



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 2, 2025

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

RE: License #: AS500015318
Investigation #: 2025A0604018
Fisher Estates Clf

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.

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) 972-9136.

Sincerely,

A handwritten signature in cursive script that reads "Kristine Cilluffo".

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 West Grand Blvd Ste 9-100
Detroit, MI 48202
(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 #:	2025A0604018
Complaint Receipt Date:	07/21/2025
Investigation Initiation Date:	07/21/2025
Report Due Date:	09/19/2025
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:	Fisher Estates Cif
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:	04/26/2024
Expiration Date:	04/25/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was taken to hospital for aggression with unexplained injuries. Despite being cleared for discharge, the AFC home refused to take him back.	Yes

III. METHODOLOGY

07/21/2025	Special Investigation Intake 2025A0604018
07/21/2025	APS Referral Referral received from Adult Protective Services (APS)
07/21/2025	Special Investigation Initiated - Letter Email to APS Worker, Debra Johns
07/21/2025	Contact - Document Sent Email to Licensee Designee, Patrica Thomas and Nicole Hagood
07/21/2025	Contact - Document Received Email from Patricia Thomas
07/21/2025	Contact - Document Received Email to MORC Case Manager, William Mathis
07/21/2025	Contact - Document Received Email from Debra Johns
07/22/2025	Contact - Document Sent Email to Patricia Thomas and Nicole Hagood. Requested incident reports, Individual Plan of Service (IPOS), Health Care Chronological (HCC) and staff list.
07/22/2025	Contact- Document Received Received documents by fax from Nicole Hagood. Records included emails, incident reports, Resident A's current IPOS, crisis plan and training logs, behavioral charts, health care chronological and staff list.
07/22/2025	Contact - Document Received Email from MORC Case Manager, William Mathis. Sent return email

07/22/2025	Contact - Document Received Emails from Debra Johns. Sent return emails
07/22/2025	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Home Manager, Edith Bakewell
07/22/2025	Contact - Document Received Email from Administrator, Nicole Hagood
07/22/2025	Contact - Document Sent Email to William Mathis
07/25/2025	Contact - Document Received Email from Debra Johns. Sent return email
07/25/2025	Contact - Document Received Received emails from Nicole Hagood
07/28/2025	Contact - Document Received Email from Nicole Hagood
07/29/2025	Contact - Document Received Email from Debra Johns re; Teams Meeting. Sent return email.
07/29/2025	Contact - Document Received Email from Nicole Hagood
08/01/2025	Contact - Document Received Email from Nicole Hagood
08/13/2025	Contact - Telephone call made Teams Meeting with APS, Easter Seals/MORC Staff, Fisher Estates staff and guardian
08/21/2025	Contact - Document Received Received emails from Patricia Thomas with discharge notices for remaining five residents. Home plans to close on 09/21/2025.
08/22/2025	Contact - Document Sent Email to licensee designee, Patricia Thomas. Received return email
09/05/2025	Contact - Document Sent Email to APS Worker, Debra Johns. Received return email. APS is substantiating case.

09/12/2025	Contact - Document Sent Email to Nicole Hagood re: training record request. Received return email.
09/15/2025	Contact- Document Received Received training records from Nicole Hagood by fax. Email to and from Nicole Hagood. Home now plans to close 09/23/2025.
10/02/2025	Exit Conference Completed exit conference with Patricia Thomas and Nicole Hagood by email. Received email from Nicole Hagood. All residents have been moved from home.

ALLEGATION:

Resident A was taken to hospital for aggression with unexplained injuries. Despite being cleared for discharge, the AFC home refused to take him back.

INVESTIGATION:

I received a licensing complaint regarding Fisher Estates on 07/21/2025. Resident A has a history of autism and schizoaffective disorder. It is unknown if he is able to verbally express himself. Relative 1 is his legal guardian. Resident A has lived at the same AFC home for several years. Edith Bakewell is a caregiver for Resident A, and works at the AFC home. It is alleged that Resident A presented to the emergency department via EMS for aggressive behavior, in need of a psychiatric evaluation. It is unknown if there were any kind of altercations at home today involving Resident A and staff or other residents. Resident A was observed to have bruising on his right eye and left upper arm. Edith has no explanation for his injuries. An attending physician evaluated him, and Resident A was discharged. The group home refused to return for Resident A until a psychiatric evaluation was completed. Hospital staff requested a petition, which Relative 1 did complete. Resident A received a virtual psychiatric evaluation, and it was recommended that Resident A discharge home and receive follow-up care. Group home staff still refused. Complaint indicated that APS spoke to 90th the guardian and he reported that Resident A has resided in home for many years and since the new manager started working, he has received multiple calls about Resident A. Prior to this he has never received not even one phone call complaining about Resident A. His guardian reported he was not notified of any bruising which APS observed. Resident A was left in the ER alone with no staffing. The guardian was advised if he was seen by psych and cleared, he could be returned. Resident A was left at the hospital.

