GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2021

Louis Hill
Hill's Support Services Inc
PO Box 648
Inkster, MI 48141

RE: License #: AS820281136
Investigation #: 2021A0101027
Kean Home

Dear Mr. Hill:

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,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820281136
Investigation #:	2021A0101027
Complaint Receipt Date:	08/11/2021
Investigation Initiation Date:	08/12/2021
Report Due Date:	10/10/2021
Licensee Name:	Hill's Support Services Inc
Licensee Address:	PO Box 648 Inkster, MI 48141
Licensee Telephone #:	(313) 671-8188
Administrator:	Louis Hill
Licensee Designee:	Louis Hill
Name of Facility:	Kean Home
Facility Address:	26645 Kean Street Inkster, MI 48141
Facility Telephone #:	(313) 561-0910
Original Issuance Date:	04/13/2006
License **Status:**	REGULAR
Effective Date:	12/16/2019
Expiration Date:	12/15/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A took medications that were not prescribed to him.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/11/2021	Special Investigation Intake 2021A0101027
08/12/2021	Special Investigation Initiated - Telephone Designated Person, Tracey Hill
08/26/2021	APS Referral
09/15/2021	Inspection Completed On-site
09/16/2021	Contact – Telephone call made Tracey Hill
10/01/2021	Contact - Document Received
10/08/2021	Inspection Completed-BCAL Sub. Compliance
10/12/2021	Exit conference with the designated person Tracey Hill
10/21/2021	ORR Referral

ALLEGATION: Resident A took medications that were not prescribed to him.

INVESTIGATION: On 08/06/2021, I received an incident report from the designated person, Tracey Hill, on behalf of Hill's Supportive Living Incorporated. The incident report stated Resident A took medications that were not prescribed to him. On 08/12/2021, I called and interviewed Ms. Hill. Ms. Hill stated on 08/05/2021, direct care staff (DCS) Siera Johnson was passing Resident B's medications. Ms. Johnson sat Resident B's medication cup down on the kitchen counter and turned her back to get him a glass of water. Resident A picked up the medication cup and took medications that were not prescribed to him.

I interviewed DCS Siera Johnson on 09/15/2021. Ms. Johnson stated Resident A is a

new resident and she was not familiar with his behavior. Ms. Johnson stated when she was passing Resident B's medications, she sat his medication down on the counter. She turned her back to get him a glass of water and Resident A grabbed Resident B's medication and took them. I asked Ms. Johnson if she was the only staff on duty. Ms. Johnson could not recall if another staff was on duty when this incident occurred.

On 09/16/2021, I called and spoke with Ms. Hill. Ms. Hill stated on 08/05/2021 when Resident A took medication that were not prescribed to him Ms. Johnson was the only staff on duty. I asked Ms. Hill to forward me the staff schedule and the resident's assessment plans.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	The licensee designee failed to take reasonable precaution to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed. On 08/05/2021 at 8:00 p.m., direct care staff (DCS) Siera Johnson was passing Resident B's medications. Ms. Johnson sat Resident B's medication cup down on the kitchen counter and turned her back to get him a glass of water. Resident A picked up the medication cup and took medications that were not prescribed to him. If the medication had been locked or remained in the staff member's hand when she turned her back, Resident A would not have had access to the medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 10/01/2021, Ms. Hill forwarded me the staff schedule dated 08/01/2021 thru 08/15/2021 and the resident's assessments plans. On 08/05/2021 from 7:00 p.m. to 12:00 a.m., Siera Johnson was the only direct care staff on duty. According to the residents' assessment plans they all require assistance with their activities of daily living (ADLs) bathing, toileting, administering medications etc. Some of them require more assistance with their ADLs than others. Therefore, whenever the sole staff on duty is assisting someone with an ADL there is no staff available to meet the needs of the other residents.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	The licensee failed to have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan. On 08/05/2021, from 7:00 p.m. to 12:00 a.m., Siera Johnson was the only direct care staff on duty. According to the residents' assessment plans they all require assistance with their activities of daily living (ADLs) bathing, toileting, administering medications etc. Some of them require more assistance with their ADLs than others. Therefore, whenever the sole staff on duty is assisting someone with an ADL there is no staff available to meet the needs of the other residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan I recommend the status of the license remains unchanged.

Edith Richardson
Licensing Consultant

10/21/2021
Date

Approved By:

10/25/2021

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Ardra Hunter Date
Area Manager