GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 10, 2023

David Call
Freedom Adult Foster Care Corp.
P.O. Box 1588
Clarkston, MI 48347

RE: License #: AS500012006
Investigation #: 2023A0990003
Fox Hill Group Home
Amended Report:
Original Report dated February 3, 2023

Dear Mr. Call:

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.

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 (248) 975-5053.

Sincerely,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500012006
Investigation #:	2023A0990003
Complaint Receipt Date:	01/11/2023
Investigation Initiation Date:	01/11/2023
Report Due Date:	02/10/2023
Licensee Name:	Freedom Adult Foster Care Corp.
Licensee Address:	3990 Bird Road Clarkston, MI 48348
Licensee Telephone #:	(248) 862-5792
Administrator:	David Call
Licensee Designee:	David Call
Name of Facility:	Fox Hill Group Home
Facility Address:	37875 Ryan Road Sterling Heights, MI 48310
Facility Telephone #:	(586) 268-2109
Original Issuance Date:	05/16/1991
License Status:	REGULAR
Effective Date:	11/10/2021
Expiration Date:	11/09/2023
Capacity:	3
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A went to a neighbor's property and attempted to assault the neighbor. There is concern that there is no supervision for the resident.	Yes

III. METHODOLOGY

01/11/2023	Special Investigation Intake 2023A0990003
01/11/2023	Special Investigation Initiated - Telephone I conducted a phone interview with the Reporting Person (RP). I sent an email to RP requesting the police report numbers and the video of the attack.
01/11/2023	APS Referral Adult Protective Services (APS) denied the investigation.
01/11/2023	Contact - Document Sent I emailed the Reporting Person (RP). I requested the police report and surveillance footage.
01/17/2023	Contact - Document Sent I texted the RP regarding the email sent.
01/17/2023	Contact - Face to Face I conducted an onsite investigation. I interviewed direct care staff Valerie Allen. Resident A was not present and at workshop. I observed two non-verbal residents.
01/18/2023	Contact - Face to Face I conducted an interview with Resident A. I interviewed direct care staff James Ash.
01/19/2023	Contact - Document Received I received a reply email from David Call, licensee designee (LD).
01/23/2023	Contact - Telephone call made I left a detailed message with Christina Hill, Supports Coordinator.

01/23/2023	Contact - Telephone call made I left a brief message with Resident A's legal guardian Jeff Starks administrative assistant.
01/24/2023	Contact - Telephone call received I conducted a phone interview with Christina Hill, Supports Coordinator.
02/02/2023	Contact - Telephone call made I conducted a phone interview with Resident A's legal guardian Jim Starks.
02/02/2023	Contact - Document Received I reviewed Resident A's Crisis Prevention and Safeguard Plan dated 01/25/2021. I reviewed Resident A's revised Crisis Prevention and Safeguard Plan.
02/02/2023	Contact - Document Sent I emailed David Call, LD to schedule an exit conference.
02/02/2003	Exit conference I conducted an exit conference with David Call.

ALLEGATION:

Resident A went to a neighbor's property and attempted to assault the neighbor. There is concern that there is no supervision for the residents.

INVESTIGATION:

On 01/11/2023, I received the complaint via email. In addition to the above allegation, the following was reported in the complaint: "Resident A has a mental health issue. Resident A's neighbors make police reports about him often due to his behavior. Resident A is a dangerous person, and he should not be staying in the home. About a year and a half ago, Resident A went to his neighbor's house, banged on the door, and he said that he was going to kill her. No one was harmed. The police were contacted. Today, Resident A went into his neighbor's shed and his neighbor came outside to confront him. Resident A tried to hit his neighbor during this incident, but his neighbor ran away and was not harmed. Resident A is a danger to others. There are concerns that his unknown caretaker cannot control him, and he needs to be removed from the home before one of his neighbors gets hurt."

On 01/11/2023, I conducted a phone interview with the Reporting Person (RP). The RP said that he is the neighbor's adult son who lives in the home. The RP said that his father is the alleged victim reported that was accosted by Resident A. The RP said that

his father is elderly and does not speak English fluently. Prior to the incident which occurred on 01/10/2023, there was one incident 2-3 months ago where Resident A tried to attack his father. His family has lived next door to the group home for 10 years. The RP said that he was present when the incident occurred on 01/10/2023 but did not witness the incident except on the surveillance camera. His father observed Resident A rummaging through their backyard shed. His father asked why he was doing this, Resident A then made a fist as if he was going to hit his father. The RP said that his father ran from Resident A who chased him. His father was not harmed but very shaken. The RP called the police, and they came out to make a report. The RP said that there is concern that the staff are not supervising Resident A properly because he was outside alone when this occurred. The police officers told him that there was not much they could do because Resident A is disabled. The RP agreed to send the video of the incident and a copy of the police report. I emailed the RP requesting the information, however to date, this information has not been received from the RP.

