GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 2, 2024

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

RE: License #: AS820014530
Investigation #: 2024A0901024
Leroy AIS Home

Dear Patricia 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,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820014530
Investigation #:	2024A0901024
Complaint Receipt Date:	03/06/2024
Investigation Initiation Date:	03/07/2024
Report Due Date:	05/05/2024
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:	Leroy AIS Home
Facility Address:	25824 Leroy Taylor, MI 48180
Facility Telephone #:	(734) 942-9166
Original Issuance Date:	11/16/1992
License Status:	REGULAR
Effective Date:	04/08/2023
Expiration Date:	04/07/2025
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

I. ALLEGATION(S)

	Violation Established?
Staff, Ashley Mosley, was observed outside in a vehicle, leaving the residents alone and unsupervised in the house.	Yes
Staff, Ashley Mosley, was observed outside in a vehicle smoking marijuana while on duty.	No

II. METHODOLOGY

03/06/2024	Special Investigation Intake 2024A0901024
03/06/2024	Referral - Recipient Rights
03/06/2024	APS Referral
03/07/2024	Special Investigation Initiated - Telephone Home Manager, April Kyle
03/14/2024	Contact - Telephone call made Home Manager, April Kyle
03/14/2024	Contact - Document Received Text
03/14/2024	Contact - Telephone call made Staff, Ashley Mosley
03/14/2024	Contact - Telephone call made Mother A
03/22/2024	Contact - Telephone call made Mother A
03/25/2024	Contact - Telephone call made Staff, Ashley Mosley

03/26/2024	Contact - Telephone call received Mother A
03/26/2024	Contact - Telephone call made Sister A
04/29/2024	Exit Conference Licensee Designee, Patricia Thomas
04/29/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Staff, Ashley Mosley, was observed outside in a vehicle, leaving the residents alone and unsupervised in the house.

INVESTIGATION:

On 03/07/2024, I made a telephone call to the home manager, April Kyle. April stated she was informed of the incident by Mother A. It was also reported that Ashley Mosley was the only staff on duty at the time and has been suspended pending investigation. I requested a copy of the incident report and contact information for Mother A.

On 03/14/2024, I received a text from April that consisted of a copy of the incident report and Mother A's telephone number. I also received a copy of the Employee Corrective Action form, which verified that Ashley was suspended. The incident report indicated that on 03/04/2024 around 5:38 p.m. Sister A was returning Resident A from a visit, when Ashley was observed outside in a car smoking weed (marijuana) with a guy. April was notified, and Ashley was relived of her duties for the day.

On 03/14/2024 and 03/22/2024, I left a voice message for Ashely. The call was returned on 03/25/2024. Ashely confirmed being the only staff on duty at the time. Ashely stated that some items were brought to the job for her. When going outside to retrieve the items, she sat briefly in the car with the individual. Ashely insisted the residents were left alone no longer than a minute.

On 03/14/2024 and 03/22/2024, I left a voice message for Mother A. The call was returned on 03/26/2024. Mother A reported not being present at the time. Mother A explained that Sister A was returning Resident A to the home and witnessed the incident. Mother A provided Sister A's telephone number.

On 03/26/2024, I made a telephone call to Sister A. Sister A reported while returning Resident A home on 03/04/2024, Ashley was observed outside in a black SUV. Resident A let herself in the house and there was no other staff.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based on the information obtained during this investigation, sufficient staff was not on duty as required. Ashley admitted to leaving the residents unsupervised in the house while she was outside sitting in the vehicle. This was also observed by Sister A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff, Ashley Mosley, was observed outside in a vehicle smoking marijuana while on duty.

INVESTIGATION:

On 03/07/2024, I made a telephone call to the home manager, April Kyle. April reported never having any issues of this nature with Ashely before and never receiving any complaints about her smoking marijuana on the job.

On 03/14/2024 and 03/22/2024 I left a voice message for Ashely. The call was returned on 03/25/2024. Ashely confirmed being in the vehicle but denied smoking marijuana and reported it was the other individual in the car who was smoking marijuana.

On 03/26/2024, I made a telephone call to Sister A. Sister A reported when returning Resident A home on 03/04/2024, Ashley was observed outside in a black SUV. Ashely exited the vehicle and weed could be smelled. Sister A stated she did not directly see Ashely smoking and there was also another individual in the car.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**

ANALYSIS:	Based on the information obtained during this investigation there is a lack of evidence to confirm the allegations. There is insufficient evidence to confirm that Ashley was impaired while at work and unable to meet the needs of the residents. She denied smoking marijuana and Sister A denied seeing her smoking, but only smelled marijuana when Ashely exited the vehicle that someone else was in.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

_______________________________________ 04/29/2024
Regina Buchanan Date
Licensing Consultant

Approved By:

05/02/2024

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Ardra Hunter Date
Area Manager