GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 9, 2025

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

RE: License #: AS820014530
Investigation #: 2025A0122024
Leroy AIS Home

Dear Mrs. Thomas:

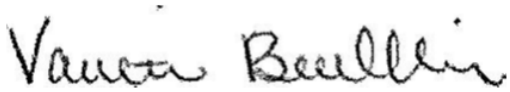
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 284-9720.

Sincerely,



Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS820014530
Investigation #:	2025A0122024
Complaint Receipt Date:	04/16/2025
Investigation Initiation Date:	04/16/2025
Report Due Date:	05/16/2025
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:	04/08/2025
Expiration Date:	04/07/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A wasn't allowed to participate in required community outings.	No
• Resident A was yelled at by staff member, Deana Harris. • Staff members, April Kyle and Ashley Smith discussed Resident A in a negative manner during a phone call. • Staff member, Silver Tally, discussed Resident A's personal information in front of a visitor, John Swanson. • Staff member, Deana Harris, used Resident A's phone charger without his permission.	Yes
Resident A was told to go to bed at 8:30 p.m.	No
• Staff member, Silver Tally, was rough when providing personal care to Resident A. • During the weekends, staff members did not provide personal assistance to Resident A in the mornings.	No
• Staff member, Silver Tally, made derogatory remarks about Resident A to Guardian A1. • Staff members threaten to write up Resident A if he did not follow instructions.	No
Guardian A1 did not receive notification that the local police department was called to the facility.	No

III. METHODOLOGY

04/16/2025	Special Investigation Intake 2025A0122024 Recipient Right referral APS Referral
04/16/2025	Special Investigation Initiated - Telephone Completed interview with recipient rights advocate, Matthew Schneider.
04/17/2025	Inspection Completed On-site Completed interviews with Resident A and Guardian A.

04/22/2025	Inspection Completed On-site Reviewed Resident A's file. Completed interviews with staff members, April Kyle and Silver Tally. Observed Residents B and C.
04/22/2025	Contact – Telephone call made Completed interview with Supports Coordinator, Leslie Collins.
04/23/2025	Contact – Telephone call made Completed interview with staff member, Francellia Montgomery.
05/06/2025	Contact – Telephone call made Completed interviews staff members, Dominique Greene, and John Swanson.
05/06/2025	Contact – Telephone call made Completed interview with Guardian BC.
05/13/2025	Contact – Telephone call made Attempted to complete interview with staff member, Tiffany Bolan, however telephone number non-working.
05/17/2025	Contact – Document received Residents Individual Plans of Service via email.
05/27/2025	Exit Conference Discussed findings with licensee designee, Patricia Thomas.

ALLEGATION: Resident A wasn't allowed to participate in required community outings.

INVESTIGATION: On 04/17/2025, I completed an interview with Guardian A1. Guardian A1 reported that on several occasions she paid for Resident A to participate in community outings, however, staff did not take him nor was money refunded for the missed community outings. Guardian A1 stated she spoke to staff member Silver Tally about the missed community outings.

On 04/17/2025, I requested documentation on the dates and monetary amount paid for the missed community outings from Guardian A1. As of 05/13/2025, I have not received the requested information.

On 04/22/2025, I conducted separate face-to-face interviews with staff members, April Kyle and Silver Tally. Ms. Kyle and Ms. Tally stated that Resident A participates

in a day program called Arkay, which has scheduled community outings that Resident A has paid for. Both stated there have been scheduled day program community outings in the past that Resident A was unable to participate in due to scheduling conflicts, i.e. a doctor appointment scheduled at the same time of the community outing. Per Ms. Kyle and Ms. Tally, if Resident A was unable to participate in a day program community outing, then the staff at the day program was responsible for reimbursement and rescheduling as it is a separate program from facility outings and day program staff received the monetary funds.

Both reported that there are scheduled monthly community outings for all residents to participate in, for example they have taken residents to McDonalds, ice cream shops, shopping malls, etc. Ms. Kyle and Ms. Tally stated residents' personal allowances were used when participating in these outings, there was no pre-payment requirement. Resident personal allowances funds were only used if the community outing was completed, therefore there was no issue with reimbursement for anyone.

