GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 6, 2023

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

RE: License #: AS250010859
Investigation #: 2023A0582012
Atlas Park

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.
- 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. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Derrick Britton, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-9721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010859
Investigation #:	2023A0582012
Complaint Receipt Date:	11/21/2022
Investigation Initiation Date:	11/22/2022
Report Due Date:	01/20/2023
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:	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:	10/26/2020
Expiration Date:	10/25/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATIONS

	Violation Established?
Resident A has been out of medication. Staff are not notifying Guardian A when Resident A is out of medication, therefore they are not administering medications to Resident A.	Yes

III. METHODOLOGY

11/21/2022	Special Investigation Intake 2023A0582012
11/22/2022	Special Investigation Initiated - On Site
12/28/2022	Contact - Telephone call made With Guardian A
01/05/2023	Contact - Document Received Email from Kim Nguyen, Recipient Rights Associate
01/05/2023	Exit Conference With Bethany Mays, Licensee Designee
01/06/2023	APS Referral Referral made to APS

ALLEGATION:

Resident A has been out of medication. Staff are not notifying Guardian A when Resident A is out of medication, therefore they are not administering medications to Resident A.

INVESTIGATION:

I received this complaint on 11/21/2022. On 11/22/2022, I conducted an unannounced, onsite inspection at the facility. I interviewed Latricia Stocker, Home Manager. Ms. Stocker stated that Resident A visits with Guardian A every week, and she takes Resident A's medication with her. Ms. Stocker stated that she does not try to let Resident A's medications run out. Ms. Stocker stated that Resident A was getting close to running out of a medication, so she called the doctor to get a refill. Ms. Stocker stated that she went to the Walmart pharmacy in Davison, Michigan to get the medication, but it was not there. Ms. Stocker stated that Guardian A had the

script filled at the Walmart pharmacy in Clio, Michigan. Ms. Stocker stated that all except one of Resident A's medications is filled at the Walmart pharmacy in Davison, which is the pharmacy they use. Ms. Stocker stated that Guardian A was responsible for getting the other medication at the Walmart pharmacy in Clio, which was closer to her residence. Ms. Stocker described the medication as a "thyroid" medication.

I reviewed Resident A's *Medication Administration Record* (MAR) for October 2022 and November 2022. The MAR documented no initials for any medications administered from 10/01/2022 through 10/05/2022. For November 2022, the MAR documented no initials for medications administered for November 5, 6, 8, and 13. Ms. Stocker stated that Resident A visits Guardian A on weekends, and also staff must do a better job of documenting medication administration. I reviewed Resident A's current medications and compared them to the MAR. All medications were current and on hand. I reviewed Resident A's *Assessment Plan*, which documented that she requires assistance with taking medications.

On 12/28/2022, I interviewed Guardian A. Guardian A stated that Resident A was out of a medication Wellbutrin and Levothyroxine back around October 2022. Guardian A stated that she typically picks up Resident A on the weekend. Guardian A stated that one weekend she went to pick up Resident A, staff did not have medications to provide her. Guardian A stated that she was told that Resident A did not have a refill from the doctor's office. Guardian A stated that she contacted the doctor's office and was told that Resident A had plenty of refills. Guardian A stated that the pharmacy informed her the prescription had not been refilled. Guardian A stated that this was the responsibility of the home staff. Guardian A stated that the discrepancy on which pharmacy that the medications come from was rectified.

On 01/05/2022, I emailed Kim Nguyen, Recipient Rights Associate. Ms. Nguyen stated that she is continuing to investigate the allegations.

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 S333.1101 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:	Based on interviews with Ms. Stocker and Guardian A, there is evidence to suggest that Resident A was not administered medications at the facility. Ms. Stocker admitted that a prescription medication was not picked up or delivered from the pharmacy where it was filled. The MAR did not have appropriate documentation to indicate whether prescription medications were administered on 10/01/2022 – 10/05/2022 and 11/05/2022, 11/06/2022, 11/08/2022, and 11/13/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed the *Medication Administration Record* (MAR) for Resident A for the months of October and November 2022. For October 2022 MAR, there were no initials from 10/01/2022 through 10/05/2022. For the November 2022 MAR, there were no initials for 11/05/2022, 11/06/2022, 11/08/2022, and 11/13/2022.

APPLICABLE RULE	
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: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Based on my review of Resident A's October 2022 *Medication Administration Record* (MAR), the medication log did not contain initials for the administration of medication to Resident A from 10/01/2022 through 10/05/2022 and 11/05/2022, 11/06/2022, 11/08/2022, and 11/13/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 11/22/2022, I interviewed Latricia Stocker, Home Manager. Ms. Stocker admitted that a prescription medication was not picked up or delivered from the pharmacy where it was filled.

On 12/28/2022, I interviewed Guardian A, who stated that she picks up Resident A for visits on weekends. Guardian A stated that on one weekend in October 2022, staff did not have a medication to provide her for administration to Resident A while he was out of the home and visiting her.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Based on interviews with Guardian A, Home Manager Latricia Stocker, and a review of Resident A's *Medication Administration Record* for October 2022, there is sufficient evidence to suggest that Resident A was not provided medications while visiting with Guardian A in October 2022. Guardian A stated that medications were not provided when she picked up Resident A for a weekend visit, and Ms. Stocker had a discrepancy in the location of the pharmacy where the medication was filled.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/05/2023, I conducted an Exit Conference with Bethany Mays, Licensee Designee. I informed Ms. Mays of the findings from the investigation and the need for an acceptable Corrective Action Plan.

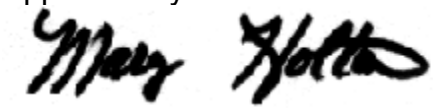
IV. RECOMMENDATION

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

01/06/2023

Derrick Britton Date
Licensing Consultant

Approved By:



01/06/2023

Mary E. Holton Date
Area Manager