On 07/14/2025, I received emails regarding incident from Administrator, Nicole Hagood, prior to receipt of licensing complaint. On 07/15/2025, I received an emergency

discharge notice for Resident A from licensee designee, Patrica Thomas. I was on leave at the time the emails were received.

On 07/14/2025, I received email from administrator, Nicole Hagood documenting incident. Ms. Hagood stated, "Last night around 9:30 pm one of the individuals at Fisher (Resident A) physically out of the blue attacked the male staff on shift. (Resident A) jumped on him, scratched his face in multiple places, punched him in the face and scratched his arm pretty badly drawing a large amount of blood. There was another individual that lives in the home in his recliner in the same room that it happened in and the staff was defending himself as well as trying to be sure that (Resident A) did not attack that individual as he is vulnerable, blind, and unable to defend himself. The scary thing is (Resident A) caused this physical damage to the staff who is an extremely large man. I can only imagine if he were to target one of his housemates what may happen. I am thankful that he did not attack anyone else. The staff is a very large guy and (Resident A's) strength during this incident was extremely scary for him. As he was also thinking of the other five individuals in the home which are all also vulnerable and unable to defend themselves. 911 was immediately called, five paramedics and one police officer arrived. The staff sat by the one individual while waiting for the paramedics so that he didn't try to attack him. (Resident A) at that time took himself into the front room, sat on the couch, was twitching, mumbling, and rocking back and forth. The paramedics could not really get him to comply, so they 'guided' him to the stretcher and strapped him in. He was transported to Henry Ford Macomb Hospital. The staff was sent to Concentra when relief came, and he was treated with antibiotics, a Tetanus shot and needs to follow up in 2 days with Concentra. They called at 4:30 am trying to discharge him home. We requested a psych. evaluation, they said they would let the doctor know. This morning @ 8 am I spoke to Rachel the ER nurse in charge of (Resident A), she stated he has been calm all night so they would not do a psych. evaluation but the guardian could come to the hospital, sign a petition and then they would get one done. I called (Relative 1) this morning and we had a lengthy conversation about how (Resident A's) mental state is changing for the worse and how violent he has become. Just so you know these steps we had taken a week ago trying to avoid this from happening, last Sunday 7/6/25 (Resident A) attacked the same staff when the staff was standing at the kitchen sink, he came up behind him and punched him in the face (not causing any significant injury). 911 did not need to be called that day. He was redirected and he ended up going into his room on his own to calm down. That next day (Monday) Edith (home manager) called Easter seals/MORC Dr. Stein(psych. Dr.) three times to try to get a med. review for (Resident A) and to tell her about that incident, she never received a call back, in the message it was stated this was URGENT. I put together an email with Patty Thomas, William Mathis (the homes support coordinator) and Ashley LaBrana (MORC/Easter Seals Behaviorist) explaining that we need a med. review quickly before he escalates and really injures someone. AND STRESSING THAT ALL OF THE OTHER 5 INDIVIDUALS ARE ALL VULNERABLE AND ONE IS BLIND. On Thursday I stressed that this med review needs to be URGENT as the weekend is approaching. On Friday early morning Marybeth the doctor's assistant told us that the doctor. is on vacation and that she would try to reschedule someone else next week so she can squeeze (Resident A) in.

As of today we have not heard of an appointment date or time. Relative 1 is going to call the hospital to sign the petition to have a psych evaluation done.”

On 07/14/2025, I received another mail from Ms. Hagood which stated, “Just an update. (Relative 1) went to sign the petition around 11 am today. The social worker at HFM called me shortly after and stated he had signed the petition and that they were admitting him and putting a treatment plan together. She said she will update me as things happen.”

