GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 12, 2022

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

RE: License #: AS820281136
Investigation #: 2022A0121039
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 was required. On September 26, 2022, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820281136
Investigation #:	2022A0121039
Complaint Receipt Date:	08/31/2022
Investigation Initiation Date:	08/31/2022
Report Due Date:	10/30/2022
Licensee Name:	Hill's Support Services Inc
Licensee Address:	PO Box 648 Inkster, MI 48141
Licensee Telephone #:	(313) 671-8188
Administrator:	Louis Hill, Designee
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:	12/16/2021
Expiration Date:	12/15/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Licensee refusing to accept resident back for placement although he is ready to be discharged from the hospital.	Yes

III. METHODOLOGY

08/31/2022	Special Investigation Intake 2022A0121039 *Note: Referral from ORR; ORR made APS referral*
08/31/2022	Special Investigation Initiated - Telephone Garden City Hospital E.R. dept.
08/31/2022	Contact - Telephone call made Tracy Hill
09/01/2022	Inspection Completed On-site
09/01/2022	Inspection Completed-BCAL Sub. Compliance Interviewed Resident A and B
09/08/2022	Contact - Telephone call made Margarita Sparks with Garden City Hospital
09/08/2022	Contact - Telephone call made Follow up call to Mrs. Hill
09/16/2022	Exit Conference Louis Hill, licensee designee
09/26/2022	Corrective Action Plan Received
09/26/2022	Corrective Action Plan Approved

ALLEGATION: Licensee refusing to accept resident back for placement although he is ready to be discharged from the hospital.

INVESTIGATION: On 8/31/22, I phoned Garden City Hospital to determine if Resident A was still at the hospital. The hospital staff indicated Resident A remains in their emergency department. Then, I contacted Tracy Hill (the licensee designee's wife who handles most licensing matters) on 8/31/22 to find out why Resident A had not been picked up from the hospital. According to Mrs. Hill, on 8/29/22 Resident A violently attacked 2 direct care workers (Betty King and Tonette Treadwell) and he hit 3 residents (Resident B, C, D). After the assault, Mrs. Hill reported Resident A ran out of the house and when he returned, he broke the front window of the group home. Staff called 911 for assistance. Police arrived on the scene and transported Resident A to Garden City Hospital for evaluation. Direct care worker, Lakeisa Jefferson followed up by going to the hospital to petition Resident A for treatment. Mrs. Hill reported the hospital contacted her "2-3 hours later" stating Resident A is "medically clear" to return home.

Mrs. Hill explained she did not feel comfortable accepting Resident A back into the home due to his explosive temperament; she further explained Resident A is not compatible with the other residents in the home. Mrs. Hill expressed great concern that Resident C, D, E, F cannot defend themselves against Resident A due to their physical and cognitive impairments. According to Mrs. Hill, the home specializes in caring for persons with physical and developmental disabilities, as well as, limited intellectual functioning. Therefore, the licensee, Mr. Hill completed an emergency discharge for Resident A. To safeguard the well-being of residents and staff, Mrs. Hill acknowledged Hill's Supportive Services, Inc. would not accept Resident A back for placement.

On 9/1/22, I made an onsite inspection at the facility. I interviewed Resident B and C. Resident B reported Resident A attacked him, Resident C, and Ms. Betty. According to Resident B, Resident A was mad, so he started "hitting people" for no reason at all. Resident C reported Resident A attacked her (broke her glasses), Resident B, and Resident D. Resident C also reported Resident A attacked Ms. Betty causing hair loss. Ms. Betty was not at work on the day of inspection. Ms. Hill indicated many of the Staff have threatened to quit if Resident A is allowed to return. Mrs. Hill also reported a worker involved in a separate attack is filing a lawsuit against the company because Resident A pulled "patches" of her hair out while she was working.

On 9/8/22, I contacted Margarita Sparks with the social work department at Garden City Hospital. Ms. Sparks reported Resident A was evaluated by the psychiatrist in their E.R. department. According to Ms. Sparks, "we didn't see any aggressive behavior", so the hospital had no reason to keep him there. Ms. Sparks said Resident A was smiling and did not display "not one sign of aggressive behavior." Ms. Sparks explained it would be better for the licensee to seek outpatient treatment

in situations like these because hospital doctors cannot “just put people on medication to stabilize them” especially since E.R. doctors don’t know the patients well. Ms. Sparks expressed an understanding that many licensees have a misunderstanding of the hospital’s role by expecting their psychiatrists to “stabilize” residents when they act out.

On 9/9/22, I made a follow up call to Mrs. Hill to determine if she was willing to allow Resident A to return to the home. Mrs. Hill declined. Mrs. Hill reiterated Resident A was given an emergency discharge notice. I reviewed Resident A’s emergency discharge letter dated 8/31/22. The letter indicates that pursuant to the brutal assault that occurred on 8/29/22 Resident A could no longer remain at the home. Mrs. Hill said she is currently working with Detroit Wayne Integrated Health Network to secure an alternate placement for Resident A.

On 9/16/22, I completed an exit conference with Mr. Hill. Mr. Hill does not agree with the department’s recommendation. Mr. Hill reasoned he could no longer protect the residents in his home because Resident A would harm them unprovoked. Mr. Hill argued he has a duty and responsibility to protect all residents under his care and supervision in accordance with the licensing rules. Mr. Hill stated his actions to discharge Resident A provided protection to others, including residents and staff.

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.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.**

	(ii) The resident shall have the right to file a complaint with the department. **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
ANALYSIS:	• Resident A has a violent temperament. Resident A is known to direct his anger at residents and Staff. • Mr. Hill completed an emergence discharge to have Resident A removed from his home before a new placement had been secured. • Resident A was left at the hospital and no one from Mr. Hill's staff returned to pick him up when the hospital called within hours to say he was ready for discharge. • Therefore, the department determined Mr. Hill did not meet the discharge criteria as outlined in the rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain unchanged.

12/12/2022

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Kara Robinson Date
Licensing Consultant

Approved By:

12/12/2022

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Ardra Hunter Date
Area Manager