GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 15, 2023

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

RE: License #: AS820352279
Investigation #: 2023A0121011
Wayne Respite Care

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,

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 #:	AS820352279
Investigation #:	2023A0121011
Complaint Receipt Date:	12/05/2022
Investigation Initiation Date:	12/06/2022
Report Due Date:	02/03/2023
Licensee Name:	Hill's Support Services Inc
Licensee Address:	PO Box 648 Inkster, MI 48141
Licensee Telephone #:	(313) 671-8188
Administrator:	Tracy Hill
Licensee Designee:	Louis Hill, Designee
Name of Facility:	Wayne Respite Care
Facility Address:	3221 John Daly Inkster, MI 48141
Facility Telephone #:	(313) 671-8188
Original Issuance Date:	04/29/2014
License **Status:**	REGULAR
Effective Date:	10/29/2022
Expiration Date:	10/28/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care worker, Jennifer Moten hit Resident A in the mouth causing her to bleed.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/05/2022	Special Investigation Intake 2023A0121011
12/06/2022	Special Investigation Initiated - Telephone Call to Tracy Hill, Administrator
12/06/2022	APS Referral
12/06/2022	Referral - Recipient Rights
12/08/2022	Inspection Completed On-site Interviewed direct care workers Daisha Fulton and Velda Moore, Resident B and C.
12/09/2022	Contact - Document Received Incident Report, Resident A's assessment plan and medical consult.
01/10/2023	Contact - Telephone call made Kayla Strong, Resident A’s case manager
01/10/2023	Contact - Telephone call made Direct care worker, Jennifer Molten
01/10/2023	Contact - Telephone call made Follow up call to Mrs. Hill
01/10/2023	Contact - Telephone call made Direct care worker, Melanese Smith
01/10/2023	Contact - Telephone call made Direct care worker, Altravese Turner

01/12/2023	Contact - Telephone call made Jeri Sterett, Recipient Rights Investigator (RRI)
01/12/2023	Contact - Telephone call made Tracey Hill
01/20/2023	Contact - Telephone call made Follow up call to Jeri Sterett, RRI
01/22/2023	Contact - Document Received Resident A-E assessment plans
02/06/2023	Exit Conference Mrs. Hill for Mr. Hill who is not available.

ALLEGATION: Direct care worker, Jennifer Moten hit Resident A in the mouth causing her to bleed.

INVESTIGATION: On 12/6/22, I initiated the complaint with a call to Tracy Hill, Administrator. Mrs. Hill was aware of the complaint allegations; she indicated that she is not sure who's telling the truth because the doctor found no evidence or signs of injury that Resident A had been harmed. Per Mrs. Hill, "things just aren't adding up." According to Mrs. Hill, direct care workers Jennifer Moton and Altravese Turner were scheduled to work the afternoon shift (4:00 p.m. – 12:00 a.m.) on 12/1/22. However, Ms. Turner had a family emergency she needed to attend to so, her daughter Melanese Smith who also works at the home, covered her shift until she arrived. Mrs. Hill reported Ms. Smith failed to report the alleged abuse to her and instead, Ms. Smith informed her mother, Ms. Turner about the encounter between Resident A and Ms. Molten. Mrs. Hill indicated Ms. Turner contacted her to report the abuse based on what Ms. Smith told her.

I completed phone interviews with Ms. Molten, Ms. Smith, and Ms. Turner. Ms. Molten denied using force with Resident A. However, Ms. Molten acknowledged that she did physically manage Resident A to redirect the aggression Resident A displayed with her 5-year-old daughter. Per Ms. Molten, her daughter entered the home to "use the bathroom" after the babysitter brought the children to the group home. Ms. Molten said she was administering resident medication when she heard her daughter "scream and cry" out loud. Ms. Molten said that is when she observed Resident A pulling her daughter's hair. Ms. Molten said she responded by walking over to Resident A and "I just tapped her on her hand." Ms. Molten reasoned "tapping her hand is the only way to get her attention", referring to Resident A. According to Ms. Molten, Resident A instantly released her daughter, then she

