



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

June 22, 2022

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

RE: License #: AS250010859  
Investigation #: 2022A0582035  
Atlas Park

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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,

A handwritten signature in grey ink that reads "Derrick L. Britton". The signature is written in a cursive, flowing style.

Derrick Britton, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(517) 284-9721

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS250010859
<b>Investigation #:</b>	2022A0582035
<b>Complaint Receipt Date:</b>	05/10/2022
<b>Investigation Initiation Date:</b>	05/11/2022
<b>Report Due Date:</b>	07/09/2022
<b>Licensee Name:</b>	Resident Advancement, Inc.
<b>Licensee Address:</b>	411 S. Leroy, PO Box 555 Fenton, MI 48430
<b>Licensee Telephone #:</b>	(810) 750-0382
<b>Administrator:</b>	Gloria Stogsdill
<b>Licensee Designee:</b>	Bethany Mays
<b>Name of Facility:</b>	Atlas Park
<b>Facility Address:</b>	2099 Atlas Road Davison, MI 48423
<b>Facility Telephone #:</b>	(810) 653-6529
<b>Original Issuance Date:</b>	12/29/1989
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	10/26/2020
<b>Expiration Date:</b>	10/25/2022
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

## II. ALLEGATIONS

	<b>Violation Established?</b>
On 5/20/21, Resident A was sent to school wearing jeans with no underwear, and two left shoes. On 10/31/21, Resident A's teacher reported that his nails were bad. On 4/8/22, Resident A went to school wearing sweatpants, and although they were dry, the sweatpants had a strong urine odor.	Yes
On 1/17/22, Relative A went to pick him up for a medical appointment and had requested two of his Diazepam pills, which are ordered to be given before medical procedures. Manager Heather Jones was unable to find the medication to administer to Resident A.	Yes
Additional Findings	Yes

## III. METHODOLOGY

05/10/2022	Special Investigation Intake 2022A0582035
05/11/2022	Special Investigation Initiated - Letter Email to Michelle Salem, Recipient Rights
05/18/2022	Inspection Completed On-site
05/18/2022	Contact - Face to Face With Heather Jones, Manager
05/18/2022	Contact - Telephone call made With Becky Thomas, School Caseload Manager
06/10/2022	Contact - Telephone call made With Direct Care Worker Anita Rogers
06/10/2022	Contact - Telephone call made With Sylvia Golson, GHS Case Manager
06/10/2022	Inspection Completed On-site
06/16/2022	Contact - Face to Face With Heather Schaefer, Teacher, and Resident A

06/16/2022	Contact - Telephone call made With Guardian A
06/21/2022	Contact - Telephone call made With Relative A
06/21/2022	Inspection Completed On-site
06/21/2022	Contact - Face to Face With Direct Care Worker Christana Bogan
06/21/2022	Exit Conference With Bethany Mays, Licensee Designee
06/21/2022	Inspection Completed-BCAL Sub. Compliance
06/21/2022	Corrective Action Plan Requested and Due on 07/06/2022
06/22/2022	APS Referral Referral made to APS regarding these allegations.

**ALLEGATION:**

**On 5/20/21, Resident A was sent to school wearing jeans with no underwear, and two left shoes. On 10/31/21, Resident A's teacher reported that his nails were bad. On 4/8/22, Resident A went to school wearing sweatpants, and although they were dry, the sweatpants had a strong urine odor.**

**INVESTIGATION:**

I received this recipient rights referred complaint on 05/10/2022 and contacted Michelle Salem, Recipient Rights Associate on 05/11/2022. Ms. Salem provided information regarding contacts for individuals involved with Resident A's care.

On 05/18/2022, I conducted an unannounced, onsite inspection at the facility. Resident A was at school during the inspection. I reviewed Resident A's *Assessment Plan*, which documented that he needs help with toileting (he goes to the toilet, needs help with wiping), grooming, dressing, and personal hygiene (needs reminder). I reviewed Resident A's Psychosocial Assessment Review dated 01/19/2021, which documented that he is nonverbal and diagnosed with Moderate Intellectual Impairment, Autism Spectrum Disorder, Unspecified Neurodevelopmental Disorder, and Bipolar I Disorder. Further, "[Resident A] requires assistance in the area of personal care and oral care due to his diagnoses which limits his ability to live independently without the care and assistance from

staff. Additionally, Resident A's Psychosocial Assessment Review documented that "there has been problems with staff not cleaning [Resident A] good after [Resident A] has a bowel movement and result in [Guardian A] and [Relative A] wanting to have meetings regarding this.

