GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 16, 2024

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

RE: License #: AS250010823
Investigation #: 2024A0576021
Henderson AFC

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.
- 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,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010823
Investigation #:	2024A0576021
Complaint Receipt Date:	02/20/2024
Investigation Initiation Date:	02/21/2024
Report Due Date:	04/20/2024
Licensee Name:	Resident Advancement, Inc.
Licensee Address:	411 S. Leroy, PO Box 555 Fenton, MI 48430
Licensee Telephone #:	(810) 750-0382
Administrator:	Gloria Stogsdill
Licensee Designee:	Bethany Mays
Name of Facility:	Henderson AFC
Facility Address:	4074 S. Henderson, Davison, MI 48423
Facility Telephone #:	(810) 653-0641
Original Issuance Date:	03/17/1989
License Status:	REGULAR
Effective Date:	02/27/2024
Expiration Date:	02/26/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was a no-call/no-show to a scheduled appointment with their prescriber on 2/13/24. This has become a pattern with the facility, and they are not following through with lab work ordered either.	Yes

III. METHODOLOGY

02/20/2024	Special Investigation Intake 2024A0576021
02/20/2024	APS Referral
02/21/2024	Special Investigation Initiated - Telephone Left message for Kim Nguyen-Forbes, Genesee County Office of Recipient Rights (ORR)
02/29/2024	Inspection Completed On-site Interviewed Home Manager, Carlin Bailey, Staff, Fresha Tate, and Resident B
03/15/2024	Contact - Telephone call made Interviewed Kim Nguyen-Forbes, Genesee County Office of Recipient Rights
03/29/2024	Contact - Face to Face Interviewed Staff, Fresha Tate
04/12/2024	Contact - Telephone call made Interviewed Katrina Cox, Genesee County Medical Examiner Office
04/12/2024	Contact - Telephone call made Interviewed Sarah LaDuke, Case Manager
04/12/2024	Contact - Telephone call made Interviewed Social Worker A
04/12/2024	Exit Conference

ALLEGATION:

Resident A was a no-call/no-show to a scheduled appointment with their prescriber on 2/13/24. This has become a pattern with the facility, and they are not following through with lab work ordered either.

INVESTIGATION:

On February 29, 2024, I conducted an unannounced on-site inspection at Henderson AFC and interviewed Home Manager, Carlin Bailey regarding the allegations. Manager Bailey stated there have been some appointments missed for the residents due to staff and residents being ill. Resident B had a missed appointment on February 14, 2024, due to not having enough staff as someone likely called in. Home Manager Bailey explained that Resident A and Resident B were having appointments via telehealth at the time of my inspection.

On February 29, 2024, I interviewed Staff, Fresha Tate who has been employed at the facility for 16 years. Regarding the allegations, Staff Tate reported she is not certain which residents require lab work. If there are missed appointments, they are rescheduled. Staff have been calling in and she is not sure why. The home is not fully staffed, and staff call in for any reason. When staff call in no one else will come in and this causes the manager to “work the floor”. When staff call in, this causes missed appointments.

On February 29, 2024, I interviewed Resident B regarding the allegations. Resident B had no knowledge of the allegations. Resident B reported if she missed any appointments, it was because her “chair was down”. Staff schedule Resident B’s appointments and she sees her medical doctor and her prescriber at Genesee Health System (GHS). Resident B sees her doctor whenever she needs to and today, she had an appointment via video chat. Resident B likes her home and staff take good care of her.

On March 15, 2024, I interviewed Kim Nguyen-Forbes Recipient Rights Officer from GHS. Officer Forbes reported Resident A had lab work ordered in August 2023. The lab work was not completed, and it was ordered again on November 22, 2023. The lab work was not completed and had to be rescheduled again. Resident A was a no-call no-show for a psychiatric medication review at GHS on December 13, 2023, and on February 13, 2024. Resident A’s case manager followed up with the home and was advised staff at the home had covid. According to Officer Forbes, the home is required to ensure Resident A attends all medical appointments and it is part of her treatment plan.

On March 29, 2024, I conducted an unannounced on-site inspection and interviewed Staff, Fresha Tate. Staff Tate advised Resident A passed away on March 19, 2024. Resident A was bleeding after using the restroom and was taken to the hospital. It was discovered that Resident A had holes in her rectum and needed surgery. After the

surgery, Resident A needed a colostomy bag and was put on a ventilator. Resident A did not recover. Staff Tate reported that on February 29, 2024, Resident A had a telehealth appointment with GHS and lab work was completed the following day.

