GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 11, 2022

Sheila Leadbetter
Barrett Regency, Inc.
1318 Maple
Rochester, MI 48307

RE: License #: AS630377781
Investigation #: 2022A0611026
Barrett Regency Inc.
Corrected Addendum REPORT which supersedes all previous versions
Original Report date: May 18, 2022

Dear Ms. Leadbetter:

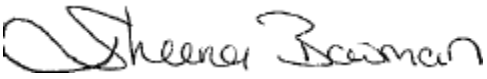
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630377781
Investigation #:	2022A0611026
Complaint Receipt Date:	04/27/2022
Investigation Initiation Date:	05/03/2022
Report Due Date:	06/26/2022
Licensee Name:	Barrett Regency, Inc.
Licensee Address:	5101 N. Rochester Rochester, MI 48306
Licensee Telephone #:	(248) 494-6719
Administrator:	Sheila Leadbetter
Licensee Designee:	Sheila Leadbetter
Name of Facility:	Barrett Regency Inc
Facility Address:	5101 N. Rochester Rochester, MI 48306
Facility Telephone #:	(248) 494-6719
Original Issuance Date:	05/10/2016
License Status:	REGULAR
Effective Date:	06/07/2021
Expiration Date:	06/06/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATIONS

	Violation Established?
Facility refused to take resident back to her home because family did not want to use her preferred hospice provider.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/27/2022	Special Investigation Intake 2022A0611026
05/03/2022	Inspection Completed On-site I completed an unannounced onsite. I interviewed staff member, Tywanna Peoples and staff member, Linda Ngonga. I received the licensee designee, Sheila Leadbetter contact information.
05/03/2022	Contact - Telephone call received I received a return phone call from the licensee designee, Sheila Leadbetter. I informed Mrs. Leadbetter I will contact her later to discuss the allegations.
05/04/2022	Contact - Document Received I received a copy of Resident V's discharge notice and incident report from the assigned licensing consultant, Kristen Donnay.
05/05/2022	Contact - Telephone call received I received a return phone call from the licensee designee, Sheila Leadbetter. The allegations were discussed.
05/05/2022	Contact - Document Received I received a copy of Resident V's discharge notice.
05/06/2022	Contact - Telephone call received I received a return phone call from Resident V's guardian. The allegations were discussed.
05/12/2022	Contact - Telephone call made I made a telephone call to Dr. Rica Stamatin. The allegations were discussed.
05/12/2022	Contact - Telephone call made

	I made a telephone call to the licensee designee, Sheila Leadbetter. A request for documents were made.
05/13/2022	Contact - Document Received I received a copy of a prescription for Haloperidol 2 mg for Resident V written by Dr. Rica Stamatin.
05/15/2022	Contact - Document Received I received a copy of the resident register, and three prescriptions from Ascension Providence Rochester hospital for Resident V.
05/17/2022	Exit Conference I completed an exit conference with the licensee designee, Sheila Leadbetter via email.

ALLEGATION:

Facility refused to take resident back to her home because family did not want to use her preferred hospice provider.

INVESTIGATION:

On 04/27/22, I received an intake regarding the above-mentioned allegations.

On 05/03/22, I completed an unannounced onsite. I interviewed staff member, Tywanna Peoples and staff member, Linda Ngonga. I received the licensee designee, Sheila Leadbetter contact information.

On 05/03/22, I interviewed staff member, Tywanna Peoples. Regarding the allegations, Ms. Peoples stated there was a resident who lived in the AFC group home for one day last week and was then admitted into the hospital. Ms. Peoples does not know why the resident did not return to the AFC group home after being discharged from the hospital. Ms. Peoples stated the resident's bed was picked up from the AFC group home. Ms. Peoples did not know the name of the resident or had any more information. Ms. Peoples could not locate the resident register. Following the interview, Ms. Peoples left the home as her shift ended.

On 05/03/22, I interviewed staff member, Linda Ngonga. Regarding the allegations, Ms. Ngonga did not know which resident was recently discharged from the AFC group home. Ms. Ngonga could not provide any information regarding the allegations.

