GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 14, 2024

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

RE: License #: AS250010959
Investigation #: 2024A0779054
Burleigh

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 #:	AS250010959
Investigation #:	2024A0779054
Complaint Receipt Date:	09/10/2024
Investigation Initiation Date:	09/11/2024
Report Due Date:	11/09/2024
Licensee Name:	Resident Advancement, Inc.
Licensee Address:	PO Box 555, Fenton, MI 48430
Licensee Telephone #:	(810) 750-0382
Administrator:	Jennifer Soto
Licensee Designee:	Bethany Mays
Name of Facility:	Burleigh
Facility Address:	8155 Burleigh, Grand Blanc, MI 48439
Facility Telephone #:	(810) 695-7455
Original Issuance Date:	05/19/1993
License **Status:**	REGULAR
Effective Date:	03/29/2024
Expiration Date:	03/28/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 9/09/2024, Resident A was observed to have a large bruise on her face and was not provided any medical care for the injury.	Yes
Staff did not report Resident A's injury to her face as required by Resident A's IPOS.	Yes

III. METHODOLOGY

09/10/2024	Special Investigation Intake 2024A0779054
09/11/2024	Special Investigation Initiated - Telephone Spoke to ORR.
09/11/2024	APS Referral Complaint was referred to APS centralized intake.
09/11/2024	Inspection Completed On-site
09/24/2024	Contact - Telephone call made Spoke to home manager, Qualeah Marzette.
09/24/2024	Contact - Telephone call made Spoke to administrator, Jennifer Soto.
10/11/2024	Exit Conference Held with licensee designee, Bethany Mays.

ALLEGATION:

On 9/9/2024, Resident A was observed to have a large bruise on her face and was not provided any medical care for the injury.

INVESTIGATION:

On 9/11/2024, a phone conversation took place with recipient rights investigator, Pat Shepard, who confirmed that she is investigating the same allegations. Investigator Shepard stated that she had interviewed assistant manager, Qualeah Marzette, who

told her that the bruise on Resident A's face was first observed on 8/31/24 and admitted that no medical assistance was provided to Resident A.

On 9/11/2024, an on-site inspection was conducted and Resident A was interviewed. Resident A was observed to have a faint bruise on the left side of her face around her chin area. Resident A stated that she fell out of bed, hit her face and then got back into bed on her own. Resident A stated that she did not tell staff about the fall when it happened. Resident A did not know the date of when the fall happened. Resident A confirmed that she was not taken to the doctor after the fall.

On 9/11/2024, staff person, Rebecca Chappell, stated that no one witnessed Resident A fall and that 1st shift staff was the first to notice the bruise the morning of 8/31/2024. Staff Chappell stated that she worked 3rd shift on 8/30/2024 and sat most of the night in Resident A's bedroom and Resident A did not fall during her shift. Staff Chappell believes Resident A must have fallen early during 1st shift on 8/31/2024. Staff Chappell reported that Resident A was not taken for medical treatment for the injury until 9/10/2024.

During the on-site inspection on 9/11/2024, hospital paperwork for Resident A was observed. It confirmed that Resident A went to the hospital on 9/10/2024, received a CT scan and was diagnosed with a facial contusion.

Resident A's *Assessment Plan for AFC Residents* was reviewed and stated that Resident A requires assistance from staff for most activities of daily living. The plan states that Resident A utilizes a walker and gait belt. Resident A's GHS Individual Plan of Service (IPOS) was also reviewed. The IPOS states that staff are to keep Resident A in their visible field when ambulating with her walker and when she appears unsteady, assist Resident A by grabbing her gait belt. There is nothing in the plans requiring Resident A to have increased supervision during sleeping hours.

On 9/24/2024, a phone interview was conducted with assistant manager (AM), Qualeah Marzette, who stated that no staff saw Resident A fall and that staff first saw the bruise on Resident A's face on 8/31/2024. AM Marzette stated that Resident A told staff that she fell out of bed, but seemed to be fine, other than the bruise. AM Marzette claims that multiple staff tried to get Resident A to go get her face looked at, but Resident A kept refusing to go. AM Marzette confirmed that the first medical treatment that Resident A had for the fall/bruise was on 9/10/2024.

On 9/24/2024, a phone conversation took place with administrator, Jennifer Soto, who stated that no staff reported to her that Resident A had even had a fall. Admin Soto stated that if she would have known about the fall, she would have made sure Resident A would have received medical services. Admin Soto reported that she has in-serviced her staff to call 911 when this type of thing happens and Resident A is refusing to go out for medical services.

On 10/11/2024, an exit conference was held with licensee designee (LD), Bethany Mays, who stated that medical attention should have been sought for Resident A as soon as staff noticed the bruise. LD Mays stated that she went over proper medical procedure with her managers regarding whenever a resident receives a blow to the head.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Resident A has confirmed that she fell out of bed, did not initially tell staff of the fall and got herself back into bed on her own. Staff appear to have first noticed the bruise to Resident A's face on the morning of 8/31/2024. Resident A was not provided any medical care for the fall/injury until 9/10/2024. Resident A was not provided immediate medical care for a blow to her face/head, warranting a citation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff did not report Resident A's injury to her face as required by Resident A's IPOS.

INVESTIGATION:

Resident A's GHS IPOS was reviewed. It states that if Resident A has a fall and hits her head/face or spine/neck, she should always be evaluated at the ER. The IPOS states that if Resident A has a fall/injury, staff are required to notify her physician, guardian, case manager, and GHS nurse consultant.

On 9/24/2024, AM Marzette, confirmed that on 8/31/2024, Resident A was observed to have a bruise on her face, as a result of her falling out of bed, and that Resident A did not receive medical care until 9/10/2024. AM Marzette stated that no incident report was completed regarding the fall and that staff did not contact Resident A's guardian, physician or GHS staff to inform them that the fall took place.

On 10/11/2024, an exit conference was held with LD Mays, who stated that staff should have taken Resident A for medical treatment and notified all required parties immediately, after becoming aware of the fall/injury. LD Mays stated that staff will be in-serviced on Resident A's IPOS.

Special Investigation Report #2022A0779024 dated 4/21/2022, cited R.400.14303 (2). Resident was not being provided BOOST supplement drink or being weighed weekly, which was required by a GHS registered dietician plan. On 4/29/2022, a corrective action plan (CAP) was submitted and signed by LD Mays. The CAP stated that the weekly weights was added to the resident's MAR and the treatment plan was changed to reflect that the BOOST is no longer required.

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 had a fall, which resulted in a bruise to her face. Resident A's GHS IPOS states that if Resident A has a fall/injury to her head/face, she should always be evaluated at the ER and that staff are required to notify her physician, guardian, case manager, and GHS nurse consultant. It was confirmed that Resident A did not receive immediate medical care and that no one was informed that the fall/injury even took place. Resident A was not provided the personal care as specified in her GHS IPOS.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2022A0779022 dated 4/21/2022.**

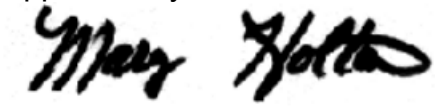
IV. RECOMMENDATION

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

10/14/2024

Christopher Holvey — Date
Licensing Consultant

Approved By:



10/14/2024

Mary E. Holton — Date
Area Manager