GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 22, 2023

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

RE: License #: AS250293330
Investigation #: 2024A0779003
Nandi Hills

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,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250293330
Investigation #:	2024A0779003
Complaint Receipt Date:	10/12/2023
Investigation Initiation Date:	10/12/2023
Report Due Date:	12/11/2023
Licensee Name:	Resident Advancement, Inc.
Licensee Address:	411 S. Leroy, PO Box 555 Fenton, MI 48430
Licensee Telephone #:	(810) 750-0382
Administrator:	Danielle Stevenson
Licensee Designee:	Bethany Mays
Name of Facility:	Nandi Hills
Facility Address:	2521 Nandi Hills Trail Swartz Creek, MI 48473
Facility Telephone #:	(810) 635-9190
Original Issuance Date:	01/23/2009
License **Status:**	REGULAR
Effective Date:	08/01/2023
Expiration Date:	07/31/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Home manager, April Monroe, tells staff not to help Resident A.	No
Resident A is being denied coffee and cereal that he purchased with his own money and use of his favorite coffee mug.	No
Home manager, April Monroe, yells at Resident A and tells other staff to do the same.	No
On 10/12-10/14/23, Resident A was given double doses of his Keppra medication.	No
Additional Findings	Yes

III. METHODOLOGY

10/12/2023	Special Investigation Intake 2024A0779003
10/12/2023	Special Investigation Initiated - Telephone Spoke to recipient rights officer, Matt Potts.
10/12/2023	APS Referral Complaint was referred to APS centralized intake.
10/18/2023	Inspection Completed On-site
10/19/2023	Contact - Telephone call made Spoke to recipient rights investigator, Matt Potts.
11/06/2023	Contact - Telephone call made Spoke to Resident A's case manager.
11/06/2023	Contact - Telephone call made Interview conducted with Resident A.
11/20/2023	Exit Conference Held with administrator, Danielle Stevenson.

ALLEGATION:

Home manager, April Monroe, tells staff not to help Resident A.

INVESTIGATION:

On 10/12/23, a phone conversation took place with recipient rights investigator, Matt Potts, who stated that he visited this home on 10/11/23 and interviewed Resident A. Matt Potts stated that Resident A said that the home manager, April Monroe, is the only staff person who has refused to help him. Matt Potts reported that when he asked Resident A for examples, Resident A told him that Manager Monroe wants him to wash his own body parts that he can reach himself, which is what is in Resident A's plan.

Resident A's Assessment Plan for AFC Residents was reviewed. The plan stated that Resident A utilizes a wheelchair but is still fairly independent. The plan states that Resident A only needs minimal assistance to complete activities of daily living like toileting and bathing.

On 10/18/23, an on-site inspection was conducted, and multiple staff persons were interviewed. Included in those interviews was recipient rights investigator, Matt Potts.

Administrator, Danielle Stevenson, stated that she is at this home a lot and that she has never seen any staff refuse to help and/or assist Resident A. Administrator Stevenson stated that Resident A's guardian and other family members would often tell Resident A that he does not have to do things he does not want to do, which makes Resident A uncooperative and/or defiant. She stated that Resident A frequently refuses to do things like shower, change his clothes, get out of bed, etc.… and that staff will keep redirecting him every 15 minutes or so. Administrator Stevensen reported that resident A will often tell staff that his guardian/family told him he does not have to do things he does not want to do.

Home manager, April Monroe denied that she has ever withheld any kind of care for Resident A. She stated that she has never told any staff not to help Resident A. Manager Monroe stated that they have been told to encourage Resident A to try and do things on his own, but that she will help him if he refuses to do things for himself. She stated that resident A is never neglected.

During the on-site inspection, five staff persons were interviewed separately and all reported the same information. They reported that Manager Monroe has never told them not to provide care to Resident A. They confirmed that they encourage Resident A to try and do things on his own, but always help him when needed. All five staff stated that Resident A will frequently refuse to do things so they will do it for him.

On 11/6/23, a phone conversation took place with Resident A's GHS case manager, Allyssia Zalewski, who said that she is aware that Resident A will often refuse to do things, but that Resident A has not ever told her that staff are refusing to help him. Case Manager Zalewski reported that she has always found Resident A to be appropriately clean and well-groomed during her visits with him.

