GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 12, 2022

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

RE: License #:	AS250010923
Investigation #:	2022A0123043
	Maple Woods

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:

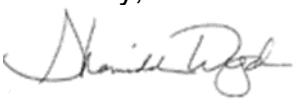
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,



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 #:	AS250010923
Investigation #:	2022A0123043
Complaint Receipt Date:	06/28/2022
Investigation Initiation Date:	06/28/2022
Report Due Date:	07/28/2022
Licensee Name:	Resident Advancement, Inc.
Licensee Address:	411 S. Leroy, PO Box 555 Fenton, MI 48430
Licensee Telephone #:	(810) 750-0382
Administrator:	Danielle Davis
Licensee Designee:	Beth Mays
Name of Facility:	Maple Woods
Facility Address:	7448 Maple Road Grand Blanc, MI 48439
Facility Telephone #:	(810) 743-2336
Original Issuance Date:	05/06/1991
License Status:	REGULAR
Effective Date:	06/22/2022
Expiration Date:	06/21/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 06/24/2022, Resident A went outside on the patio to sit. Staff reported they heard Resident A coughing. When staff checked on Resident A, he had lighter fluid in his hands and had appeared to have drunk the lighter fluid. Resident A was taken to the hospital by ambulance and is hospitalized due to aspiration pneumonia. Resident A is on a ventilator.	Yes

III. METHODOLOGY

06/28/2022	Special Investigation Intake 2022A0123043
06/28/2022	Special Investigation Initiated - Telephone I spoke with Complainant 1 via phone.
06/29/2022	APS Referral Information received regarding APS referral.
06/30/2022	Inspection Completed On-site I conducted an unannounced visit at the facility. I interviewed staff.
07/08/2022	Contact - Telephone call made I spoke with Resident A's public guardian, Guardian 1, via phone.
07/08/2022	Contact - Telephone call made I spoke with licensee designee Bethany Mays via phone.
07/08/2022	Contact - Telephone call made I made a call to the facility. I spoke with home manager Lakeitha Anderson via phone.
07/08/2022	Contact- Document Received I received a copy of Maple Woods' training policy via email from Ms. Mays.
07/14/2022	Contact - Telephone call made I spoke with recipient rights investigator Matt Potts via phone.
07/14/2022	Contact- Document Received I received an email from Mr. Potts, including Resident A's hospital records.

07/29/2022	Contact-Documentation Sent I sent an email to Mr. Potts from recipient rights.
07/29/2022	Contact- Telephone call made I spoke with licensee designee Beth Mays via phone.
07/29/2022	Contact- Document Received I received requested documentation via fax.
08/03/2022	Contact- Documentation Received I received an email response from Mr. Potts.
08/04/2022	Contact- Telephone call made I made an attempted call to Guardian 1 to follow up on documentation regarding Resident A's cause of death.
08/05/2022	Contact- Telephone call made I made a call to Guardian 1's office. I left a message requesting documentation that confirms Resident A's death.
08/12/2022	Exit Conference I spoke with licensee designee Beth Mays via phone.
08/12/2022	Contact- Telephone call made I made a call to Allen Funeral Home. I requested a copy of the death certificate.
08/12/2022	Contact- Document Received I received a copy of Resident A's death certificate.

ALLEGATION: On 06/24/2022, Resident A went outside on the patio to sit. Staff reported they heard Resident A coughing. When staff checked on Resident A, he had lighter fluid in his hands and had appeared to have drunk the lighter fluid. Resident A was taken to the hospital by ambulance and is hospitalized due to aspiration pneumonia. Resident A is on a ventilator.

