GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 15, 2022

Rochelle Molyneaux
Resident Advancement, Inc.
PO Box 555
Fenton, MI 48430

RE: License #: AS250263541
Investigation #: 2022A0580058
Embury Home

Dear Ms. Molyneaux:

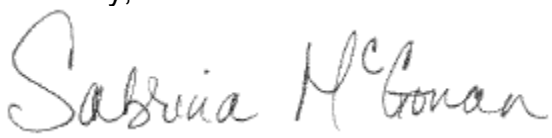
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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,



Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250263541
Investigation #:	2022A0580058
Complaint Receipt Date:	09/27/2022
Investigation Initiation Date:	09/28/2022
Report Due Date:	11/26/2022
Licensee Name:	Resident Advancement, Inc.
Licensee Address:	411 S. Leroy, PO Box 555 Fenton, MI 48430
Licensee Telephone #:	(810) 750-0382
Administrator:	Rochelle Molyneaux
Licensee Designee:	Rochelle Molyneaux
Name of Facility:	Embury Home
Facility Address:	3127 McGregor Grand Blanc, MI 48439
Facility Telephone #:	(810) 694-2816
Original Issuance Date:	05/10/2004
License Status:	REGULAR
Effective Date:	12/21/2020
Expiration Date:	12/20/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 9/22/22, Resident A was taken to the hospital by EMS due to not responding to verbal directives. Resident A has a UTI, low sodium, a feeding tube with maggots in it, and bowel movements with maggots which means he has them in his intestines.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/27/2022	Special Investigation Intake 2022A0580058
09/27/2022	APS Referral This referral was denied by APS for investigation.
09/28/2022	Special Investigation Initiated - Telephone A call was made to the complainant.
10/05/2022	Inspection Completed On-site An onsite inspection was conducted. Contact was made with staff, Ms. Yashisha Coffee, Mr. John Stogdill, and Ms. Latonya Laury.
10/19/2022	Contact - Telephone call made A call was made to Ms. Natasha Nunn, Home Manager.
10/19/2022	Contact - Document Received Documents requested were received.
11/09/2022	Contact - Telephone call made A call was made to Relative Guardian A.
11/09/2022	Contact - Telephone call made A call was made to Ms. Crystal Perkins, GHS Case Manager for Resident A.
11/09/2022	Contact - Telephone call made A call was made to Nurse Practitioner, Ms. Lisa Lindsay.

11/15/2022	Exit Conference An exit conference was held with the licensee designee, Ms. Bethany Mays.

ALLEGATION:

On 9/22/22, Resident A was taken to the hospital by EMS due to not responding to verbal directives. Resident A has a UTI, low sodium, a feeding tube with maggots in it, and bowel movements with maggots which means he has them in his intestines.

INVESTIGATION:

On 09/27/2022 I received a complaint via BCAL Online Complaints. This complaint was denied by APS for investigation.

On 09/28/2022, I made a call to the complainant, who reiterated the allegations. She also shared that there was a prior open APS case a few weeks ago involving this resident.

On 10/05/2022, I conducted an onsite inspection at Embury AFC. Contact was made with staff, Ms. Yashisha Coffee. She shared that Resident A is currently in the hospital and is not anticipated to return to the home. She shared that Resident A was bed ridden, required a feeding tube for feeding and a catheter for toileting. She shared that Resident A was turned every 2 hours while in the home. She denied ever observing any maggots when turning Resident A.

Also present on shift was staff, Mr. John Stogdill and new staff trainee, Ms. LaTonya Laury. Other residents were observed about the home in the living room and in their bedrooms. The residents appeared to be receiving appropriate care.

On 10/19/2022, I spoke with Ms. Natasha Nunn, home manager. Although he cannot speak, Resident A usually responds to touch, or his name being called. She shared that on 09/23/2022 staff went to check on Resident A and he was not responding, however, he was breathing. He was sent to the hospital. It was determined that his sodium was low. He returned home, however, on 10/02/2022 Resident A was observed to projectably vomiting and had to be sent back to the hospital. To her knowledge, he is currently in rehabilitation facility and will not be returning to the home. Ms. Nunn states that 1 maggot was observed. She does not know how it could have occurred. She indicated that Resident A is turned every 2 hours. This information is being documented. She adds that Resident A receives his medication and is fed through his tube. His tube is not cleaned or changed by staff in the home as they are not equipped with the medical knowledge. Cleaning or any adjustments to the tube were to be completed by the Nurse Practitioner, Ms. Lisa Lindsay, and staff, who come in once a week.

