GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 29, 2022

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

RE: License #:	AS250010923
Investigation #:	2023A0123010
	Maple Woods

Dear Ms. Mays:

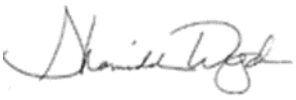
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010923
Investigation #:	2023A0123010
Complaint Receipt Date:	11/17/2022
Investigation Initiation Date:	11/18/2022
Report Due Date:	01/16/2023
Licensee Name:	Resident Advancement, Inc.
Licensee Address:	411 S. Leroy, PO Box 555 Fenton, MI 48430
Licensee Telephone #:	(810) 750-0382
Administrator:	Danielle Davis
Licensee Designee:	Bethany Mays
Name of Facility:	Maple Woods
Facility Address:	7448 Maple Road Grand Blanc, MI 48439
Facility Telephone #:	(810) 743-2336
Original Issuance Date:	05/06/1991
License Status:	1ST PROVISIONAL
Effective Date:	08/24/2022
Expiration Date:	02/23/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 11/11/2022, Resident A was observed to be slouched over in his wheelchair, and with his face, bib, and shirt collar completely soaked with tears and mucus.	Yes
On 11/11/2022, Resident B was observed self-harming, and staff failed to intervene appropriately per Resident B's behavioral treatment plan.	Yes

III. METHODOLOGY

11/17/2022	Special Investigation Intake 2023A0123010
11/18/2022	Special Investigation Initiated - Telephone I spoke with recipient rights investigator Pat Shephard via phone.
11/21/2022	Contact - Telephone call made I spoke with GHS case manager Carla Webb via phone.
11/30/2022	Inspection Completed On-site I conducted an unannounced on-site visit at the facility.
12/01/2022	APS Referral APS referral completed.
12/08/2022	Contact - Telephone call made I spoke with Witness 1 via phone.
12/08/2022	Contact - Telephone call made I spoke with Witness 2 via phone.
12/08/2022	Contact - Telephone call made I attempted to contact Witness 4 via phone.
12/08/2022	Contact - Telephone call made I spoke with staff Linda Grisby via phone.
12/08/2022	Contact - Telephone call made I left a voicemail requesting a return call from staff Paris Folsom.
12/08/2022	Contact - Telephone call received

	I interviewed staff Paris Folsom via phone.
12/09/2022	Contact - Telephone call made I spoke with Witness 3 via phone.
12/12/2022	Contact - Telephone call made I spoke with recipient rights investigator Brandy Martin via phone.
12/28/2022	Contact- Telephone call made I left a voicemail requesting a return call from Bethany Mays regarding an exit conference.
12/29/2022	Exit Conference I spoke with licensee designee Bethany Mays via phone.
12/29/2022	Contact- Telephone call made I conducted a Facetime call with the facility, observed the residents, and interviewed Guardian 1.

ALLEGATION:

- On 11/11/2022, Resident A was observed to be slouched over in his wheelchair, and with his face, bib, and shirt collar completely soaked with tears and mucus.

- On 11/11/2022, Resident B was observed self-harming, and staff failed to intervene appropriately per Resident B's behavioral treatment plan.

INVESTIGATION:

On 11/18/2022, I spoke with recipient rights investigator Pat Shephard via phone. She stated that Resident A was observed on 11/11/2022 to have been crying, and that his face, neck, shirt, and bib were soaked in tears and mucus to the point his neck was irritated. She stated that staff had not attended to Resident A. She stated that Resident B was not wearing her helmet and was observed banging her head on the floor, and also had a soaking wet brief. She stated that a witness suggested to Staff Grigsby that she should put Resident B's helmet on her, and Staff Grigsby was observed shoving the helmet onto Resident B's head. Resident B later took it off and proceeded to bang her head again. Ms. Shephard stated that Staff Grigsby and staff Paris Folsom were on shift at the time of the incidents.

On 11/21/2022, I made a call to Resident A and Resident B's Genesee Health System's case manager Carla Webb. Ms. Webb stated that Resident B is supposed to wear her helmet, and that Resident B does not keep the helmet on. She also stated that Resident B has gloves as well that are to keep her from hitting herself in the face. She stated that Resident B will hit her head and face full force.