INVESTIGATION: On 06/25/2022, and 06/27/2022, I received a copy of an *AFC Licensing Division-Incident/Accident Report* dated 06/24/2022. The incident report stated that Resident A was on the patio, staff Lynda Grisby informed home manager Lakiesha Anderson that she heard Resident A coughing and witnessed Resident A holding lighter fluid. The incident report notes that staff contacted 911 so Resident A could be examined, and Resident A was admitted to the hospital. Staff contacted 911, the home manager, program manager, the guardian, and case manager. Under the *Corrective Measures Taken to Remedy and/or Prevent Recurrence* section, it states "*Staff will make sure lighter fluid is always locked away, after each use.*"

On 06/28/2022, I spoke with Complainant 1 via phone. Complainant 1 stated that staff left lighter fluid outside. Resident A aspirated on the lighter fluid and is on a ventilator. Resident A has a public guardian. Staff Lynda Grisby and Staff Tim MacGown were working when the incident occurred on 06/24/2022 during second shift. Complainant 1 stated that Resident A is clever about doing things. He seeks out food and things to put into his mouth. It is common sense to lock things up. The facility recently had a barbecue and left the lighter fluid out. It is unknown which staff did the BBQ.

Complainant 1 stated that the home has patio furniture, and it is normal for Resident A to go outside to sit. Resident A was put on a vent yesterday about 2:00 pm. Resident A is 71 years old and deaf. He has eaten raw foods before and must be watched because he will grab anything. Staff called 911, an ambulance came and picked Resident A up. Staff Lynda Grisby heard Resident A outside coughing and saw him with the lighter fluid bottle but was not sure if Resident A had drunk any of the fluid or not. Last week, there was an annual meeting for Resident A, everything was good, and there were no health-related changes.

On 06/30/2022, I conducted an unannounced on-site visit at the facility. I interviewed staff Tim MacGown. He stated that the incident occurred last Friday (06/24/2022). He stated that Resident A was on the patio, while he (Staff MacGown) was in the kitchen starting dinner. Staff Grisby came up to him saying that Resident A got into the lighter fluid. He stated that he called 911, and Staff Grisby got on the phone with management. Staff MacGown stated that Resident A was on the back patio for about ten minutes. He stated that from where he was standing, he could see Resident A from the door, and when Resident B started screaming, Staff Grisby was attending to Resident B. He stated that this is when he believes that Resident A got the lighter fluid. He stated that he believes Staff Grisby was watching Resident A through the window. Staff MacGown stated that he could see Resident A through the kitchen window, and he did not know that the lighter fluid was outside and does not know the last time the grill was used.

On 06/30/2022 I interviewed staff Lynda Grisby at the facility. Staff Grisby stated that she works at the facility two days per week. She stated that on last Friday (06/24/2022), she was attending to Resident B who was having a behavior in the living room/dining room area of the home. Resident A was on the patio, and she

heard Resident A coughing. She stated that she went out to see Resident A and saw the lighter fluid bottle sitting along the back wall of the house. Resident A was standing in the area, she saw droplets on the ground, and assumed Resident A had drunk the lighter fluid. She stated that she called Staff MacGown to the door, and Staff MacGown called 911, and she called the administrator Danielle (Davis) Stevenson. She stated that she then called the home manager, Lakeitha Anderson. Staff Grisby stated that the EMT's and the Sherriff's Department responded and assessed Resident A and transported him to Hurley Medical Center for observation. Staff Grisby stated that Staff MacGown washed Resident A's mouth out with water and brushed his gums and teeth. She denied that they smelled any lighter fluid on Resident A, and the EMT's did not say that smelled anything either. She stated that the lighter fluid bottle was practically full.

After this interview, I asked Staff Grisby to show me where the lighter fluid is stored. We went to the garage, where she unlocked the cabinet and showed me two lighter fluid bottles. Both bottles appeared to be a little over half full. She stated that she has no idea who used the lighter fluid, and that they never barbecue on their shift.

On 07/08/2022, I spoke with Resident A's public guardian, Guardian 1 via phone. Guardian 1 stated that Resident A passed away this morning. He stated that the best prognosis would have been to be on a trach and vent for the rest of his life. He stated that no one is disputing he ingested the lighter fluid. He stated that it burned the inside of Resident A's lungs and throat. Guardian 1 stated that he has not heard anything from the facility. He stated that Resident A was at Hurley Medical Center, and he does not believe Resident A has any family. Guardian 1 stated that his is working on getting Resident A's funeral together.

