GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 03, 2022

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

RE: License #:	AS250010959
Investigation #:	2022A0123027
	Burleigh

Dear Ms. Mays:

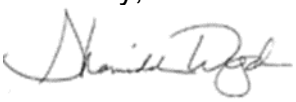
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- 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 (906) 226-4171.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010959
Investigation #:	2022A0123027
Complaint Receipt Date:	03/16/2022
Investigation Initiation Date:	03/18/2022
Report Due Date:	05/15/2022
Licensee Name:	Resident Advancement, Inc.
Licensee Address:	411 S. Leroy, PO Box 555 Fenton, MI 48430
Licensee Telephone #:	(810) 750-0382
Administrator:	Bipan Kapoor
Licensee Designee:	Beth 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:	03/29/2020
Expiration Date:	03/28/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 03/14/2022, a staff person gave a snack and a plate of lunch to Resident A without sitting next to Resident A and providing necessary prompting as required in his plan of service. Staff also did not re-offer the lunch, or a substitution as required when Resident A did not eat enough.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/16/2022	Special Investigation Intake 2022A0123027
03/16/2022	APS Referral Information received regarding APS referral.
03/18/2022	Special Investigation Initiated - Telephone I spoke with recipient rights investigator Pat Shepard via phone.
03/18/2022	Inspection Completed On-site I conducted an unannounced on-site at the facility.
04/01/2022	Contact - Telephone call made I interviewed staff Kaniah Griffith via phone.
04/20/2022	Inspection Completed On-site I conducted a follow-up on-site visit at the facility.
04/25/2022	Contact - Telephone call made I made an attempted call to Guardian 1. I left a voicemail requesting a return call.
04/25/2022	Contact - Telephone call made I made a follow-up call to the facility. I spoke with Staff Pennywell via phone.
04/25/2022	Contact- Document Received I received requested documentation via fax.
04/26/2022	Contact- Telephone call received I spoke with Guardian 1 via phone.
04/27/2022	Contact- Telephone call made I made a follow-up call to Pat Shephard of recipient rights.

04/27/2022	Contact- Telephone call made I spoke with case manager Tammy Lafella via phone.
05/03/2022	Exit Conference I spoke with licensee designee Beth Mays via phone.

ALLEGATION: On 03/14/2022, a staff person gave a snack and a plate of lunch to Resident A without sitting next to Resident A and providing necessary prompting as required in his plan of service. Staff also did not re-offer the lunch, or a substitution as required when Resident A did not eat enough.

INVESTIGATION: On 03/16/2022, I spoke with recipient rights investigator Pat Shephard via phone. She stated a staff person was reportedly observed not following Resident A's plan of service. Resident A has been losing weight, about 30 to 35 lbs. in the last year. Staff are supposed to save Resident A's food, and re-offer after 30 minutes. The plan for Resident A has been implemented recently. Staff stated that Resident A had ate enough, and staff were also observed not sitting with Resident A while he ate.

On 03/18/2022, I made an unannounced on-site visit at the facility. I spoke with home manager Rasheedah Pennywell. Staff Kel Stocker was present as well. Staff Pennywell stated that Resident A has issues with food textures. Resident A was raised on an unhealthy diet (i.e., junk food), and has not taken to the meals that are served at the facility. She stated that she was present the day of the alleged incident, and that Resident A had a big breakfast prior to lunch. She stated that staff offered Resident A an Equate nutritional shake, and then two snacks (banana chips and lemonade, and then crackers). She stated that if Resident A is served a meal he does not like, he has behaviors and will get up and walk away from the table. She stated that staff stand by the kitchen counter and watch the residents when they are eating. She stated that on that day, there was a lot going on and they had about three visitors. She stated that when there is a lot going on in the home Resident A has behaviors. She reported that Resident A had a double portion of food for breakfast that morning. She stated that when he walks away from the table, he is content, and when he wants something, he will come back. She stated that it was not like staff Kaniah Griffith was refusing to give Resident A any food.

On 03/18/2022, staff Kel Stocker was interviewed at the facility. Staff Stocker stated that she thinks the allegations are a misunderstanding. She denied ever witnessing any staff not following Resident A's Individual Plan of Service. She stated that Resident A leaves the table when he wants to and comes back to his food when he is ready. She stated that staff watch and observe Resident A when he is eating.

During this onsite, I reviewed the *Resident Register*. Resident A's documented move in date on the Resident Register is 07/01/2020.

