GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 10, 2022

Carol Freeman
Family Supp Svcs For Mental Rec
G-3445 Mackin Rd.
Flint, MI 48504

RE: License #: AS250010767
Investigation #: 2022A0572051
Family Support Group Home

Dear Ms. Freeman:

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 (517) 643-7960.

Sincerely,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010767
Investigation #:	2022A0572051
Complaint Receipt Date:	08/12/2022
Investigation Initiation Date:	08/17/2022
Report Due Date:	10/11/2022
Licensee Name:	Family Supp Svcs For Mental Rec
Licensee Address:	G-3445 Mackin Rd. Flint, MI 48504
Licensee Telephone #:	(810) 732-9160
Administrator:	Carol Freeman
Licensee Designee:	Carol Freeman
Name of Facility:	Family Support Group Home
Facility Address:	G-3445 Mackin Road Flint, MI 48504
Facility Telephone #:	(810) 732-9160
Original Issuance Date:	10/28/1986
License Status:	REGULAR
Effective Date:	05/08/2021
Expiration Date:	05/07/2023
Capacity:	6
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff, Demond Grays is listening in on Residents' phone conversations.	Yes
Resident A was upset with Staff, Demond Grays and left the residence and walked into downtown Flushing. Demond Grays threatens to kick a Resident out if they lied on him. Demond Grays threw a walker into the wall.	Yes

III. METHODOLOGY

08/12/2022	Special Investigation Intake 2022A0572051
08/12/2022	APS Referral APS Made complaint.
08/17/2022	Special Investigation Initiated - Letter
09/01/2022	Inspection Completed On-site Resident A; Licensee, Carol Freeman; Resident B, Resident C and Assistant Manager, Perry Compton.
10/06/2022	Contact - Telephone call made Ex-staff, Demond Gray.
10/06/2022	Inspection Completed-BCAL Sub. Compliance
10/06/2022	Exit Conference Licensee, Carol Freeman.

ALLEGATION:
Staff, Demond Grays is listening in on Residents' phone conversations.

INVESTIGATION:
On 08/12/2022, the local licensing office received a complaint for investigation. Adult Protective Services made the complaint.

On 09/01/2022, an unannounced onsite was conducted at Family Support Group Home, located in Genesee County, Michigan. Interviewed/observed were: Resident A, Licensee, Carol Freeman; Resident B, Resident C and Assistant Manager, Perry Compton.

On 09/01/2022, I interviewed Resident A regarding the above allegation. He informed that staff, Demond Grays sometimes listens to resident's phone conversations. He has been seen eavesdropping on a couple of the residents.

On 09/01/2022, I interviewed Licensee, Carol Freeman regarding the above allegation. She informed that she was not aware of Mr. Grays listening in on resident's phone conversations. This is news to her and can't say that he has or hasn't because she has never witnessed it and none of the residents informed her of this.

On 09/01/2022, Ms. Freeman gave me a copy of a letter that she sent to the Unemployment Office. It states, "Mr. Grays was terminated on 08/26/2022 due to insubordination, insolence and lack of respect to the provider, to other staff and to mentally ill who are protected by the Mental Health Code."

On 09/01/2022, I observed Resident B. He was unable to be interviewed. His well-being and supervision appeared to be adequate.

On 09/01/2022, I interviewed Resident C regarding the allegation. Resident C stated, "Yes, he does eavesdrop on our phone conversations, but he never said why he was doing it."

On 09/01/2022, I interviewed Assistant Manager, Perry Compton regarding the above allegation. He informed that he was not aware of Mr. Grays listening in on any Resident's conversations.

On 10/06/2022, I interviewed former staff, Demond Grays regarding the allegation. Mr. Grays denied eavesdropping on any of the residents' conversations. He informed he did not have to as he was the only staff that the residents confided in, and they would come to him and share things with him on their own.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.**
ANALYSIS:	Based on the interviews that were conducted during my investigation, there is evidence that there was a rule violation as two of the residents that were interviewed, informed that Mr. Grays was observed listening in on their conversations. The Licensee and Assistant Manager were not aware of this issue and Mr. Grays denied that this occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
Resident A was upset with Staff, Demond Grays and left the residence and walked into downtown Flushing. Demond Grays threatens to kick a Resident out if they lied on him. Demond Grays threw a walker into the wall.