On 05/03/22, I received a return phone call from the licensee designee, Sheila Leadbetter. Ms. Leadbetter stated that she was at the airport as she just got back in town. Mrs. Leadbetter stated the allegations were pertaining to Resident V. I informed

Mrs. Leadbetter about my observations regarding Ms. Ngonga and the medication cabinet. I told Mrs. Leadbetter that I will contact her later to discuss the allegations.

On 05/04/22, I received a copy of Resident V's discharge notice from the assigned licensing consultant, Kristen Donnay. The discharge notice was written to Ms. Donnay and was dated 05/26/22. Ms. Donnay also provided a copy of an incident report dated 04/24/22. The incident report indicated Resident V had an altered mental status, she was combative, screaming, and wanted to hurt herself. There were no medications provided for Resident V from Ascension of Rochester. According to the incident report, the action that was taken was Resident V was administered Haloperidol 2 mg by Mrs. Leadbetter per Dr. Stamatin. The medication had no effect on Resident V and; Dr. Stamatin issued a verbal order to send her to Ascension of Rochester for further tests.

On 05/05/22, I received a return phone call from the licensee designee, Sheila Leadbetter. Regarding the allegations, Mrs. Leadbetter stated on 04/24/22, she admitted Resident V into the AFC group home following an assessment she completed while Resident V was at Ascension Hospital in Rochester. When Mrs. Leadbetter observed Resident V at the hospital, she was sedated as she was medicated around the clock. Resident V was discharged from the hospital without any medications. Mrs. Leadbetter received three prescriptions for Resident V. Mrs. Leadbetter stated when Resident V arrived to the home, she was having behavioral problems and she was combative. Resident V was also jumping out of bed, screaming, and threatening to kill herself and Mrs. Leadbetter.

Mrs. Leadbetter stated she tried to use calming techniques with Resident V. Mrs. Leadbetter contacted her in-house doctor (Dr. Rica Stamatin) and the doctor advised her to send Resident V back to Ascension hospital. Resident V was admitted into Ascension hospital. Resident V has Alzheimer's and she also had a UTI. Resident V was only in the AFC group home for four hours before she was admitted back to Ascension hospital. Mrs. Leadbetter stated the following day she spoke to the doctor at Ascension and they discuss referring Resident V to a neurologist and physical therapy due to her recent hip surgery.

Mrs. Leadbetter stated she spoke to Resident V's guardian over the phone and advised him that Resident V was not a good fit at her AFC group home. Mrs. Leadbetter also sent Resident V's guardian a text message stating Resident V was not a good fit. Resident V's guardian understood. Mrs. Leadbetter stated she provided a written emergency discharge notice to Resident V's guardian via email on 04/26/22. Resident V was still in the hospital on 04/27/22. Mrs. Leadbetter assisted Resident V's guardian with finding another placement for Resident V. Resident V's guardian located an assisted living placement for Resident V and she was placed on hospice. Resident V was discharged from the hospital on 04/29/22 and admitted into the assisted living placement that was chosen by her guardian. Mrs. Leadbetter stated Resident V's guardian picked up Resident V's belongings from the AFC group home on 04/27/22.

On 05/05/22, I received a copy of Resident V's discharge notice from Mrs. Leadbetter. The discharge notice is written to Resident V's guardian. The discharge notice is dated 04/26/22. The discharged notice explained Resident V's behavior and indicated Resident V will be discharged from the AFC group home.

On 05/06/22, I received a return phone call from Resident V's guardian. The guardian confirmed that Resident V was admitted to the AFC group home on 04/24/22 around 3:00 pm. The guardian received a phone call around 6:30 pm from Mrs. Leadbetter stating Resident V was being transported back to the hospital. The guardian stated on 04/26/22, he was at the hospital in Resident V's room. A social worker from Assured Hospice came in and informed him that she will be Resident V's hospice provider. The guardian did not agree to this and informed the social worker that Assured will not be providing hospice care for Resident V. The guardian stated he later received a phone call from Mrs. Leadbetter. The guardian informed Mrs. Leadbetter that he was going to use hospice of Michigan for Resident V. Mrs. Leadbetter did not agree with this decision as she wanted the guardian to use Assured Hospice. The guardian informed Mrs. Leadbetter that Assured was not going to work for him and Mrs. Leadbetter stated hospice of Michigan was not going to work for her.