On 07/14/2025, I was sent email from the Administrator, Nicole Hagood, with three pictures of Staff, Harlan Crother’s injuries from incident. The pictures showed scratches and wounds on staff’s wrist, bloody lower lip and two small scratches on staff’s nose.

On 07/15/2025, I was sent copy of emergency discharge notice for Resident A dated 07/14/2025 from licensee designee, Patrica Thomas. The discharge notices indicate that an emergency discharge is being issued as there is a substantial risk to the resident due to their inability to meet the resident’s needs or assure the safety and well-being of the other residents of the home. The notice indicates that Resident A committed a serious physical assault on 07/13/2025. The notices state that to date they have attempted to rectify this volatile situation before it became violent by contacting the support coordinator, contacting IDD Counseling and Behavior Supports team at MORC/Easter Seals, attempting to get Resident A an appointment with his psychiatrist but no appointments were available, and leaving repeating messages to the doctor to try on obtain assistance.

On 07/21/2025, I contacted Resident A’s Easter Seals/MORC Care Coordinator, William Mathis, regarding discharge notice received and placement. I received email from Mr. Mathis on 07/22/2025. He indicated that Resident A’s guardian does not want him to return to the Fisher Estates home, so he has been working on placements. Mr. Mathis indicated that Resident A’s violence escalation is new to him. The house requested a medication visit and change in March 2025, which they helped get set up. Resident A’s medications were changed and the house reported that he was doing better. Mr. Mathis indicated that the incident report they received for the event does not give them what happened leading up to that, and he is not sure how staff was reacting or what was happening leading up to his explosion. Resident A has not really shown aggression until recently. Mr. Mathis indicated that he is currently working on placements and has six potential providers at this point. Between today and tomorrow, he is making calls and following up to see what is happening with those placements, but he has yet to hear from any of them. Mr. Mathis indicated that he was not 100% sure it was safe for Resident A to return to the home. He indicated that he believes he would be safe but at this time the guardian does not want him to live at Fisher Estates anymore.

I completed an unannounced onsite investigation at Fisher Estates on 07/22/2025. I interviewed Home Manager, Edith Bakewell. Ms. Bakewell stated that she was not present during incident. She indicated that Resident A is known to self-harm. He will punch himself in the face, arms and legs. Ms. Bakewell stated that she did not know

how Resident A sustained injuries to his eye and upper arm that he had in hospital but believed that it was possible he self-injured. Ms. Bakewell indicated that she has been asking for help with Resident A's behaviors. He has stated that the voices are getting louder in his head, and he tried to go after another staff in February 2025. She is not sure what changed in February to affect Resident A's behaviors. He has been living in the home for approximately ten years. She believes it would be unsafe for him to return to the Fisher Estates home. There are no other residents in the home with a history of aggression. Ms. Bakewell stated that Staff, Harlan Crothers, has worked at Fisher Estates for over a year. He had worked at Fisher Estates on and off before. Ms. Bakewell stated that she was not aware of Harlan hitting Resident A back during the incident on 07/13/2025 or causing injuries to Resident A. Ms. Bakewell stated that she left the home at 4:00 pm on Friday, 07/11/2025. The incident occurred on Sunday 07/13/2025. Ms. Bakewell indicated that Resident A did not have any injuries or marks/bruises to his eye or arm when she left the home on Friday. Ms. Bakewell indicated that there were no other witnesses to the altercation between Mr. Crothers and Resident A. She stated that the only resident present is blind and has limited verbal ability. He can only say things like numbers and colors. The other residents were in bed when the incident occurred. Ms. Bakewell indicated that she does not have any concerns about Mr. Crothers interactions with residents. She has no concerns about Mr. Crothers or other staff at the home. She has not seen any staff be physically aggressive with residents.

On 07/22/2025, I received resident records from Nicole Hagood by fax. The records included emails, incident reports, Resident A's current IPOS, crisis plan and training logs, behavioral charts, HCC and staff list.

