GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 8, 2024

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

RE: License #: AS250010859
Investigation #: 2024A0569054
Atlas Park

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,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010859
Investigation #:	2024A0569054
Complaint Receipt Date:	09/03/2024
Investigation Initiation Date:	09/05/2024
Report Due Date:	11/02/2024
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:	Atlas Park
Facility Address:	2099 Atlas Road Davison, MI 48423
Facility Telephone #:	(810) 653-6529
Original Issuance Date:	12/29/1989
License Status:	REGULAR
Effective Date:	10/26/2022
Expiration Date:	10/25/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was sent to day program on 8/28/24 with a lunch that was not prepared per his care plan.	Yes

III. METHODOLOGY

09/03/2024	Special Investigation Intake 2024A0569054
09/05/2024	APS Referral Referral to APS.
09/05/2024	Special Investigation Initiated - Telephone Contact with Matt Potts, RRO.
10/07/2024	Contact - Telephone call made Contact with Matt Potts, RRO.
10/08/2024	Inspection Completed On-site
10/08/2024	Inspection Completed-BCAL Sub. Compliance
10/08/2024	Exit Conference Exit conference with Bethany Mays, licensee designee.
10/08/2024	Corrective Action Plan Requested and Due on 10/30/2024

ALLEGATION:

Resident A was sent to day program on 8/28/24 with a lunch that was not prepared per his care plan.

INVESTIGATION:

This complaint was received via the on-line complaint portal. The complainant reported that Resident A was sent to his day program on 8/28/24 with a lunch that contained food that was not prepared as required by Resident A's plan of service.

Matt Potts, GHS recipient rights officer, stated on 10/7/24 that he investigated this complaint. Matt Potts stated that Resident A is non-verbal and requires his food to be cut into bite-sized pieces. Matt Potts stated that Resident A was sent to his day program with a "honey bun" in his lunch that was not cut into bite-sized pieces which posed a potential choking hazard for Resident A. Matt Potts stated that staff at the day program were able to get the food out of Resident A's lunch prior to him consuming it. Matt Potts stated that Resident A was not injured, but Matt Potts did cite a violation of Resident A's recipient rights.

An unannounced inspection of this facility was conducted on 10/8/24. Resident A is non-verbal and could not give a statement regarding this incident. Resident A was appropriately dressed and groomed with no visible injuries. Resident A's file contains a plan of service dated 3/22/24. The plan of service documents that Resident A's food must be cut into bite-sized pieces to mitigate a potential choking hazard.

Diana Reed, assistant manager, stated on 10/8/24 that she was working on 8/28/24. Diana Reed stated that she was preparing the residents' lunches that go to day program and some of the food was laying out on the counter. Diana Reed stated that Resident A grabbed one of the "honey buns" lying on the counter and threw it into his lunch bag. Diana Reed stated that she did not notice this and sent the lunch with Resident A without cutting the "honey bun" into bite-sized pieces. Diana Reed admitted that Resident A was sent with a lunch that was not prepared in compliance with Resident A's care plan.

An exit conference was conducted on 10/8/24 with Bethany Mays, licensee designee. The findings in this report were reviewed and a corrective action plan was requested. Bethany Mays stated on 10/8/24 that the staff have been re-in serviced regarding Resident A's care plan and requirements for being served bite-sized pieces of food.

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:	The complainant reported that Resident A was sent to his day program on 8/28/24 with a lunch that contained food that was not cut into bite-sized pieces as required in his care plan. Resident A's current plan of service requires Resident A be given food cut into bite-sized pieces to mitigate a choking hazard. Diana Reed admitted to sending Resident A to his day program with a "honey bun" that was not cut into bite-sized pieces. Based on the statements given and documentation reviewed, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

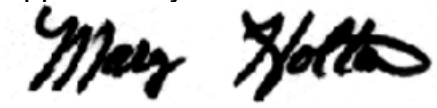
IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

10/08/2024

Kent W Gieselman Date
Licensing Consultant

Approved By:



10/08/2024

Mary E. Holton Date
Area Manager