On 11/6/23, a phone interview was conducted with Resident A, who stated that he recently moved out of this home and is now living with his sister. He stated that Manager Monroe and the other staff were always trying to get him to do things on his own and that they did not like it when he refused to do things. Resident A stated that staff helped him when he needed it. Resident A stated that staff seemed a little less helpful the last couple of weeks, but he could not provide examples as to how.

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:	Resident A is fairly independent and can do most things on his own. Resident A stated that staff did not like it when he refused to do things, but that staff helped him when he needed it. Multiple staff deny that they have ever denied any care to Resident A and denied that home manager, April Monroe, had ever told them not to help Resident A. There was insufficient evidence found to prove that Resident A was being denied personal care at this home or to warrant a citation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is being denied coffee and cereal that he purchased with his own money and use of his favorite coffee mug.

INVESTIGATION:

On 10/12/23, recipient rights investigator, Matt Potts, stated that he found Resident A's coffee mug in an upper cupboard during his visit to the home on 10/11/23. He stated that the mug appeared to be simply misplaced and was not actually missing. Matt Potts reported that Resident A told him that he is getting his coffee and cereal that he had purchased for himself.

On 10/18/23, administrator, Danielle Stevenson, stated that shortly after Resident A first arrived at this home, the home's nurse practitioner had put Resident A on a 64-ounce daily fluid restriction, but that the guardian took Resident A to a new primary care physician and had the fluid restriction stopped on 8/31/23. Administrator Stevenson stated that was the only time when Resident A's coffee intake may have been restricted,

but stated that after 8/31/23, no fluid, food or personal items have been restricted from Resident A. She stated that Resident A has a bin that is located in the laundry room, where he keeps his coffee, cereal and other personally bought items, that he has full access too. Administrator Stevenson stated that Resident A's mug and/or coffee was misplaced by staff and put into a cupboard and not Resident A's bin.

A review of Resident A's record did confirm that there was a physician order in place putting Resident A on a fluid restriction of 64 ounces daily. That restriction was removed/discontinued on 8/31/23.

During the on-site inspection on 10/18/23, five staff persons were interviewed separately and all denied that they have restricted Resident A having access to his coffee mug, coffee, cereal, or any other personal item. They all confirmed that Resident A keeps those things in a bin in the laundry room, which he has full access too.

On 10/18/23, home manager, April Monroe, denied that Resident A has been restricted from things that are in his personal bin or his mug. She stated that Resident A's coffee mug was accidentally placed in the cupboard for a while, but that it was not intentionally kept from him.

On 11/6/23, a phone conversation took place with Resident A's GHS case manager, Allyssia Zalewski, who said that Resident A suffers from Schizo-effective disorder, can be very manipulative and has been known to lie. She stated that Resident A's guardian/family often took what Resident A was saying at face value when Resident A was not telling the truth. Case Manager Zalewski reported that Resident A did not want to be on a diet or fluid restrictions and that the guardian/family would tell Resident A that he did not have to be on any restrictions if he did not want too. She stated that she was not aware of any staff restricting Resident A from his personal items and that Resident A never reported that to her as being any issue.

On 11/6/23, Resident A stated that his coffee cup was found and that staff were allowing him to use it. Resident A claims that his coffee was moved out of his bin and put into a cupboard for a while. He stated that he had access to his bin but that he felt that staff would sometimes try and prevent him from getting things out of his bin. Resident A confirmed that he was on fluid restrictions for a while and that he does not understand why.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or

	the resident's designated representative, a copy of all of the following resident rights: **(j) The right of reasonable access to and use of his or her personal clothing and belongings.**
ANALYSIS:	Resident A stated his coffee mug and/or coffee was misplaced but had been found. Resident A confirmed that he was on fluid restrictions for a while and that his coffee, cereal, and other personal items were keep in a bin that he had access to, but that he felt that staff would sometimes try and prevent him from getting things from his bin. Multiple staff, including the home manager and administrator, deny that Resident A was ever denied items from his personal bin. Resident A's GHS case manager, Allyssia Zalewski, stated that Resident A suffers from Schizo-effective disorder, can be very manipulative and has been known to lie. She stated that she was not aware of any staff restricting Resident A from his personal items and that Resident A never reported that to her as being any issue. There was lack of sufficient evidence found to prove that Resident A was being denied access to his personal items.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Home manager, April Monroe, yells at Resident A and tells other staff to do the same.