On 07/22/2025, I received copies of July 2025 emails between Quest and Easter Seals/MORC team. They include an email sent on 07/10/2025 by administrator, Nicole Hagood. Ms. Hagood emailed Resident A's Case Manager, William Mathis and Behaviorist, Ashley LaBrana indicating that it is URGENT that he get a medication review and is he telling the staff he is hearing voices and getting extremely anxious. She indicates that they need an appointment ASAP because she is afraid Resident A will become violent again. Emails indicate that doctor was on vacation and an appointment was going to be scheduled for when the doctor returned. On 07/14/2025, Ms. Hagood sent an email notifying Mr. Mathis and Ms. LaBrana of the incident. On 07/15/2025, an email was sent by Mr. Mathis requesting additional information as to whether Resident A was officially evicted from the home as Resident A was cleared and ready for discharge. Licensee Designee, Patricia Thomas, responded and indicated that they are not able to accept him back into the home and Resident A is violent and a danger to the other vulnerable clients who live there.

On 07/22/2025, I received a copy of Accident/Incident Investigation Report dated 07/14/2025 with pictures of staff injuries. The report details staff, Harlan Crothers, injuries and states that EMS and state police showed up to home. Resident A was not complying with them and had to be guided to a stretcher where they strapped him in. I received a copy of incident report completed by Harlan Crothers on 07/14/2025. He

states in report that Resident A was sitting on couch twitching and talking to himself. He asked Resident A if he wanted to go to his room and relax. Resident A jumped up, grabbed him, scratched him and pulled his hair, punched him, bit him and spit on him. He stated that he was able to pry him off and he tried to protect another consumer who was in a recliner as well as himself. 911 was called and five EMS and one police officer showed up. Resident A did not seem compliant, so they guided him to the stretcher and strapped him in. Home Manager, Edith arrived shortly after and he went to Concentra for treatment of injuries. Resident A was taken to Henry Ford Macomb.

I received an incident report dated 07/06/2025, completed by Harlan Crothers. The report states that Resident A attacked staff. Staff went to sink and turned around and Resident A punched him in the face. Resident A was redirected to a quiet place to calm down and he eventually calmed down. Action taken indicates that home manager is calling psychiatrist for a medication review. An incident report was received dated 04/26/2025 that was completed by Home Manager, Edith Bakewell. The report states that Resident A's anxiety was high and he stood up and started stomping in the living room. He spit on another housemate. An incident report was received dated 03/03/2025 completed by Ms. Bakewell. The report states that Resident A pushed staff and slammed bedroom door. I received a copy of the incident report dated 02/19/2025, completed by Staff, Autumn McCall-Prince. The report indicates that Resident A had slapped himself in the face twice. He later grabbed staff's arm and pushed the staff onto his roommate's bed. Staff yelled for help and other staff came running and calmed down the situation.

I received a copy of Resident A's February 2025 behavior log. Comments indicate that Resident A was demonstrating behaviors that included hitting himself, screaming no/shut up, screaming and one note states attacked staff. I also received a copy of July 2025 behavior log. Log indicates that Resident A exhibited physical aggression, verbal aggression, increased anxiety, refusal to complete hygiene and self-injury during the month.

I reviewed a copy of Resident A's HCC. Resident A's HCC documents incident on 07/13/2025 as well as contacts with MORC/Easter Seals, psychiatrist's office and guardian. The HCC also documents Resident A's medical appointments.

I reviewed Resident A's IPOS dated 05/01/2025. Plan states that Resident A presents to have increased symptoms of anxiety and schizophrenia. Resident A in the past has had minimal behavioral challenges but was redirectable. Behavioral challenges include SIB, refusals, increased anxiety symptoms such as crying spells and verbal and attempts at physical aggression. The clinician recommends continued support from psychiatrist due to recent change in symptoms.

I reviewed Resident A's Crisis Prevention & Safeguard Plan dated 05/07/2025. Plan recommends calming and grounding activities to reduce to risk of a crisis. The plan indicates that in the past Resident A has made attempts to engage in physical aggression towards staff. Plan indicates that when this occurs staff should use their

words to communicate he is safe, give themselves space, maintain a calm and neutral posture, do not turn back, ask another caregiver to engage with him and remove themselves from situation to break the pattern or train of thought.

