GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 10, 2021

Carol Freeman
Family Supp Svcs For Mental Rec
G-3445 Mackin Rd.
Flint, MI 48504

RE: License #: AS250010767
Investigation #: 2022A0576006
Family Support Group Home

Dear Ms. Freeman:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 284-9730.

Sincerely,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010767
Investigation #:	2022A0576006
Complaint Receipt Date:	10/27/2021
Investigation Initiation Date:	10/29/2021
Report Due Date:	12/26/2021
Licensee Name:	Family Supp Svcs For Mental Rec
Licensee Address:	G-3445 Mackin Rd. Flint, MI 48504
Licensee Telephone #:	(810) 732-9160
Administrator:	Carol Freeman
Licensee Designee:	Carol Freeman
Name of Facility:	Family Support Group Home
Facility Address:	G-3445 Mackin Road Flint, MI 48504
Facility Telephone #:	(810) 732-9160
Original Issuance Date:	10/28/1986
License Status:	REGULAR
Effective Date:	05/08/2021
Expiration Date:	05/07/2023
Capacity:	6
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff, George Clark left the residents of the home unattended for several hours while he was out in the parking lot visiting a relative. Mr. Clark was unaware that a previous resident entered the home during this time.	Yes

III. METHODOLOGY

10/27/2021	Special Investigation Intake 2022A0576006
10/27/2021	APS Referral Intake received from Adult Protective Services (APS)
10/29/2021	Special Investigation Initiated - On Site Interviewed Licensee Designee, Carol Freeman and Resident A
11/04/2021	Contact - Telephone call made Left message for Staff, George Clark to return call
11/05/2021	Contact - Telephone call made Left message for Mr. Clark to return call
11/26/2021	Contact - Document Received Reviewed report from Pat Shepard, Genesee County Office of Recipient Rights (ORR)
12/09/2021	Contact - Telephone call made Left message for Mr. Clark to return call
12/09/2021	Exit Conference Exit Conference conducted with Licensee Designee, Carol Freeman

ALLEGATION:

Staff, George Clark left the residents of the home unattended for several hours while he was out in the parking lot visiting a relative. Mr. Clark was unaware that a previous resident entered the home during this time.

INVESTIGATION:

On October 27, 2021, I received this intake from Adult Protective Services (APS). The intake was rejected for APS investigation.

On October 29, 2021, I completed an unannounced on-site inspection at Family Support Group Home and interviewed Licensee Designee, Carol Freeman. Ms. Freeman reported Staff, George Clark told her that a previous resident, Resident C who lived at the home in 2004, came to the home from Hurley Hospital on October 21, 2021. Ms. Freeman stated she thought something was amiss, so she looked at the cameras. Video revealed Mr. Clark had a visitor to the home on October 21, 2021, at 11:36pm. Mr. Clark went outside and into the visitor's car. On October 22, 2021, at 1:39am Resident C walked up to the facility, knocked on the front door, and entered the facility. Mr. Clark was unaware Resident C had entered the home. Mr. Clark was inside the car for over 2 hours until 1:51am on October 22, 2021, when a van came to the home. Mr. Clark got out of the car to investigate why the van was at the home. The van picked up Resident C and Mr. Clark returned to the car until 2:07am when the visitor in the car left. Ms. Freeman advised she suspended Mr. Clark for 2 weeks pending investigation and she is quite upset that Mr. Clark who behave in this manner. Mr. Clark explained that his relatives were in town, and he was visiting with them in the car.

On October 29, 2021, I interviewed Resident A regarding the allegations. Resident A reported he has lived at his home since 2006, he loves his home and does not want to leave. Regarding the allegations, Resident A reported Staff, George Clark "took off' and may have been in the driveway. Resident C came to the home and Resident A was upstairs in his bedroom sleeping. Resident B went to Resident A's bedroom and told him there was someone at the home to see him. Resident A thought someone was hurt or in trouble. Resident A went downstairs and saw Resident C sitting down inside the home. Resident A reported Resident C used to live at the home. Resident A eventually went back to bed because he was sleepy and the next day, Mr. Clark said he was in the driveway. Resident A reported this has never happened before and indicated he was concerned he was going to get hurt.

On November 4, 2021, November 5, 2021, and December 9, 2021, I left messages for Staff, George Clark to return my call. On December 9, 2021, I spoke to Carol Freeman who advised she terminated Mr. Clark's employment given what occurred. Mr. Freeman advised she cannot tolerate Mr. Clark leaving the residents unattended.

On November 23, 2021, I received Pat Shepard's report involving Staff, George Clark leaving residents at Family Support Group Home unattended. Ms. Shepard's report included her interview with Mr. Clark, and he confirmed he was the only staff person working during the overnight hours on October 21, 2021. Mr. Clark received a visitor at the home from approximately 11:30pm on October 21, 2021, to 1:50am on October 22, 2021. On October 22, 2021, at 1:50am a van pulled in the driveway and picked up a previous resident, Resident C. Mr. Clark was unaware of Resident C's presence at the home and did not have a view of the interior or front door during the time he was outside

of the home. Mr. Clark learned that another resident allowed Resident C in the home unbeknownst to him. Mr. Clark acknowledged he was responsible for monitoring the safety of the residents and failed to do so when he left the facility unattended. Ms. Shepard substantiated a rule violation against Mr. Clark as a result of her investigation.

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:	It was alleged that Staff, George Clark left the residents of the home unattended for an extended period during sleeping hours. During this time, a previous resident entered the home. Upon conclusion of investigative interviews, there is a preponderance of evidence to conclude a rule violation. Staff, George Clark was the only staff scheduled to work the midnight shift on October 21, 2021. Shortly after arriving on shift, Mr. Clark was captured on video visiting with relatives in the driveway of the home in a parked car for over 2 hours. During this time, a previous resident, Resident C walked to the facility and gained entry without Mr. Clark's knowledge. Resident A was woken up by another resident and was told he had a visitor, Resident C. Resident A reported he was concerned and thought someone was hurt or in trouble. Resident C was eventually picked up by a van that arrived at the home. There is a preponderance of evidence to conclude there was not sufficient staff on duty at all times for the supervision and protection of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On December 9, 2021, I completed an Exit Conference with Licensee Designee, Carol Freeman. I advised Ms. Freeman I would be citing a rule violation and requesting a corrective action plan.

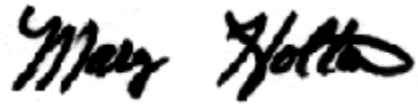
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan no change in the license status is recommended.

12/10/21

Christina Garza — Date
Licensing Consultant

Approved By:



12/10/21

Mary E Holton — Date
Area Manager