On 03/18/2022, I observed documentation of Resident A's weight records from November 2021 to March 2022. Resident A's weigh on 11/15/2021 is documented as 122.6 lbs. In December 2021, it was 122.4, and between January and March 2022 his weights are 126.2, 126.4, and 126.8 respectively. I obtained a copy of Resident A's *Assessment Plan for AFC Residents* date 03/14/2022. His assessment plan indicates that he does not need assistance with eating but eats bite size pieces. Resident A's Individual Plan of Service (IPOS) dated for 02/04/2022 states that his guardian wants Resident A to "*gain some weight as he has lost a lot of weight over the past couple of years*." The IPOS stated that staff will monitor his weight for regression and document when he refuses a meal, accepts a meal, and when a substitution is provided. The IPOS also stated that "*During the meal, the staff will sit NEXT to [Resident A] at the table to allow caregivers to intervene before he scoops or grabs too much food and puts in his mouth at one time or drinks too much liquid at one time while giving [Resident A] verbal prompts to eat at a safe pace and take safe size bits. If he does not respond to the verbal prompt and begins to put another bite or spoonful in his mouth, staff should provide touch prompts to his forearm while repeating the verbal prompt. With the food positioned in front of [Resident A] and the staff sitting NEXT to [Resident A] the staff should provide verbal prompts to begin eating if he does not attempt to feed himself initially. If he does not begin eating if he does not attempt to feed himself initially. If he does not begin to feed himself, the staff should provide a few bites of food fed to him throughout the first 5 minutes along with verbal prompts to encourage him to eat. Continue the process of verbal prompts and feeding him a few bites throughout the first 5 minutes. If he does not start to feed himself within the first 5 minutes, the staff should feed him the remainder of the meal, as much of the meal as he will eat. He has lost a significant amount of weight recently. Do not throw his meal away but present the meal again in 30 minutes or again in 60 minutes. He may be more willing to eat when the others have completed their meal and left the table as there is less distracting sensory input. If he does not eat the meal when offered at 30 minutes and 60 minutes, offer him something that he is known to be willing to eat. Document the percentage of food he has eaten when he has to be fed."* Resident A's *Health Care Appraisal* dated for 06/22/2020 was reviewed. It states that Resident A is diagnosed with Cerebral Palsy, severe intellectual disability, and hypothyroid.

On 04/01/2022, I interviewed staff Kaniah Griffith via phone. Staff Griffith stated that she did feed Resident A. She stated that she sits close behind him or within the vicinity. She stated that she was kiddy corner behind him by the kitchen island and could see him from where she was sitting. She stated that Resident A ate all his vegetables and whatever else was on his plate, but he did not want the main part of the dish. She stated that it is protocol to let him get up and walk away and have him come back 30 minutes later. She stated that if that does not work, they give him a substitution. She stated that on that day, Resident A had a big breakfast, and the lunch served was a texture he did not like. She stated that Resident A took an alternative instead which was a protein shake and some banana chips. She stated that Resident A is non-verbal. She stated that his case manager asked her if that is what Resident A normally does, not eat his food. Staff Griffith stated that she

answered yes to the question and explained that he will eat if it is a food he really likes. Staff Griffith stated that Resident A has been this way since she has been working there, and there have been no issues with his weight. She stated that the only other staff person present at the time was the home manager.

On 04/20/2022, I conducted a follow-up visit at the facility to see Resident A. Resident A could not be interviewed due to being non-verbal. Resident A appeared clean and appropriately dressed.

On 04/25/2022, I made a call to the facility. I spoke with Staff Pennywell and requested documentation for Resident A regarding staff noting how much Resident A eats daily. I received a copy of the documentation via fax. The documentation was reviewed and indicates that Resident A ate 100% of his breakfast the morning of 03/14/2022. It is difficult to make out the percentage for lunch but appears to be 50%. It is noted that he ate 100% of dinner that day. Snacks and alternatives do not appear to be noted on the document.

On 04/26/2022, I received a return call from Guardian 1. Guardian 1 stated that Resident A likes to shove food in his mouth, and if you are not paying attention he will choke. She stated that Resident A needs to be prompted to slow down sometimes. Guardian 1 stated that Resident A was at 116 lbs., and that she got upset about this. She stated that staff reported that Resident A would not eat the food that they served. She stated that she bought Resident A Boost supplements and other foods that he likes and told staff not to substitute the Boost for his food. Guardian 1 stated that Resident A looked a little smaller about a week ago, but she does not know what his current weight is. She stated that staff had not being giving Resident A enough to drink to the point his urine would be orange. She stated that she took Resident A to the doctor in January 2022 to address his dietary needs. She stated that Resident A is non-verbal and cannot tell her anything. Guardian 1 stated that Resident A has been in the facility since 07/01/2020.