The guardian stated later that day, he received a text message from Mrs. Leadbetter stating that her home is not a good fit for Resident V and she cannot take her back. The guardian stated he never received a discharge notice or anything in writing regarding Resident V being discharged from the AFC group home from Mrs. Leadbetter. The guardian checked his email while we were on the phone and he confirmed that he never received a discharge notice from Mrs. Leadbetter. The guardian's spouse also checked her email and the only email she received from Mrs. Leadbetter was regarding an invoice.

The guardian stated he went to the AFC group home on 04/27/22 to pick up Resident V's belongings. The guardian returned to the AFC group home a couple days later to pick up Resident V's bed.

On 05/12/22, I made a telephone call to Dr. Rica Stamatin. Regarding the allegations, Dr. Stamatin stated when Resident V was admitted into the AFC group home, she was extremely agitated. Dr. Stamatin stated he could not remember if he wrote Mrs. Leadbetter a prescription for Haloperidol. Dr. Stamatin then stated he gave Mrs. Leadbetter a verbal order to administer Haloperidol to Resident V to calm her down. Dr. Stamatin was later advised two-three hours later that the medication was not working therefore; he told Mrs. Leadbetter to send Resident V back to the hospital due to her violent behaviors and agitation.

On 05/12/22, I made a telephone call to the licensee designee, Sheila Leadbetter. Mrs. Leadbetter stated she received a prescription for Haloperidol from Dr. Stamatin. Mrs. Leadbetter stated a pharmacy delivered Haloperidol to the AFC group home. Mrs. Leadbetter stated Resident V was not prescribed Haloperidol when she was discharged from the hospital. Mrs. Leadbetter confirmed she received three prescriptions for

Resident V when she was discharged from the hospital. Mrs. Leadbetter stated one of the prescriptions was for Norco however; she cannot remember the names of the medications for the other prescriptions.

Mrs. Leadbetter said she did not discharge Resident V because the family did not want to use her hospice provider. Mrs. Leadbetter stated Resident V's family choose another hospice provider for Resident V. Mrs. Leadbetter agreed to send me the resident register, a copy of the prescription from Dr. Stamatin, and Resident V's three prescriptions.

On 05/13/22, I received a copy of a prescription for Haloperidol 2 mg from Mrs. Leadbetter for Resident V written by Dr. Rica Stamatin. The prescription is dated for 04/22/22. It's important to note that Resident V was not admitted into the AFC group home until 04/24/22 per Mrs. Leadbetter.

On 05/15/22, I received a copy of the resident register, and three prescriptions from Ascension Providence Rochester hospital for Resident V. According to the resident register, Resident V was admitted on 04/24/22 and discharged on 04/26/22. The three prescriptions from Ascension Providence Rochester hospital were for Seroquel 50 mg, Ativan 0.5 mg, and Norco 5 mg.

On 05/17/22, I completed an exit conference with the licensee designee, Sheila Leadbetter via email. Mrs. Leadbetter was informed that the allegations will be substantiated and a corrective action plan will be required.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.**

ANALYSIS:	Based on my investigation and information gathered, Resident V's guardian and the licensing consultant did not receive a written discharge notice 24 hours before Resident V's discharge from the AFC group home. Resident V was admitted into the AFC group home on 04/24/22. On 04/26/22, Resident V was discharged from the AFC group home. Mrs. Leadbetter stated she provided a written emergency discharge notice to Resident V's guardian via email on 04/26/22. On 05/04/22, I received a copy of Resident V's discharge notice. The discharge notice was written to the assigned licensing consultant and was dated 05/26/22. However, Resident V was discharged on 04/26/22. I requested Mrs. Leadbetter to forward me the email she sent to Resident V's guardian containing the discharge notice. On 05/05/22, I received a copy of Resident V's discharge notice from Mrs. Leadbetter that was sent directly from Mrs. Leadbetter's email and there was no forwarding email attached that was sent to the guardian. The discharge notice is written to Resident V's guardian and dated 04/26/22. On 05/06/22, Resident V's guardian never received a discharge notice or anything in writing regarding Resident V being discharged from the AFC group home from Mrs. Leadbetter. The guardian checked his email while we were on the phone and he confirmed that he never received a discharge notice from Mrs. Leadbetter.
CONCLUSION:	**VIOLATION ESTABLISHED**

