheduled to move out of Fisher Estates soon. She stated that Resident A's guardian has filed a lawsuit against them.

On 05/04/2022, I interviewed MORC Supports Coordinator, Christina Hill by phone. Ms. Hill stated that Resident A is scheduled to move out of the home in one to two weeks. He is moving to the Pine Valley Home. She stated that they are finalizing details regarding his replacement. Ms. Hill stated that Community Mental Health (CMH) has been referring Resident B for other placements. Two providers have turned him down due to his behaviors. She believes finding another placement for Resident B will be difficult due to his history and current staffing issues for homes. Many homes do not have the staffing to accommodate his needs. She stated that they are actively trying to find placement for Resident B and may be making a referral for an apartment. Ms. Hill stated that her visits to Fisher Estates are scheduled. She does have concerns that the home has only had one staff on shift at times. She indicated that they are currently short staffed and are supposed to have two staff on shift when all six residents are home. Ms. Hill was not aware of the gaming system in the home and has not seen the crib/pack and play. Ms. Hill stated that she did discuss concerns regarding a dog being at the home with the home manager. She has not seen the dog since. She did not believe it was typical for Resident A to be in bed at 2:00 pm. I informed Ms. Hill that the home's non-compliance is placing the home at risk of a provisional license.

On 05/05/2022, I completed a second onsite investigation at 3:00 pm. I interviewed Home Manager, Jessica O'Berry, Staff Edith Bakewell, Resident B and Resident C. I observed Resident A, Resident D, Resident E and Resident F who were unable to be interviewed due to verbal ability. All the residents were in the living area at the time of inspection. I did not observe the gaming system in the home during onsite investigation. Ms. O'Berry stated that it belongs to Staff Jared, who brings it in for residents to play and then takes it back home.

I interviewed Resident B. He stated that he has lived at the home a long time. He likes living at the home. Staff help him with laundry and making his bed. He helps do the dishes. Resident B stated that he is not sure how many staff work at a time. He has never seen a crib or play pen in the home. Resident B stated that he plays video games with staff, but no one wears headphones when playing. Resident B did not report any concerns.

I interviewed Resident C. He stated that he was unsure how long he has lived at the home. He stated that staff assist him with everything he needs help with such as going to the gym and the Dollar Store. He stated that he likes living there and attending workshop at Life Skills. Resident B stated that two staff work. He has never seen a crib in the home. Resident C stated that he has played video games but not at the home. Resident C did not report any concerns.

I interviewed Staff, Edith Bakewell. She stated that she has worked at Fisher Estates for two months. She stated that there is adequate staffing in the home. They typically have two staff per shift. There is sometimes one staff on shift for only one to two hours. She stated that she has never seen a crib or play pen in home. She stated that some of the staff play video games with Resident C. She stated that Resident A gets up around 6:30 am and sits in living room or in bean bag in living area. He lays back down at around 2:00 after medications. They do turn television on for him. She stated that no one else goes in Resident A's room besides his roommate. They do bed checks every 30 minutes.

On 05/06/2022, I received copies of Fisher Estates Staff schedules for March, April and May 2022 from Administrator, Nicole Hagood. The staff schedules indicated that the home has two staff scheduled for afternoon and night shifts. I observed some periods on weekends when all six residents would be home, where only one staff was scheduled between the hours of 8:00 am- 12:00 pm. Ms. Hagood stated that it is not in any of the resident's Individual Plan of Service to have two staff every shift, however, they always strive to have two staff on shift. Ms. Hagood stated that due to the staffing crisis, there are a couple days here and there where they may have one staff on shift for a few hours. Ms. Hagood stated that she contacted Supports Coordinator, Christina Hill, who confirmed incorrect information was provided and she "assumed" the home needed to have two staff on shift. Ms. Hagood indicated she would provide information to licensing and Case Coordinator would also confirm information.

On 05/09/2022, I received an email from Licensee Designee, Patricia Thomas. Ms. Thomas stated that Resident A moved out of the Fisher Estates home today, 05/09/2022.

On 05/10/2022, I interviewed Staff, Jaren Vernatter, by phone. He stated that he has worked at Fisher Estates for over six months. He stated that there are two staff per shift unless one staff is a few minutes late. He believes the residents are very well cared for and the home has adequate supervision. He stated that everyone cares deeply. Mr. Vernatter stated that he never saw a crib or play pen in home. He stated that he heard one staff dropped it off because they were giving it away. Mr. Vernatter stated that he used to bring in his gaming system for the residents to play. He stated that residents would wear the headphones. Staff never wore the headphones. Mr. Vernatter stated that he is no longer bringing in the gaming system because he was asked not to bring it anymore. He stated that Resident A used to lay down and take a nap in the afternoon,

however, his mother prohibited naps. He indicated that Resident A is no longer in the home.

I completed an exit conference with Licensee Designee, Patricia Thomas by email on 05/11/2022. I informed her of the violation found and that a copy of the special investigation report would be mailed once approved. I also informed her that a corrective action plan would be requested.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	I completed an unannounced onsite investigation on 03/10/2022. Resident A was observed in his bed. Home Manager, Jessica O' Berry, stated that he lays down in afternoon and they will lower bed when he sleeps. I observed a gaming system in home. Ms. O' Berry stated that staff do play games with residents, however, they keep one headphone off. I did not observe a crib or play pen in the home. Ms. O' Berry and Patricia Thomas stated that it was only in the home temporarily because it was being given away.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	The home was previously cited in Special Investigation Report #2021A0604016 dated 11/02/2021 due to complaint that Resident A was sexually abused by Resident B. It was found that Resident B was not compatible with other residents in the

	home. Resident B's Individual Plan of Service dated 09/07/2021 indicates that he is diagnosed with Major Depressive Disorder, Mixed Disturbance of Conduct/Emotion and Pedophilia. He requires monitoring at all times when in the community due to his history of behavioral challenges including inappropriate sexual behavior towards small children and less capable peers. Despite Resident B's history he was placed in the home with two resident's that are non-verbal, and wheelchair bound. Patricia Thomas submitted a corrective action plan dated 11/11/2021. The CAP indicated that Resident B was given a 30-day notice on 11/08/2021. The plan also stated that alarms were placed on bedroom doors and Resident B was moved to his own bedroom. On 04/01/2022, I received an email from Patricia Thomas. She stated that she started the emergency discharge process for Resident B. MORC disagrees with the emergency discharge, so they cannot discharge him at this time. Resident A and Resident B have remained in the same home. The corrective action plan has not been implemented within the time frames as outlined in plan. On 05/04/2022, I spoke to MORC Supports Coordinator, Christina Hill. She stated that Resident A will be moving to the Pine Valley Home in one to two weeks. Ms. Hill stated that Resident B has been referred for placements, however, has been turned down by two providers due to behaviors. They continue to seek an alternative placement for Resident B. Licensee Designee, Patricia Thomas reported that Resident A moved out of the home on 05/09/2022. The previous CAP indicated that Resident B was given a 30-day notice on 11/08/2021, therefore Resident A and Resident B should not have remained in the same home as of 12/08/2021. Resident A and Resident B remained in the home together for five additional months.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2021A0604016 dated 11/02/2021; CAP dated 11/11/2021**

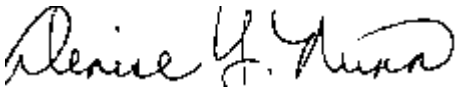
IV. RECOMMENDATION

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

05/11/2022

Kristine Cilluffo Date
Licensing Consultant

Approved By:



05/11/2022

Denise Y. Nunn Date
Area Manager