During the on-site on 06/30/2022, I obtained documentation regarding Resident A. Resident A's *Health Care Appraisal* dated for 03/01/2022, has HTN, ASCVD, CHF, CKD II, GERD, and intellectual disabilities noted as diagnoses. A copy of *Resident A's Assessment Plan for AFC Residents* dated for 03/30/2022 states that Resident A "*doesn't have self-injurious behavior*." A copy of Resident A's Genesee Health System IPOS Meeting notes (effective date 07/23/2021 thru 07/22/2022). The IPOS outlines the safety guidelines staff are to follow when Resident A is eating, and his "food stealing" behaviors. His diet consisted of ground food texture and regular liquids, and the IPOS also states "*Food stealing is considered potentially severe in that [Resident A] is on a restricted diet due to significant health concerns, i.e., food allergies, Barrett's esophagus, and elevated triglycerides*." The plan does not mention anything pertaining to keeping poisonous liquids out of reach.

On 07/08/2022, I spoke with Resident A's public guardian, Guardian 1 via phone. Guardian 1 stated that Resident A passed away this morning. Guardian 1 stated that Resident A's best prognosis would have been a trach and vent for the rest of his life. He stated that no one is disputing that Resident A ingested lighter fluid, which burned the inside of Resident A's lungs and throat, and that this was the equivalent of drinking gasoline. He stated that Resident A was at Hurley Medical Center when

he passed, and that he is getting Resident A's funeral together. Guardian 1 stated that Resident A would take others food and drinks. If someone left out a pop, Resident A would take it and drink it.

On 07/08/2022, I spoke with licensee designee Bethany Mays via phone. She stated that staff have provided her with written statements. She stated that staff are trained to keep anything flammable locked up in the garage, and that is their company's policy. She stated that staff are supposed to be within line of sight when Resident A or others are eating, and that Resident A had free access to the home. She stated that his plan of service did not specify that anything needed to be locked up.

On 07/08/2022, I received a copy of excerpts from Maple Woods' staff training manual. On page two of the *Home Safety Checklist*, it states "*Any item which bears the label 'keep away from heat of flame' should be kept in the fire safe closet in the garage."* On the *Summer Preparations Training Guide- Barbecue Safety Tips* page it states, *"store charcoal lighter fluid in detached shed or fire rated cabinet."*

On 07/08/2022, I spoke with home manager Lakeitha Anderson via phone. She stated that Staff Grisby called her and told her she was passing meds to Resident B when she heard Resident A coughing. Staff Grigsby went outside, saw Resident A with the lighter fluid bottle in his hands, and staff called 911. Staff Anderson stated that she has never known Resident A to consume anything like lighter fluid. She stated that she was not working that day. She stated that Staff McGown told her that he was in the kitchen preparing dinner at the time of the incident. Staff Anderson stated that she was just informed via phone by a VPA doctor who told her that Resident A passed away today.

On 07/08/2022, I received an *AFC Licensing Division- Incident/Accident Report* dated for 07/08/2022 written by home manager Lakeitha Anderson that states" *I received a call from VPA stating that [Resident A] passed away*."

