GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 25, 2022

Bethany Mays
Resident Advancement, Inc.
PO Box 555
Fenton, MI 48430

RE: License #: AS250010823
Investigation #: 2022A0871030
Henderson AFC

Dear Ms. Mays:

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 (989) 732-8062.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010823
Investigation #:	2022A0871030
Complaint Receipt Date:	04/06/2022
Investigation Initiation Date:	04/11/2022
Report Due Date:	06/05/2022
Licensee Name:	Resident Advancement, Inc.
Licensee Address:	411 S. Leroy, PO Box 555 Fenton, MI 48430
Licensee Telephone #:	(810) 750-0382
Administrator:	Gloria Stogsdill
Licensee Designee:	Bethany Mays
Name of Facility:	Henderson AFC
Facility Address:	4074 S. Henderson Davison, MI 48423
Facility Telephone #:	(810) 653-0641
Original Issuance Date:	03/17/1989
License **Status:**	REGULAR
Effective Date:	02/27/2022
Expiration Date:	02/26/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Home Manager Carlin Bailey told Family Member 1 they were too busy to address Family Member 1's concerns. Resident A had an open head wound that it was not documented, and Family Member 1 was never notified as she discovered the head wound when brushing Resident A's hair.	No
Staff attempted to get a doctor to write a prescription for discontinued Ativan for Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

04/06/2022	Special Investigation Intake 2022A0871030
04/12/2022	Inspection Completed On-site Interviewed Home Manager Carlin Bailey, Staff Shamari Phillis
05/12/2022	Contact - Telephone call made Telephone call to Case Manager Erik Kahn
05/12/2022	Contact – Telephone call made Telephone call to Family Member 1
05/12/2022	Inspection Completed On-site Interviewed Home Manager Carlin Bailey
05/16/2022	Contact – Document received Received *AFC Licensing Division Incident/Accident Report*
05/16/222	APS Referral Through Central Intake to Genesee County MDHHS
05/23/2022	Inspection Completed On-site Obtained copy of Resident A's *Medication Administration Records*
05/23/2022	Exit conference Telephone exit conference with Licensee Bethany Mays

ALLEGATION:

Home Manager Carlin Bailey told Family Member 1 they were too busy to address Family Member 1's concerns. Resident A had an open head wound that was not documented, and Family Member 1 was never notified as she discovered the head wound when brushing Resident A's hair.

INVESTIGATION:

On April 12, 2022, I conducted an unannounced on-site investigation and interviewed Home Manager Carlin Bailey. Manager Bailey said Resident A "has a history of bumping his head." Manager Bailey indicated Resident A was used to Family Member 1 being with him and whenever Family Member 1 brought him back from an outing or leave the facility, Resident A "became very upset, aggressive. He would bite staff and bump his head." Manager Bailey said staff would try to calm him down and sometimes it would take three hours. Manager Bailey said Resident A's doctor would try changing his medications, but he still would be aggressive and bang his head. Manager Bailey showed me an activity board that had dents in it from Resident A banging his head.

Manager Bailey said on March 14, 2022, Family Member 1 came to the facility to visit Resident A. Manager Bailey said Resident A "never cut his head" but Family Member 1 was at the facility and wanted Resident A to go to the hospital. Manager Bailey stated Resident A "did have a red mark" from banging his head but it was not an open wound. Resident A was sent out to the hospital. Manger Bailey said Family Member 1 was not told that they were too busy to tend to Resident A.

On April 12, 2022, I interviewed Staff Shamari Phillis. Ms. Phillis said she was working on March 14, 2022, and Resident A did not have a cut on his head. Ms. Phillis said Resident A "would bang his head every day." Ms. Phillis said no one ever told Family Member 1 that they were too busy for Resident A.

I then interviewed Staff Sharon Fresh. Ms. Fresh stated that on the morning of March 14, 2022, she showered Resident A. Ms. Fresh indicated that Resident A had a red mark from banging his head, but he always banged his head and sometimes it would leave a red mark. Ms. Fresh said Family Member 1 wanted Resident A to go to the hospital to be checked out and he was taken to the hospital by ambulance. Ms. Fresh said staff provided attention to Resident A was no one told Family Member 1 that they were too busy.

On April 12, 2022, Manager Bailey said Family Member 1 would not provide any information for Resident A. A phone call could not be made to the hospital to see how Resident A was doing because Family Member 1 would not give staff the PIN for Resident A and he did not return to the facility.

