GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 31, 2022

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

RE: License #: AS820278669
Investigation #: 2022A0116008
Oak Tree

Dear Mr. Hill:

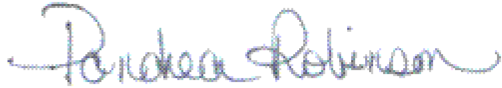
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820278669
Investigation #:	2022A0116008
Complaint Receipt Date:	01/06/2022
Investigation Initiation Date:	01/10/2022
Report Due Date:	03/07/2022
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:	Oak Tree
Facility Address:	600 Oak St. Wyandotte, MI 48192
Facility Telephone #:	(734) 246-3633
Original Issuance Date:	05/25/2006
License Status:	REGULAR
Effective Date:	01/04/2021
Expiration Date:	01/03/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Per incident report, on 01/03/2022, Resident A, admitted to staff that he had been snorting his medication, buspirone 10 mg, through his nose.	Yes

III. METHODOLOGY

01/06/2022	Special Investigation Intake 2022A0116008
01/06/2022	Referral - Recipient Rights
01/06/2022	APS Referral Made
01/10/2022	Special Investigation Initiated - Telephone Interviewed Home Manager, Candance Gee-Long.
01/14/2022	Inspection Completed On-site Interviewed Resident A and B, and staff, Ida Lowery.
01/14/2022	Inspection Completed-BCAL Sub. Compliance
01/24/2022	Contact - Telephone call made Left a message for licensee designee, Louis Hill.
01/26/2022	Exit Conference With licensee designee, Louis Hill.

ALLEGATION:

Per incident report, on 01/03/2022, Resident A, admitted to staff that he had been snorting his medication, buspirone 10 mg, through his nose.

INVESTIGATION:

On 01/10/22, I interviewed home manager, Candance Gee-Long and she reported that on or about 01/03/22, Resident B informed her that he had observed Resident A crush and snort one of his medications. Ms. Gee-Long reported that Resident B reported it happened a couple of months ago and stated that he only saw Resident A do this one time. Ms. Gee-Long reported that she spoke to Resident A about it and initially he denied that he had snorted the medication, but later admitted to her that it was true. Ms. Gee-Long reported that Resident A stated that he snorted the 10mg Buspirone and had only done it once since living in this home.

Ms. Gee-Long reported that back in December of 2021, after administering Resident A's medication, he turned away from her and headed toward the stairs to go to his bedroom. Ms. Gee-Long reported that she called Resident A back into the room she was in to check his mouth to ensure he had swallowed his medication. Ms. Gee-Long reported in doing so she observed Resident A's hand was closed and she asked him to open it. Ms. Gee-Long reported observing the 10mg Buspirone pill. Ms. Gee-Long reported she asked Resident A to take the medication with some water and again checked his mouth to make sure he had ingested it.

Ms. Gee-Long reported she has spoken with the staff since this incident and re-iterated the importance of them watching and checking each resident's mouth after the taking of medication to ensure that it has been swallowed.

On 01/14/22, I conducted a scheduled onsite inspection and interviewed Resident A-B, and staff Ida Lowery. Resident A reported that in his previous home he used to snort his medication all the time. Resident A reported that while living in this home he has only been able to sneak his 10mg Buspirone pill twice. Resident A reported that Resident B caught him once and Ms. Gee-Long caught him on one other occasion with the pill in his hand going upstairs. Resident A reported he was unable to snort that pill.

Resident A reported that the staff have been "watching him like a hawk," when he takes his medication and reported he has not been able to sneak and snort it since he was caught.

I interviewed Resident B and he reported that he observed Resident A crush a small pill and put it in his nose. Resident B reported that it happened a while ago and that later that day he told one of the staff what he had observed. Resident B could not recall the staff who was on shift at the time. Resident B reported that staff always check his mouth and asks him to move his tongue around after taking medication. Resident B reported that he swallows all of his medication.

I interviewed Ms. Lowery, and she reported that she has worked in the home for about 10 years. Ms. Lowery reported that she always ensures that each resident swallows their medications, by checking their mouths after administration.

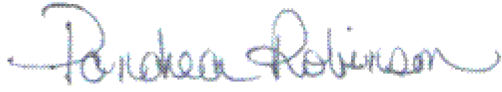
On 01/26/22, I conducted the exit conference with licensee designee, Louis Hill. Mr. Hill reported being aware of the allegation. Mr. Hill reported that all of the staff are trained and know that all prescribed medication is to be taken according to label instructions. Mr. Hill reported all staff are fully trained and know that they have to watch each resident and ensure that medication has been swallowed before that resident leaves their sight.

I informed Mr. Hill of the findings of the investigation, and he reported an understanding of the rule violation. Mr. Hill reported that he would submit an acceptable corrective action plan to address the violation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, applied pursuant to label instructions.
ANALYSIS:	Based on the findings of the investigation, which included interviews of Ms. Gee-Long and Residents A-B, I am able to corroborate the allegation. Resident A admitted that on two separate occasions that he snorted his 10mg Buspirone pill. Resident B reported that on one occasion he observed Resident A crush and snort his medication. Ms. Long reported that Resident B informed her that he observed Resident A snort his medication. This violation is established, as staff failed to ensure that Resident A's 10mg Buspirone pill was taken by mouth pursuant to the label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.



01/27/22

Pandrea Robinson
Licensing Consultant

Date

Approved By:

01/31/22

Ardra Hunter
Area Manager

Date