On 08/13/2025, A Teams Meeting was held to discuss investigation and interview staff. Individuals present for meeting included Debra Johns-APS Worker, William Mathis-Easter Seals/MORC Care Coordinator, Lindsey Stokes- Easter Seals/MORC Care Coordinator Supervisor, Patricia Thomas- licensee designee, Nicole Hagood- Administrator, Stacy Bateau- Recipient Rights, Susan Stein- Psychiatrist, Ashley LaBrana- Easter Seals/MORC Behaviorist, Lisa Kimball- Easter Seals/MORC Nursing Supervisor, Kendra Casper- Easter Seals/MORC, Carolynne Vanderveen- Easter Seals/MORC, Relative 1- Resident A's Guardian, Harlan Crothers- Fisher Estates Staff, Kelly Martin- Fisher Estates Staff, Edith Bakewell- Home Manager. The licensee, Quest Inc. also had an attorney present for the meeting.

On 08/13/2025, Resident A's Psychiatrist, Susan Stine, indicated that Resident A had a medication change in March 2025. She received report that Resident A was doing better in June 2025 and that he did not need PRN for breakthrough issues. Dr. Stine stated that Resident A is on multiple medications and has not had many medication changes over the last five years. She does not see any correlation between his current behaviors and recent medication changes. She indicated that Resident A is more sensitive to environmental issues.

On 08/13/2025, Resident A's guardian, Relative 1, indicated that he feels Resident A is being blamed for outbursts. He stated that Resident A has been in the system since 2001 with no incidents prior to this. Relative 1 believed that things changed at home when Edith Bakewell took over as home manager. He reported concerns that included Resident A missing workshop and receiving order from doctor taking away candy from Resident A. Relative 1 expressed concern that Resident A is now being denied from placements due to his alleged behaviors. Relative 1 stated that he is a pediatrician and getting close to someone's face can be part of autistic behavior. He stated that Resident A has slapped his arm and thighs when anxious or upset since childhood. He indicated that Resident A's black eye at hospital was "non-tender" which could indicate it was not recent.

On 08/13/2025, administrator, Nicole Hagood, indicated that Relative 1 did not give his input regarding his concerns during planning meetings. She also indicated that they reached out to team for help with Resident A's behaviors. In regard to bruising to Resident A's eye and arm, Ms. Hagood indicated that Resident A also had to be put in physical restraints by EMS when taken to hospital on 07/13/2025.

On 08/13/2025, licensee designee, Patricia Thomas, stated that she has known Resident A since 2006. Ms. Thomas stated that Resident A has had behaviors before that include hearing voices, talking about hurting people and had a prior incident being violent towards staff. Ms. Thomas does not believe Fisher Estates is a suitable placement for Resident A as there are other vulnerable residents in the home.

On 08/13/2025,Carolynn Vanderveen, from MORC/Easter Seals indicated she had concern about blaming medication for Resident A's behavior. She also indicated that Resident A's Behaviorist should have been consulted before asking Resident A's doctor for a prescription for him not to have candy.

On 08/13/2025, MORC/Easter Seals Behaviorist, Ashley LaBrana, stated that it is "always environment with (Resident A)", in regard to the change in his behaviors. She confirmed that a prescription was received from Resident A's primary care doctor to take away sweets. Ms. LaBrana stated that Resident A has hit arms, legs and head. He has had no known bruises or injuries from these behaviors.

On 08/13/2025, Staff Halan Crothers, denied that he made any comments to Resident A about fighting or hitting him. Mr. Crothers indicated that nothing in particular happened the day of the incident prior to its occurrence. Resident A was sleeping when he started his shift at 8:00 am. Resident A woke up around 9:00 am. Resident A ate breakfast and took his morning medication. Mr. Crothers indicated that Resident A had been antsy all day but was not sure if there was anything specific that triggered Resident A's behavior. Mr. Crothers stated that Resident A was talking to himself and hitting the couch. He stated that he asked Resident A if he wanted alone time or activity to draw attention away. When Resident A has behaviors, he will ask him what he wants to do and leave it up to him. He will walk or play games with Resident A. Mr. Crothers denied seeing any bruises on Resident A the day of the incident or doing anything during physical altercation to cause bruises. He denied hitting or punching Resident A during the incident. Mr. Crothers indicated that they did go to floor. He stated that Resident A had him by his face and he had to get Resident A off him.

