GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 20, 2026

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

RE: License #: AS820410264
Investigation #: 2026A0993006
Donna

Dear Mrs. Thomas:

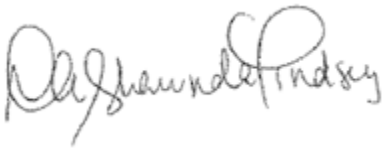
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (313) 456-0380.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820410264
Investigation #:	2026A0993006
Complaint Receipt Date:	03/25/2026
Investigation Initiation Date:	03/26/2026
Report Due Date:	05/24/2026
Licensee Name:	Quest, Inc
Licensee Address:	36141 Schoolcraft Road Livonia, MI 48150-1216
Licensee Telephone #:	(734) 838-3400
Administrator:	Michele Smith
Licensee Designee:	Patricia Thomas
Name of Facility:	Donna
Facility Address:	19414 Donna Livonia, MI 48157
Facility Telephone #:	(734) 469-4182
Original Issuance Date:	06/29/2022
License Status:	REGULAR
Effective Date:	12/29/2024
Expiration Date:	12/28/2026
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff Ashley White, who was not fully trained, was left alone to care for the residents.	Yes
The following allegations were reported: • There are no paper towels in the facility. • There are not enough washcloths for the residents. • There is no soap to shower/bath the residents. • There was no medicated shampoo to wash Resident B's hair. • There is no laundry detergent to do laundry. Therefore, there is a pile of laundry on the basement floor. • The basement smells of urine.	No
On 03/23/2026, at midnight, Resident A's brief was soiled and his pillow and bedding had dried blood on it.	No

III. METHODOLOGY

03/25/2026	Special Investigation Intake 2026A0993006
03/26/2026	Referral - Recipient Rights Received allegations from Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights
03/26/2026	Contact - Telephone call made Telephone call made to recipient right officer Tiffany Burgess. Left a message.
03/26/2026	Special Investigation Initiated - Telephone Telephone call made to administrator Michele Smith
03/26/2026	APS Referral Forwarded allegations to Adult Protective Services (APS)
03/30/2026	Contact - Telephone call made Telephone call made to DWIHN recipient rights officer Tiffany Burgess
03/30/2026	Contact - Telephone call made Telephone call made to staff Ashley White

03/30/2026	Contact - Telephone call made Telephone call made to staff Terri Battles. Left a message.
03/30/2026	Inspection Completed On-site Conducted an unannounced onsite investigation
03/31/2026	Contact - Telephone call made Telephone call made to staff Terri Battles
03/31/2026	Contact - Telephone call made Telephone call made to Guardian A1
03/31/2026	Contact - Telephone call made Telephone call made to staff Keyonte Long
04/01/2026	Contact - Document Received Received documentation
04/02/2026	Contact - Document Received Received additional allegations
04/02/2026	Contact - Telephone call made Telephone call made to staff Ashley White
04/02/2026	Inspection Completed On-site Conducted an unannounced onsite investigation
04/08/2026	Contact - Telephone call made Telephone call made to staff Cedrina Brown. Left a message.
04/08/2026	Contact - Telephone call made Telephone call made to staff Keyonte Long. Left a message.
04/08/2026	Contact - Telephone call made Telephone call made to staff Terri Battles. Left a message.
04/08/2026	Contact - Telephone call made Telephone call made to administrator Michele Smith
04/08/2026	Contact - Telephone call received Telephone call received from staff Terri Battles
04/15/2026	Contact - Telephone call made Telephone call made to staff Cedrina Brown

04/15/2026	Contact - Telephone call made Telephone call made to staff Keyonte Long. Left a message.
03/31/3026	Contact - Telephone call made Telephone call made to staff Keyonte Long
04/16/2026	Exit Conference Held with licensee designee Patricia Thomas

ALLEGATION:

Staff Ashley White, who was not fully trained, was left alone to care for the residents.

INVESTIGATION:

On 03/26/2026, I received the allegations from Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights.

On 03/26/2026, I conducted a telephone interview with administrator Michele Smith. The recipient rights training consists of two parts, an online section and an in-person section. You must complete both parts to be considered fully trained. Per Ms. Smith, as of today, Ms. White completed the in-person section of recipient rights and is considered a full-trained staff. Ms. Smith confirmed that Ms. White worked alone in the facility on 03/20/2026 from 4:00 p.m. to midnight and on 03/23/2026 from midnight to 8:00 a.m. On 03/20/2026, staff Keyonte Long came in to administer medications to the residents and left afterwards.

On 03/26/2026, I forwarded the allegations to Adult Protective Services (APS).

On 03/30/2026, I conducted a telephone interview with recipient rights officer Tiffany Burgess. She confirmed she is investigating the allegations. An investigation is pending.