INVESTIGATION:

On 10/18/23, Administrator Stevenson stated that she is at this home a lot and has never witnessed Manager Monroe yelling at Resident A. She stated that Resident A can be very challenging at times and she feels that Manager Monroe has showed a good deal of patience when working with him. Administrator Stevenson reported that no other staff have reported this to her as being an issue. She confirmed that no other residents besides Resident A have the cognitive abilities to speak about whether this allegation is happening.

On 10/18/23, Manager Monroe denied ever yelling at Resident A. She denied that she has ever told other staff to yell or disrespect Resident A in any way.

On 10/18/23, five staff persons were interviewed separately and all provided the same information. They all denied that they have yelled at Resident A and that Manager Monroe has told them to do so. They all stated that they have not witnessed Manager Monroe yelling at Resident A.

On 11/6/23, Case Manager Zalewski stated that she is not aware of any evidence that Manager Monroe is yelling at or verbally abusing Resident A. She stated that Resident A has never reported to her this being an issue.

On 11/6/23, Resident A stated that Manager Monroe does not yell at him. He stated that all the other staff are nice and do not yell at him.

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:** **(ii) Verbal abuse.**
ANALYSIS:	Home manager, April Monroe, denied that she has ever yelled at Resident A or told other staff to do so. Five other staff stated that they do not yell at Resident A and that Manager Monroe has not told them to that. Resident A stated that Manager Monroe and the other staff do not yell at him. There was evidence found to support the allegation that Manager Monroe or any other staff has yelled at or verbally abused Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On 10/12-10/14/23, Resident A was given double doses of his Keppra medication.

INVESTIGATION:

On 10/18/23, Administrator Stevenson stated that Resident A's prescription for Levetiraceta, which is the generic form of Keppra, changed from him taking three 500mg tablets to taking two 750mg tablets twice daily. She stated that it is the same daily dosage but with fewer tablets taken daily. Administrator Stevenson reported that when the 750mg script was delivered to the home on 10/7/23, it was not discontinued on the Medication Administration Record (MAR) form because they were told they should use up the 500mg script first. She stated that when the 500mg script ran out and they started using the 750mg script in the PM on 10/12/23, staff forgot to discontinue the 500mg script on the MAR, so staff were accidentally initially that they were passing both scripts when they were not. Administrator Stevenson stated that

Resident A was not double dosed with this medication and showed no signs of being done so.

On 10/18/23, staff person, Vadis Russey, confirmed that she worked 2nd shift on 10/12/23 and both 1st and 2nd shifts on 10/14/23. Staff Russey stated that when she went to pass the PM meds on 10/12/23, there were no more 500mg tablets of the Keppra medication left, so she started passing the 750mg tablets. She admits that she did not discontinue the 500mg script on the MAR and did initial that script on the MAR, but circled her initials to indicate that it was not passed. Staff Russey reported that she did the same for both medication passings on 10/14/23. Staff Russey stated that Resident A showed no known side effects related to receiving double doses of this medication.

On 10/18/23, staff person, Tamika Howell, confirmed that she worked and passed meds during 1st shift on 8/13/23. Staff Howell stated that there were no more 500mg tablets left and that she passed the 750mg tablets. She stated that the 500mg script was not discontinued on the MAR yet and she admits that she accidentally initialed as passing both scripts and forgot to circle the 500mg initials, indicating that it was not passed.

On 10/18/23, staff person, Marsha Shine, confirmed that she worked and passed meds on 2nd shift on 10/13/23. Staff Shine stated that she gave Resident A the two tablets of 750mg Keppra that shift. She stated that she did not pass the 500mg tablets as there were none left to pass. Staff Shine admits that she initialed both scripts and forgot to circle her initials on 500mg script on the MAR, indicating that it was not passed.

