GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 26, 2022

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

RE: License #: AS500284586
Investigation #: 2022A0990024
Dodge Park AIS

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500284586
Investigation #:	2022A0990024
Complaint Receipt Date:	06/28/2022
Investigation Initiation Date:	06/28/2022
Report Due Date:	08/27/2022
Licensee Name:	Quest, Inc
Licensee Address:	36141 Schoolcraft Road Livonia, MI 48150-1216
Licensee Telephone #:	(734) 838-3400
Administrator:	Nicole Hagood
Licensee Designee:	Patricia Thomas
Name of Facility:	Dodge Park AIS
Facility Address:	11530 16 1/2 Mile Rd. Sterling Heights, MI 48312
Facility Telephone #:	(586) 268-2458
Original Issuance Date:	09/29/2006
License Status:	REGULAR
Effective Date:	03/29/2021
Expiration Date:	03/28/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Direct care staff Denise LaRowe became irate with Resident A and slapped her in the face five times.	Yes

III. METHODOLOGY

06/28/2022	Special Investigation Intake 2022A0990024
06/28/2022	APS Referral Adult Protective Services (APS) referral initiated at intake.
06/28/2022	Special Investigation Initiated - Telephone I conducted a phone interview with Nicole Hagood, administrator and requested several documents related to the investigation.
06/30/2022	Inspection Completed On-site I conducted an unannounced onsite investigation. I briefly interviewed Ms. Hagood, observed Resident A and three residents sitting in the living room area.
07/08/2022	Contact - Telephone call made I interviewed direct care staff Denise Larrowe.
08/10/2022	Contact - Document Received I reviewed Resident A's documents.
08/10/2022	Contact - Telephone call made I contacted direct care staff Jeri Rivers. I left a detailed message.
08/12/2022	Exit conference I conducted an exit conference with Ms. Hagood.

ALLEGATION:

Direct care staff Denise LaRowe became irate with Resident A and slapped her in the face five times.

INVESTIGATION:

On 06/27/2022, I received an Incident Report (IR) via fax from Nicole Hagood, administrator. I called Ms. Hagood to discuss the allegations. Ms. Hagood said that she made a complaint to Adult Protective Services (APS) and to the Office of Recipient Rights (ORR). I informed Ms. Hagood that a complaint would more than likely be made to licensing and I will conduct a special investigation.

In review of the IR, it was reported that on 006/27/2022 Ms. Hagood received a phone call at 2:15AM from direct care staff Jerri Rivers. Ms. Rivers reported that at 1:15AM direct care staff Denise LaRowe slapped Resident A five times in the face because Resident A wanted her brief changed. Ms. Hagood proceed to Dodge Park AIS to investigate. Ms. Hagood found Ms. LaRowe sitting on the couch and asked her did she slap Resident A. According to the IR, Ms. LaRowe said “She [Resident A] was acting up and I didn’t know what to do and I am sorry for what I did.” Ms. LaRowe said, “I’ve been here all day and I’m tired.” Ms. Hagood sent Ms. LaRowe home and reported the incident to Resident A’s guardian, APS, ORR, and Licensing. Ms. Hagood went to check Resident A who was in bed asleep.

On 06/28/2022, I received the complaint via email. In addition to the above allegations in IR, it was reported that Resident A is diagnosed with Downs Syndrome. Resident A needs assistance in bathing and other personal hygiene. Resident A can dress herself and feed herself. This morning, around 1:45AM the manager, Denise LaRowe and staff, Jerri Rivers was on shift. Resident A came out her room with a dry brief in one hand and was pointing at her private area saying indicating that she was wet and needed to be changed. Ms. LaRowe became irate and slapped Resident A in the face five times. Resident A put herself on the ground and direct care staff Ms. Rivers got her up. The administrator, Ms. Hagood was contacted and came to the home. Ms. LaRowe reported that Resident A was not cooperating with her. Ms. LaRowe was told this is no excuse for her behavior, to get her things and leave. This morning, Resident A has red dots on the left side of her face, and it appears some blood vessels were broken. An IR was completed. Licensing, law enforcement, ORR and Macomb Oakland Regional Center placing agency were all notified of the incident. Resident A’s guardian was also made aware. The police came to the home and took statements from staff. It was reported that law enforcement was coming back to take pictures of Resident A’s face this afternoon. Staff is also taking Resident A to urgent care to be checked out this afternoon. Resident A does not appear to be in pain and is not bothered by touch. Ms. LaRowe has been removed from the schedule and suspended pending investigation. Ms. LaRowe will be terminated once the investigation is completed.