On 04/27/2022, I made a follow-up call to recipient rights investigator Pat Shephard. She stated that there is no dietician involved, and Resident A's IPOS does not specify how much Resident A is supposed to eat. She stated that she will be substantiating for staff not sitting next to Resident A while he was eating as that puts Resident A at risk of physical harm and choking. She stated that the occupational therapist who put the language regarding providing substitutions in Resident A's plan said that Boost supplements would be an okay substitution, but Guardian 1 took issue with this. She stated that the case manager says the reason to reoffer food is to get Resident A to eat his food and not drink it. Ms. Shephard stated that the plan is not clear, and it is just focused on eating by mouth. She stated that staff don't reoffer meals twice because it causes Resident A to have a behavior.

On 04/27/2022, I spoke with Genesee Health System case manager Tammy Lafella via phone. Ms. Lafella reviewed her notes from 03/14/2022. She stated that staff was giving Resident A his lunch. Resident A has an issue with food texture.

Resident A was observed to eat about 30% of his food (generously speaking). She stated that Staff Griffith said they were not going to give Resident A a substitution because Resident A did not refuse enough food to offer a substitution, but Staff Griffith could not quantify what is enough to not offer a substitution. She stated that staff reported that Resident A had ate oatmeal and two to three Nutrigrain bars for breakfast and said that Resident A was fine until dinner. Ms. Lafella stated that Resident A's plan states that staff will sit next to Resident A at the table, but staff were observed standing behind Resident A's back and behind the other side of the kitchen counter. She stated that Staff Griffith said that she could see Resident A and respond from behind the counter. She stated that after Resident A ate 30% of his food, staff took the meal and threw it in the trash and did not re-offer the food as outline in his plan of service. She stated that Staff Griffith reported that she had threw the meal away because Resident A would not eat it anyway and it would cause a behavior. She stated that Guardian 1 has provided Resident A with foods that she knows Resident A will eat and told staff it is okay to serve him the foods (i.e., macaroni and cheese, soups, etc.). Ms. Lafella stated that Staff Pennywell has said that the foods Guardian 1 brings in for Resident A are not healthy. Ms. Lafella stated that Resident A's plan of service was written due to Resident A's history of gagging, choking, and aspirating. Ms. Lafella stated that Staff Griffith reported that she gave Resident A a Boost supplement. Ms. Lafella then stated that Boost is not in Resident A's plan, and that Staff Griffith had poured cranberry juice mixed with water. She stated that if Boost was given, why was it mixed with water. Ms. Lafella stated that Genesee Health Systems does not have a dietician on staff currently, and that Resident A did not have a dietician anyway.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Pat Shephard of recipient rights stated that Resident A has lost about 30 to 35 pounds in the last year, and staff were observed on 03/14/2022 to not be following his individual plan of service regarding eating and feeding. Staff Pennywell and Staff Stocker denied the allegations, however they both indicated that Staff Stocker was not sitting right next to Resident A during this mealtime as it is expressed in his individual plan of service. Staff Stocker stated that she was kiddy corner behind him by the kitchen

	island and could see him from where she was sitting. Ms. Lafella also reported that Staff Griffith was not sitting next to Resident A to provide the necessary prompting and assistance with feeding as specified in his Individual Plan of Service during his mealtime. There is a preponderance of evidence to substantiate a rule violation regarding staff not following Resident A's plan of service.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 03/18/2022, I made an unannounced on-site visit at the facility. I requested copies of Resident A's weight records. Staff Pennywell explained that she could not find any weight records for Resident A prior to November 2021 and provided me copies of his weights for November 2021 through March 2022. I checked the Resident Register which has a documented move-in date of 07/01/2020.

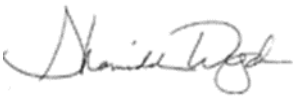
On 04/25/2022, I made a call to the facility. I spoke with Staff Pennywell. I inquired again about the weight records. She stated that she could not find any documentation regarding his weight records prior to November 2021.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	On 03/18/2022, I conducted an unannounced on-site visit. I was informed by Staff Pennywell that weight records for Resident A prior to November 2021 are missing. Per the Resident Register, Resident A moved into the facility in July 2020. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/03/2022, I conducted an exit conference with licensee designee Beth Mays. I informed her of the findings and conclusions.

IV. RECOMMENDATION

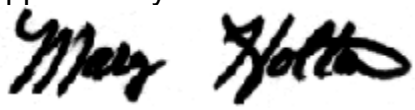
Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 6).



05/03/2022

Shamidah Wyden Date
Licensing Consultant

Approved By:



05/03/2022

Mary E Holton Date
Area Manager