Resident A's MAR's and 750mg bubble pack of Keppra were reviewed. The 500mg bubble pack had been thrown away after the script had run out. A pharmacy delivery log was also viewed, and it confirmed that the new script of 750 mg tablets of Levetiraceta (generic for Keppra) was delivered to the home on 10/7/23. The MAR matched the information provided during interviews with staff. The MAR shows that the 750mg script was started in the PM on 10/12/23. It shows that the 500mg script was not discontinued on the MAR form until 10/15/23 and there were initials of staff located on the PM dose on 10/12/23 through the PM dose on 10/14/23. Three of the five sets of initials were circled and two were not. The number of tablets punched out of the bubble pack for the 750mg script match the number of tablets that the MAR indicates were passed starting on the PM of 10/12/23 through the AM on 10/18/23, the day the pack was reviewed.

On 10/19/23, recipient rights investigator, Matt Potts, stated that he had spoken to a GHS nurse about these allegations. He stated that the nurse reported that a few days of double doses of this medication would not cause significant risk of harm. He stated that the nurse said that the side effects could typically be sedation, aggression, and/or respiratory issues. Matt Potts reported that no staff reported that Resident A displayed any of these possible side effects during the few days that are in question.

On 11/16/23, Resident A could not remember if he was given double doses of his Keppra medication. He stated that he normally knows what medications he is on, but would typically just take what meds the staff gave him.

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:	It was confirmed that this home had both the 500mg and 750mg scripts of Keppra present in the home starting on 10/7/23. All staff that passed the medication, during the dates in question, stated that the 500mg tablets were gone and no longer available to pass after the AM dose on 10/12/23. They all deny that they gave Resident A double doses of his Keppra medication. Although the MAR does give the appearance that both doses of the medication were passed, the number of tablets punched out of the bubble pack for the 750mg script match the number of tablets that the MAR indicates were passed starting on the PM of 10/12/23 through the AM on 10/18/23, the day the pack was reviewed. Unfortunately, the bubble pack of the 500mg script was thrown away after the script run out. The staff reported that Resident A showed no signs of being double dosed. There was insufficient evidence found to prove that Resident A was provided double the dose prescribed of his Keppra medication.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/18/23, Administrator Stevenson, stated that when the 500mg script of Resident A's Keppra medication ran out and they started using the 750mg script in the PM on 10/12/23, the 500mg script was not discontinued on the MAR, so staff were accidentally initialed that they were passing both scripts when they were not.

On 10/18/23, Staff Russey stated that she did not discontinue the 500mg script on the MAR when the script had run out. She admitted that she did initial that script on the MAR, but circled her initials to indicate that it was not passed during the three shifts she worked between 10/12/23-10/14/23.

On 10/18/23, Staff Howell stated that she worked the 1st shift on 10/13/23. She admitted that she accidentally initialed the script for 500mg of Keppra when she did not actually pass the medication. Staff Howell claims that she forgot to circle her initials indicating that the meds were not passed.

On 1018/23, Staff Shine stated that she worked 2nd shift and passed meds on 10/13/23. She admits that she initialed the 500mg script on the MAR, when she did not actually pass the medication. Staff Shine stated that she did not circle her initials indicating that the meds were not passed.

Resident A's MAR for the 500mg of Keppra was reviewed. It showed that the 500mg script was not discontinued on the MAR form until 10/15/23 and there were initials of staff located on the PM dose on 10/12/23 through the PM dose on 10/14/23. Three of the five sets of initials were circled and two were not.

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:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**

ANALYSIS:	Staff persons, Vadis Russey, Tamika Howell, and Marsha Shine admitted that they had initialed Resident A's script for 500mg of Keppra when they did not actually pass the medication. The script for 500mg of Keppra had run out after the morning dose was given on 10/12/23, but it was not discontinued on the MAR until 10/15/23. The MAR shows that staff initialed indicating that they had passed the medication during this time, when they did not. There was sufficient evidence found to prove that multiple staff inaccurately initialed, which provided false information on Resident A's MAR.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/20/23, an exit conference was held with administrator, Danielle Stevenson. She was informed that a written corrective action plan is required.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

11/22/2023

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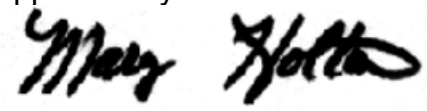
Christopher Holvey Date
Licensing Consultant

Approved By:



11/22/2023

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Mary E. Holton Date
Area Manager