GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 9, 2023

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

RE: License #: AS500012006
Investigation #: 2023A0990009
Fox Hill Group Home

Dear David 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 #:	2023A0990009
Complaint Receipt Date:	06/23/2023
Investigation Initiation Date:	06/26/2023
Report Due Date:	08/22/2023
Licensee Name:	Freedom Adult Foster Care Corp.
Licensee Address:	3990 Bird Road Clarkston, MI 48348
Licensee Telephone #:	(248) 625-7923
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?
On 05/29/2023, Resident A grabbed direct care staff, Valerie Allen's hot coffee and she slapped him.	Yes

III. METHODOLOGY

06/23/2023	Special Investigation Intake 2023A0990009
06/23/2023	APS Referral Adult Protective Services (APS) complaint denied at intake.
06/26/2023	Special Investigation Initiated - Face to Face I conducted an unannounced onsite investigation. I interviewed Kawanda Person, direct care staff. I observed Resident A who is non-verbal. I attempted to interview Resident B who was not able to be interviewed due to limited cognitive abilities.
06/26/2023	Contact - Document Sent I requested documents from David Call, licensee designee (LD). The LD sent the documents via email on 06/27/2023.
07/10/2023	Contact - Telephone call made I conducted a phone interview with direct care staff, Valerie Allen.
07/10/2023	Contact - Document Received I reviewed Resident A's resident file and Ms. Allen's employee record.
08/01/2023	Contact - Telephone call made I left a detailed message with Resident A's supports coordinator Christina Hill. No return call received.
08/01/2023	Contact - Telephone call made I left a detailed message with Relative A/Resident A's legal guardian. No return call received.
08/01/2023	Contact - Telephone call made I spoke to Sterling Heights Police Department regarding the complaint.

08/02/2023	Exit Conference I conducted an exit conference with the LD.

ALLEGATION:

On 05/29/2023, Resident A grabbed direct care staff, Valerie Allen's hot coffee cup and she slapped him.

INVESTIGATION:

On 06/23/2023, I received the complaint via email. In addition to the above allegation, it was indicated that Resident A suffers from an unknown diagnosis; however, he is non-verbal. Resident A has a legal guardian. On 05/29/2023, staff member, Valerie Allen slapped Resident A. It is unknown where on the body Ms. Allen slapped Resident A; however, it is believed it was around his face. Resident A did not have any marks or bruises. Ms. Allen was sent home while the allegation was investigated; however, the allegations were unsubstantiated by the group home, and Ms. Allen is back to work with access to Resident A. Resident A's guardian is aware of the allegations and did not think that Ms. Allen would do any harm to Resident A and has always had a positive experience with Ms. Allen. Sterling Heights Law Enforcement was involved, and it was found that Resident A grabbed Ms. Allen's hot coffee, and she was taking the coffee away from him and somebody could have mistaken that for an assault.

On 06/26/2023, I conducted an unannounced onsite investigation. I interviewed Kawanda Person, direct care staff. I observed Resident A who is non-verbal. I did not observe any marks or bruises on Resident A. Resident A was observed excessively pacing throughout the home. I attempted to interview Resident B who was not able to be interviewed due to limited cognitive abilities. There is a third resident that lives in the home that was not present and was attending workshop. That resident is non-verbal as well.

Ms. Person said that she was not working on the day of the incident. Ms. Person said that Resident A likes to take drinks from others, and it is a known behavior of his. Ms. Person has been with the company for 2.5 years and works multiple shifts.

On 07/10/2023, I conducted a phone interview with direct care staff, Valerie Allen. Ms. Allen denied having a physical altercation with Resident A and referred to it as an incident that occurred on May 29, 2023. Ms. Allen said that she worked the midnight shift that day and was waiting on the next shift to relieve her around 7:30AM when the incident occurred. Ms. Allen said that she went to the driveway to start her vehicle and she brought Resident A with her because he requires one-on-one supervision. Ms. Allen had a cup of hot coffee in her hand and Resident A grabbed the coffee from her hand while standing near her car. Ms. Allen said that Resident A always grabs drinks from others and tries to drink them. Ms. Allen said that the coffee was very hot, so she grabbed the coffee back from him as he was attempting to drink the coffee and she did

not want him to burn himself. Resident A began to struggle with Ms. Allen for the coffee. Ms. Allen said that she was able to retrieve the coffee from Resident A. Ms. Allen said that an unknown male civilian was driving by and stopped to witness the incident and confronted her as to why she was taking the coffee away from Resident A. Ms. Allen said that shortly thereafter Sterling Heights Law Enforcement arrived at the home as the unknown civilian called and reported the incident. Ms. Allen said that she provided a statement to the officer and completed an incident report. Ms. Allen said that Resident A was not injured and did not require medical treatment. Ms. Allen prevented Resident A from getting burned and she had coffee spilled on her hands. The other residents were inside of the home, and she was the only staff on shift when the incident occurred. Ms. Allen said that she has worked for the company for 17 years and has worked at Fox Hill for eight years. Ms. Allen continues to work at the home.

