GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 14, 2026

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

RE: License #: AS820352279
Investigation #: 2026A0121008
Wayne Respite Care

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 was required. On March 25, 2026, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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

K. Robinson, MSW, 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 #:	AS820352279
Investigation #:	2026A0121008
Complaint Receipt Date:	03/17/2026
Investigation Initiation Date:	03/19/2026
Report Due Date:	05/16/2026
Licensee Name:	Hill's Support Services Inc
Licensee Address:	PO Box 648 Inkster, MI 48141
Licensee Telephone #:	(313) 671-8188
Administrator:	Louis Hill
Licensee Designee:	Louis Hill
Name of Facility:	Wayne Respite Care
Facility Address:	3221 John Daly Inkster, MI 48141
Facility Telephone #:	(313) 671-8188
Original Issuance Date:	04/29/2014
License **Status:**	REGULAR
Effective Date:	10/29/2024
Expiration Date:	10/28/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A and B were given night medication instead of day medication on 3/6/26.	Yes

III. METHODOLOGY

03/17/2026	Special Investigation Intake 2026A0121008
03/17/2026	Referral - Recipient Rights Tiffany Burgess, Recipient Rights Investigator
03/17/2026	APS Referral
03/19/2026	Special Investigation Initiated - Letter Email to Tiffany Burgess
03/20/2026	Contact - Document Received Email response from Ms. Burgess
03/20/2026	Inspection Completed On-site Reviewed Medication Administration Records and Incident Report
03/20/2026	Contact - Telephone call made Tracy Hill
03/24/2026	Exit Conference Louis Hll
03/24/2026	Contact - Document Sent Follow up email to Tracy Hill
03/25/2026	Corrective Action Plan Received/Approved

ALLEGATION: Resident A and B were given night medication instead of day medication on 3/6/26.

INVESTIGATION: On 3/19/265, I initiated the complaint with an email to Recipient Rights Investigator, Tiffany Burgess. Ms. Burgess replied, "yes", she did substantiate the allegation based on her recent investigation. On 3/20/26, I conducted an unannounced onsite inspection at the facility. Lead direct care staff, Daisha Fulton provided me with copies of the incident report related to the medication error, medication administration records for the month of March, and hospital discharge reports for Resident A and B. On 3/20/26, I spoke with Administrator, Tracy Hill by phone. Mrs. Hill confirmed direct care staff (DCS), Latisha Ely administered Resident A and B's 8:00 p.m. medication at 8:00 a.m. on 3/6/26. Mrs. Hill reported Resident A and B were transported to Garden City Hospital for evaluation. Both Resident A and B were discharged the same day with no unusual findings to report.

On 4/17/26, I completed a phone interview with DCS Latisha Ely. Ms. Ely acknowledged that she "accidentally" gave Resident A and B their evening medication in the morning; however, Ms. Ely explained the mix-up shouldn't prove detrimental since the affected medication is prescribed twice daily. So, essentially, Resident A and B receive the same pills twice per day with the exception of Resident A's melatonin that's given strictly at bedtime. Upon review of Resident A and B's March 2026 medication administration records, I determined Ms. Ely's statement is false. At 8:00 a.m. Resident A is prescribed Buspirone Hcl 5mg tab, Risperidone tab 0.5mg, Escitalopram 10 mg tab, Levothyroxine 75 Mcg tab, Cetirizine 10mg tab, Hydrocortizone Val 0.2% cream, Bacitracin Oin 500/gm, Olanzapine Tab 2.5mg, and NAC CAP 600mg. At 8:00 p.m. Resident A is prescribed Montelukast Sod 10 mg tab, Buspirone Hcl 5mg tab, Risperidone tab 0.5mg, Hydrocortizone Val 0.2% cream, Olanzapine Tab 2.5mg, and NAC CAP 600mg. At 8:00 a.m. Resident B is prescribed Cyclosporine 0.05% Eye Emuls and Docusate Sod 100 mg Softgel. At 8:00 p.m. Resident B is prescribed Risperidone tab 0.5mg. Simvastatin 20mg tab, and Cyclosporine 0.05% Eye Emuls.

On 3/24/26, I completed an exit conference with licensee designee, Louis Hill. Mr. Hill submitted an acceptable corrective action plan on 3/25/26. As part of the corrective measures, Ms. Ely was required to complete a medication administration refresher course.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	DCS Latisha Ely did not give Resident A and B their medication as prescribed on 3/6/26 at 8:00 a.m. based on her own admission and other witness statements.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain unchanged.

05/05/26

Kara Robinson Date
Licensing Consultant

Approved By:

05/14/26

Ardra Hunter Date
Area Manager