On 03/30/206, I completed a telephone interview with staff Ashley White. Ms. White stated she began working in the facility in February 2026. She confirmed she worked alone in the facility on 03/20/2026 from 4:00 p.m. to midnight and on 03/23/2026 from midnight to 8:00 a.m. Ms. White confirmed she completed the online section of the recipient rights training prior 03/20/2026, but she did not complete the in-person section of the training until after 03/23/2026. Ms. White could not recall the exact date she completed the in-person section. Ms. White confirmed she is not supposed to administer medications. When she worked alone, another staff came in and administered medications. Per Ms. White, one day she administered medications because no one came in to do so. On another day, the residents did not receive their medications because no one came in. Ms. White did not provide the dates of those incidents.

On 03/30/2026, I conducted an unannounced onsite investigation. I interviewed home manager Debrielle Cheese and staff Cedrina Brown. I was unable to interview Resident A due to his limited cognitive abilities. I did not observe any abuse or neglect concerns.

Ms. Chase confirmed that Ms. White worked alone in the facility on 03/20/2026 from 4:00 p.m. to midnight and on 03/23/2026 from midnight to 8:00 a.m. On 03/20/2026, staff Keyonte Long came in to administer medications to the residents and left afterwards. Ms. Cheese stated Ms. White does not administer medications. Ms. Cheese acknowledged Ms. White should not have worked alone, and a fully trained staff should have worked in the facility with Ms. White on the days she worked alone.

Ms. Brown stated she worked on 03/23/2026 from 8:00 a.m. to 4:00 p.m. She did not know Ms. White was not fully trained and could not work alone in the facility. Per Ms. Brown, if she was aware Ms. White could not work alone, she would have stayed with her.

On 03/31/2026, I conducted a telephone interview with staff Terri Battes. Ms. Battles stated she worked on 03/20/2026 from 4:00 p.m. to midnight. She did not know Ms. White could not work alone in the facility. Ms. Battles stated she thought if someone came in to administer medications, it would be okay for Ms. White to work alone.

On 03/31/2026, I conducted a telephone interview with Guardian A1. Guardian A1 denied knowledge of Ms. White working alone in the facility, despite not being fully trained. Guardian A1 stated she did not have any concerns about the care being provided in the facility.

On 03/31/2026, I conducted a telephone interview with staff Keyonte Long. Ms. Long stated she heard Ms. White worked alone when she was not fully trained. She confirmed she went to the facility on 03/20/2026 to administer medications to residents. Ms. Long stated she worked from around 7:25 p.m. to 12:03 a.m. that day.

On 04/01/2026, I received a copy of the staff schedule for February 2026 and March 2026 as well as verification of Ms. White's training courses. Per the staff schedule, Ms. White worked alone on 03/20/206 from 4:56 p.m. to midnight and on 03/23/2026 from midnight to 8:00 a.m. Ms. White did not work alone on any other day. I verified that Ms. White completed the online recipient rights training on 02/11/2026 and the in-person recipient rights training on 03/26/2026.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(5) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be trained and

	competent in all of the following areas before performing assigned tasks independently: **(e) Resident rights.**
ANALYSIS:	The recipient rights training consists of two parts, an online section and an in-person section. You must complete both parts to be considered fully trained. Ms. White completed the online section on 02/11/2026 and the in-person section on 03/26/2026. Ms. White worked alone for at least part of a shift on 03/20/2026 and the entire shift on 03/23/2026. Ms. White was not trained in resident rights before performing tasks independently.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(b) 12 residents for small group and family homes.**
ANALYSIS:	The recipient rights training consists of two parts, an online and an in-person section. You must complete both parts to be considered fully trained. Ms. White completed the online section on 02/11/2026 and the in-person section on 03/26/2026. Ms. White worked alone for at least part of a shift on 03/20/2026 and an entire shift on 03/23/2026. Ms. White was not fully trained for the supervision, personal care and protection of residents and to provide services to the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The following allegations were reported:

- **There are no paper towels in the facility.**
- **There are not enough washcloths for the residents.**
- **There is no soap to shower/bath the residents.**

- **There was no medicated shampoo to wash Resident B's hair.**
- **There is no laundry detergent to do laundry. Therefore, there is a pile of laundry on the basement floor.**
- **The basement smells of urine.**

INVESTIGATION:

On 04/02/2026, the above allegations were forwarded to me via text message.

On 04/02/2026, I conducted a telephone interview with the complainant. The complainant stated there were no paper towels in the facility. There were not enough soap and washcloths available to bathe the residents. There was no medicated shampoo to wash Resident B's hair. There was no laundry detergent to do the laundry. There is a pile of clothes on the basement floor. As a result, the basement smelled of urine.