On 07/10/2023, I reviewed Resident A's resident file and Ms. Allen's employee record. Ms. Allen is fully trained. I reviewed Resident A's *Individual Plan of Service* (IPOS). Resident A has lived at Fox Hill since 2015. Resident A is non-verbal and a full assist with activities of daily living (ADL's). Resident A is diagnosed with infantile autism, affective psychosis, obsessive compulsive disorder, and moderate intellectual disabilities. Resident A requires one-on-one; 24/7 supervision and does to not possess safety skills and is an elopement risk. Resident A may elope and becomes physically aggressive. Resident A is obsessive over anything with liquids and will become aggressive, should he not get what he wants. Resident A struggles with anxiety, becomes overstimulated when someone enters his environment which causes pacing. Resident A obsesses over liquids and does not know the difference between good or harmful liquids. Resident A will do anything to retrieve liquids and will drink liquids.

It is documented in the IPOS that staff are to observe what Resident A is putting in his mouth. Resident A will become physically aggressive with staff. In review of Resident A *Crisis Prevention and Safeguard Plan* Resident A has the following items listed as "situation to avoid" by staff:

- Hard to control environments with a lot of compulsive items (drinks or food).
- Avoid loud, busy, or chaotic environments.
- Avoid events known to trigger aggression (open drinks) such as food courts and restaurants.

Per the plan, the following items were listed as items to "minimize triggers":

- Avoid exposure to food and drinks during non-scheduled times.
- Refrain from drinking/eating in front of Resident A.
- Prompt Resident A away from the area when he is done eating and if others are eating.
- The caregivers should keep their drinks and food put away from Resident A.

I reviewed the incident report dated 05/29/2023 at 7:39AM. Ms. Allen was the writer of the incident report. Ms. Allen documented that Resident A tried to retrieve her coffee in the driveway of the home. A bystander called the police. The police officer came to take

a report as someone reported abuse at 8:04AM. The corrective action plan on the incident report documented “removing all beverages in sight”.

On 08/01/2023, I spoke to Sterling Heights Police Department (SHPD) regarding the complaint. The SHPD operator indicated that the complaint was closed. I was informed that if a copy of the report was needed, it would be $21 and an in-person request should be made by those involved with the incident. I attempted to reach the detective department however, the phone call would not go through after several attempts.

On 08/02/2023, I conducted an exit conference with the LD. The LD was informed of the findings and agreed with the rule violation found. The LD said that Ms. Allen is aware of Resident A’s IPOS, and that staff are not to eat or drink in front of him. The LD does not have a report from SHPD however, will retrieve one and send if necessary. The LD agreed to submit a corrective action plan within 15 days of the receipt of the report.

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 evidence to support that Valerie Allen, direct care staff failed to provide protection as defined in Resident A’s IPOS which indicates that staff should avoid eating or drinking in his presence. It is documented throughout Resident A’s IPOS and *Crisis Prevention and Safeguard Plan* that Resident A has an obsessive compulsion with liquids. Resident A cannot determine which liquids are harmful or safe. On May 29, 2023, Ms. Allen was in direct contact with Resident A with a cup of hot coffee. As a result, Resident A grabbed the coffee and Ms. Allen had to physically retrieve the coffee from his hands. Resident A was not injured however, he could have been burned if he had drunk the hot coffee. The presence of the drink triggered Resident A’s aggression and resulted in what could have appeared to be a physical altercation to bystanders.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	On May 29, 2023, an incident occurred in which, Resident A attempted to take direct care staff Valerie Allen's hot cup of coffee. Resident A took the coffee from Ms. Allen's hand, and she had to grab it back however, Resident A continued to try to take the coffee which appeared to be struggle. There is insufficient evidence to support that Resident A was slapped by Ms. Allen as alleged. Resident A was not injured. Resident A is non-verbal and there were no known witnesses to the incident except a civilian that reported the incident to law enforcement. The Sterling Heights Police Department closed the investigation. Ms. Allen continues to work at Fox Hill.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

L. Reed

08/02/2023

LaShonda Reed — Date
Licensing Consultant

Approved By:

Denise Y. Nunn

08/09/2023

Denise Y. Nunn — Date
Area Manager