Mr. Crothers stated that Resident A was talking to himself and hitting himself. He asked Resident A if he wanted to go to his room and Resident A attacked him. Resident A grabbed him by the hair and face. Mr. Crothers stated that he wrapped his arms around Resident A, facing him, and slowly brought him to the floor. Resident A continued to spit, hit, scratch and kicked him in groin. Mr. Crothers stated that he never hit Resident A back. He indicated that he rolled Resident A to his stomach and put his hands behind back. He laid his chest across Resident A's hands and asked him to stop. Mr. Crothers stated that Resident A continued to fight and the altercation went on for a few minutes. Mr. Crothers indicated that he spoke calmly and sternly to Resident A. When Resident A stopped, he let him up. Mr. Crothers indicated that he acted on instinct and did not want to hurt Resident A. He stated that after the incident Resident A sat on couch, did not say a word and gave mean looks. He contacted managers, Edith and Nicole. Mr. Crothers indicated that he has not had crisis intervention training for the use of restraint. MORC/Easter Seals team indicated during meeting that restraining in a prone position is dangerous and not approved method of restraint.

On 08/13/2025, Staff Kelly Martin indicated that he worked 8:00 am- 8:00 pm the day of incident. He was not present when the incident occurred. He noticed different behavior from Resident A that day. Mr. Martin stated that Resident A was hitting himself, could

not sit still and was talking to himself. He did not see Resident A punch himself in eye or left upper arm. Resident A was saying, "stop", over and over. He tried to redirect Resident A to ride his bike but he refused. Mr. Martin indicated that Resident A will hit himself in the head and arms and will hit couch. He indicated that Resident A sat at the table all day and would not move despite redirection. Resident A was very irritated and would not engage in any activity. He tried to give Resident A dinosaurs, coloring books, and gave him juice and snack.

On 08/21/2025, I received emails from licensee designee, Patricia Thomas, with 30-day discharge notices for the five remaining residents in the home. The home plans to close on 09/21/2025.

On 09/05/2025, I received an email from APS Worker, Debra Johns. Ms. Johns indicated that APS would be substantiating case.

On 09/12/2025, I received email from Administrator, Nicole Hagood. She indicated that Quest Inc. was unaware that physical intervention training was available and no one from Easter Seals/MORC on Resident A's team suggested it.

On 09/15/2025, I received copy of Staff, Harlan Crothers, training records by fax. Resident A's IPOS training log indicates that Mr. Crothers was trained on his plan of service and crisis plan on 05/11/2025. Mr. Crothers has completed multiple trainings that include Recipient Rights, CPR/First Aid, Introduction to Human Services and Meeting Special Needs, Direct Support Professional Training, Environmental Emergencies, Bloodborne Pathogens, Medication Administration, Human Relationships, Person Centered Planning Process, Crisis Planning, Behavior & Crisis Intervention and Trauma Informed Supports.

I completed an exit conference with licensee designee, Patricia Thomas and administrator, Nicole Hagood, on 10/02/2025. I sent an email to Ms. Thomas and Ms. Hagood with recommendations and findings. I informed them that a copy of special investigation report would be mailed once approved. Nicole Hagood, confirmed that all residents have been moved. The four residents moved out of the home on 09/17/2025 and 09/23/2025. Copies of discharge notices have been received for all residents. The home will be closed once an approved corrective action plan is received.

APPLICABLE RULE	
R 400.14302	Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.
	<p>(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists:</p> <p>(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home.</p> <p>(b) Substantial risk, or an occurrence, of self-destructive behavior.</p> <p>(c) Substantial risk, or an occurrence, of serious physical assault.</p>
ANALYSIS:	<p>On 07/13/2025, Resident A was involved in a serious physical altercation with staff, Harlan Crothers. Mr. Crothers stated that Resident A jumped up, grabbed him, scratched him, pulled his hair, punched him, bit him and spit on him. Resident A was taken to hospital by EMS and Mr. Crothers was treated at Concentra for injuries. The licensee issued an emergency discharge notice for Resident A on 07/15/2025 due to a substantial risk to the resident and due to their inability to meet the resident's needs or assure the safety and well-being of the other vulnerable residents of the home.</p> <p>On 07/21/2025, I contacted Resident A's Easter Seals/MORC Care Coordinator, William Mathis, regarding discharge notice, received and placement. I received an email from Mr. Mathis on 07/22/2025. He indicated that Resident A's guardian did not want him to return to the Fisher Estates home and he was working to identify a new placement.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14309	Crisis intervention.
	(1) Crisis intervention procedures may be utilized only when a person has not previously exhibited the behavior creating the crisis or there has been insufficient time to develop a specialized intervention plan to reduce the behavior causing the crisis. If the resident requires the