On 04/02/2026, I conducted an unannounced onsite investigation. I interviewed home manager Debrielle Cheese. She denied the allegations. Per Ms. Cheese, there are paper towels in the facility. She stated there were no paper towels in the bathroom due to residents' behavior. She agreed to place a roll in there out of the residents' reach. Each resident has bar soap and body wash. There are enough washcloths for the residents. Resident B has not used a medicated shampoo in over one year. There is enough shampoo to wash the residents' hair. There is laundry detergent available to do laundry. There is not a pile of clothes on the basement floor. The basement does not smell like urine.

During the onsite investigation, I observed the following:
- Paper towels in the kitchen
- An adequate number of washcloths and towels in linen closet
- Individual bins for each resident with bar soap and body wash in the linen closet
- An adequate amount of shampoo
- An adequate amount of liquid laundry detergent in the basement
- No pile of clothes on the basement floor
- No urine smell in the basement

I also observed Resident A, Resident B, Resident C, and Resident D. I did not observe any abuse or neglect concerns.

On 04/08/2026, I conducted a telephone interview with administrator Michele Smith. Ms. Smith stated Ms. White contacted her one day and informed her the following:
- There were no paper towels in the facility.
- There are not enough washcloths for the residents.
- There is no soap to shower/bath the residents.
- There was no medicated shampoo to wash Resident B's hair.
- There is no laundry detergent to do laundry. Therefore, there is a pile of laundry on the basement floor.

- The basement smells of urine.

Per Ms. Smith, she went to the facility that day to take paper towels, laundry detergent, and soap. Ms. White stated she told staff they must notify her sooner if they are running low on supplies. She confirmed there was pile of laundry on the basement floor, and the basement smelled of urine. The laundry was completed the day she was notified about it. Ms. Smith stated Resident B has not been prescribed shampoo in over one year, and there is an adequate amount of shampoo in the facility for resident use.

On 04/08/2026, I conducted a telephone interview with staff Terri Battles. Ms. Battles confirmed there once was a pile of laundry on the basement floor due to the dryer going out. As a result, the basement smelled like urine. Staff had to go to the laundromat to do laundry. Ms. Battles stated there have been times when the facility ran out of laundry detergent, body wash, shampoo, and paper towels. Staff had to water down the body wash to stretch it. There have been times when staff used hand soap to bathe the residents. Ms. Battles stated the area manager came in to talk to staff about the concerns, but running out of supplies has been an ongoing issue.

On 04/15/2026, I conducted a telephone interview with staff Cedrina Brown. She denied the allegations. Per Ms. Brown, there are paper towels and tissue in the facility. Each resident has bar soap and body wash. There are enough washcloths for the residents. There are four stacks of 8-10 washcloths and towels in the linen closet. Resident B has not used a medicated shampoo in over one year. There is enough shampoo to wash the residents' hair. There is laundry detergent available to do laundry. There is not a pile of clothes on the basement floor. Ms. Brown stated she does laundry on all her shifts. The basement does not smell like urine.

APPLICABLE RULE	
R 400.645	**Environmental health.**
	(9) Hand-washing fixtures must be provided in both the kitchen and bathroom areas and include hot and cold water, soap, and individual towels.
ANALYSIS:	Ms. Smith acknowledged Ms. White informed her that the facility needed paper towels. Ms. Smith stated she took paper towel to the facility that same day. During an unannounced onsite investigation on 04/02/2026, I observed paper towels in the kitchen. Ms. Cheese stated there were no paper towels in the bathroom due to residents' behavior. She agreed to place a roll in there out of the residents' reach.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.
ANALYSIS:	Ms. Smith acknowledged Ms. White informed her there was a pile of laundry on the basement floor, and the basement smelled of urine. Ms. Smith stated she took laundry detergent to the facility that day, and laundry was done. During an unannounced onsite investigation, there was not a pile of laundry on the basement floor. The basement did not smell like urine. I observed the housekeeping standards presented as comfortable, clean and in an orderly appearance.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.669	**Linens.**
	(1) A licensee shall provide all of the following: **(a) Clean bedding in good condition that includes a minimum of a fitted sheet, top sheet, pillowcase, and blanket or comforter for each bed.** **(b) At least 1 standard bed pillow that is comfortable, clean, and in good condition for each resident.** **(c) Bath towels and washcloths.**
ANALYSIS:	Ms. Smith acknowledged Ms. White informed her there were no washcloths for the residents. Ms. Smith stated she took laundry detergent to the facility that day, and laundry was done. During an unannounced onsite investigation, I observed an adequate number of washcloths and towels in linen closet,
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(2) A licensee shall ensure the resident receives or has access to all of the following:

	(d) Availability of all the following resident hygiene supplies: **(iv) Shampoo.** **(v) Soap.**
ANALYSIS:	Ms. Smith acknowledged Ms. White informed her the facility needed soap. Ms. Smith stated she took soap to the facility that same day. During an unannounced onsite investigation on 04/02/2026, I observed individual bins for each resident with bar soap and body wash in the linen closet as well as an adequate amount of shampoo.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On 03/23/2026, at midnight, Resident A's brief was soiled and his pillow and bedding had dried blood on it.

