GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 28, 2025

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

RE: License #: AS820292182
Investigation #: 2025A0901014
Oak Tree II

Dear Louis 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 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,

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 #:** | AS820292182 |
| | |
| **Investigation #:** | 2025A0901014 |
| | |
| **Complaint Receipt Date:** | 12/03/2024 |
| | |
| **Investigation Initiation Date:** | 12/05/2024 |
| | |
| **Report Due Date:** | 02/01/2025 |
| | |
| **Licensee Name:** | Hill's Support Services Inc |
| | |
| **Licensee Address:** | PO Box 648<br>Inkster, MI 48141 |
| | |
| **Licensee Telephone #:** | (313) 671-8188 |
| | |
| **Administrator:** | Louis Hill |
| | |
| **Licensee Designee:** | Louis Hill |
| | |
| **Name of Facility:** | Oak Tree II |
| | |
| **Facility Address:** | 608 Oak St.<br>Wyandotte, MI 48192 |
| | |
| **Facility Telephone #:** | (734) 282-6630 |
| | |
| **Original Issuance Date:** | 11/02/2007 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 07/12/2024 |
| | |
| **Expiration Date:** | 07/11/2026 |
| | |
| **Capacity:** | 6 |
| | |

| | |
|---|---|
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## I. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A and B were given the wrong medication. | Yes |

## II. METHODOLOGY

| | |
|---|---|
| 12/03/2024 | Special Investigation Intake<br>2025A0901014 |
| 12/03/2024 | Adult Protective Services Referral |
| 12/05/2024 | Special Investigation Initiated - Telephone<br>Program Manager, Tracy Hill |
| 12/09/2024 | Contact - Document Received |
| 12/13/2024 | Referral - Recipient Rights |
| 12/17/2024 | Inspection Completed On-site<br>Resident A<br>Resident B |
| 12/17/2024 | Contact - Telephone call made<br>Staff, Ronald Johnson |
| 01/28/2025 | Inspection Completed-BCAL Sub. Compliance |
| 01/28/2025 | Exit Conference<br>Licensee Designee, Louis Hill |

**ALLEGATION:**

**Resident A and B were given the wrong medication.**

**INVESTIGATION:**

On 12/05/2024, I made a telephone call to the program manager, Tracy Hill. She confirmed the allegations were true and that staff, Ronald Johnson, was working at the time. She explained that he got distracted and gave Resident A and B there night medications for their morning medications. Ronald contacted the resident's doctor, and he said they would be fine and did not need to go to the hospital. They were monitored the rest of the day and there were no changes.

On 12/09/2024, I received an email from Tracy, which consisted of copies of the incident reports, the residents' medication logs, and verification of Ronald being re-trained on medication administration, and a copy of the disciplinary warning he was given. Ronald completed incident reports for Resident A and B. They were dated for 11/25/2024 at 8:00 a.m. and indicated that at 8:00 a.m. the residents were inadvertently administered their 8:00 p.m. medications, due to Ronald being distracted with another resident. The incident reports also indicated that upon realizing the error, he contacted the supervisor and the residents' doctor. I reviewed the residents' November 2024 medication log sheets. Resident A had a total of four nighttime medications: Olanzapine, Simvastatin, Risperdone, and Benzotropine. Two of those medications, the Risperdone and Benzotropine, were prescribed to be given in the morning as well. Therefore, only the Olanzapine and Simvastaion were administered at the wrong time. Resident B had three nighttime medications: Atorvastatin, Mirtazapine, and Ketotif Fum. The Ketotif Fum was also prescribed to be given in the morning, so only the Atorvastatin and Mirtazapine were given at the wrong time.

On 12/17/2024, I conducted an onsite inspection at the facility. Resident A and B were interviewed separately. They both spoke well of the home and staff. They said they were fine after the incident and did not have to go to the hospital. Resident B stated Ronald was talking to another resident when he made the mistake.

On 12/17/2024, I made a telephone call to Ronald. He confirmed the incident occurred and was very apologetic. He stated he never made that type of mistake before but was dealing with another resident, got sidetracked, and was not fully paying attention to what he was doing. He said each resident was given their own medication but was given their night medications instead of their morning medications. Ronald said he immediately called Tracy and the residents' doctor. Neither resident had to go to the hospital, but they were monitored the rest of the day.

On 01/25/2025, I made a telephone call to the licensee designee, Louis Hill, for an exit conference. I informed him of my investigative findings. He had no questions or

comments and said he would send a corrective action plan as soon as he receives the report.

| APPLICABLE RULE | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | **(2) Medication shall be given, taken, or applied pursuant to label instructions.** |
| **ANALYSIS:** | Based on the information obtained during this investigation, the allegations are confirmed. Resident A and B's medications were not administered based on label instructions. Ronald mistakenly gave them their nighttime medications for their morning medications. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## III. RECOMMENDATION

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

01/28/2025

Regina Buchanan — Date
Licensing Consultant

Approved By:

01/28/2025

Ardra Hunter — Date
Area Manager