	repeated or prolonged use of crisis intervention procedures, the licensee shall contact the resident's designated representative and the responsible agency or, in the absence of a responsible agency, a professional who is licensed or certified in the appropriate scope of practice to initiate a review process to evaluate positive alternatives or the need for a specialized intervention plan.
ANALYSIS:	Resident A did not have a crisis intervention plan that included the use of physical crisis management. I reviewed Resident A's Crisis Prevention & Safeguard Plan dated 05/07/2025. Resident A's plan recommends calming and grounding activities to reduce the risk of a crisis. The plan indicates that in the past Resident A has made attempts to engage in physical aggression towards staff. Plan indicates that when this occurs, staff should use their words to communicate he is safe, give themselves space, maintain a calm and neutral posture, do not turn back, and ask another caregiver to engage with him and remove themselves from situation to break the pattern or train of thought. Incident reports provided indicate that Resident A had become physically aggressive with staff prior to 07/13/2025 incident on 02/19/2025, 03/03/2025 and 07/06/2025.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14309	Crisis intervention.
	(4) Crisis intervention shall be employed to allow the resident the greatest possible comfort and to avoid physical injury and mental distress.
ANALYSIS:	On 07/13/2025, Resident A was involved in physical altercation with staff, Harlan Crothers. Resident A was taken to Henry Ford Hospital to be evaluated. Resident A was observed to have bruising to his eye and left upper arm at hospital. Mr. Crothers denies hitting or doing anything to Resident A during altercation to cause injuries. Administrator, Nicole Hagood, indicated that Resident A had to be put in physical restraints by EMS when taken to hospital on 07/13/2025. Fisher Estates staff and MORC/Easter Seals Behaviorist stated that Resident A does have a history of hitting himself in head, arms and legs,

	<p>however, this behavior is not known to cause bruising. It is unknown how and when the bruising occurred.</p> <p>Staff, Harlan Crothers, completed an incident report on 07/14/2025 that stated that he was able to pry Resident A off him and he tried to protect another consumer who was in recliner as well as himself. On 08/13/2025, staff Harlan Crothers was interviewed and provided additional information regarding incident and restraint. He stated that Resident A grabbed him by the hair and face. Mr. Crothers stated that he wrapped his arms around Resident A, facing him, and slowly brought him to the floor. Resident A continued to spit, hit, scratch and kicked him in groin. Mr. Crothers stated that he never hit Resident A back. He indicated that he rolled Resident A to his stomach and put his hands behind back. He laid his chest across Resident A's hands and asked him to stop. Mr. Crothers stated that Resident A continued to fight and the altercation went on for a few minutes. Mr. Crothers indicated that he spoke calmly and sternly to Resident A. When Resident A stopped, he let him up. Mr. Crothers indicated that he acted on instinct and did not want to hurt Resident A. MORC/Easter Seals team indicated during meeting that restraining in a prone position is dangerous and not approved method of restraint. Mr. Crothers has not received training in physical crisis management.</p>
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14309	Crisis intervention.
	(8) A licensee or a direct care staff member shall not use crisis intervention until he or she has successfully completed crisis intervention training that has been approved by the department.
ANALYSIS:	On 09/15/2025, I received copy of staff, Harlan Crothers, training records. Resident A's IPOS training log indicates that Mr. Crothers was trained on his plan of service and crisis plan on 05/11/2025. Mr. Crothers has completed multiple trainings that include Recipient Rights, CPR/First Aid, Introduction to Human Services and Meeting Special Needs, Direct Support Professional Training, Environmental Emergencies, Bloodborne Pathogens, Medication Administration, Human Relationships,

	<p>Person Centered Planning Process, Crisis Planning, Behavior & Crisis Intervention and Trauma Informed Supports.</p> <p>Mr. Crothers has not completed training in physical crisis management. Administrator, Nicole Hagood stated that Quest Inc. was unaware that physical intervention training was available and no one from Easter Seals/MORC on Resident A's team suggested it.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change in the license status. All residents have discharged and the home will be closed once an approved corrective action plan is received.

Kristine Cilluffo

10/02/2025

 Kristine Cilluffo
 Licensing Consultant

 Date

Approved By:

Denise Y. Nunn

10/02/2025

 Denise Y. Nunn
 Area Manager

 Date