GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 14, 2024

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

RE: License #: AL820398356
Investigation #: 2024A0992040
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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820398356
Investigation #:	2024A0992040
Complaint Receipt Date:	06/28/2024
Investigation Initiation Date:	07/01/2024
Report Due Date:	08/27/2024
Licensee Name:	Hudson Home I Inc
Licensee Address:	750 Virginia Park St Detroit, MI 48282
Licensee Telephone #:	(313) 875-5499
Administrator:	Lillar Hudson
Licensee Designee:	Lillar Hudson
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 stated home manger, Denise Higgins, pushed her down and attacked her.	Yes

III. METHODOLOGY

06/28/2024	Special Investigation Intake 2024A0992040
07/01/2024	Special Investigation Initiated - On Site Dante Grantham, administrator; Residents A and B.
07/12/2024	Contact - Telephone call made Direct care staff, Denise Higgins.
07/12/2024	Contact - Telephone call made Direct care staff, Laurice Henderson. Telephone number no longer in service.
07/12/2024	Contact - Telephone call made Direct care staff, Veronica Clark.
07/12/2024	Contact - Telephone call received Mr. Graham
07/12/2024	Contact - Telephone call made Office of Recipient Rights, Zachary Flynn.
07/12/2024	Contact - Telephone call made Resident A's guardian, Tyree Harper with Michigan Guardian Services
07/25/2024	Contact - Telephone call made Adult protective services, Laneisha Steen.
07/25/2024	Contact - Telephone call made Mr. Graham
07/302024	Contact - Document Received Resident A's individual plan of service (IPOS)
08/01/2024	Exit Conference Licensee designee, Lillar Hudson.

ALLEGATION: Resident A stated home manger, Denise Higgins pushed her down and attacked her.

INVESTIGATION: On 07/01/2024, I completed an unannounced onsite inspection and interviewed administrator, Dante Graham, Residents A and B regarding the allegation. Mr. Graham stated he was not on shift when the incident occurred but was made aware of what happened by the home manager, Denise Higgins. He stated the incident occurred during the evening shift and assistant manager, Veronica Clark, direct care staff, Laurice Hudson and Resident B were present. Mr. Graham stated he spoke with all involved parties and based on the information he received Resident A attacked Ms. Higgins. However, Mr. Graham stated Resident A contacted Relative A1 and stated she was attacked by Ms. Higgins. Mr. Graham stated Resident A remains in the home. He stated the Office of Recipient Rights (ORR), Zachary Flynn is involved. Mr. Graham identified Resident A's guardian as Tyree Harper with Michigan Guardian Services.

Resident A stated on 06/20/2024, she went downstairs to take her medicine, but prior to taking her medicine she received a telephone call from Ms. Higgins. Resident A stated Ms. Higgins was talking about the conditions of the bathroom and told her to clean the toilet and mop the floor. Resident A stated she was not feeling well, and she just wanted to take her medication and go to bed. She stated she is not the only one that uses the bathroom, and she was not going to clean it up. Resident A stated while in the process of getting her medication, Ms. Higgins arrived at the facility, and she started talking about the bathroom conditions and telling her to clean it up. Resident A stated she just wanted to lay down. She stated Ms. Higgins blocked the doorway preventing her from leaving the area where medications are given. She stated Ms. Higgins had one hand on the washing machine and the other on the chair, which prevented her from exiting the room. Resident A stated she tried to move the chair to bypass Ms. Higgins and Ms. Higgins pushed her. Resident A stated she fell in the chair and Ms. Higgins was over top of her, restricting her to the chair. Resident A stated she was very winded and weak. Resident A stated she called Relative A1 and told him what happened. Resident A stated Relative A1 called the police. Resident A stated the police arrived and she spoke with them. She stated she was later transported to the hospital by direct care staff, Veronica Clark to be examined for injuries. Resident A stated she was not injured, and she returned to the facility. Resident A stated she feels uncomfortable in the facility.

Resident B could not provide any information, she stated she did not witness what happened.