I interviewed Heather Jones, Home Manager. Ms. Jones stated that Resident A requires "complete care" to include showering and dressing. Ms. Jones stated that Direct Care Worker (DCW) Anita Rogers, who works third shift, showers Resident A every morning before school. Ms. Jones stated that Resident A could have sat on the couch after another resident urinated, which may have caused Resident A to smell like urine. Ms. Jones stated that she did not know about Resident A going to school without underwear. Ms. Jones stated that Relative A1 bought Resident A two left shoes, which was not realized until later.

On 05/18/2022, I interviewed Becky Thomas, Caseload Manager at Resident A's school, GISD Transition Center. Ms. Thomas stated that Resident A came to school once with a strong urine smell. Additionally, Ms. Thomas stated that there was an occasion in which Resident A arrived at school with mismatch shoes. Ms. Thomas stated that there were a few occasions in which Resident A arrived at school with no underwear. Ms. Thomas stated that these instances have been minimal, as Resident A has been with them for five years.

On 06/10/2022, I interviewed Direct Care Worker (DCW) Anita Rogers. Ms. Rogers stated that she works third shift and gets Resident A up and ready for school each day with a shower and shave before she leaves at 6:30 AM. Ms. Rogers stated that Resident A has on underwear before she leaves, so she did not know how he would arrive at school without underwear. Ms. Rogers stated that she had no knowledge of Resident A smelling like urine while at school.

On 6/10/2022, I interviewed Sylvia Golson, GHS Case Manager for Resident A. Ms. Golson stated that she has been Resident A's Case Manager for four months and has seen him three times. Ms. Golson stated that she had no concerns about Resident A's care.

On 6/10/2022, I conducted an unannounced, onsite inspection at the facility. I observed Resident A to be dressed appropriately, and he appeared to be receiving proper care.

On 06/16/2022, I conducted an unannounced inspection at Resident A's school, GISD Transition Center. I observed Resident A to be dressed appropriately with long nails that were not dirty. I interviewed Heather Schaefer, teacher. Ms. Schaefer stated that Resident A is usually dressed "pretty decent," but there were 3-4 occasions that he arrived at school with no underwear and needing a belt. Ms. Schaefer stated that Resident A arrived once with two left shoes on. Ms. Schaefer stated that recently Resident A arrived at school with a strong urine smell. Ms. Schaefer stated that Resident A sometimes refuses to have his nails cut.

On 06/16/2022, I interviewed Guardian A, who stated that she is in the process of trying to move Resident A due to issues mentioned in the complaint. Guardian A stated that the home has “questionable” workers. Guardian A stated that she receives texts from the school regarding Resident A’s dress and appearance when he arrives. Guardian A stated that she has no reason to believe that the allegations are false.

On 06/21/2022, I interviewed Relative A, who stated that she receives updates from the school and was informed that he has arrived with no underwear, dirty nails, and mismatch shoes. Relative A stated that she visited Resident A yesterday at the home, and he was unshaven with long hair and nails, which is consistent with his care there.

On 06/21/2022, I conducted an unannounced, onsite inspection at the facility. I observed Resident A to be dressed appropriately and he appeared to be receiving proper care.

<b>APPLICABLE RULE</b>	
<b>R 400.14303</b>	<b>Resident care; licensee responsibilities.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Based on a review of Resident A’s <i>Assessment Plan</i> and <i>Psychosocial Assessment Review</i> , Resident A requires assistance with toileting, grooming, dressing, and personal hygiene due to his diagnoses. Interviews with Resident A’s school staff (Ms. Thomas and Ms. Schaefer), Guardian A, and Relative A confirm that Resident A has arrived at school without underwear, with two left shoes, and smelling of urine on an occasion.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**On 1/17/22, Relative A went to pick him up for a medical appointment and had requested two of his Diazepam pills, which are ordered to be given before medical procedures. Manager Heather Jones was unable to find the medication to administer to Resident A.**

## INVESTIGATION:

I received this recipient rights referred complaint on 05/10/2022 and contacted Michelle Salem, Recipient Rights Associate on 05/11/2022. Ms. Salem provided information regarding contacts for individuals involved with Resident A's care.