On 04/22/2025, I completed an interview with the support coordinator for Resident A, Leslie Collins. Ms. Collins reported that she received several reports of concern from Resident A regarding staff members and the personal care he received from them. Ms. Collins stated that her observations of Resident A and staff members' interactions were limited. Ms. Collins reported that she did not observe any of the concerns Resident A reported and could give no information regarding the allegations stated in this report.

On 05/27/2025, I completed an exit conference with licensee designee, Patricia Thomas, and discussed my findings with her. Ms. Thomas agreed with my findings.

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:	Based upon my investigation, which consisted of interviews with staff members, April Kyle and Silver Tally, interviews with Resident A and Guardian A. The requested information from Guardian A1 was never received, so I was unable to review pertinent documentation relevant to this investigation; therefore, there is no evidence to substantiate the allegation that Resident A wasn't allowed to participate in the required community outings. There is no evidence to document the licensee did not provide personal care as outlined in Resident A's assessment plan.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Resident A was yelled at by staff member, Deana Harris.**
- **Staff members April Kyle and Ashley Smith discussed Resident A in a negative manner during a phone call.**
- **Staff member, Silver Tally, discussed Resident A's personal information in front of a visitor, John Swanson.**
- **Staff member, Deana Harris, used Resident A's telephone charger without his permission.**

INVESTIGATION: On 04/17/2025, I completed interviews with Resident A and Guardian A1. They reported the following: On an unknown date, staff member Deana Harris screamed at Resident A for reporting an incident where she disrupted his sleep by taking a personal phone call. Resident A stated he was receiving personal care from another staff member, Dominique Green, and Ms. Harris came into the bathroom and confronted him about reporting his disrupted sleep incident. Resident A stated he was scared of the behavior Ms. Harris was displaying.

On 04/24/2025, I completed an interview with staff member, Deana Harris. Once I described the alleged incident to Ms. Harris, she denied confronting and yelling at Resident A. Ms. Harris stated she does not answer her personal cell phone while working at the facility, therefore, she had no knowledge of the incident Resident A referred to.

On 05/06/2025, I completed an interview with staff member, Dominique Greene. Ms. Greene stated that she did not remember Resident A nor the alleged incident I described. Ms. Greene knows staff member, Deana Harris, but stated she did not observe an incident where Ms. Harris was yelling at Resident A.

On 04/17/2025, both Resident A and Guardian A1 reported staff members, April Kyle and Ashley Smith contacted each other via a telephone call and discussed Resident A in a negative manner. Neither Resident A nor Guardian A1 could give

examples of the alleged statements made by either April Kyle or Ashley Smith, but felt the context of the discussion were negative comments about Resident A.

On 04/22/2025, I completed an interview with April Kyle. Ms. Kyle reported the following: Ashley Smith called the facility, and Ms. Kyle spoke with her. Ms. Kyle reported that Ms. Smith requested a copy of Resident A's *Resident Care Agreement*. Per Ms. Kyle, Ms. Smith confirmed that Resident A had been admitted to her facility, and this was the reason she requested the document. Ms. Kyle stated she ended her conversation with Ms. Smith after the short exchange and denied that Resident A was discussed in a negative way. Ms. Kyle denied making negative comments about Resident A to Ashley Smith.

On 05/06/2025, I completed an interview with Ashley Smith. Ms. Smith confirmed that she and April Kyle had a conversation discussing Resident A. Ms. Smith stated no negative comments were made about Resident A, but the requirements of his personal care was discussed. Ms. Smith stated Ms. Kyle reported what activities Resident A enjoyed, how to assist him in the bathroom, along with additional personal care information.

On 04/17/2025, I completed interviews with Resident A and Guardian A1. Both reported on an unknown date, visitor, John Swanson, entered the facility to visit Resident A and staff member, Silver Tally, stated, Resident A "had a bowel movement on himself." Resident A stated he felt embarrassed. Guardian A1 stated Ms. Tally should not have reported Resident A's personal information in front of anyone.

