GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 21, 2023

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

RE: License #:	AS250010959
Investigation #:	2024A1039003
	Burleigh

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,

Martin Gonzales, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010959
Investigation #:	2024A1039003
Complaint Receipt Date:	10/03/2023
Investigation Initiation Date:	10/10/2023
Report Due Date:	12/02/2023
Licensee Name:	Resident Advancement, Inc.
Licensee Address:	411 S. Leroy, PO Box 555 Fenton, MI 48430
Licensee Telephone #:	(810) 750-0382
Administrator:	Jennifer Soto
Licensee Designee:	Bethany Mays
Name of Facility:	Burleigh
Facility Address:	8155 Burleigh Grand Blanc, MI 48439
Facility Telephone #:	(810) 695-7455
Original Issuance Date:	05/19/1993
License **Status:**	REGULAR
Effective Date:	03/29/2022
Expiration Date:	03/28/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL / AGED

II. ALLEGATION(S)

	Violation Established?
On 10/01/23, Resident A stated they needed to go use the bathroom. Staff put a barrier up to prevent Resident A from accessing the hallway to the bathroom with his wheelchair.	Yes

III. METHODOLOGY

10/03/2023	Special Investigation Intake 2024A1039003
10/10/2023	Special Investigation Initiated - Telephone Spoke with GHS ORR Kim Nguyen-Forbes.
10/20/2023	Inspection Completed On-site Interviewed Assistant House Manager Qualeah Marzette.
11/07/2023	Contact - Face to Face completed a second on site interview. Interviewed House Manager Rebecca Chappell and Resident A.
11/09/2023	Contact - Telephone call made Attempted contact with Staff Destiny Willis and former Staff Kel Stocker. No answer left message for both parties.
11/16/2023	Contact - Telephone call made Attempted contact with former Staff Kel Stocker. No answer left message.
11/20/2023	Contact - Telephone call made Interview with Staff Destiny Willis.
11/20/2023	Contact - Telephone call made Attempted phone contact with former Staff Kel Stocker. No answer. Unable to leave message.
11/20/2023	Contact - Telephone call made Interview with GHS case manager Teevia Brown.
11/20/2023	Exit Conference Completed with Bethany Mays vis telephone.

11/20/2023	Inspection Completed-BCAL Sub. Compliance
11/21/2023	APS Referral Completed and sent via email.

ALLEGATION:

On 10/01/23, Resident A stated they needed to go use the bathroom. Staff put a barrier up to prevent Resident A from accessing the hallway to the bathroom with his wheelchair.

INVESTIGATION:

On 10/03/2023, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. According to the complaint Resident A needed to use the bathroom and a staff member moved an end table in between two couches. This prevented Resident A from accessing the hallway which led to the bathroom.

On 10/10/2023, I completed a phone interview with Genesee County Office of Recipient Rights (ORR) Kim Nguyen-Forbes. ORR Nguyen-Forbes stated that she was aware of the allegations that Resident A was prevented from using the bathroom due to staff putting furniture in his way so that he could not access the hallway. ORR Nguyen-Forbes stated that she interviewed Staff Destiny Willis who was working during the time of the incident. ORR Nguyen-Forbes stated that Staff Willis informed her that on 10/01/2023, she witnessed Staff Kel Stocker move the end table to where it blocked Resident A from using the bathroom. Staff Willis stated that she was passing out medication during this time and that when she went to go move the end table for Resident A that it had already been moved and he was headed down the hallway to use the bathroom. ORR Nguyen-Forbes stated that she looked at the incident as a freedom of movement restriction.

On 10/25/2023, I completed an unannounced on-site investigation at Burleigh AFC home. I interviewed Assistant Home Manager (AHM) Qualeah Marzette regarding the allegations. AMH Marzette stated that she was out of town at the time of the incident but that she was aware of the allegations involving Resident A. AMH Marzette stated that Staff Kel Stocker was the staff member that prevented Resident A from using the bathroom and blocking his access to the hallway with furniture. AMH Marzette stated that Staff Stocker was no longer working there and had been let go after the incident occurred. AMH Marzette provided the phone numbers of the staff that were working at that time and provided the records for Resident A. Resident A was not interviewed at the on-site investigation as there was a health issue in the Burleigh AFC home and I informed AHM Marzette that I would come back to complete my on-site interview with Resident A on a later date.

On 11/07/2023, I completed a second unannounced on-site investigation at Burleigh AFC home. I interviewed the following people: House Manager (HM) Rebecca Chappell and Resident A. The allegations were reviewed with HM Chappell. HM Chappell stated that she was familiar with the allegations and that they had already addressed the situation and that Staff Stocker's employment was terminated on 10/10/2023, and that she had not worked since the incident occurred on 10/01/2023. HM Chappell stated that the other staff member on duty was Staff Destiny Willis. HM Chappell stated that Staff Willis is the employee who informed the management team of what occurred between Staff Stocker and Resident A.

On 11/07/2023, I attempted to complete an on-site interview with Resident A regarding the allegations. Resident A is diagnosed with the following disorders: Intellectual disability and Major Neurocognitive disorder. These diagnoses severely limit Resident A's ability to communicate or acknowledge the allegations that were being reviewed with him. No information was able to be gathered due to Resident A's current condition.

On 11/20/2023, I completed a phone interview with Staff Destiny Willis regarding the allegations involving Resident A. Staff Willis stated that she remembered the incident and that she reported it to management. Staff Willis stated that she was giving medication out to other residents when she saw Staff Stocker use furniture to block Resident A in from using the bathroom. Staff Willis stated that she went to go help Resident A but by the time she got there to help him that he had already moved the end table and was heading down the hallway to use the bathroom. Staff Willis stated that she doesn't let any staff neglect the residents while she is working. Staff Willis stated that she had no additional information regarding the situation.

On 11/20/2023, I completed a phone interview with Genesee Health System Case Manager (CM) Teevia Brown regarding the allegations involving Resident A. CM Brown stated that she was not aware of the allegations involving Resident A. CM Brown was informed of the allegations and how the staff member was dealt with that was involved in incident. CM Brown did not have any further questions or information regarding the allegations.

Staff Kel Stocker was unable to be contacted to be interviewed for this investigation. I attempted to contact Staff Stocker by telephone on the following days with no success: 11/09/2023, 11/16/2023 and 11/20/2023.

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:

	(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.
ANALYSIS:	It was alleged that a staff member moved furniture to prevent Resident A's wheelchair from being able to access the hallway to use the bathroom. After completing interviews with Burleigh staff, GHS ORR, and Case Manager it was determined that there was a preponderance of evidence to conclude that R 400.14308 (2) (b) was violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/20/2023, I conducted an exit conference with Licensee Designee Bethany Mays. I informed Licensee Designee Mays that I would be citing the rule violation listed above and that a corrective action plan would be required.

IV. RECOMMENDATION

I recommend that no changes be made to the licensing status pending the receipt of an appropriate corrective action plan.

11/21/2023

Martin Gonzales Licensing Consultant	Date

Approved By:

11/21/2023

Mary E. Holton Area Manager	Date