GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 30, 2024

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

RE: License #: AS820278669
Investigation #: 2024A0116017
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 #:	2024A0116017
Complaint Receipt Date:	01/12/2024
Investigation Initiation Date:	01/17/2024
Report Due Date:	03/12/2024
Licensee Name:	Hill's Support Services Inc
Licensee Address:	PO Box 648 Inkster, MI 48141
Licensee Telephone #:	(313) 617-3317
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:	01/04/2023
Expiration Date:	01/03/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Residents of the home are being verbally, mentally and physically abused.	Yes
All of the residents receive SSI checks but are not given a monthly allowance nor are they allowed to purchase toiletries, underwear and socks.	No

III. METHODOLOGY

01/12/2024	Special Investigation Intake 2024A0116017
01/12/2024	APS Referral Received.
01/16/2024	Referral - Recipient Rights Made.
01/17/2024	Special Investigation Initiated - On Site Interviewed home manager Candance Gee-Long, Residents A-F and reviewed funds and valuables part II forms for each resident.
01/24/2024	Contact - Telephone call made Interviewed Tracy Hill, Program manager.
01/26/2024	Contact - Telephone call made Interviewed staff, Dinah Fulton.
01/29/2024	Exit Conference With licensee designee, Louis Hill.
01/29/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Residents of the home are being verbally, mentally and physically abused.

INVESTIGATION:

On 01/17/24, I conducted an unscheduled onsite inspection at the home and interviewed home manager, Candance Gee-Long, and Residents A-F. Ms. Gee-Long reported that she was not at work at the time of the incident, however, reported that she was contacted by staff, Dinah Fulton, and made aware of the situation. Ms. Gee-Long reported that on the night of 01/08/24, staff Chfone McGillberry was the staff on shift for this home. She reported that staff, Marcellous Lawler, was the staff on shift for the attached licensed home next door, Oak Tree II (License #AS820292182). Ms. Gee-Long reported that on the morning of 01/09/24, she received a call from Ms. Fulton stating that Resident A's right eye was black, and he had what appeared to be a small area blood on the white area of eye. Ms. Gee-Long reported that she instructed Ms. Fulton to take Resident A to the hospital for evaluation and treatment. Ms. Gee-Long reported that Ms. Fulton informed her that Resident A reported he had fallen out of his bed and hit his eye. Ms. Gee-Long reported that Ms. Fulton called her back while in the emergency room, after Resident A disclosed to the nurse that staff, Marcellous Lawler, had punched him in the eye. Ms. Gee-Long reported that she was confused as Mr. Lawler was the staff assigned to the facility next door and was curious as to why he was even over on that side of the home.

Ms. Gee-Long reported her belief, after speaking to Resident C (Resident A's roommate), that Mr. McGillberry was actually the staff who punched him. Ms. Gee-Long reported that she thinks Mr. McGillberry may have threatened Resident A and he's afraid to disclose that Mr. McGillberry is the staff who actually punched him. Ms. Gee-Long reported that both Mr. Lawler and Mr. McGillberry were terminated and never returned to work after the incident.

I interviewed Resident A and he reported that the allegation is true and reported that he and the other residents were not being treated right by staff, Chfone McGillberry and staff, Marcellous Lawler. Resident A reported that when they were on shift, normally the midnight shift, it was always a stressful time for him and the other residents. He reported that they were mean to all of them, and he felt like they were always walking on eggshells. He reported that they were afraid to report the mistreatment, because they did not want the two staff to retaliate against them. Resident A reported that the home has been so peaceful since both staff were terminated.

Resident A further reported that on the night of 01/08/24 staff, Marcellous Lawler, punched him in the eye after he asked him for a cigarette. Resident A reported that they exchanged words, and next thing he knew he was getting punched. Resident A reported that this happened in his bedroom. Resident A reported that staff, Chfone

McGillberry, was in the bedroom when it happened and told him to go put some water on his eye. He reported they both threatened him and told him he better not tell anyone. Resident A reported that both staff instructed him to say he fell out of his bed and hit his eye.