On 07/12/2024, I contacted Ms. Higgins and interviewed her regarding the allegation. Prior to addressing the allegation, Ms. Higgins explained that she had

recently had a procedure and was not feeling well; she stated she was nauseous and unsteady. Ms. Higgins further stated she does not typically work on Thursday's but on 06/20/2024, she realized she had mistakenly taken the facility phone home with her. Ms. Higgins said when she arrived at the facility to take the phone back, Ms. Clark made her are of the condition of the bathroom. Ms. Higgins stated there was feces throughout the bathroom, on the toilet seat and on the floor. She stated there are three women that use this bathroom because the other residents have a bathroom in their bedroom. Ms. Higgins stated although Resident A has a history of leaving the bathroom in that condition, she attempted to speak with each resident privately. Ms. Higgins stated she asked Resident A to step into the sitting area but, instead Resident A got loud stating, "I did not do anything," and "you're listening to her," referring to Ms. Clark. Ms. Higgins said she tried to verbally redirect Resident A and calm her down, but Resident A was carrying on. Ms. Higgins stated Ms. Clark called Resident A to administer her medication; she stated medications are administered in the laundry room area. Ms. Higgins stated Resident A was sitting down preparing to take her medication, when direct care staff, Laurice Henderson, came into the area and started talking about the condition of the bathroom, and Resident A became agitated. Ms. Higgins stated at this time she was standing in the laundry room area with one hand on the washing machine and the other on a chair, to help her balance. Ms. Higgins stated Resident A got up and tried to leave the room but where she was standing Resident A could not leave. Ms. Higgins stated because she was unsteady, she told Resident A to give her a minute, she was trying to move. Ms. Higgins stated she was not moving fast enough for Resident A and Resident A bumped into her four times. Ms. Higgins stated on the fourth time, Resident A attempted to bombard her with her entire body causing them to fall forward. Ms. Higgins stated she grabbed onto Resident A, and Resident A's hand was across her chest. She stated Resident A landed in the chair. Ms. Higgins stated Resident A grabbed onto her shirt, was pinching her and would not let her go. She stated Ms. Henderson had to pry Resident A's hands a loose. Ms. Higgins stated the police were called but she is not sure if Resident A called the police or Relative A1. Ms. Higgins denied she provoked the incident; she stated Resident A was triggered by Ms. Henderson bringing the issue back up. She denied attacking Resident A or restraining her in any form. Ms. Higgins confirmed she is still on shift, and she does not interact with Resident A. She stated she always works alongside other staff. I explained that typically the direct care staff is transferred to another facility or removed from the schedule pending the investigation. I made Ms. Higgins aware that I would speak with Mr. Graham to ensure Resident A is protected and feels comfortable.

On 07/12/2024, I contacted Ms. Clark and interviewed her regarding the allegation. Ms. Clark confirmed she was on shift the day the incident occurred. Ms. Clark provided statements consistent with the statements Ms. Higgins provided to me during her interview. She further stated Ms. Higgins just tried to talk to Resident A about the condition of the bathroom, but she instantly became agitated. Ms. Clark stated that Resident A pushed Ms. Higgins in a confrontational manner. She stated Resident A's fists were balled up as if she was fighting. Ms. Clark stated Ms. Higgins

did not slam Resident A down and she did not beat her up. Ms. Clarks stated the police were called and she explained what happened. Ms. Clark stated Resident A was later transported to the hospital; to be examined, but no injuries were noted.

On 07/12/20024, I received a telephone call from Mr. Graham. He explained that he received a call from Ms. Higgins stating there is some concern regarding her remaining on schedule during the investigation. I explained to Mr. Graham in my experience if a staff is involved in some form of altercation with a resident, the staff is either removed from the schedule or transferred to another facility pending the investigation. Mr. Graham stated that he spoke with Mr. Flynn, and his supervisor and he was not advised to remove Ms. Higgins from the schedule. He said he agreed to keep Resident A and Ms. Higgins separated at all times. I agreed to contact with Mr. Flynn and Mr. Harper regarding Resident A's safety.

On 07/12/2024, I contacted Mr. Flynn regarding the allegation. Mr. Flynn confirmed he recently received the complaint, and he has interviewed Mr. Graham, Resident A and Ms. Higgins. He stated based on the information he received, there were no witnesses, and it appears to be Resident A's word against the direct care staff. He stated although he is still investigating there does not appear to be any concerns of physical abuse. Mr. Flynn stated he did not discuss Ms. Higgins remaining on shift. He stated based on the notes Mr. Graham spoke with ORR supervisor, Andre Hardrick. He stated although Mr. Hardrick did not specifically state Ms. Higgins could remain on shift, Mr. Graham ensured Mr. Hardrick that a plan was implemented to protect Resident A, and Ms. Higgins would not have contact with Resident A.

On 07/12/2024, I contacted Resident A's guardian, Tyree Harper with Michigan Guardian Services and discussed the allegation. Mr. Harper confirmed he was aware of the allegation. He stated Resident A does have a history of being aggressive. However, in her defense Mr. Harper stated Resident A cannot see too well, which may be the reason the bathroom was in such condition. I made Mr. Harper aware that Ms. Higgins remains on shift and that Resident A stated she feels uncomfortable in the facility. Mr. Harper stated he was not aware the staff remains on schedule. He stated was in the process of trying to enroll Resident A into a program to occupy her time. However, he stated he will work on finding her a new placement.