INVESTIGATION:

On 03/26/2026, I conducted a telephone interview with administrator Michele Smith. Ms. Smith stated that Ms. White reported when she arrived at the facility at midnight on 03/23/2026, Resident A had a soiled brief. In addition, there was dried blood on his pillow and bedding. Per Ms. White, staff either take Resident A to the bathroom to toilet or check and change him every ½ hour.

On 03/30/2026, I conducted a telephone interview with staff Ashley White. Ms. White stated when she arrived at the facility at midnight on 03/23/2026, Resident A's brief was soiled. In addition, Resident A had fecal matter, mucus, and blood coming out of his nose. His pillow and bedding were soiled as a result. Resident A was transported to the hospital for treatment, as a result. Ms. White stated she learned Resident A has a medical condition where bowel movement (BM) comes out of another part of his body if it does not come out of his buttocks. Ms. White did not know how long Resident A was in a soiled brief or how long Resident A's pillow and bedding was soiled. Ms. Battle worked the prior shift but did not provide a handoff.

On 03/30/2026, I conducted an unannounced onsite investigation. I interviewed home manager Debrielle Cheese and staff Cedrina Brown. I observed Resident A. I did not observe any abuse or neglect concerns.
Ms. Cheese confirmed that Ms. White reported that when she worked on 03/23/206, she observed that Resident A's brief was soiled, and he had dried blood on his pillow and bedding. Ms. Cheese stated Resident A was transported to the hospital that day and it was learned that it was not dried blood on Resident A's pillow and bedding. Instead, it

was fecal matter. Ms. Cheese stated staff check and change Resident A at least every two hours.

Ms. Brown stated she never observed staff intentionally leaving Resident A in a soiled brief. She never observed dried blood on Resident A's pillow or bedding. Ms. Brown stated she checks and changes Resident A every two hours.

During the onsite investigation, I observed Resident A's bedroom. Resident A's pillow was clean. There was no bedding on his bed. Staff reported he had soiled his bedding, and it was being laundered. I observed adequate bedding in the linen closet.

On 03/31/2026, I conducted a telephone interview with staff Terri Battles. Ms. Battles confirmed she worked from 4pm to midnight on 03/23/2026. When she left the facility, Resident A's brief was not soiled, and his pillow and bedding were not soiled. Ms. Battles stated she checks and/or changes Resident A every two hours during the day. After he is in bed, she checks and/or changes Resident A every 30 minutes.

On 03/31/2026, I conducted a telephone interview with staff Keyonte Long. Ms. Long states she did not work on 03/23/2026. She checks and changes Resident A every two hours or more if needed.

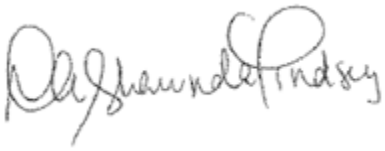
On 04/16/2026, I conducted an exit conference with licensee designee Patricia Thomas. I informed her of the findings. She agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.669	**Linens.**
	(1) A licensee shall provide all of the following: **(a) Clean bedding in good condition that includes a minimum of a fitted sheet, top sheet, pillowcase, and blanket or comforter for each bed.** **(b) At least 1 standard bed pillow that is comfortable, clean, and in good condition for each resident.**
ANALYSIS:	Ms. White reported Resident A's pillow and bedding was soiled on 03/23/2026. That day, Resident A was taken to the hospital for treatment. During an unannounced onsite investigation, I observed Resident A's bedroom. Resident A's pillow was clean. There was no bedding on his bed. Staff reported he had soiled his bedding, and it was being laundered. I observed adequate bedding in the linen closet.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(2) A licensee shall ensure the resident receives or has access to all of the following: **(b) Toileting as needed.** **(c) Assistance with resident hygiene as needed.**
ANALYSIS:	Ms. Smith stated when she arrived at the facility on 03/23/2026, Resident A's brief was soiled. Ms. Battles stated when she left the facility that day, Resident A's brief was not soiled. Staff stated Resident A is checked and changed at least every two hours. Ms. Battle stated Resident A may be changed more often, if needed. Ms. Cheese stated staff take Resident A to the bathroom to toilet as well. Evidence suggests Resident A is being toileted as needed, and staff are assisting him with his hygiene needs.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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



04/16/2026

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DaShawnda Lindsey Date
Licensing Consultant

Approved By:

04/20/2026

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Ardra Hunter Date
Area Manager