Resident A reported that the following morning, when staff, Dinah Fulton, came in and saw his eye, she was concerned and asked him what happened. Resident A reported that because he was afraid, he told her that he fell out of bed and hit his eye. He reported that she took him to the emergency room and once there he told the truth about what really happened to the nurse and doctor. Resident A reported that his eye is no longer black, and he is doing good. I shared with Resident A that if he is ever being mistreated in any way that he needs to tell another staff that he trusts, the home manager, his case manager, the licensee designee, or anyone else he is comfortable speaking to. I informed him that this is his home and that he should never not feel comfortable or safe living there. Resident A reported that he understood and that if there were a next time he would tell somebody about the mistreatment.

I interviewed Residents B-E and they all reported that they were mistreated when staff, Chfone McGillberry and Marcellous Lawler were working. They all reported that they were mean, they would yell at them, and they always felt uneasy with them around. Resident C reported it felt like a military base when they worked. Resident D reported that the two staff mostly picked on Resident A. They all reported that the home is much more peaceful since Mr. McGillberry and Mr. Lawler were terminated. They reported that they never told anyone because they were afraid. They all denied that Mr. McGillberry and Mr. Lawler were ever physical with them. Resident C added that he is Resident A's roommate, and he observed the incident and saw Mr. McGillberry punch Resident A in the eye. Resident C reported that he is not sure why Resident A keeps saying that it was Mr. Lawler, other than him still being afraid of Mr. McGillberry.

At the conclusion of my interviews with each resident, I reiterated the importance of them telling someone when staff are mistreating them. I informed them all that this is their home and that they should always feel safe in it, and when they don't, they need to report it. They all agreed and reported that they would.

On 01/24/24, I interviewed program manager, Tracy Hill, and she reported that she was made aware of the incident by Ms. Gee-Long and she and her husband, licensee designee, Louis Hill, immediately terminated both staff members after conducting an internal investigation. Ms. Hill reported that she also reported the incident to APS and the Office of Recipient Rights (ORR). Ms. Hill reported that she and Mr. Hill have spoken to staff about their responsibility to take care of the residents and to treat them with the dignity and respect that they deserve. Ms. Hill also reported that she has always told the residents that she and Mr. Hill are only a call away and that they can call them anytime to report concerns about staff or other things that may be going on in the house. Ms. Hill reported that she hopes moving

forward if any type of mistreatment happens, the residents will share it with someone.

On 01/26/24, I interviewed staff, Dinah Fulton, and she reported that she was the staff that took Resident A to the emergency room (ER) on 01/09/24. Ms. Fulton reported that when she arrived at work the morning of 01/09/24, staff, Chfone McGillberry immediately told her that Resident A had fallen out of his bed during the night and hit his eye but refused to go the ER. Ms. Fulton reported that she asked Mr. McGillberry if he had completed an incident report detailing the incident. Ms. Fulton reported that Mr. McGillberry reported that he did not because Resident A was good. Ms. Fulton reported that Mr. McGillberry left, and she went to Resident A's bedroom to check on him and reported as soon as she opened his door, he popped up and said, "Hi, I fell out of bed and hit my eye." Ms. Fulton reported that she turned the light on and saw Resident A's right eye was black and she called Ms. Gee-Long to inform her of her observation. Ms. Fulton reported that Ms. Gee-Long advised her to take Resident A to the ER, which she reported she did. Ms. Fulton reported that while in triage the nurse asked Resident A what happened to his eye and initially, he reported that he fell out of bed and hit his eye. Ms. Fulton reported that the triage nurse, asked him if he was sure, and that he was safe there. Ms. Fulton reported that Resident A then stated that he was going to tell the truth and reported that staff, Marcellous Lawler, punched him in the eye. Ms. Fulton reported that after the doctor evaluated Resident A, they prescribed an eye drop for his eye and advised that he follow up with an eye specialist. Ms. Fulton reported that on the ride home she talked to Resident A about making sure he tells staff, his family, or someone he trusts if he feels that he is being mistreated in any way by staff or anyone else in the home. Ms. Fulton reported that Resident A reported that he was scared to tell, but reported being glad that both staff were terminated. Ms. Fulton further reported her belief that Mr. McGillberry was the staff person who punched Resident A as he initially told her it was him, and then changed his story and said it was Mr. Lawler. Ms. Fulton reported that she believes Resident A is still fearful of Mr. McGillberry, even though he is no longer employed by the company.