On 10/19/2022, I received an emailed copy of the Incident Report (IR) involving Resident A were received. The IR dated 09/23/2022 indicated that staff walked into the room to administer resident his feeding tube for the night. Touched Resident A and called him by his name and received no response. Staff checked and determined that Resident A was still breathing but not responding. 911 was called. The IR dated 10/02/2022 indicated that staff went in Resident A's room to change his brief and observed that he'd vomited all over himself. 911 was called.

Data Collection forms provided for Resident A indicate that staff enters their initials verifying that Resident A is toileted each shift, with the exception of the days that he was out of the facility. It does not include the frequency. The Data Collection form for the month of September 2022 indicates that Resident A was repositioned every 2 hours from 8am-6am, noting the position he was in and whether any redness or skin breakdown was observed. This form also notes that Resident A was either bathed or received bathing care daily, while at the facility, per staff initials during the month of September.

The AFC Assessment Plan for Resident A indicates that he does not move independently and requires the use of either a powered or regular wheelchair. The plan states that Resident A requires the use of a feeding tube for eating, uses briefs and a catheter for toileting and full care is required for bathing. The plan also indicates that Resident A requires assistance with dressing, grooming, and personal hygiene, walking/mobility, and stair climbing. The plan does not address how Resident A will be assisted with grooming, personal hygiene, walking/mobility, and stair climbing.

On 11/09/2022, I spoke with Relative Guardian A. She shared that Resident A entered the facility in either March or April of 2021. At the time of entry, Resident A required the use of a catheter and a feeding tube. He was not bed bound. She shared that she and other family members visited regularly, at least twice a week. In her opinion, the staff was not able to meet his needs. She was informed that maggots were found by the nurse at the Ascension Genesys Hospital. Resident A is currently placed at Wellbridge in Grand Blanc where he is doing much better.

On 11/09/2022, I spoke with Ms. Crystal Perkins, Genesee Health Systems (GHS) Case manager for Resident A. She verified that Resident A was a on feeding tube when he was placed in the home in 2021. To her knowledge, Ms. Lisa Lindsay and staff provided Resident A with once a week services, however, he still ended up with both maggot and a bedsore since being placed in the home. Ms. Perkins shared that Guardian A informed her about the maggots. Guardian A was informed by the nurse staff while he was in the hospital. She did not obtain a copy of his discharge papers.

On 11/ 09/2022, I spoke with the secretary at Lisa Lindsay's office. She reports that the AFC Home is responsible for cleaning Resident A's feeding tube.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**
ANALYSIS:	Based on my investigation, which included interviews with multiple direct staff members, and Relative Guardians A1, Ms. Crystal Perkins of GHS and Nurse Practitioner Lisa Lindsay's office, and a review of the documents provided, there is sufficient evidence to substantiate the allegation that home is unable to provide the services and skills required to meet Resident A's needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

The AFC Assessment Plan for Resident A indicates that he does not move independently and requires the use of either a powered or regular wheelchair. The plan states that Resident A requires the use of a feeding tube for eating, uses briefs and a catheter for toileting and full care is required for bathing. The AFC Assessment plan also indicates that Resident A requires assistance with dressing, grooming, and personal hygiene, walking/mobility, and stair climbing. The plan does not address how Resident A will be assisted with grooming, personal hygiene, walking/mobility, and stair climbing.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible

	agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on the 10/19/2022 observation of the AFC Assessment Plan for Resident A, it was not fully completed. The plan did not address the specific methods of providing care for the resident based on his needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/15/2022, I conducted an exit conference with the license designee, Ms. Bethany Mays, sharing the findings of this investigation.

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.

November 15, 2022

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Sabrina McGowan Date
Licensing Consultant

Approved By:

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Mary E. Holton Date
Area Manager