R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.
ANALYSIS:	On 05/04/22, I received a copy of the incident report. The date of the incident was 04/24/22. The incident report indicated

	Resident V had an altered mental status, she was combative, screaming, and wanted to hurt herself. There were no medications provided for Resident V from Ascension of Rochester. According to the incident report, the action taken was that Resident V was administered Haloperidol 2 mg by Mrs. Leadbetter per Dr. Stamatin. On 05/12/22, Dr. Stamatin could not remember if he wrote Mrs. Leadbetter a prescription for Haloperidol. Dr. Stamatin then stated he gave Mrs. Leadbetter a verbal order to administer Haloperidol to Resident V to calm her down. On 05/13/22, I received a copy of a prescription for Haloperidol 2 mg from Mrs. Leadbetter for Resident V written by Dr. Rica Stamatin. The prescription is dated for 04/22/22. Resident V was not admitted into the AFC group home until 04/24/22.
CONCLUSION:	**VIOLATION NOT ESTABLISHED (UPDATED 8-10-2022)**

ADDITIONAL ALLEGATION

INVESTIGATION:

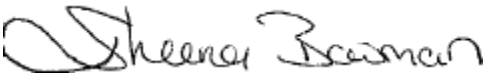
On 05/03/22, I interviewed staff member, Linda Ngonga. Prior to interviewing Ms. Ngonga, I observed the residents medications in a cabinet that was left opened. Ms. Ngonga was the only staff member on shift during this time. However, Ms. Ngonga was not in the vicinity of where the medication is kept and was not visibly seen in the kitchen area, the front entrance of the home, or in the common area for a noticeable amount of time. Ms. Ngonga then entered the home from the garage door. Ms. Ngonga stated she took out the trash. Ms. Ngonga closed the medication cabinet but she did not lock it. I advised Ms. Ngonga that the medication cabinet should never be left unlocked. I observed Ms. Ngonga locking the medication cabinet.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being §333.1101 et seq. of the Michigan

	Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	On 05/03/22, I observed the resident's medications in a cabinet that was left opened. Ms. Ngonga was the only staff member on shift during this time. However, Ms. Ngonga was not in the vicinity of where the medication is kept and was not visibly seen in the kitchen area, the front entrance of the home, or in the common area for a noticeable amount of time.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

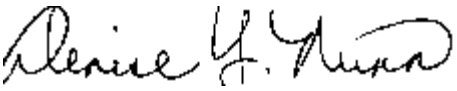
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



05/17/22

Sheena Bowman — Date
Licensing Consultant

Approved By:



05/18/2022

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Denise Y. Nunn — Date
Area Manager

Continued…..

ADDENDUM REPORT
SIR #2022A0611026

PURPOSE OF ADDENDUM:

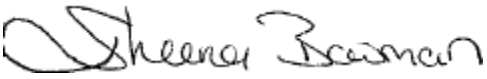
Mrs. Leadbetter contacted the department to inquire about the violations cited in the special investigation report. The special investigation report was re-reviewed and an addendum report was completed.

DESCRIPTION OF FINDINGS AND CONCLUSIONS

Mrs. Leadbetter contacted the department to discuss the findings for R14302(5) and R14312(4). The special investigation report was re-reviewed by management and it was decided that R14312(4) was incorrectly cited as a violation therefore; an addendum report is being completed to change the conclusion for R14312(4) to no violation.

RECOMMENDATION:

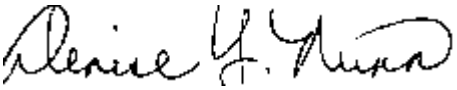
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



8/11/2022

Sheena Bowman — Date
Licensing Consultant

Approved By:



8/11/2022

Denise Y. Nunn — Date
Area Manager