On 05/18/2022, I conducted an unannounced, onsite inspection at the facility. Resident A was at school during the inspection. I reviewed Resident A's *Assessment Plan*, which documented that he requires assistance with taking medications. I interviewed Heather Jones, Home Manager. Ms. Jones stated that she recalled that she could not find the medication that Relative A was looking for, as Resident A did not have a script for it, and it was not in the Medication Administration Record. Ms. Jones stated that the issue with this medication occurred before she was manager. I reviewed Resident A's current *Medication Administration Record (MAR)*, which documented that since 05/08/2020, Resident A is prescribed Diazepam 5MG. Instructions for this medication are to "take 1 tablet orally 1 hour prior to medical procedure, give a second tablet if needed 5-10 minutes before procedure." I asked Ms. Jones to provide the MAR for January 2022, but she could not locate it at the time of the inspection and stated that she would provide it at a later time.

On 6/10/2022, I interviewed Sylvia Golson, GHS Case Manager for Resident A. Ms. Golson stated that she was not aware of Resident A having any issues with medications being administered. Ms. Golson stated that she was not aware of the allegation.

On 06/16/2022, I conducted an unannounced inspection at Resident A's school, GISD Transition Center. I interviewed Heather Schaefer, teacher. Ms. Schaefer stated that Resident A is prescribed Diazepam to "calm down," and Relative A had staff administer the medication to Resident A before a medical procedure.

On 06/16/2022, I interviewed Guardian A, who stated that Relative A went to pick up Resident A for an appointment, but staff did not have the prescribed medication that he requires before medical appointments. Guardian A stated that Resident A becomes nervous during appointments and needs the medication.

On 06/21/2022, I interviewed Relative A, who stated that she was taking Resident A to receive a COVID-19 booster shot in January. Relative A stated that Resident A has issues with medical procedures, which is why Diazepam is prescribed to him. Relative A stated that Resident A have problems with blood draws, shots, and other medical procedures. Relative A stated that she contacted home manager Heather Jones to administer the medication, but Ms. Jones informed her that she could not find the medication. Relative A stated that she currently has Resident A's prescription for Diazepam to administer it to him before appointments.

On 06/21/2022, I conducted an unannounced, onsite inspection at the facility. I reviewed the current MAR for June 2022, which documented that Resident A is



currently prescribed Diazepam 5MG. Staff could not provide me with the January 2022 MAR.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(2) Medication shall be given, taken, or applied pursuant to label instructions.</b>
<b>ANALYSIS:</b>	Based on a review of Resident A's <i>Medication Administration Record</i> , he is prescribed Diazepam 5MG, to be taken 1 hour prior to a medical procedure. Home Manager Heather Jones and Relative A both confirm that the facility did not have the medication to administer to Resident A before an appointment on 01/17/2022.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 06/21/2022, I interviewed Relative A who stated that she currently has Resident A's prescription for Diazepam to administer it to him before appointments.

On 06/21/2022, I interviewed Direct Care Worker Christana Bogan, who stated that Relative A informed staff that she would be keeping the medication to administer to Resident A before appointments, since she takes him to appointments and does not trust staff to have the medication when she needs it. There was no prescription for Diazepam in the facility, and nothing in writing to authorize Relative A to administer the medication.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.</b>

<b>ANALYSIS:</b>	Interviews with DCW Christana Bogan and Relative A reveal that Resident A's prescribed Diazepam is in the possession of Relative A. As such, Relative A supervises the administration of Resident A's Diazepam prescription, without documentation and authorization of a physician.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

I reviewed Resident A's Assessment Plan, which documented that the most recent plan was dated 02/23/2021. The plan was only signed by Guardian A, with no signature on who completed the plan, no signature by the responsible agency, and no signature by the licensee.

<b>APPLICABLE RULE</b>	
<b>R 400.14301</b>	<b>Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.</b>
	<b>(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.</b>
<b>ANALYSIS:</b>	Upon reviewing Resident A's Assessment Plan on 05/18/2022, the last assessment was completed on 02/23/2021. The assessment did not have the required signatures of who completed the plan, the responsible agency, or the licensee designee.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Contingent on an acceptable corrective action plan, I recommend no change in the license status.



06/22/2022

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Derrick Britton  
Licensing Consultant

Date

Approved By:



06/22/2022

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Mary E. Holton  
Area Manager

Date