



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 12, 2022

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

RE: License #: AL820398356
Investigation #: 2022A0901035
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,

A handwritten signature in black ink that reads "Regina Buchanan". The signature is written in a cursive style with a large initial 'R'.

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820398356
Investigation #:	2022A0901035
Complaint Receipt Date:	07/11/2022
Investigation Initiation Date:	07/13/2022
Report Due Date:	09/09/2022
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:	Dante Graham
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:	12/13/2021
Expiration Date:	12/12/2023
Capacity:	19

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED
----------------------	--

II. ALLEGATION(S)

	Violation Established?
On 07/08/2022, Resident A had an accident in her pants when she came to her STEP program. She said she told the home manager, but she did not allow her to change her diaper.	No
Resident A has been using a broken mobility cane.	No
Resident A ran out of her nighttime medications.	Yes

III. METHODOLOGY

07/11/2022	Special Investigation Intake 2022A0901035
07/11/2022	Referral - Recipient Rights
07/11/2022	APS Referral
07/13/2022	Special Investigation Initiated - Telephone Administrator, Dante Graham
07/13/2022	Contact - Document Received Email
07/26/2022	Contact - Telephone call made Resident A Staff, Cynthia Rivers Staff, Sharvonda Powell
07/26/2022	Contact - Telephone call made Suzzane Ogunkunle, Supervisor
08/02/2022	Inspection Completed On-site
08/19/2022	Contact - Telephone call made Resident A's niece

08/19/2022	Inspection Completed-BCAL Sub. Compliance
09/08/2022	Exit Conference Administrator, Dante Graham

ALLEGATION:

On 07/08/2022 Resident A had an accident in her pants when she came to her STEP program. She said she told the home manager, but she did not allow her to change her diaper.

INVESTIGATION:

On 07/13/2022, I made a telephone call to the administrator, Dante Graham. He stated the home manager, Cynthia Rivers, did not work on 07/08/2022 and the staff on duty at that time, Sharvonda Powell, stated Resident A did not tell her that she had an accident on herself.

On 07/26/2022, I made a telephone call to the facility and spoke to Resident A. She stated she forgot to tell staff she had an accident on herself. She also said she no longer use it on herself and has been going to the bathroom.

On 07/26/2022, I interviewed the home manager, Cynthia Rivers. She stated she did not work on 07/08/2022. She also stated it was rare for Resident A to have an accident on herself and when she does, she does not always speak up and let staff know. Ms. Rivers further stated Resident A has plenty of diapers in the office.

On 07/26/2022, I interviewed staff, Sharvonda Powell. She confirmed she was working the morning of 07/08/2022 and that Resident A did not tell her she had an accident and her diaper needed to be changed. She stated there were plenty of diapers in the home and she had sent two diapers with her to the STEP program that morning.

On 07/26/2022, I made a telephone call to Suzzane Ogunkunle, supervisor from Services to Enhance Potential (STEP). She explained that Resident A was recently assigned a new Supports Coordinator but that she, Ms. Ogunkunle, was more familiar with her. Ms. Ogunkunle stated it was not normal for Resident A to come to STEP soiled and that her appearance is normally clean.

On 08/02/2022, I completed an onsite inspection at the facility and observed plenty of diapers stored in the office.

On 08/19/2022, I made a telephone call to Resident A's niece. She spoke very well of the facility and staff. She also stated Resident A is always clean when she sees her. She felt Resident A was just anxious to go to STEP and failed to tell staff. Based on her interaction with the home, Resident A's niece stated she knows staff would have changed her if they knew.

APPLICABLE RULE	
R 400.15303	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:	Based on the information obtained during this investigation, there is a lack of information to confirm the allegations. Resident A denied telling staff she had an accident on herself before going to STEP. In addition to this, staff denied knowing her diaper needed to be changed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A has been using a broken mobility cane.

INVESTIGATION:

On 07/13/2022, I made a telephone call to the administrator, Dante Graham. He indicated Resident A's walking stick is broke, but she does not use it. He also stated that Resident A indicated on her last Individual Plan of Service (IPOS) that she wanted a new walking stick and that her doctor also wrote it on her health appraisal. According to the nurse from Michigan Home Physician, she will have the doctor to write a prescription for it.

On 07/13/2022, I received a copy of Resident A's IPOS from Mr. Graham. It was dated 07/01/2022-06/30/2023. One of the objectives documented on it was for Resident A to work with her supports coordinator to obtain resources from the Bureau of the Blind to obtain a new walking stick by 12/31/2023.

On 07/26/2022, I made a telephone call to the facility and interviewed Resident A. She stated she has a walking stick but does not use it because it is broke.

On 07/26/2022, I made a telephone call to the home manager, Cynthia Rivers. She stated Resident A's walking stick was broken and she does not use it. She also

stated even when it was not broken, Resident A still did not use it but liked to carry it with her.

On 07/26/2022, I made a telephone call to Suzzane Ogunkunle, supervisor from Services to Enhance Potential (STEP). She stated that she was aware of Resident A's walking stick being broken and her and the new Supports Coordinator, Valerie Pianga, has completed an application for a new one, which Resident A should have it soon. Ms. Ogunkunle also indicated that Resident A walks well on her own and does not like to use the walking stick. Instead of using it, she carries it with her.

APPLICABLE RULE	
R 400.15306	Use of assistive devices.
	(1) An assistive device shall only be used to promote the enhanced mobility, physical comfort, and well-being of a resident.
ANALYSIS:	Based on the information obtained during this investigation, there is a lack of evidence to confirm the allegations. Although her walking stick was broken, she was not using it, therefore, her mobility and well-being was not at risk with the broken assistive device. Her case management agency, STEP, was aware of her need for a new walking stick and was already working to replace it and has submitted an application for a new one.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A ran out of her nighttime medications.

INVESTIGATION:

On 07/13/2022, I made a telephone call to the administrator, Dante Graham. He confirmed Resident A ran out of her nighttime medication Seroquel XR 07/07/2022-07/10/2022. He explained that the home manger, Cynthia Rivers, missed Resident A's last psychiatric appointment and this is why her prescription was not refilled timely. The medication has since been refilled.

On 07/13/2022, I received from Mr. Graham a copy of the medication log sheet documenting the missed medication.

On 07/26/2022, I made a telephone call to Ms. Rivers. She confirmed that Resident A missed 4 days of her medication because she failed to get the prescription timely.

On 08/02/2022, I conducted an onsite inspection at the facility and observed Resident A's Seroquel XR to be filled and available in the home.

APPLICABLE RULE	
R 400.15312	Resident medications.
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information obtained during this investigation, the allegation is confirmed. Resident A's medication was not given daily as prescribed. She missed 4 days of her Seroquel XR due to staff missing her psychiatric appointment and subsequently not getting the new prescription timely. This was reflected on the medication log sheet and confirmed by Mr. Graham and Ms. Rivers.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



Regina Buchanan
Licensing Consultant

09/08/2022
Date

Approved By:



Ardra Hunter
Area Manager

09/12/2022
Date