Onn 04/22/2025, I completed an interview with staff member, Silver Tally. Ms. Tally reported that she remembered a time when Guardian A came to the facility with a male visitor, however, she denied making a comment about Resident A in front of Guardian A1 and the male visitor. Ms. Tally denied stating that Resident A "had a bowel movement on himself" in front of Guardian A1 and the male visitor.

On 05/06/2025, I completed an interview with John Swanson. Mr. Swanson reported that staff member, Silver Tally made the following comment when he was visiting Resident A, "It will be just a minute, he shit himself again." Per Mr. Swanson, Ms. Tally should have used different language to inform him that Resident A was unavailable at that time. Mr. Swanson stated Guardian A1 was present and observed Ms. Tally make this statement.

On 04/17/2025, I completed an interview with Resident A and Guardian A. Both reported that staff member, Deana Harris, used his telephone charger without permission. Resident A stated that initially he gave permission to Ms. Harris to use his charger, however, after several incidents when she did not return his charger to its proper place, he told Ms. Harris she no longer had permission to use his phone charger. Resident A stated staff member: Deana Harris used his phone charger after she did not have his permission. Resident A stated he reported this issue to staff

member, April Kyle. April Kyle responded to Resident A by stating he should hide his phone charger so that Deana Harris could not find it.

On 04/22/2025, I completed an interview with staff member, April Kyle. Ms. Kyle confirmed that Resident A reported to her that staff member, Deana Harris, was using his phone charger and he wanted her to stop. Ms. Kyle stated she addressed this issue by having Resident A store his phone charger in his bedside drawer and suggested that he keep its location private. She also had a conversation with Ms. Harris, directing her to no longer make the request to use Resident A's phone charger, specifically that she stop using Resident A's phone charger. Ms. Kyle stated to her knowledge her actions addressed the issue, and it was no longer a concern for Resident A as she never received another report from Resident A that it was an issue.

On 04/24/2025, I completed an interview with Deana Harris. Ms. Harris acknowledged that she used Resident A's telephone charger once. After the one-use, Ms. Harris stated she received directions from staff member, April Kyle, not to ask nor use Resident A's phone charger. Ms. Harris stated she complied with Ms. Kyle's request. Per Ms. Harris, after she complied with Ms. Kyle's directive, she felt the issue was resolved and she never received report(s) that it was an issue.

On 04/22/2025, I completed an interview with the support coordinator for Resident A, Leslie Collins. Ms. Collins reported that she received several reports of concern from Resident A regarding staff members and the personal care he received from them. Ms. Collins stated that her observations of Resident A and staff members' interactions were limited. Ms. Collins reported that she did not observe any of the concerns Resident A reported and could give no information regarding the allegations stated in this report.

On 04/22/2025, I completed an onsite inspection. I observed the facility to be clean and organized. I observed Residents B and C in the facility, they were both appropriately dressed, clean, and displayed no signs of discomfort or distress. I observed them to be comfortable in the facility, receiving appropriate personal care from staff members, April Kyle and Silver Tally.

On 05/06/2025, I completed an interview with Residents B and C's guardian (Guardian B1/C1). Guardian B1/C1 reported no issues and/or concerns with the personal care being provided to Residents B and C. Guardian B1/C1 stated she has observed staff member, April Kyle provide personal care to Residents B and C. Per Guardian B1/C1, Ms. Kyle is always appropriate with Residents B and C, also the care Ms. Kyle provides to them is sufficient and meets their needs.

On 05/27/2025, I completed an exit conference with licensee designee, Patricia Thomas, and discussed my findings with her. Ms. Thomas stated she understands my findings, but does not believe that staff member, Silver Tally made that statement about Resident A. Ms. Thomas stated she has always known Ms. Tally to be

respectful and kind, however, she will submit a corrective action plan to address the rule violation.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with staff members, Deana Harris, Dominique Greene, April Kyle, Ashley Smith, and Silver Tally, interviews with Resident A, Guardian A1, and John Swanson. Other than what was reported by Resident A, there is no evidence to substantiate the allegations that Resident A was yelled at by staff member, Deana Harris, that April Kyle and Ashley Smith discussed Resident A in a negative manner, and staff member Deana Harris used Resident A's phone charger without his permission. However based upon interviews with Resident A, Guardian A1, staff member Silver Tally, and John Swanson, there is enough evidence to substantiate the allegation that staff member, Silver Tally, discussed Resident A's personal information in front of visitor, John Swanson, therefore, Resident A was not treated with respect or personal dignity during this incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was told to go to bed at 8:30 p.m.