On 07/25/2024, I contacted Adult Protective Services (APS), Laneisha Steen regarding the allegation. Ms. Steen confirmed she is currently investigating the allegation. She stated she interviewed Resident A and Ms. Higgins at the facility, but currently the investigation is pending.

On 07/25/2024, I contacted Mr. Graham. I explained that I had an opportunity to speak with Mr. Flynn and Mr. Harper regarding Resident A's safety. As for Mr. Flynn, his investigation is pending, and he didn't have any concerns regarding physical abuse. Mr. Graham stated that he also spoke with Mr. Flynn's supervisor and made him aware Ms. Higgins will not have contact with Resident A. Mr. Graham stated Ms.

Higgins works alongside other staff and a plan has been implemented to prevent Resident A and Ms. Higgins from occupying the same space. I explained that after speaking with Mr. Harper, he stated that he intends to find a new placement for Resident A. Mr. Graham stated when he spoke with Mr. Harper, he did not express any concerns or mentioned anything about moving Resident A. Mr. Graham stated Resident A is doing good and things are going well. I explained that the decision to move Resident A is up to Mr. Harper and if he sees fit for her to stay, that is up to him. As for the findings, I made him aware that although I cannot determine that physical force was used by Ms. Higgins against Resident A or Resident A used physical force against Mr. Higgins. I have determined Ms. Higgins did not handle the situation appropriately. Ms. Higgins was not technically on shift when the incident occurred, so she should have allowed the direct care staff on shift to handle the situation. When Ms. Higgins initially tried to talk to Resident A about the bathroom conditions, it seems Resident A responded in a confrontational manner which should have been an indication for Ms. Higgins to leave the situation alone. Also, as it pertains to chores, it is the direct care staff responsibility to clean the facility. Mr. Graham stated he understands and although they teach the residents independent skills such as cleaning up behind themselves, the direct car staff is ultimately responsible for the cleanliness of the facility. I requested a copy of Resident A’s individual plan of service (IPOS), to determine if chores are outlined as a goal in her plan. Mr. Graham agreed to provide me with a copy.

On 07/30/2024, received Resident A's IPOS. Based on the IPOS, skill building is one of Resident A's goals. Skill building include keeping her bedroom clean and cleaning up after herself in the bathroom.

On 08/01/2024, I contacted Licensee designee, Lillar Hudson and interviewed her regarding the allegation. Ms. Hudson confirmed she was previously made aware of the allegation. Ms. Hudson stated that she has spoken with Ms. Higgins about the allegation and that she too agrees the situation could have been handled differently. I proceeded to have an exit conference with Ms. Hudson. I made her aware that I am unable to determine physical force was used by Ms. Higgins against Resident A or Resident A used physical force against Mr. Higgins. I explained that I have determined Ms. Higgins did not handle the situation appropriately. Ms. Higgins was not technically on shift when the incident occurred, so she should have allowed Ms. Clark and Ms. Henderson to handle the situation. I explained that I understand skill building including cleaning up after herself in the bathroom is in Resident A’s IPOS, however, the direct care staff is responsible for the chores in the facility. When Ms. Higgins initially tried to talk to Resident A about the bathroom conditions, and Resident A responded in a confrontational manner which should have been an indication for Ms. Higgins to leave the situation alone. I further stated based on the violation in the report, a written corrective action plan is required. Ms. Hudson agreed to review the report and respond accordingly.

APPLICABLE RULE	
R 400.15308	**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: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.** **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.** **(e) Withhold food, water, clothing, rest, or toilet use.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.** **(g) Refuse the resident entrance to the home.** **(h) Isolation of a resident as defined in R 400.15102(1)(m).** **(i) Any electrical shock device.**
ANALYSIS:	During this investigation, I conducted interviews with licensee designee, administrator, home manager, assistant manager, ORR, APS, Resident A's guardian, Tyree Harper, Residents A and B regarding the allegation. I am unable to determine that physical force was used by Ms. Higgins against Resident A. There is insufficient evidence to substantiate the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications:

	(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident. **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with the licensee designee, administrator, home manager, assistant manager, Resident A's guardian, ORR, APS, Residents A and B, as well as a review of pertinent documentation relevant to this investigation, there is sufficient evidence to substantiate the allegation that direct care staff Denise Higgins did not handle the situation appropriately. She engaged in a verbal confrontation with Resident A which resulted in physical contact. The allegations are substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same.

08/08/2024

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Denasha Walker Date
Licensing Consultant

Approved By:

08/14/2024

_____

Ardra Hunter Date
Area Manager