INVESTIGATION:
On 09/01/2022, I interviewed Resident A regarding the allegation. Resident A was not aware that Mr. Grays had thrown a walker but informed that he did walk away from an incident involving Mr. Grays. He was upset with Mr. Grays because he would not allow him to go into his bedroom, so he took off walking. His intentions were to cool off and take a walk to the mailbox, but he kept going and ended up in Flushing, MI. He is not allowed to go out walking on his own. Denied being lost as he grew up in Flushing and knew the geography. He was found by a family member, who was driving up the road and he took him back home. Resident A informed that he gets along with Mr. Grays most of the time, but he is kind of afraid of him.

On 09/01/2022, I interviewed Licensee, Carol Freeman regarding the allegation. She informed that Mr. Grays threw a walker against the wall, and he was disciplined for his actions. Regarding Resident A walking to Flushing. She informed that Resident

A was upset with Mr. Grays and went walking 8 miles to Flushing without any shoes on because he was so upset. Resident A can go out into the community, but he must be accompanied by family, per his plan. She is not sure about any threats made by Mr. Grays but informed that he was very disrespectful towards her and the residents.

On 09/01/2022, Ms. Freeman gave me a copy of a letter that she sent to the Unemployment Office. It states, “Mr. Grays was terminated on 08/26/2022 due to insubordination, insolence and lack of respect to the provider, to other staff and to mentally ill who are protected by the Mental Health Code.”

On 09/01/2022, I reviewed Resident A’s Assessment Plan and it indicates that Resident A can go out into the community with family supervision.

On 09/01/2022, I interviewed Resident C regarding the allegation. Resident C heard that Resident A went walking but does not know why. Resident C observed Mr. Grays throwing a resident’s walker into the wall at full force because he was upset with a resident. Resident C stated, “I don’t think he should be working with residents because he’s terrible. He’s here because we need help and he’s not helping us.”

On 09/01/2022, I interview Assistant Manager, Perry Compton regarding the allegation. Mr. Compton was aware Resident A leaving the facility on his own and Ms. Freeman wrote a critical incident report. He was unaware that Mr. Grays threw a walker but knows that the walker in question was placed in a locked storage unit.

On 10/06/2022, I interviewed former staff, Demond Grays regarding the allegation. He informed that in 20 years of working in the field, he has never had these types of allegations against him. He denied ever getting upset and throwing a wheelchair at the wall. He informed that Resident A did leave the facility and being that he was the only staff, he could not follow him. He did not know that he was going to walk to Flushing. Mr. Grays informed that he followed protocol by calling the Home Manager, Tawana Gloud and they went out looking for him.

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:	Based on the interviews that were conducted during my investigation, there is evidence that there was a rule violation. Those that were interviewed all informed that Resident A went walking and he ended up being in Flushing. Resident A went walking by himself to “cool off” because he was upset with Mr. Grays for not allowing him to go into his bedroom. There was a separate incident where Mr. Grays was upset with a resident and threw the wheelchair into the wall. Resident C observed this incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**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.**
	Based on the interviews that were conducted during my investigation, there is substantial evidence Mr. Grays is not suitable to provide care to vulnerable adults. Mr. Grays displayed behaviors that showed lack of empathy and compassion towards the vulnerable adults that he was hired to supervise and protect. Mr. Grays was terminated from employment from employment by Ms. Freeman on 8/26/22 due to his behavior.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/06/2022, an Exit Conference was held with Licensee, Carol Freeman. Ms. Freeman was informed of the results of this special investigation.

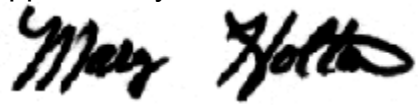
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that no changes be made to the licensing status of this small adult foster care group home (capacity 1-6).

10/06/2022

Anthony Humphrey Date
Licensing Consultant

Approved By:



10/10/2022

Mary E. Holton Date
Area Manager