separated the two by sending Resident A to her bedroom. Per Ms. Molten, Resident A was not harmed during the altercation and there were no witnesses other than the child. Ms. Molten indicated Ms. Smith was outside on a smoke break when the incident happened, and the remaining 5 residents were in their bedroom. Resident A is non-verbal. Ms. Smith explained when she returned from a smoke break, Ms. Molten instructed her to "go check on {Resident A}" because "I think I hit her kind of hard because I lost it when she hit my baby." Ms. Smith said she went to Resident A's bedroom to check on her and that's when she noticed Resident A's "mouth was bleeding." Ms. Smith added, "you could tell in her face, she was frightened and confused about what was going on." According to Ms. Smith, she informed Ms. Molten that Resident A's mouth was bleeding. Per Ms. Smith, Ms. Molten cleaned Resident A's wound. Ms. Smith reported she contacted Ms. Turner to report the abuse. Ms. Smith acknowledged she "should have called the provider [licensee]", but in the moment, she only thought to contact Ms. Turner since that is the person she was covering for. Ms. Smith indicated Ms. Turner arrived to relieve her approximately 15-20 minutes later. Ms. Turner reported when she arrived at work, she observed Resident A's "mouth was swollen, and in the corner, it had a slit." Ms. Turner was adamant that she observed a cut on the inside of Resident A's mouth. As a result, Ms. Turner contacted Mrs. Hill to report the abuse. Ms. Turner said she took 2 pictures of the injury prior to the call, but she was instructed by Mrs. Hill to "delete them", so she did.

On 12/8/22, I completed an onsite inspection at the facility. Resident A was not present. Direct care worker, Daisha Fulton and Velda Moore were on duty. Ms. Fulton reported she worked the following day after the incident, and she did not observe Resident A with any signs of injury. Ms. Fulton also reported she checked Resident A's bedding and did not observe any blood stains on the sheets or pillow. Ms. Moore worked the next morning with Ms. Fulton. Ms. Moore reported she did not observe Resident A with any skin tears, scratches, or cuts inside her mouth. Ms. Moore said she even checked the floors and dirty towels for evidence of the clean-up, but she saw no blood anywhere. Nevertheless, Ms. Fulton was directed by Mrs. Hill to take Resident A to the hospital for evaluation.

I reviewed the After Visit Summary from Garden City Hospital which verifies Resident A was seen on 12/2/22. The reason for visit is documented as "wellness check." Resident A's, after visit instructions were for her to follow-up with her primary care physician. No unusual findings reported.

On 1/10/23, I contacted Kayla Strong with Psygenics. Ms. Strong reported she's been Resident A's case manager for the past 1½ year. Ms. Strong stated she has no concerns about the care provided to Resident A at the home. Ms. Strong is aware of the incident involving Ms. Molten. Ms. Strong confirmed Resident A is known to be combative with others.

I spoke to Recipient Rights Investigator, Jeri Sterett on 1/12/23 and 1/20/23. Ms. Sterett reported Rights is substantiating the abuse case. Ms. Sterett determined Ms.

Molten is not a credible witness and by Ms. Molten's own admission she physically managed Resident A.

On 2/6/23, I completed an exit conference with Mrs. Hill for Mr. Hill who was not available. Mrs. Hill denied having instructed Ms. Turner to delete photos of Resident A. Mrs. Hill stated she had no knowledge that photos were taken. Mrs. Hill is suspicious of the allegations made by Ms. Smith and Ms. Turner because the medical evaluation showed no signs of injury to Resident A. In addition, Mrs. Hill reported Ms. Turner and Ms. Smith "stopped coming to work" and they both will not return her calls. Mrs. Hill acknowledged Ms. Molten "admitted to putting her hands on her", referring to Resident A. Therefore, the department finds the allegation is substantiated.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	• Both Ms. Smith and Ms. Turner reported seeing Resident A with injuries to her mouth on the evening of 12/1/22. • Ms. Smith said Ms. Molten admitted to hitting Resident A "too hard" when she observed her 5-year-old daughter being attacked by Resident A. • Ms. Molten acknowledged she hit Resident A on the hand regardless of the severity. • Therefore, based on Ms. Molten's own admission, she used physical force to get Resident A to release her hold on her daughter.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: When gathering the facts surrounding this case, I learned that a young child was involved. It was reported by Mrs. Hill that Ms. Molten's 2 children were at the facility unexpectantly. There was an apparent problem with the children's caregiver, so they were brought to work. Both Ms. Smith and Ms. Turner reported seeing Ms. Molten's 2 young children inside the home while she worked on