On March 29, 2024, I reviewed Resident A's AFC Assessment Plan, Health Visit Record, and Individual Plan of Service (IPOS) which revealed Resident A was 63 years old. Resident A was diagnosed with chronic kidney disease, late stage requiring dialysis treatments. The IPOS documented that AFC Staff will schedule and take Resident A to and from all needed medical appointments. Resident A's blood is to be drawn as ordered by her physician to monitor for medication side effects.

On March 29, 2024, I reviewed an Incident Report (IR) regarding Resident A. The IR documented that on March 15, 2024, at 6:30pm, Resident A was using the restroom, and she was bleeding from her rectum. 911 was contacted and Resident A was transported to the hospital.

On April 12, 2024, I interviewed Katrina Cox, Staff from the Genesee County Medical Examiner's Office. Staff Cox reported Resident A's death was not reported to the Medical Examiner's Office due to her death taking place at the hospital.

On April 12, 2024, I interviewed Resident A's Case Manager from GHS, Sarah LaDuke. Case Manager LaDuke reported the home had problems getting Resident A to her schedule medication reviews and lab work. Case Manager LaDuke is the case manager for all 6 residents who reside at the home and the facility has a pattern of not getting residents to medication reviews at GHS. The home was responsible to ensure Resident A attended all medical appointments and it was part of her treatment plan. Resident A required dialysis 3 times per week, and she was getting to dialysis. The medication reviews at GHS and the lab work ordered by the psychiatrist were what the home had trouble getting Resident A to. Regarding Resident A's death, Case Manager LaDuke stated Resident A's missed appointments at GHS or missed lab work was not related to her death. Resident A had rectal bleeding and she was taken to the hospital. It was discovered that Resident A had a proliferated bowel and required surgery. Resident A was put on a ventilator and ostomy bag. Resident A had been on dialysis and her health had been deteriorating. At the time of her death, Resident A had been seen by her psychiatrist at GHS and ordered lab work had been completed.

On April 12, 2024, I interviewed Social Worker (SWA) from Resident A's guardian's office. SWA reported Resident A lived at Henderson AFC for 2 years. Resident A's guardian, Guardian A was unaware of any missed appointments for Resident A. SWA saw Resident A in March 2024, shortly before her death and had no concerns. According to SWA, Resident A's death was not due to any missed appointments. Resident A had problems with her bowels and required surgery. Resident A became septic after the surgery, and she did not recover.

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:	It was alleged that Resident A was not being taken to her medical appointments with her psychiatrist and lab work ordered by the doctor was not being completed. Upon conclusion of investigative interviews and a review of documentation, there is a preponderance of to conclude a rule violation. Resident A's IPOS revealed that AFC Staff were to schedule and take Resident A to and from all needed medical appointments. Additionally, Resident A's blood is to be drawn as ordered by her physician to monitor for medication side effects. Resident A's case manager, Sarah LaDuke reported the home had problems getting Resident A to her scheduled medication reviews and lab work. Kim Nguyen-Forbes from the Office of Recipient Rights reported Resident A had lab work ordered in August 2023, which was not completed. The lab work was ordered again on November 22, 2023, and was not completed. Additionally, Resident A was a no-call no-show for a psychiatric medication review at GHS on December 13, 2023, and on February 13, 2024. Resident A's IPOS was reviewed and documented that AFC Staff will schedule and take Resident A to and from all needed medical appointments. Additionally, Resident A's blood is to be drawn as ordered by her physician to monitor for medication side effects. Staff were interviewed and reported that when staff call in it causes residents to miss appointments. Per Resident A's IPOS, staff were to ensure Resident A attended all medical appointments and her lab work was completed. Resident A missed psychiatric appointments and lab work. Resident A was not provided personal care as specified in her written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On April 12, 2024, I conducted an Exit Conference with Licensee Designee, Bethany Mays. I advised Licensee Designee Mays I would be requesting a corrective action plan for the cited rule violation.

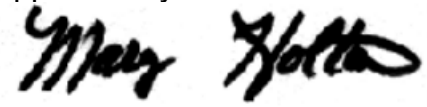
IV. RECOMMENDATION

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

4/16/2024

Christina Garza Date
Licensing Consultant

Approved By:



4/16/2024

Mary E. Holton Date
Area Manager