On 01/17/2023, I conducted an onsite investigation. I interviewed direct care staff Valerie Allen. Resident A was not present and was at workshop. I observed two non-verbal residents who could not be interviewed. Ms. Allen said that Resident A would be home all day tomorrow. Ms. Allen said that she was the only staff present the day of the incident 01/10/2023, between Resident A and the neighbor. Ms. Allen pointed towards the rear of the home saying that it was that home involved. Ms. Allen said that Resident A enjoys taking out the trash on garbage day and this is one of his chores. Ms. Allen said that Resident A is to be checked every 15 minutes. On the day of the incident, Resident A was outside about 15 minutes before coming inside. Resident A left out the front door with the trash to take to the curb, but he re-entered the home through the back door. Shortly after, the police arrived at the home informing her that Resident A was inside of the neighbors shed, had a confrontation with the neighbor and chased him in a threatening manner. Ms. Allen said that to her knowledge, Resident A has had threatening confrontations with the neighbors about three times and once with the neighbors across the street. Resident A has not physically assaulted anyone but does threaten verbally.

On 01/18/2023, I conducted an interview with Resident A. I interviewed direct care staff James Ash. Resident A has a pronounced speech impediment and is difficult to understand verbally. Resident A said, “I wanted to fight the man” and pointed to the neighbor’s home (rear next door). Resident A said, “I don’t like the small old man.” Resident A said that neighbor did not do anything to him, and said, “I just want him to die.” Resident A takes the trash out alone. Resident A displayed his fists balled up in a fighting stance when I asked him what he did to the neighbor. Nothing further could be understood.

Direct care staff James Ash said that he was not present when the incident occurred nor has never been present when incidents have occurred with Resident A and the neighbors. Mr. Ash said that Resident A does take trash out every Tuesday or Wednesday. Mr. Ash was told that Resident A’s Crisis Prevention and Safeguard plan

has been updated and he is required to have two-minute checks rather than 15-minute checks as before when he's outside.

On 01/19/2023, I received an email from David Call, licensee designee. Mr. Call emailed attached Resident A's Resident ID form and current crisis and safeguard plan. Mr. Call said that Resident A's Individual Plan of Service (IPOS) meeting was held on 01/12/2023 and staff are now required to provide visual checks every two minutes while he is outside in the yard. Previously, it had been every 15 minutes. A printed copy of his new plan is not available yet. Mr. Call said that per Resident A's IPOS meeting, he will be moving to one of their homes in Oakland County as soon as it can be arranged.

On 01/24/2023, I conducted a phone interview with Christina Hill, Supports Coordinator. Ms. Hill said that she was aware of the allegations that occurred with Resident A and the neighbor on 01/10/2023. Ms. Hill was told that Resident A was going through the neighbor's trash. Ms. Hill said that the plan is to relocate Resident A to a new home because of the issues that he has with the neighbors. Ms. Hill spoke to the social worker at the police department (name unknown) who told her that Resident A made fighting gestures to the neighbor. Ms. Hill was not aware that Resident A chased the neighbor. Ms. Hill said that Resident A likes cleaning litter and taking out the trash and this is something that he enjoys doing. The visual checks with the staff for Resident A prior to the change which just occurred, was 15 minutes and it is now every two minutes. Ms. Hill said that they cannot restrict him further or remove the chores because this is something that brings him joy. Ms. Hill said that Resident A does not require 1-on-1 visual supervision. The home has been updated on his new plan and the goal is to keep Resident A with the same provider. However, the home in which they would like to move Resident A is in Oakland County and he is a Macomb County recipient of services. The hold up on the move would be the counties agreeing to move his services between the two which is not a straightforward process. Ms. Hill said that she does not have copy of the police report or the updated plan.