INVESTIGATION: On 04/17/2025, I completed an interview with Resident A and Guardian A1. Resident A stated that he liked to stay up late on Fridays to drink a weekly beer, it takes a long time for him to urinate due to medical reasons, therefore, he needed to stay up longer. Resident A stated he attempted to explain this issue to staff, however, he was made to go to bed by staff at 8:30 p.m. Resident A did not have particular dates of the alleged incident but stated it was an ongoing issue.

On 04/22/2025, 04/23/2025, 04/24/2025, and 05/06/2025 I completed separate interviews with staff members April Kyle, Silver Tally, Francellia Montgomery, Deana Harris, and Dominique Greene. All denied making a request or forcing Resident A to go to bed at 8:30 p.m. on any day. They all stated they had not received reports from Resident A that he had problems with his bedtime.

On 04/22/2025, I completed an interview with the support coordinator for Resident A, Leslie Collins. Ms. Collins reported that she received several reports of concern from Resident A regarding staff members and the personal care he received from them. Ms. Collins stated that her observations of Resident A and staff members' interactions were limited. Ms. Collins reported that she did not observe any of the concerns Resident A reported and could give no information regarding the allegations stated in this report.

On 04/22/2025, I completed an onsite inspection. I observed the facility to be clean and organized. I observed Residents B and C in the facility, they were both appropriately dressed, clean, and displayed no signs of discomfort or distress. I observed them to be comfortable in the facility, receiving appropriate personal care from staff members, April Kyle and Silver Tally.

On 05/06/2025, I completed an interview with Residents B and C's guardian (Guardian B1/C1). Guardian B1/C1 reported no issues and/or concerns with the personal care being provided to residents B and C. Guardian B1/C1 stated she has observed staff member, April Kyle provide personal care to Residents B and C. Per Guardian B1/C1, Ms. Kyle is always appropriate with Residents B and C, also the care Ms. Kyle provides to them is sufficient and meets their needs.

On 05/27/2025, I completed an exit conference with licensee designee, Patricia Thomas, and discussed my findings with her. Ms. Thomas agreed with my findings.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:

	(p) The right of access to his or her room at his or her own discretion. **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with staff members, April Kyle, Silver Tally, Francellia Montgomery, Deana Harris, Dominique Greene, interviews with Resident A, Guardian A, supports coordinator, Leslie Collins, and Guardian BC, and observations of Residents B and C, other than what was reported by Resident A there is no evidence to substantiate the allegations that Resident A was told to go to be at 8:30 p.m. Therefore, Resident A was given the right of access to his bedroom at his discretion.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Staff member, Silver Tally, was rough when providing personal care to Resident A.**
- **During the weekends staff members did not provide personal assistance to Resident A in the mornings.**

INVESTIGATION: On 04/17/2025, Resident A stated that staff member, Silver Tally, tended to be “heavy handed” when providing personal care to him. Resident A stated he informed Silver Tally of this issue; however, she did not change the manner in which she assisted him. Resident A did not provide specific dates of these alleged incidents but stated it was an ongoing matter.

On 04/22/2025, I completed an interview with staff member, Silver Tally. Ms. Tally denied that Resident A reported that she was being heavy handed while providing personal care to him. Ms. Tally stated she had no knowledge that Resident A had an issue with the manner in which she assisted him and had nothing further to report.