On 07/14/2022, I received a copy of Resident A's physician discharge summary for his hospital stay between 06/24/2022 thru 07/08/2022. The principal problem is noted to be "*Aspiration into lower respiratory tract.*" The following was listed under "*Active Problems*"- *Aspiration into lower respiratory tract, hypoxia, caustic esophageal injury, initial encounter, Esophageal dysphagia, acute tubular necrosis, respiratory acidosis, acute respiratory failure with hypoxia, hypernatremia, and essential hypertension*. *Aspiration pneumonitis 2/2 chemical ingestion* is noted as one of the discharge diagnoses. Resident A's condition at admission was noted to be "*poor*" and his discharge condition is noted to be "*deceased*." In the hospital notes on page 18 of 28, is an attestation signed by Mohammed Berrou, MD on 06/30/2022. It states the following:

"I personally saw and examined the patient. I discussed the patient with the mid-level providers, nurse, case manager etc. and have reviewed their documentation. I personally directed the assessment and development of the plan. I visually reviewed

the labs, imaging, telemetry, hemodynamic trends, respiratory status, nutritional status, and renal function. The patient's clinical diagnoses requiring ICU management are:

1. *Accurate hypoxemic respiratory failure, ARDS*
2. *Multifocal pneumonia*
3. *Acute kidney injury*
4. *Hydrocarbon ingestion with aspiration*
5. *Autism*
6. *Deafness*

On 07/29/2022, I received a faxed copy of staff's written statements from licensee designee Beth Mays. The administrator's (Danielle (Davis) Stevenson) statement says that staff saw Resident A with the lighter fluid in his hand when they responded due to him coughing. Staff Thomyeisha Martin denied knowing or remembering when the last time the lighter fluid was used. Staff Grigsby and Staff MacGown's statements were similar to the interviewed on 06/30/2022.

On 08/12/2022, I received a copy of Resident A's death certificate via email from Jessica Pashby of Allen Funeral Home. The death certificate lists "*Complications of chemical induced aspiration pneumonia and caustic esophageal injury*" as cause of death. A note at the bottom in box *41c. Describe How Injury Occurred* it states, "*Ingested and aspirated lighter fluid*."

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	An incident report dated for 06/24/2022, stated that 911 was called after Staff Grisby witnessed Resident A on the patio coughing and holding lighter fluid. Complainant 1 reported Resident A was hospitalized due to ingesting lighter fluid that was left out on the patio at the facility. Staff MacGown was interviewed and stated that Staff Grisby came up to him and told him that Resident A got into the lighter fluid, and he called 911. Staff Grisby was interviewed and reported that Resident A was on the patio. He was coughing, and she saw the bottle

	sitting on the backside of the home but saw droplets on the ground and assumed Resident A drank the lighter fluid. Resident A's Guardian 1 stated that no one is disputing that Resident A ingested the lighter fluid. On 07/08/2022, Guardian 1 reported that Resident A passed away in the hospital. Medical records from Hurley Medical Center stated that Resident A had caustic esophageal injury, and hydrocarbon ingestion with aspiration, etc. Licensee Designee Beth Mays reported that the facility has a company policy that flammables are to be kept locked up, and staff are trained on this policy. A copy of Resident A's death certificate states his cause of death was complications of chemical induced aspiration pneumonia and caustic esophageal injury. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

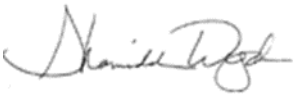
APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.
ANALYSIS:	An incident report dated for 06/24/2022, stated that 911 was called after Staff Grisby witnessed Resident A on the patio coughing and holding lighter fluid. Complainant 1 reported Resident A was hospitalized due to ingesting lighter fluid that was left out on the patio at the facility. Staff Grisby was interviewed and reported that Resident A was on the patio. He was coughing, and she saw the bottle sitting on the backside of the home but saw droplets on the ground and assumed Resident A drank the lighter fluid.

	Resident A's death certificate indicates that his cause of death was related to ingesting and aspirating lighter fluid. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 08/12/2022, I spoke with licensee designee Beth Mays via phone. I informed her of the findings and conclusion.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional.

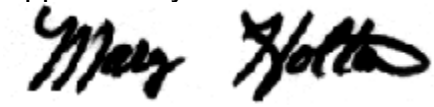


08/12/2022

_____

Shamidah Wyden Date
Licensing Consultant

Approved By:



08/12/2022

_____

Mary E. Holton Date
Area Manager