GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 9, 2023

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

RE: License #: AS250293330
Investigation #: 2023A0779054
Nandi Hills

Dear Bethany 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 (517) 643-7960.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250293330
Investigation #:	2023A0779054
Complaint Receipt Date:	06/28/2023
Investigation Initiation Date:	06/28/2023
Report Due Date:	08/27/2023
Licensee Name:	Resident Advancement, Inc.
Licensee Address:	411 S. Leroy, PO Box 555 Fenton, MI 48430
Licensee Telephone #:	(810) 750-0382
Administrator:	Danielle Stevenson
Licensee Designee:	Bethany Mays
Name of Facility:	Nandi Hills
Facility Address:	2521 Nandi Hills Trail Swartz Creek, MI 48473
Facility Telephone #:	(810) 635-9190
Original Issuance Date:	01/23/2009
License **Status:**	REGULAR
Effective Date:	08/01/2021
Expiration Date:	07/31/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 6/29/23, home manager, April Monroe, slapped Resident C in the face.	No
On 6/22/23, Staff was administering meds when she placed the meds on the counter belonging to Resident A however, Resident B picked up the cup of meds and ingested them.	Yes

III. METHODOLOGY

06/28/2023	Special Investigation Intake 2023A0779054
06/28/2023	Special Investigation Initiated - On Site
06/29/2023	APS Referral Complaint was referred to APS.
07/05/2023	Contact - Telephone call made Spoke to recipient rights investigator, Pat Shepard.
07/05/2023	Contact - Telephone call made Spoke to administrator, Danielle Stevenson.
07/07/2023	Inspection Completed On-site
07/18/2023	Contact - Telephone call made Interview conducted with staff person, Vadis Russey.
08/09/2023	Exit Conference Held with licensee designee, Bethany Mays.

ALLEGATION:

On 6/29/23, home manager, April Monroe, slapped Resident C in the face.

INVESTIGATION:

On 7/5/23, a phone conversation took place with recipient rights investigator, Pat Shepard, who confirmed that she was investigating the same allegation. Pat Shepard

stated that she had already spoken to Resident A, the only verbal resident residing in this home, and that Resident A claims to have witnessed home manager, April Monroe, slap Resident C in the face twice on 6/29/23. Pat Shepard stated that Resident A told her that he does not remember any other incidents of physical abuse or that he has observed any other staff hit a resident. Pat Shepard reported that there are no other known witnesses to this alleged slap.

On 7/5/23, a phone conversation took place with administrator, Danielle Stevenson, who stated that she was at this home a good portion of the day on 6/29/23 and that she did not observe home manager, April Monroe, slap Resident C or any other resident. Administrator Stevenson stated that no other staff have reported to her anything about Manager Monroe ever slapping a resident and that there have been no concerns of this nature regarding Home Manager Monroe. Administrator Stevenson reported that Resident C has a history of slapping staff, other residents, and himself.

On 7/7/23, an on-site inspection was conducted, and Resident C was observed to be clean, well-groomed and with no visible marks, bruises, or injuries. Due to Resident C's cognitive deficiencies and the fact that he is non-verbal, Resident C was not able to be interviewed. Resident C was observed slapping himself on the head very hard several times as a form of agitation.

On 7/7/23, Resident A claimed to have witnessed home manager, April Monroe, slap Resident C twice, during one incident on 6/29/23. Resident A stated that he thought the slap was to Resident C's head or face area but that he could not remember. Resident A claims that Manager Monroe has slapped Resident C before, but Resident A could not remember how many times, any specific dates, or details about these alleged incidents. Resident A admitted that he does not like Manager Monroe and does not want to be in this home.

On 7/7/23, home manager, April Monroe, was interviewed. Manager Monroe denied ever slapping Resident C or any other resident. Manager Monroe reported that Resident C is the one who is physically aggressive toward staff and other residents and is frequently slapping himself on the head. Manager Monroe stated that Resident A was upset on 6/29/23 because he did not want to take a shower after having an accident and Resident A threatened to call in a complaint against her.

On 7/7/23, staff person, Tamika Howell, was interviewed. Staff Howell stated that she worked with manager Monroe on 6/29/23 and that she did not observe or hear manager Monroe slap Resident C. Staff Howell confirmed that part of Resident C's behaviors is that Resident C will slap staff, other residents, and himself. Staff Howell reported that she has never seen manager Monroe slap or be mean toward any resident.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Other than Resident A, there were no other witnesses to the alleged slap of Resident C on 6/29/23. Resident A could not provide and detailed information about the alleged incident and Resident A admitted that he does not like home manager, April Monroe, does not like this home and wants to move. Manager Monroe denies ever slapping Resident C or any other resident. Staff person, Tamika Howell, was the staff that worked with manager Monroe on 6/29/23 and stated that she has never seen manager Monroe slap or be mean toward any resident. On 7/7/23, Resident C was observed to be clean and free from any visible marks, bruises, or injuries. There was insufficient evidence found to prove that home manager, April Monroe, slapped Resident A or used any form of inappropriate physical force.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On 6/22/23, staff was administering meds when she placed the meds on the counter belonging to Resident A however, Resident B picked up the cup of meds and ingested them.

INVESTIGATION:

On 6/28/23, an on-site inspection was conducted, and Resident B was observed to be clean, well-groomed, and doing well. Due his cognitive deficiencies, Resident B was not able to be interviewed.

On 6/28/23, Resident A confirmed that Resident B took his medications from him. Resident A stated that staff placed his medications in front of him on the table, but then walked away and that Resident B came over and took them before he could take them.

On 6/28/23, administrator, Danielle Stevenson, confirmed that Resident B had taken Resident A's medications on 6/22/23. Administrator Stevenson stated that staff person, Vadis Russey, placed Resident A's medication on the dining table in front of Resident A and then walked into the kitchen to get a spoon. Administrator Stevenson stated that upon Staff Russey's return to the table, staff Russey observed Resident B grab the medications and swallow them. Administrator Stevenson reported that they called Resident B's case manager and guardian to report the incident and then took Resident B to the emergency room, where labs were taken, and Resident B was sent back home. Administrator Stevenson stated that other than being a little tired, Resident B had no other side effects from taking the wrong medication.

On 7/18/23, a phone interview was conducted with staff person, Vadis Russey, who confirmed this allegation to be true. Staff Russey stated that Resident A was sitting at the dining table with the medication sitting in front of him in a cup, with water and some yogurt, but no spoon. Staff Russey stated that she went back in the kitchen to grab a spoon and saw Resident B grab Resident A's medication and take it. Staff Russey reported that she tried to get Resident B to spit the medication out, but that Resident B had already swallowed it. Staff Russey stated that they took Resident B to the hospital, but that Resident B was not admitted and appeared to be okay the rest of the night.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Staff person, Vadis Russey, confirmed that Resident B had taken Resident A's medication after she had left the medication sitting on the table in front of Resident A. Resident A confirmed this incident to be true. There was sufficient evidence found to prove that in this circumstance, reasonable precautions were not taken to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/9/23, an exit conference was held with licensee designee, Bethany Mays. She was informed of the outcome of this investigation and that a corrective action plan is required.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

8/9/2023

Christopher Holvey — Date
Licensing Consultant

Approved By:

8/9/2023

Mary E. Holton — Date
Area Manager