On 06/28/2022, I conducted a phone interview with Nicole Hagood, administrator. Ms. Hagood said that Ms. LaRowe has been employed since 2018 and is fully trained. Ms. Hagood said that in the past there had been some disciplinary issues regarding Ms. LaRowe job performance but no issues with resident rights or allegations of neglect/abuse. Ms. Hagood said that Resident A was initially taken to urgent care but

was advised by urgent care that she be taken to the hospital because of the potential of a head injury for more testing. Ms. Hagood said that at the emergency room (ER) the doctor suspected that Resident A's jaw was slightly dislocated, but it was not. I requested to review Ms. LaRowe employee record and Ms. River's phone number. Ms. Hagood said that Resident A is non-verbal but can occasionally use sign language to say "yes" or "no." Ms. Hagood said that ORR investigators came to the home today to observe Resident A. Ms. Hagood has an audio recording of Ms. LaRowe admitting to slapping Resident A.

On 06/30/2022, I conducted an unannounced onsite investigation. I briefly interviewed Ms. Hagood. I observed Resident A. Resident A is non-verbal and could not be interviewed. Resident A reached out for hug. I observed three residents sitting in the living room area that are not able to be interviewed due to limited cognitive abilities. I did not observe any marks or injuries on Resident A's face.

On 07/08/2022, I interviewed direct care staff Denise LaRowe. Ms. LaRowe admitted to slapping Resident A in the face three times. Ms. LaRowe said that it was 1AM and Resident A became combative and hit her first in the face. Ms. LaRowe said that Ms. Rivers was with another resident changing him when Resident A got out of bed. Ms. LaRowe said that she did not slap Resident A hard but more like taps on her cheek. Ms. LaRowe understands what she did was wrong and is embarrassed and ashamed of her actions. Ms. LaRowe had never hit Resident A or any other resident in the past and she has been employed there for six years. Ms. LaRowe said that after she slapped Resident A, she apologized to her and kissed her forehead. Ms. LaRowe was very apologetic and expressed that she was willing to accept the repercussions of her actions.

On 08/10/2022, I reviewed Resident A's documents and Ms. LaRowe's disciplinary records as the home manager. I observed that Ms. LaRowe had the following employee corrective actions/warning statements:

1. 08/28/2019 for failure to follow instructions and/or procedures and policy and/or work rule regarding a medication error (prescription was out for two days).
2. 09/10/2019 for failure to follow instructions and/or procedures and policy and/or work rule for allowing a new staff person to work one without providing TB test results.
3. 01/13/2020 for failure to follow instructions and/or procedures and policy and/or work rule for a MORC audit and seven-line items were incomplete for their billing.
4. 09/16/2020 for failure to follow instructions and/or procedures and policy and/or work rule not having in a new employees record their physical at hire and TB test results.
5. 10/08/2020 for failure to follow instructions and/or procedures and policy and/or work rule not having in a new employee record their physical at hire and TB test results (noted that the next infraction would result in demotion).

Ms. LaRowe was the home manager and I observed and confirmed with Ms. Hagood that she was fully trained.

I observed Resident A discharge summary. Resident A was diagnosed with blunt facial trauma at McLaren Macomb Hospital on 06/27/2022.

On 08/12/2022, I conducted an exit conference with Ms. Hagood. I informed Ms. Hagood that there is one rule violation and that a corrective action plan will be required. Ms. Hagood said that ORR substantiated their investigation. Ms. Hagood was uncertain if there are criminal charges. Ms. Hagood said that she spoke to the detective (name not provided) on the case two weeks ago he said that he tried calling Ms. LaRowe two times with no return call. According to Ms. Hagood the detective said that he finished his report and was taking it to the prosecutor's office that next morning. Ms. Hagood tried calling the detective last Thursday to find out if the warrant was approved or denied and have not heard back from him yet although, he works the midnight shift so he can be difficult to reach. Ms. Hagood said that she will try calling him again today. Ms. Hagood said that Resident A still lives in the home. Ms. Hagood is not sure what the specific violations are from ORR and was told that they would be getting something in writing to their central office within 30 days and as of today's date no report received.

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: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on the investigation conducted there is substantial evidence that direct care staff Denise LaRowe slapped Resident A on her face on 6/27/2022 during the midnight shift. According to the IR, direct care staff Jerri Rivers reported the incident after observing Ms. LaRowe slapping Resident A in the face five times because Resident A wanted her brief changed. Ms. LaRowe admitted to slapping Resident A to Ms. Hagood, administrator as well as licensing. Ms. LaRowe said that she slapped Resident A three times in the face because Resident A hit her first and was combative. Resident A is non-verbal. Resident A was diagnosed with blunt facial trauma. According to Ms. Hagood, the law enforcement investigation is still pending. Ms. LaRowe was terminated and has not worked in the home since the incident occurred on 06/27/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

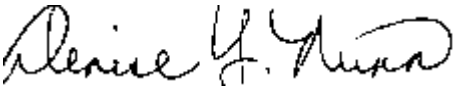
IV. RECOMMENDATION

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

08/15/2022

LaShonda Reed — Date
Licensing Consultant

Approved By:



08/26/2022

Denise Y. Nunn — Date
Area Manager