GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 21, 2024

Bridget Malek
RGRPS
33930 W. 8 Mile Rd. Ste. 4-B
Farmington Hills, MI 48335

RE: License #: AS820397466
Investigation #: 2024A0119031
Fenton II

Dear Mrs. Malek:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 05/10/2024, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (313) 456-0380.

Sincerely,

Shatonla Daniel

Shatonla Daniel, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-3003

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820397466
Investigation #:	2024A0119031
Complaint Receipt Date:	03/25/2024
Investigation Initiation Date:	03/26/2024
Report Due Date:	05/24/2024
Licensee Name:	RGRPS.
Licensee Address:	33930 W. 8 Mile Rd. Ste. 4-B Farmington Hills, MI 48335
Licensee Telephone #:	(248) 477-5209
Administrator:	Bridget Malek
Licensee Designee:	Bridget Malek
Name of Facility:	Fenton II
Facility Address:	8273 Fenton St Dearborn Heights, MI 48127
Facility Telephone #:	(248) 477-5209
Original Issuance Date:	06/12/2019
License **Status:**	REGULAR
Effective Date:	12/12/2023
Expiration Date:	12/11/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 02/23/2024, It was discovered that Resident A was left in a soaked incontinent brief overnight by Staff- Lillian Braxton.	Yes

III. METHODOLOGY

03/25/2024	Special Investigation Intake 2024A0119031
03/25/2024	APS Referral Received
03/25/2024	Referral Recipient Rights Made
03/26/2024	Special Investigation Initiated - Telephone Adult Protective Services Investigator- Kya Lockett
03/28/2024	Contact Telephone call made Human Resource Manager for RGRPS- Shawta Reed
04/02/2024	Inspection Completed On-site Staff- Rowena Webb, Angela Williams, Observed Resident A
05/10/2024	Contact Document Received Staff- Lillian Braxton's Signed Written Reprimand and Corrective Action Plan
05/10/2024	Corrective Action Plan Requested
05/10/2024	Corrective Action Plan Received
05/10/2024	Corrective Action Plan Approved
05/10/2024	Contact- Telephone call made Resident A's guardian
05/10/2024	Exit Conference Licensee Designee-Bridget Malek
05/17/2024	Contact- Telephone call made

	Staff- Lillian Braxton

ALLEGATION:

On 02/23/2024, It was discovered that Resident A was left in a soaked incontinent brief overnight by Staff- Lillian Braxton.

INVESTIGATION:

On 03/26/2024, I telephoned and interviewed Adult Protective Services Investigator- Kya Lockett regarding the above allegations. Ms. Lockett stated she has substantiated her case. Ms. Lockett stated in Resident A's individual plan of service indicated she is to be changed every two hours by staff. Ms. Lockett stated Staff- Lillian Braxton did not change Resident A's incontinent brief for her entire eight-hour shift.

On 03/28/2024, I telephoned and interviewed Human Resource Manager for RGRPS- Shawta Reed regarding the above allegations. Ms. Reed stated all resident incontinent briefs should have a written initial of the staff with the time the brief was changed. Ms. Reed stated Lillian Braxton was assigned to the care of Resident A for the afternoon shift. She stated Ms. Braxton did not change Resident A's incontinent brief for her entire shift. Ms. Reed stated the date of the incident was 02/27/2024. Ms. Reed stated Ms. Braxton received a written reprimanded for failure to provide proper care for Resident A and a three-day suspension from work.

On 04/02/2024, I completed an unannounced onsite inspection and interviewed Staff- Rowena Webb, Vereen Hunter, and Home Manager- Angela Williams regarding the above allegations. It should be noted Resident A could not be interviewed due to her disability. I observed Resident A to require total assistance for staff and utilizes a wheelchair. Ms. Webb stated all resident's diapers are changed every two hours with staff initials and time on them. Ms. Webb stated there are four residents in the home that require incontinent briefs are changed every two hours.

Ms. Hunter stated residents' incontinent briefs are to be changed every two hours by staff. She stated she always puts the time and her initials on the resident's brief. Ms. Hunter stated the time and staff initials are placed on the front of the brief. She stated the incontinent brief changing schedule is the standard practice for all residents. Ms. Hunter stated sometimes residents require more incontinent brief changing throughout the day. Ms. Hunter stated she was working the daytime shift on 02/27/2024 and she stated Resident A was changed at least four times during her shift.

Ms. Williams stated Resident A is nonverbal and requires total care assistance from staff. Ms. Williams stated there is usually 2 to 4 staff working on every shift. Ms. Williams stated staff will initial and time stamp each resident incontinent brief

change. Ms. Williams stated the last time Resident A's incontinent brief was changed was at 2:00 p.m. by Staff- Verren Hunter. Ms. Williams stated the midnight shift person noted Resident A's incontinent brief had not been changed by Ms. Braxton.

On 05/10/2024, I telephoned and interviewed Resident A's guardian/mother regarding the above allegations. Resident A's guardian/mother stated she was made aware of Resident A not being changed by staff. Resident A's guardian/mother stated she visits with her daughter regularly and does not have any concerns about the care she receives at the home.

On 05/17/2024, I telephoned and interviewed Staff-Lillian Braxton regarding the above allegations. Ms. Braxton denies the allegations. Ms. Braxton stated she was assigned to care for three other residents and not Resident A. Ms. Braxton stated she had only worked in the home for a week and a half at the time of the incident. Ms. Braxton stated she does not know any of her co-worker's names that worked with her that day. Therefore, Ms. Braxton stated she was not able to identify who was supposed to care for Resident A during that time. Ms. Braxton stated she feels that another staff person was responsible for the personal care needs of Resident A. She stated she was made aware by the midnight staff person that Resident A had not been changed during the evening shift.

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:	Adult Protective Services Investigator- Kya Lockett stated Resident A's individual plan of service indicates she is to be changed every two hours. Ms. Lockett and Human Resource Manager for RGRPS- Shawta Reed stated Staff- Lillian Braxton did not change Resident A's incontinent brief for her entire eight-hour shift. Ms. Reed stated Ms. Braxton received a written reprimanded for failure to provide proper care for Resident A and a three-day suspension from work. Staff- Rowena Webb, Verren Hunter, and Home Manager- Angela Williams stated all resident's incontinent briefs are changed every two hours with staff initial and time on them. Ms. Williams stated the last time Resident A's incontinent briefs was changed was at 2:00 p.m. by Staff- Verren Hunter. Ms. Williams stated the midnight shift person noted Resident A's incontinent brief had not been changed by Ms. Braxton. Ms. Braxton denied it was her responsibility to change Resident A's incontinent briefs during her shift and feels that it was another staffs responsibility. Therefore, Resident A did not receive the proper personal care specified in her individual plan of service by staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend that the status of the license remains the same.

05/21/2024

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Shatonla Daniel Date
Licensing Consultant

Approved By:

05/21/2024

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Ardra Hunter Date
Area Manager