On 04/22/2025, I reviewed Resident A’s file. His health care appraisal dated 07/19/2024, documents that he is diagnosed with cerebral palsy and has ongoing medical issues that are being addressed by his primary care physician. Resident A’s assessment plan dated 07/26/2024, documents that he receives assistance from staff members with eating/feeding, toileting, bathing, grooming, personal hygiene, walking/mobility, meal preparation, etc. His assessment plan states that he can communicate his needs and has the ability to understand verbal communication. Resident A had Medical Chronological logs dated 03/23/2024 through 02/25/2025 documenting that he received sufficient medical treatment as needed. There was no documentation in Resident A’s file to support that his personal needs were not attended to nor that staff members were not providing adult foster care to Resident A based upon his needs.

On 04/17/2025, Resident A stated that on the weekends residents are allowed to sleep in until approximately 11:00 a.m. Per Resident A, staff did not check to see if he needed assistance with urinating. Resident A gave no specific dates for these alleged incidents but stated it was an ongoing issue.

On 04/22/2025, 04/23/2025, 04/24/2025, and 05/06/2025 I completed separate interviews with staff members April Kyle, Silver Tally, Francellia Montgomery, Deana Harris, and Dominique Greene. All stated they checked in with Resident A on weekends to see if he needed assistance with urinating. All reported that it is policy for staff to check at least every two hours for residents that have issues with incontinence or to change residents as needed. All stated they provided Resident A with appropriate personal care, assisting him with incontinent care as needed.

On 04/22/2025, I completed an interview with the support coordinator for Resident A, Leslie Collins. Ms. Collins reported that she received several reports of concern from Resident A regarding staff members and the personal care he received from them. Ms. Collins stated that her observations of Resident A and staff members' interactions were limited. Ms. Collins reported that she did not observe any of the concerns Resident A reported and could give no information regarding the allegations stated in this report.

On 04/22/2025, I completed an onsite inspection. I observed the facility to be clean and organized. I observed Residents B and C in the facility, they were both appropriately dressed, clean, and displayed no signs of discomfort or distress. I observed them to be comfortable in the facility, receiving appropriate personal care from staff members, April Kyle and Silver Tally.

On 05/06/2025, I completed an interview with Residents B and C's guardian, Guardian B1/C1. Guardian B1/C1 reported no issues and/or concerns with the personal care being provided to Residents B and C. Guardian B1/C1 stated she has observed staff member, April Kyle provide personal care to Residents B and C. Per Guardian B1/C1, Ms. Kyle is always appropriate with Residents B and C, also the care Ms. Kyle provides to them is sufficient and meets their needs.

On 05/27/2025, I completed an exit conference with licensee designee, Patricia Thomas, and discussed my findings with her. Ms. Thomas agreed with my findings.

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 upon my investigation, which consisted of multiple interviews with staff members, Silver Tally, April Kyle, Francellia Montgomery, Deana Harris, Dominique Greene, interviews with Resident A, Guardian A, supports coordinator, Leslie Collins, and Guardian BC, and observations of Residents B and C, other than what was reported by Resident A there is no evidence to substantiate the allegations that staff member, Silver Tally, was rough when providing personal care to Resident A or that staff members did not provide personal care to Resident A on weekend mornings. Therefore, there is no evidence to substantiate that Resident A's personal needs were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Staff member, Silver Tally, made derogatory remarks about Resident A to Guardian A.**
- **Staff members threaten to write up Resident A if he did not follow instructions.**

INVESTIGATION: On 04/17/2025, Guardian A reported during a discussion with staff member, Silver Tally, it was stated by Ms. Tally that Resident A was having incidents of urinary incontinence on purpose. Per Guardian A, Ms. Tally felt like Resident A was asking to go to the bathroom too much. Guardian A felt these remarks from Ms. Tally were derogatory towards Resident A.

On 04/22/2025, I completed an interview with staff member, Silver Tally. Ms. Tally denied making statements to Guardian A1 stating that Resident A's urinary incontinence issues were behavior related or done on purpose.