On 11/30/2022, I conducted an unannounced on-site visit at the facility. Home manager Lakeitha Anderson and administrator Danielle (Davis) Stevenson were present. Staff Anderson stated that she was not at the facility at the time of the alleged incident. Staff Anderson stated that Resident B takes her helmet off sometimes, and staff have to put the helmet back on her or get a pillow or something, as it is one of Resident A's behaviors to bang her head. Mrs. Stevenson and Staff Anderson stated that the individuals who witnessed the incident arrived at the home at 4:00 pm, and that they left at 5:00 pm. Staff Folsom and Staff Grigsby were working second shift at the time. They stated that Resident A and Resident B were at school that day, and that Resident A would have been arriving straight from school during that time frame. Mrs. Stevenson stated that the witnesses reported they observed that Staff Grigsby refused Resident A access to the kitchen, Staff Folsom was cooking dinner, and Resident B was on the floor banging her head. She stated that Staff Grigsby wheeled Resident A back out of the kitchen due to Staff Folsom cooking, and that when Resident A gets off of the bus, his bib is always soaked. She stated that Resident A does not arrive home until 4:30 pm. Staff Anderson stated that she has since directed staff to get Resident A out of his chair, clean him up, take his braces off, check his brief, and make him comfortable after arriving home from school. She stated that she has no knowledge of how staff were handling Resident A prior to this incident. Mrs. Stevenson stated that Resident B will fight staff and resist when they try to put her helmet on. During this on-site, Resident A and Resident B were not present. The residents observed in the home appeared clean and appropriately dressed.

On 12/08/2022, I interviewed Witness 1 via phone. Witness 1 stated that upon arrival to the home, it took some time before staff answered the door. There were two staff present in the home, and there were a few residents that appeared to be in distress, one of them being Resident A. Resident A's face was covered in tears. His face and shirt were soaked, and he had neckline irritation. Staff Grigsby was not assisting Resident A. Resident A was leaning all the way down in his seat slouched. Staff Grigsby was being rough when pulling Resident A upright in his wheelchair. Resident A was observed being redirected from the kitchen more than once, staff did not interact with him, and he continued crying. Resident B was on the floor banging her head. Staff Grigsby was asked if the helmet observed in the vicinity was Resident B's, and Staff Grigsby was informed that Resident B's helmet needed to be put on. Staff Grigsby then put the helmet on Resident B incorrectly, by not adjusting her hair or the helmet straps, and just pushed the helmet down on her head. Witness 1 stated that Resident B's brief and pants were also soaked through, and staff did not try to change her brief. The dining room chair was soaked after Resident B got up to get seconds for dinner. Witness 1 stated that Resident B had another incident right before eating where she sat on another spot on the floor and was banging her head again. Witness 1 stated that they asked for a blanket. She stated that staff made it seem like it was normalized behavior. Witness 1 stated that upon arrival to the home, both Resident A and Resident B were already present, and upon entry, Resident B was on the other side of a table banging her head, and Resident A was

observed with a face and bib covered in boogers and tears, and a soaked shirt. Witness 1 stated that they got to the home at about 4:00 pm and left after 5:00 pm.

On 12/08/2022, I interviewed Witness 2 via phone. Witness 2 stated that upon arrival to the facility, they could hear screaming and crying from inside the home and that it took about ten minutes for a staff person to open the door. Witness 2 stated that Resident A was in his wheelchair crying, with tears, snot, and mucus on his face, and his bib was soaked through as well as his shirt. Witness 2 stated that another witness cleaned Resident A's face. Resident B was observed on the floor beating herself in the head with her fist, and Staff Grigsby stated that it was normal behavior. Resident B having her helmet put on was suggested, then Staff Grigsby put the helmet on Resident B without unstrapping it. Witness 2 stated that Staff Grigsby had to be redirected by a witness to unbuckle the helmet. Staff Grigsby was observed not interacting with the residents and ignored Resident A who was still crying. Staff Folsom reported that Resident A was hungry, and no snack was provided to him after it was suggested. Resident B took her helmet off and was beating her head on the floor. A witness asked for a blanket to intervene with Resident B's head banging, and Staff Grigsby blew it off. Two witnesses found a blanket and put it under Resident A's head. During this on-site, Witness 2 also stated that Staff Grigsby was observed roughly taking off Resident A's bib and braces, and had to be told she needed to unsnap the bib and shoes. Witness 2 also reported that Resident A and Resident B were already physically present in the home upon their arrival.