the evening of 12/1/22. When I spoke to Ms. Molten, she only made mention of the little girl being onsite. Ms. Molten downplayed the reason why the child was onsite, stating, “She came inside to use the bathroom.” According to Ms. Molten, the babysitter brought the children to the home to hand them off to her once her shift ended at 6:30 p.m. Ms. Molten indicated she did not leave at 6:30 p.m. because Mrs. Hill asked her to work longer. Ms. Molten reported she left work at 9:00 p.m. According to Ms. Molten, the children remained in the car until her shift ended because she wasn’t comfortable having them inside the facility nor did she feel comfortable leaving Ms. Smith alone to supervise all 6 residents. Ms. Molten acknowledged the babysitter left the children in her care although she was still working.

Ms. Smith reported seeing Ms. Molten’s 2 children inside of the home when she arrived at work. Ms. Smith suspects both children are elementary school-aged, suggesting they are young. Specifically, Ms. Smith said, “The little boy was sleep in the chair and the little girl had her mama’s phone.” Ms. Smith was adamant, “wasn’t no kids in the driveway!”

There are 2 of 6 residents in the home that are verbal. On 12/8/22, I interviewed Resident B and C. Resident B reported she has observed Ms. Molten’s children at the facility at least 4-5 times. Resident B said the children come to work with their mom and they usually play on their phones while there. Resident C said she’s also seen Ms. Molten bring her children to work. Resident C reported seeing the children come to work with Ms. Molten on more than one occasion.

On 1/12/23 and 1/20/23, I conferenced the case with Recipient Rights Investigator, Jeri Sterett. Ms. Sterett said she found Ms. Molten to not be a credible witness because “she lied about how many children” were there. Per Ms. Sterett, Ms. Molten only mentioned the little girl being at the facility, when all the other witnesses said there were 2 children (a girl and boy) present. I explained to Ms. Sterett that my experience with Ms. Molten was very similar in that, Ms. Molten made no mention of her son being there.

On 1/12/23, Mrs. Hill completed the exit conference in lieu of Mr. Hill who was not available. Mrs. Hill said she was not aware the little girl came inside the home to use the bathroom. However, Mrs. Hill does not dispute the department’s findings that Ms. Molten disregarded the rules by having children on the premises while she worked.

Upon request, I received copies of the resident assessment plans on 1/22/23. The home primarily cares for persons with developmental disabilities, including those with physical limitations and medically fragile needs. Based on the needs of residents, Mrs. Hill stated the staff-to-resident ratio is always 2:6.

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:	• Ms. Molten's credibility is questionable because she led me to believe it was only her daughter onsite, whereas Ms. Smith was very clear that she saw Ms. Molten's daughter and son at the facility. • Ms. Molten's children were dropped off at the facility around 6:30 p.m.; Ms. Molten reported she left work at 9:00 p.m. • It is unreasonable to believe, Ms. Molten left young children in a car for hours while she worked. • Resident B and C reported Ms. Molten has brought her children to work on multiple occasions, so the incident does not appear isolated. • Therefore, the department determined Ms. Molten did not provide adequate supervision, personal care, and protection of residents based on their assessment plans as she was likely distracted paying attention to her own children.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

2/10/23

Kara Robinson — Date
Licensing Consultant

Approved By:

2/15/23

Ardra Hunter — Date
Area Manager