On 04/17/2025, both Resident A and Guardian A1 reported that staff members would threaten to write up Resident A or issue a 30-day notice if they didn't follow staff instructions or if they did not like the way that Guardian A responded to something. Resident A stated if he did not come to receive his snack "on time," or if he was attempting to translate or assist another resident with verbalizing their needs then staff would attempt to write him up. Resident A stated he did not know if he was ever "written up," but stated he felt threatened by the comment. Neither Resident A nor Guardian A1 gave specific dates or names of staff members of these alleged incidents.

On 04/22/2025, 04/23/2025, 04/24/2025, and 05/06/2025 I completed separate interviews with staff members April Kyle, Silver Tally, Francellia Montgomery, Deana

Harris, and Dominique Greene. All denied that they threatened Resident A with being written up if he refused to follow instructions. All stated that Resident A was given choices of following staff instructions and as long as his decisions did not place him at risk, his decisions were respected. All denied threatening Guardian A1 with a 30-day discharge notice and had no further comments to add to this allegation.

On 04/22/2025, I completed an interview with the support coordinator for Resident A, Leslie Collins. Ms. Collins reported that she received several reports of concern from Resident A regarding staff members and the personal care he received from them. Ms. Collins stated that her observations of Resident A and staff members' interactions were limited. Ms. Collins reported that she did not observe any of the concerns Resident A reported and could give no information regarding the allegations stated in this report.

On 04/22/2025, I completed an onsite inspection. I observed the facility to be clean and organized. I observed Residents B and C in the facility, they were both appropriately dressed, clean, and displayed no signs of discomfort or distress. I observed them to be comfortable in the facility, receiving appropriate personal care from staff members, April Kyle and Silver Tally.

On 05/06/2025, I completed an interview with Residents B and C's guardian, Guardian B1/C1. Guardian B1/C1 reported no issues and/or concerns with the personal care being provided to Residents B and C. Guardian B1/C1 stated she has observed staff member, April Kyle provide personal care to Residents B and C. Per Guardian B1/C1, Ms. Kyle is always appropriate with Residents B and C, also the care Ms. Kyle provides to them is sufficient and meets their needs.

On 05/27/2025, I completed an exit conference with licensee designee, Patricia Thomas, and discussed my findings with her. Ms. Thomas agreed with my findings.

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: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with staff members, Silver Tally, April Kyle, Francellia Montgomery, Deana Harris, Dominique Greene, interviews with Resident A, Guardian A, supports coordinator, Leslie Collins, and Guardian BC, and observations of Residents B and C, other than what was reported by Resident A there is no evidence to substantiate the allegations that staff member, Silver Tally, made derogatory remarks about Resident A to Guardian A1 or that staff members threatened to write up Resident A if he did not follow instructions. Therefore, there is no evidence to substantiate that staff members used threats towards Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Guardian A1 did not receive notification that the local police department was called to the facility.

INVESTIGATION: On 04/17/2025, both Resident A and Guardian A1 reported that the local police department was called to address an argument involving staff members, Shy and Tiffany. Guardian A1 stated she never received notification of the incident from the licensee designee. Resident A stated that staff member, Silver Tally, told him not to report the incident to Guardian A but he informed her of the incident anyway.

On 04/22/2025, I completed individual interviews with both April Kyle and Silver Tally. Both denied that there was a staff member by the name of Shy employed by the company and denied that the local police department was ever called to the facility for intervention of any kind.

Ms. Kyle reported that there was an incident between staff members, Tiffany Bolan and Francellia Montgomery. Ms. Kyle does not remember the date of the incident but stated she received a phone call from Ms. Montgomery. Ms. Montgomery reported that she and Ms. Bolan were arguing and having issues getting along. Ms. Kyle stated she went to the facility, spoke to them both individually, sent Ms. Bolan home, and she covered Ms. Bolan's shift, providing personal care to the residents. Ms. Kyle stated the police were not involved in this incident and she found the residents were well when she arrived and checked on them.

Ms. Kyle reported that staff member, Tiffany Bolan quit her employment with the company in December 2024.

On 04/23/2025, I completed an interview with staff member, Francellia Montgomery. Ms. Montgomery confirmed that she got into an argument with co-worker Tiffany Bolan and April Kyle was called to intervene. Ms. Montogomery stated that as she

and Ms. Bolan were arguing, their voices never became elevated, so she didn't believe that the residents were aware, but the arguments continued, and she did not want them to interfere with the completion of her job duties, so she contacted Ms. Kyle for assistance.