On 12/09/2022, I interviewed Witness 3 via phone. Witness 3 stated that on 11/11/2022, it took a while for staff to open the door, and it was loud inside the facility because residents were yelling. Resident A was really upset, crying in his wheelchair. Resident B was laying on the dining room floor screaming and hitting herself in the head. She stated that there were two staff on shift. Staff Grigsby was doing laundry, and Staff Folsom was cooking dinner. Witness 3 stated that one of the witnesses that accompanied her tended to Resident A's face. Witness 1 asked Staff Grigsby if Resident A should be sitting slouched in his wheelchair, Staff Grigsby said no and yanked Resident A upright. Staff was asked where Resident B's helmet was, and Staff Grigsby grabbed the helmet, but said that Resident B would just take it off. Witness 3 stated that at one-point, Resident B stood up, and her pants were wet, and as Resident B was making her way to her room, she dropped to the floor and started banging her head on the floor. Witness 3 stated that they retrieved a blanket and put it under Resident B's head. Witness 3 stated that Resident B's helmet was placed back on, and Staff Grigsby stated that it was typical behavior. Witness 3 stated that Staff Grigsby pushed Resident A in his wheelchair to his room, and that is where Witness 3 saw Staff Grigsby grab Resident A's bib and pulled it over his face. Witness 3 stated that all of the food on his bib got all over his face, and that Staff Grigsby was observed pulling on his leg braces as well. Witness 3 stated that Staff Grigsby was being aggressive, not gentle. Witness 3 also reported that both Resident A and Resident B were in the home upon their arrival. She stated that during the visit, Staff Folsom did not stop and try to tend to any of the residents.

On 12/08/2022, I interviewed staff Linda Grigsby via phone. She denied the allegations. She stated that there were four visitors from Genesee Health Systems who came to the home on 11/11/2022 for a visit. They walked around and talked. She stated that she was told that she neglected Resident B because Resident B was having an episode. She stated that she got Resident B's helmet, and another time, one of the visitors got Resident B the helmet. Staff Grigsby stated that she retrieved Resident B's helmet on her own, she was not directed to do so, and that it is in Resident B's plan of service to wear her helmet for 30 minutes. She stated that Resident B had been bumping her head on the floor. She stated that Resident B will either hit herself in the face or will bump her head on the floor. She stated that Resident B was not bumping her head seriously (i.e., in a serious manner). She stated that she tried to tell the visitors that, but they did not want to hear it. She stated that Staff Folsom was in the kitchen cooking, and they don't want accidents to happen while staff is cooking, so that is why she took Resident A out of the kitchen. She stated that Resident A was crying. She stated that when she was taking off Resident A's braces and vest, she was told that she was being rough. She denied that she was being rough or harsh. She stated that she has worked at the facility for 13 years and has never mistreated a resident. She stated that all four witnesses said the same thing, but she does not understand how because three of them were looking at paperwork and going through resident books. She stated that Resident B was on the floor by the couch. She stated that recipient rights substantiated for Class III neglect against her. She stated that when the visitors left, they told her good job. She stated that if something was wrong, they should have addressed it right when it happened. She stated that Resident A's bib was damp, not soaked and not full of mucus or anything. She stated that Resident B did not go to school that day, and Resident A came home around 4:00pm or 4:30 pm. She stated that she was terminated from her position on 12/01/2022, and that she has never had any prior abuse or neglect complaints. She stated that Resident B did not hurt herself, and at the end stated, "*why would I put my job in jeopardy in front of all those people like that*?"

