GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 13, 2024

Lillar Hudson
Hudson Home I Inc
P.O. Box 02752
Detroit, MI 48202

RE: License #: AL820398356
Investigation #: 2024A0121008
Hudson Home I Inc

Dear Ms. Hudson:

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 #:	AL820398356
Investigation #:	2024A0121008
Complaint Receipt Date:	12/11/2023
Investigation Initiation Date:	12/14/2023
Report Due Date:	02/09/2024
Licensee Name:	Hudson Home I Inc
Licensee Address:	750 Virginia Park St Detroit, MI 48282
Licensee Telephone #:	(313) 875-5499
Administrator:	Dante Graham
Licensee Designee:	Lillar Hudson, Designee
Name of Facility:	Hudson Home I Inc
Facility Address:	750 Virginia Park Detroit, MI 48202
Facility Telephone #:	(313) 875-5499
Original Issuance Date:	06/13/2019
License **Status:**	REGULAR
Effective Date:	12/13/2023
Expiration Date:	12/12/2025
Capacity:	19
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had a blood transfusion in August or September of 2023, but group home staff failed to arrange her follow up care. Then on 11/23/2023, Resident A required emergency surgery and that's when doctors discovered a hole in her intestine. Resident A was also found to have tumors in her stomach, liver, and lungs. There is concern that group home staff neglected her needs.	Yes

III. METHODOLOGY

12/11/2023	Special Investigation Intake 2024A0121008
12/14/2023	Special Investigation Initiated - Telephone Dante Graham, Administrator
12/15/2023	Contact - Telephone call received Mr. Graham reported he is having trouble faxing the requested documents.
12/18/2023	Contact - Telephone call made Call to Mr. Graham to pick up documents at the facility, but he said Staff have no access to the records and he's not at the AFC home today.
12/19/2023	Inspection Completed On-site Received copy of Resident A's medical records and incident reports related to SI.
01/19/2024	Contact - Telephone call made Dante Graham
01/19/2024	Contact - Telephone call made Michelle Livous, Recipient Rights Investigator
01/19/2024	Contact - Telephone call made Follow up call to Mr. Graham
01/19/2024	Contact - Telephone call made Home Manager, Cynthia Rivers

01/29/2024	Contact - Telephone call made Left message for DCW Veronica Clark
02/02/2024	Contact - Telephone call received Return call from Veronica Clark
02/05/2024	Contact - Telephone call made Karen Graham, Quality Assurance Manager for Hudson Home
02/06/2024	Contact - Telephone call made Left message for Lawanda Felton with Lincoln Behavior Services; no response.
02/06/2024	Contact - Telephone call made Left message for Ms. Livous with ORR
02/08/2024	Contact - Telephone call received Return call from Ms. Livous
02/08/2024	Contact – Document received Received ORR investigative findings.
02/09/2024	Exit Conference Lillar Hudson

ALLEGATION: Resident A had a blood transfusion in August or September of 2023, but group home staff failed to arrange her follow up care. Then on 11/23/2023, Resident A required emergency surgery and that's when doctors discovered a hole in her intestine. Resident A was also found to have tumors in her stomach, liver, and lungs. There is concern that group home staff neglected her needs.

INVESTIGATION: On 12/14/23, I initiated the complaint with a phone call to the home's Administrator, Dante Graham. Mr. Graham indicated that the Office of Recipient Rights (ORR) had an open complaint investigation too involving Resident A. The assigned Recipient Rights Investigator is Michelle Livous. On 12/19/23, I conducted an onsite inspection at the facility. I gathered copies of Resident A's medical records and incident reports related to Resident A's refusal to eat. According to Mr. Graham, Resident A is her own guardian who has little contact with her family by choice. Mr. Graham described Resident A as a very private person and an overall "picky eater." Mr. Graham stated Resident A self-discharged when he went to visit her at the hospital on 11/26/23. Mr. Graham assumed Resident A

didn't want to be a burden on the home after recently discovering she had cancerous tumors that would present serious health challenges for her.

On 1/19/24 and 2/8/24, I interviewed Ms. Livous with ORR. Ms. Livous expressed concern that the home didn't do enough to advocate for Resident A as it relates to the resident refusing to eat. Ms. Livous interviewed Resident A during her hospital stay on 12/13/23. Per Livous, Resident A reported the food is "nasty" at Hudson Home. Resident A reported she prefers fried foods, and the home does not fry food. However, Resident A confirmed food was prepared and offered to her daily which she tended to decline. Ms. Livous said when she saw Resident A at the hospital, she looked like a "skeleton." Resident A subsequently passed away on 1/12/24.