On May 12, 2022, I telephoned Family Member 1. Family Member 1 said on March 14, 2022, she went to the home. Family Member 1 said "three staff were talking in the kitchen and they warned her not to talk to them." Family Member 1 said "something was not right." Family Member 1 said she had seen a couple of things before that she was not quite sure of but would not explain what she meant. Family Member 1 said Resident A was having "a lot more behaviors that day" and she wanted Resident A to go to the hospital. Family Member 1 said Staff Sharon Fresh showered Resident A and when he was out of the shower, Family Member 1 noticed dried blood on his head. Family Member 1 said she was at the facility on the Friday before that Monday and said that something must have happened between Friday and Monday. Family Member 1 said she felt like they were lying to her. Family Member 1 said Resident A went to the hospital because "of the gash on his head." When I asked what hospital Resident A went to, she would not provide me with that information and asked me why I needed that information. I advised Family Member 1 that if the facility did something to Resident A, I must investigate it. Family Member 1 said she was just going to hire an attorney and would not provide that information to me.

On May 12, 2022, I telephone Case Manager Erik Kahn. Mr. Kahn said he had "no concerns about the care [Resident A] received" while at the facility. Mr. Kahn stated Resident A was "self-injurious and it was becoming more frequent." Mr. Kahn said Resident A has a history of bumping his head but never bumped his head so hard to cut himself. Mr. Kahn said his head bumping was becoming more frequent and staff always tried to intervene. Mr. Kahn indicated Resident A's behaviors were worse when Family Member 1 would leave the facility. Mr. Kahn indicated Resident A moved into the facility in August 2021 and feels that because of the increase in his behaviors, he was not a good fit for the home. Mr. Kahn said, "I love that home" and the staff provide very good care.

On April 12, 2022, and May 12, 2022, I observed three other residents in the facility. They all appeared clean and no noted bruising or injuries on them.

APPLICABLE RULE	
R 400.14303	**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:	Home Manager Carlin Bailey, Staff Sharon Fresh and Shamari Phillis all said care was provided to Resident A. They all said no one said they were too busy to tend to Resident A's care. There is no evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff attempted to get a doctor to write a prescription for discontinued Ativan for Resident A.

INVESTIGATION:

On April 12, 2022, I asked Staff Sharon Fresh if anyone had called to get a prescription for Ativan for Resident A. Ms. Fresh said she was unaware of anyone calling to get a prescription and she is not allowed to do that. I also asked Staff Shamari Phillis if she knew who called to get a prescription for Ativan and she said, "no one that I know of." Ms. Phillis denied called to get a prescription for Ativan.

On May 23, 2022, I conducted an on-site investigation and obtained Resident A's *Medication Administration Records.* According to the records, Resident A's Ativan prescription was written on January 24, 2022, as PRN and never discontinued.

I interviewed Home Manager Carlin Bailey and she stated the Resident A's doctor continuously changed Resident A's medications to see what would help with his behaviors. According to Resident A's *Medication Administration Records,* Resident A was not administered Ativan, but the prescription was still active. Manager Bailey said no one contacted the doctor about Resident A's Ativan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On May 23, 2022, I observed a prescription for Ativan that was written on January 24, 2022. Home Manager Carlin Bailey said a discontinued notice was never received and the Ativan was to be given as a PRN. There is no evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On May 12, 2022, at the onsite investigation, I asked Home Manager Carlin Bailey for a copy of the *AFC Licensing Division Incident/Accident Report* regarding Resident A going to the emergency room on March 14, 2022. Manager Bailey faxed me a copy of the report on May 16, 2022. The date and time of the incident was not recorded. The *AFC Licensing Division Incident/Accident Report* was written on March 15, 2022 and signed only by Home Manager Carlin Bailey. What happened indicates "[Resident A] and [Family Member 1] had been on an outing during the outing [Family Member 1] noticed [Resident A] was acting different. He was drowsy leaning forward. On the way home when they got home [Family Member 1] and Carlin decided to take him to ER." Action taken indicates "Called 911, called case manager – called Gloria, Program Director."

On May 12, 2022, I looked in the file for the indecent/accident report. The report had not been sent to adult foster care licensing division, and it was not signed by the licensee or administrator.

On May 23, 2022, I conducted a telephone exit conference with Licensee Bethany Mays. Licensee Mays was advised that the *AFC Licensing Division Incident/Accident Reports* must be completed thoroughly and accurately, and also signed by the Licensee or Administrator.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (b) Any accident or illness that requires hospitalization.
ANALYSIS:	On May 12, 2022, I observed the Henderson AFC file, and an *AFC Licensing Division/Incident Accident Report* was not found. I did receive a report on May 16, 2022, that was not completed accurately and not signed by the licensee or administrator. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

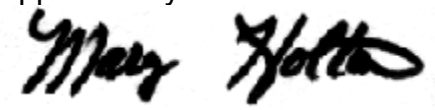
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care small group home remain unchanged (capacity 1-6).

05/25/2022

Kathryn A. Huber — Date
Licensing Consultant

Approved By:



05/25/2022

Mary E Holton — Date
Area Manager