On 01/29/24, I conducted the exit conference with licensee designee, Louis Hill, and informed him of the findings of the investigation. Mr. Hill reported an understanding of the rule violation and reported taking swift action upon becoming aware of the matter. Mr. Hill reported that the home has house meetings all the time which give the residents an opportunity to share their concerns, wants, dislikes etc. and he reported none of the residents ever disclosed any type of mistreatment. Mr. Hill reported that moving forward he and his wife, Ms. Hill will be meeting privately with the residents in hopes that they would feel more comfortable sharing any staff concerns with them. Mr. Hill reported that he has been working in AFC for 23 years and he never wants the residents he serves to be mistreated or feel unsafe in their homes.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A was punched in his right eye by staff and sustained a black eye. Residents A-E all reported being yelled at, being treated mean, feeling as if the home was a military camp, and having an overall feeling of uneasiness when staff, Mr. McGillberry and Mr. Lawler were responsible for their care. This violation is established as staff, Chfone McGillberry and Marcellous Lawler failed to treat Residents A-E with dignity and respect and failed to attend to their personal needs, including protection and safety at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

All of the residents receive SSI checks but are not given a monthly allowance nor are they allowed to purchase toiletries, underwear and socks.

INVESTIGATION:

On 01/17/24, I conducted an unscheduled onsite inspection at the home and interviewed home manager, Candance Gee-Long and Residents A-F. Ms. Gee-Long reported that all of the residents get monthly allowance, and they will confirm that. Ms. Gee-Long reported that Resident A's cousin is his payee and reported that he puts his allowance on a debit card that Resident A uses to purchase whatever he wants and/or needs. Ms. Gee-Long reported that the home cannot restrict what the residents decide to purchase with their money. She added that if the residents need toiletries, they are available in the home. She further reported that the family members and guardians also assist with supplying the residents with any additional items they need. Ms. Gee-Long reported that the home distributes Residents B-D monthly allowance and reported that Resident E's guardian loads his allowance monthly on a debit card that he uses at his leisure. She reported that Resident F's brother is his payee and mails his monthly allowance directly to him. Ms. Gee-Long reported that once they give the monthly allowance to the residents, they decide how and what they want to spend it on.

I interviewed Residents A-F and they reported that they get their monthly allowance and are able to spend it on what they want or need. They all reported that no one has ever told them what they can or cannot purchase with their money. Resident D reported that he likes a certain brand of dryer sheets and laundry detergent and reported he purchases that out of his money to wash and dry his clothes. They all reported that there has never been a time where they haven't received their monthly allowance.

I reviewed Resident's B-D part II funds and valuables transactions forms for the past year. The forms document the monthly amount of cost of care that each resident receives and it contained all required signatures.

On 01/29/24, I conducted the exit conference with licensee designee, Louis Hill and informed him of the findings of the investigation. Mr. Hill agreed with the findings.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(7) A resident shall have access to and use of personal funds that belong to him or her in reasonable amounts, including immediate access to not less than $20.00 of his or her personal funds. A resident shall receive up to his or her full amount of personal funds at a time designated by the resident, but not more than 5 days after the request for the funds. Exceptions to this requirement shall be subject to the provisions of the resident's assessment plan and the plan of services.

ANALYSIS:	Residents A-F were interviewed and all confirmed that they have been receiving their monthly allowance. The home is only responsible for distributing the allowance for Residents B-D and those residents confirmed they are receiving their allowance and are able to spend it on the items that they want or need. This violation is not established as all of the residents have access to and use of their personal funds as required by these rules.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

01/30/24

Pandrea Robinson
Licensing Consultant

Date

Approved By:

01/30/2024

_____

Ardra Hunter
Area Manager

Date