Ms. Montgomery reported at the request of Ms. Kyle she went to sit in her car until Ms. Kyle arrived. Ms. Montgomery observed that Ms. Bolan followed her outside and watched her, leaving the residents unattended and unsupervised in the facility. Ms. Montgomery stated that Ms. Kyle arrived in approximately 7 minutes, but again stated at that time she was in her car and Ms. Bolan was a few feet away watching her.

Per Ms. Montgomery, Ms. Kyle came to the facility, had a discussion with both of them, and requested that Ms. Bolan leave. Ms. Montgomery stated that she and Ms. Kyle finished the shift by providing care to the residents without issue.

On 04/22/2025, I completed an interview with the support coordinator to Resident A, Leslie Collins. Ms. Collins reported that she received several reports of concern from Resident A regarding staff members and the personal care he received from them. Ms. Collins stated that her observations of Resident A and staff members' interactions were limited. Ms. Collins reported that she did not observe any of the concerns Resident A reported and could give no information regarding the allegations stated in this report.

On 04/22/2025, I completed an onsite inspection. I observed the facility to be clean and organized. I observed Residents B and C in the facility, they were both appropriately dressed, clean, and displayed no signs of discomfort or distress. I observed them to be comfortable in the facility, receiving appropriate personal care from staff members, April Kyle and Silver Tally.

On 05/06/2025, I completed an interview with Residents B and C's guardian, Guardian B1/C1. Guardian B1/C1 reported no issues and/or concerns with the personal care being provided to Residents B and C. Guardian B1/C1 stated she has observed staff member, April Kyle provide personal care to Residents B and C. Per Guardian B1/C1, Ms. Kyle is always appropriate with Residents B and C, also the care Ms. Kyle provides to them is sufficient and meets their needs.

On 05/13/2025, I attempted to complete an interview with staff member, Tiffany Bolan, however, the telephone number was not in working order.

On 05/27/2025, I reviewed Residents B, C, D, and E's individual plans of service. They do not require 1:1 staffing but require visual checks by staff every 15 minutes. Therefore, even though Ms. Montgomery and Ms. Bolan were outside of the facility for approximately 7 minutes, proper supervision of the residents were maintained.

On 05/27/2025, I completed an exit conference with licensee designee, Patricia Thomas, and discussed my findings with her. Ms. Thomas agreed with my findings.

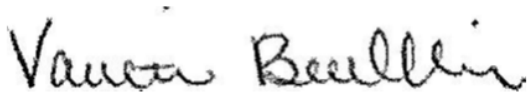
APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(c) Physical hostility or self-inflicted harm or harm to others resulting in injury that requires outside medical attention or law enforcement involvement.**
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with staff members, April Kyle, Silver Tally, interviews with Resident A, Guardian A, supports coordinator, Leslie Collins, and Guardian B1/C1, and observations of Residents B and C, other than what was reported by Resident A, there is no evidence to substantiate the allegations that Guardian A1 did not receive notification that the local police department was called to the facility. Therefore, there is no evidence to substantiate that the licensee failed to report law enforcement involvement.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
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 upon my investigation, which consisted of multiple interviews with staff members, Silver Tally, April Kyle, Francellia Montgomery, Deana Harris, Dominique Greene, interviews with Resident A, Guardian A, supports coordinator, Leslie Collins, and Guardian BC, observations of Residents B and C, and review of pertinent documentation relevant to this investigation there is no evidence to substantiate that the resident's protection and safety were not attended to. The residents do not require 1:1 supervision. Therefore, even though Ms. Montgomery and Ms. Bolan were outside of the facility for approximately 7 minutes, proper supervision of the residents was maintained.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of an acceptable corrective action plan I recommend no change to the status of the license.



Vanita C. Bouldin — Date: 05/27/2025
Licensing Consultant

Approved By:

06/09/2025

Dawn Timm — Date
Area Manager