On 01/24/2023, I reviewed the Sterling Heights Police Report dated 01/10/2023. The police were dispatched to the home at 12:17PM. The report documented the offense and assault and battery/domestic/simple assault. The RP translated for the victim (the elderly neighbor). The report documented that it should be noted that the police department has taken multiple police reports regarding Resident A and neighbors making complaints. There were six report numbers documented as follows: one in year 2019, two in 2020, two in 2021 and one 2022. The police report documented that Resident A walks on to neighboring properties picking up pieces of trash. On 01/10/2023, the alleged victim/neighbor observed Resident A inside of his garden shed. The neighbor asked Resident A what he was doing, and Resident A balled up his fist and cocked back his arms in a fighting stance. The neighbor ran back inside of his home. The neighbor does not speak English. The officer spoke to direct care staff Valerie Allen who was present with two other residents. The officers attempted to speak with Resident A but there appeared to be a barrier with his understanding. Resident A was able to retrace his steps to where he walked onto the neighbor's property, and he admitted to going inside of the neighbors shed. The report documents

that the neighbor's son showed the officers the video footage and it clearly showed Resident A going into the neighbors shed. The camera footage did not capture Resident A attempting to hit the neighbor. The neighbor could be seen running from Resident A.

On 02/02/2023, I conducted a phone interview with Resident A's legal guardian Jim Starks. Mr. Starks said that he was aware of the incident that occurred with Resident A and the neighbor. Resident A is known to wander off a bit and have issues with the neighbors. There have been complaints in the past from other neighbors. Mr. Starks said these issues have not always occurred as Resident A has been living in the home since May 22, 1991. Mr. Starks said that the neighbors feels that Resident A is threat to safety. The neighbor that Resident A had the altercation with is elderly although, Resident A is 70 years old, he still gets around well. Mr. Starks said that MORC is exploring a new placement in a rural area for Resident A. The delay in the move is regarding which county will take over his support's services.

02/02/2023, I reviewed Resident A's Crisis Prevention and Safeguard Plan dated 01/25/2021. I observed that some of Resident A's triggers for aggression documented are experiencing a lack of input or control regarding an expectation and routine; perceiving an immediate need being unfulfilled; being criticized, especially negatively. It is documented that Resident A will raise his voice, posture in an intimidating stance, and use profanity. It is documented that the caregivers should be always aware of Resident A's whereabouts; caregivers should maintain contact within eyesight due to history of physical aggression with others; while working, staff are to complete visual checks every 15 minutes to ensure safety and the safety of others. I reviewed Resident A's revised Crisis Prevention and Safeguard Plan dated 02/01/2023. The plan documents that the caregivers are to do two-minute visual checks.

On 02/02/2023, I conducted an exit conference with David Call, LD. Mr. Call said that Resident A has not been moved however, he will be as soon as the counties make the decision. Mr. Call said that Resident A will be moving north of Clarkston, MI which is right near their central office. He will be in a rural setting on three acres of land. Mr. Call said that Resident A is familiar with the staff that work in that home as he works at the central office sometimes and his workshop is in Clarkston. I discussed with Mr. Call that according to the police reports there have been multiple issues with Resident A and the neighbors and the IPOS should have been updated prior to this incident. Mr. Call agreed.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	There is sufficient information to support that Resident A lacks supervision from staff. Resident A's Crisis Prevention and Safeguard plan documented that the caregivers should be always aware of Resident A's whereabouts and the caregivers should maintain contact within eyesight due to his history of physical aggression with others. The plan documented that he should be checked every 15 minutes however, there have been six police reports made by neighbors reporting aggressive behaviors by Resident A. Direct Care Staff Valerie Allen admitted that Resident A was outside alone to take out the trash. Ms. Allen said that Resident A exited the front door and returned through the back door. Resident A admitted to going into the neighbors shed and wanting to fight him. Resident A will be relocated to a rural area placement. Resident A's plan has been updated to two-minute checks rather than 15-minute checks by staff when he is outside.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

L. Reed

02/02/2023

LaShonda Reed
Licensing Consultant

Date

Approved By:

Denise Y. Nunn

02/03/2023

Denise Y. Nunn
Area Manager

Date

Continued….

AMENDED REPORT
SIR# 2023A0990003

PURPOSE:

Upon further review from upper management, there were edits needed to the narrative section of the report to clarify information.

DESCRIPTION OF FINDINGS AND CONCLUSIONS:

I changed some of the wording in the narrative section of the report as follows:

- Paragraphs one and two on page 4.
- Paragraph three on page 5.
- Paragraphs one and two on page 6.
- Paragraphs one, two and three on page 7.

I removed a sentence in the analysis on page 8. There were no changes made to the rule violation or recommendation.

RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the license.

L. Reed 02/17/2023

LaShonda Reed Date
Licensing Consultant

Approved By:

Denise Y. Nunn 03/10/2023

Denise Y. Nunn Date
Area Manager