GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 19, 2024

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

RE: License #: AS440284123
Investigation #: 2024A0569057
Hampshire

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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS440284123
Investigation #:	2024A0569057
Complaint Receipt Date:	09/25/2024
Investigation Initiation Date:	09/25/2024
Report Due Date:	11/24/2024
Licensee Name:	Resident Advancement, Inc.
Licensee Address:	411 S. Leroy, PO Box 555 Fenton, MI 48430
Licensee Telephone #:	(810) 750-0382
Administrator:	Lisa Savage
Licensee Designee:	Bethany Mays
Name of Facility:	Hampshire
Facility Address:	3200 Hampshire Road Lapeer, MI 48446
Facility Telephone #:	(810) 245-6037
Original Issuance Date:	09/01/2006
License **Status:**	REGULAR
Effective Date:	04/03/2023
Expiration Date:	04/02/2025
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A is being verbally mistreated by staff Olivia Ritchie.	Yes

III. METHODOLOGY

09/25/2024	Special Investigation Intake 2024A0569057
09/25/2024	APS Referral Referral from APS.
09/25/2024	Special Investigation Initiated - Letter Email from Lisa Jolly, RRO.
10/31/2024	Inspection Completed On-site
11/07/2024	Contact - Face to Face Contact with Justine Brown, CMH case manager.
11/12/2024	Contact - Telephone call made Attempted contact with Olivia Ritchie, staff person. Left voicemail requesting return phone call.
11/12/2024	Contact - Telephone call made Attempted contact with Hannah Austin, staff person. Requested return phone call.
11/12/2024	Contact - Telephone call made Attempted contact with Ken Gill, staff person. No answer, voicemail not in service.
11/14/2024	Contact - Telephone call made Attempted contact with Ken Gill, staff person.
11/18/2024	Contact - Telephone call received Contact with Hannah Austin, staff person.
11/18/2024	Contact - Telephone call made Attempted contact with Ken Gill, staff person. Voicemail not in service.

11/19/2024	Inspection Completed-BCAL Sub. Compliance
11/19/2024	Exit Conference Exit conference with Beth Mays, licensee designee.
11/19/2024	Corrective Action Plan Requested and Due on 12/15/2024

ALLEGATION:

Resident A is being verbally mistreated by staff Olivia Ritchie.

INVESTIGATION:

This complaint was received from the adult protective services central intake department. The complainant reported that a staff person has verbally mistreated Resident A. The complainant reported that Olivia Ritchie, staff person, verbally mistreated Resident A on 9/25/2024. The complainant reported that the incident was observed by Hannah Austin, staff person.

Lisa Jolly, recipient rights officer, stated on 9/25/2024 that she is investigating this allegation. Lisa Jolly stated that she has attempted to interview staff Olivia Ritchie, but she has quit working at this facility. Lisa Jolly stated that she anticipates that she will cite a violation of Resident A's recipient rights.

An unannounced inspection of this facility was conducted on 10/31/2024. Resident A was unable to give a reliable statement regarding this incident due to limited verbal abilities. Resident A was appropriately dressed and groomed with no visible injuries.

Justine Brown, Resident A's CMH case manager, stated on 10/31/2024 that she did not observe this incident. Justine Brown stated that she has never observed any of the staff at this facility verbally or physically mistreat Resident A or any of the other residents. Justine Brown stated that she has no concerns regarding Resident A's care at this facility. Justine Brown stated that Olivia Ritchie no longer works at this facility, and that the staff were all re-trained regarding appropriate treatment of residents following this incident.

Lisa Savage, administrator, stated on 10/31/2024 that this incident was reported to her on 9/25/2024. Lisa Savage stated that a staff person had called off for the first shift on 9/25/2024 and Olivia Ritchie was asked to stay past her shift until another staff person could be called in to work. Lisa Savage stated that Olivia Ritchie was upset that she had to work past her shift. Lisa Savage stated that it was reported to her that Olivia Ritchie started "yelling at" Resident A and was swearing in front of Resident A. Lisa Savage stated that she then started the process of terminating Olivia Ritchie from employment,

but Olivia Ritchie quit prior to being terminated. Lisa Savage stated that all of the staff we re-trained following this incident to address proper treatment of residents.

Several attempted contacts with Olivia Ritchie were made. Olivia Ritchie has not responded with a statement regarding this incident.

Hannah Austin, staff person, stated on 11/18/2024 that she reported for her shift on 9/25/2024 which was the first shift. Hannah Austin stated that Olivia Ritchie had worked the third shift and was upset that she had been asked to stay past her shift until another staff person could be called in to work. Hannah Austin stated that Olivia Ritchie was helping Resident A get ready for the day when she started being verbally aggressive with Resident A. Hannah Austin stated that she observed Olivia Ritchie “yell at” Resident A and saying, “quit being lazy” when trying to dress Resident A. Hannah Austin stated that Olivia Ritchie also called Resident A “lazy, weird, and creepy”. Hannah Austin stated that Olivia Ritchie then said “this is fucking bullshit” in front of Resident A while still assisting Resident A. Hannah Austin stated that Olivia Ritchie then left the facility before a second staff arrived for the first shift.

An exit conference was conducted with Bethany Mays, licensee designee, on 11/19/2024. The findings in this report were reviewed. Bethany Mays will submit a corrective action plan to address the rule violation cited in this report.

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: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.**
ANALYSIS:	Olivia Ritchie, staff person, was observed calling Resident A “lazy, weird, and creepy” on 9/25/24. Olivia Ritchie was also observed to have said, “this is fucking bullshit” while assisting Resident A in his bedroom on 9/25/24. Based on the statement given, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

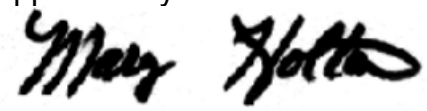
IV. RECOMMENDATION

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

11/19/2024

Kent W Gieselman — Date
Licensing Consultant

Approved By:



11/19/2024

Mary E. Holton — Date
Area Manager