I reviewed Resident A's records. Resident A was placed at Hudson Home on 6/1/22. At the time of placement, Resident A weighed in at 130 pounds. Resident A's last weight was taken on 11/15/23; she weighed 105 pounds. Resident A was admitted to Henry Ford Hospital on 11/23/23 with complaints of abdominal pain. Resident A was diagnosed with "severe protein-calorie malnutrition", and she had to undergo emergency surgery for a perforated bowel. During surgery, doctors discovered Resident A had "cancerous tumors in her stomach, liver, and lungs." Mr. Graham insisted Resident A received routine medical care at Bloomfield Medical Center where her primary care physician practices. Resident A's records document doctor visits on the following days: 6/20/23, 6/21/23, 7/20//23, 8/17/23, and 10/10/23. Mr. Graham reasoned the doctor's office completed weigh-ins at every office visit, so they had no reason to be alarmed about Resident A's weight loss since the doctor didn't address it. However, Resident A was seen by Nurse Practitioner, Lisa Jones on 4/20/23; lab tests were done. Resident A's hemoglobin was 6.3, so the doctor's office contacted Hudson Home (no worker specified) to request that Resident A be brought in for follow up. Resident A wasn't brought back to the doctor until 6/20/23. Nurse Jones also prescribed Ferrous Sulfate for Resident A at their April visit, but she had not started the medication by the time of the June visit with Staff citing they no longer use the current pharmacy on record. The prescription was forwarded to Executive Care Pharmacy and more lab tests were ordered. On 6/21/23, Resident A was instructed to go to the emergency room because her lab results returned with severely low hemoglobin levels. While there, Resident A received a blood transfusion to treat Anemia, unspecified type. Per Mr. Graham, Home Manager, Cynthia Rivers was responsible for managing Resident A's medical care. Mr. Graham stated it is likely, Ms. Rivers transported Resident A to and from all doctor appointments.

On 1/19/4, I interviewed Ms. Rivers by phone. Ms. Rivers acknowledged she transported Resident A to routine doctor appointments. Ms. Rivers confirmed the doctor would take Resident A's vitals, including weights at every office visit. Ms. Rivers also stated Resident A would only allow her to enter the exam room on occasion. Ms. Rivers described Resident A as "high functioning", so she was allowed to manage her care as desired.

On 2/2/24, I interviewed direct care worker, Veronica Clark. Ms. Clark reported Resident A would refuse to eat often. According to Ms. Clark, Staff would try to encourage Resident A to eat by offering her an alternate meal, but she would still decline unless they gave her fast food. Ms. Clark also reported Resident A refused medical treatment. Specifically, Ms. Clark said Resident A would not go to recommended specialist like the hematologist, optometrist, dentist, or podiatrist. Ms. Clark has a long-time history with Resident A because she worked at the resident's previous placement. Ms. Clark explained these are long-time behaviors of Resident A.

On 2/5/24, I interviewed Karen Graham, Quality Assurance Manager with Hudson Home. Mrs. Graham reported Resident A was taken to Bloomfield Medical Center at least once per quarter to be evaluated by her primary care physician. Mrs. Graham emphasized the doctor only had concerns with Resident A's "iron levels," so the home had no reason to suspect the resident had other health concerns despite her weight loss.

On 2/9/24, I completed an exit conference with licensee, Lillar Hudson. Ms. Hudson maintains Resident A's primary care doctor only reported concerns about her iron deficiency. Ms. Hudson insisted the doctor did not report any stomach pain or problems with malnourishment.

APPLICABLE RULE	
R 400.15305	**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 seen at Bloomfield Medical Center on 4/20/23. After receiving Resident A's lab results, Nurse Lisa Jones asked Staff to bring her back for follow up care/treatment. Resident A wasn't brought to the office until 6/20/23. • On 6/21/23, Resident A received emergency medical treatment due to her very low hemoglobin levels; she required a blood transfusion on this day. • On or around 4/20/23, Resident A was prescribed Ferrous Sulfate tablets, but as of 6/20/23 she hadn't received the medicine because Staff said they changed pharmacies. • On 11/23/23, Resident A was seen at Henry Ford Hospital; doctors listed her as severely malnourished. • There are several incident reports written to document Resident A's refusal to eat, but otherwise, Staff allowed the resident to continuously refuse meals. No action was taken than to encourage her to eat or by offering her an alternate meal. • Therefore, the department has determined Ms. Hudson did not attend to Resident A's needs at all times in accordance with the provisions of the Act.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

2/12/24

Kara Robinson — Date
Licensing Consultant

Approved By:

2/13/24

Ardra Hunter — Date
Area Manager