On 12/08/2022, I interviewed staff Paris Folsom via phone. She stated that the visitors arrived at the home about 20 to 30 minutes after she arrived at work. Resident B was having a behavior on the dining room floor. The visitors were concerned and questioned staff about it, and she and Staff Grigsby explained that the behavior Resident B was displaying is a reoccurring thing. Resident B escalated from hitting herself to banging her head on the floor. Staff Grigsby was doing laundry, and the visitors were tending to Resident B. She stated that it was four people crowding around (Resident B), and she did not take responsibility to walk over to Resident B, but Staff Grigsby did eventually. She stated that while she was still cooking dinner, the others got Resident B's situation settled. Resident A was crying because he was hungry. The expectation was that he got a snack, but dinner was a few minutes from being done. Staff Folsom stated that Resident A's face was wet with tears, and Staff Grigsby was expected to take note of that. She stated that because Staff Grigsby is hard of hearing, the visitors may have taken that as Staff Grigsby was ignoring them. She stated that during this time, Resident A was in his

wheelchair. She stated that she thinks he arrived home after she started her shift. She stated that Resident A was fine after he received his cup and food. She stated that she heard that Staff Grigsby was being aggressive with taking off Resident A's braces. She denied noticing how wet Resident A's bib was. She stated that she assumes Resident B hurt herself because she was punching herself, but she does not think Resident B was seriously harmed. She denied witnessing any intentional abuse or neglect from Staff Grigsby.

On 12/12/2022, I spoke with North Country recipient rights investigator Brandy Martin via phone. Ms. Martin stated that she completed an investigation on Resident B, and that she substantiated Class III neglect for staff Linda Grigsby and staff Paris Folsom. She stated that Staff Grigsby was terminated, and Staff Folsom is to receive a written reprimand and 90 days of disciplinary probation. She stated that the stories were consistent with all witnesses, and that Resident B's behavioral plan notes that she is to wear a helmet and mitts for her hands. She stated that staff cannot just let Resident B self-harm. She stated that the standard of care was not followed.

A copy of Resident A's *Genesee Health System- Individual Plan of Service* (IPOS) dated 05/04/2022 was reviewed during this investigation. The IPOS states that Resident A is dependent on staff for all of his personal hygiene. His plan of service also indicates that *"staff should position [Resident A] in an upright position either in his wheelchair or on another supportive surface where his feet, hips, trunk, back, and neck are supported properly."*

A copy of Resident B's *Genesee Health System- Individual Plan of Service* (IPOS) dated 01/31/2022 was reviewed during this investigation. The IPOS states that Resident B she has a history of lengthy hospitalizations due to "*serious aggressive and self-abusive behaviors.*" The plan of service states that Resident B "*has a doctor ordered helmet that is to be utilized during episodes of self-abusive behavior judged to be potentially self-injurious.*" The plan also states that her helmet is to be kept close at hand and placed on her head whenever she exhibits potentially self-injurious behaviors for no more than 30 minutes, and that attempts at, or actually physical aggression are to be addressed verbally by staff with prompting and redirecting.

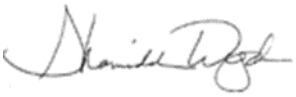
On 12/29/2022, I conducted a Facetime call with the facility. I observed Resident A and Resident B, and the other two residents in the home. They all appeared to be clean and appropriately dressed. During this call, I spoke with Resident B's Guardian 1 via phone. Guardian 1 stated that she was notified of the situation and received a report in the mail from recipient rights. Guardian 1 stated that she was told that Staff Grigsby was fired. She stated that she was concerned after reading the report, but staff is nice and friendly.

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:	On 11/11/2022, Staff Paris Folsom, and Staff Linda Grisby were observed by Witness 1, 2 and 3, not following Resident A's or Resident B's plan of service in regard to their personal care, supervision, and protection. Staff were observed to have failed to provide appropriate personal care to Resident A and failed to safeguard Resident B from attempted/actual self-harming behaviors. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/29/2022, I conducted an exit conference with licensee designee Bethany Mays via phone. I informed her of the findings and conclusion.

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the provisional license.

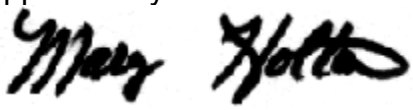


12/29/2022

_____

Shamidah Wyden Date
Licensing Consultant

Approved By:



12/29/2022

_____

Mary E. Holton Date
Area Manager