GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 30, 2023

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

RE: License #: AS250263541
Investigation #: 2024A0779004
Embury Home

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 #:	AS250263541
Investigation #:	2024A0779004
Complaint Receipt Date:	10/17/2023
Investigation Initiation Date:	10/19/2023
Report Due Date:	12/16/2023
Licensee Name:	Resident Advancement, Inc.
Licensee Address:	411 S. Leroy, PO Box 555 Fenton, MI 48430
Licensee Telephone #:	(810) 750-0382
Administrator:	Jennifer Soto
Licensee Designee:	Bethany Mays
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:	12/21/2022
Expiration Date:	12/20/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has a physician order for nectar thick liquids, which the home has not been providing.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/17/2023	Special Investigation Intake 2024A0779004
10/19/2023	Special Investigation Initiated - Telephone Voicemail left for ORR investigator.
10/23/2023	Contact - Telephone call made Spoke to recipient rights investigator, Michelle Salem.
10/26/2023	Inspection Completed On-site
11/29/2023	Contact - Telephone call made Spoke to Occupational Therapist.
11/29/2023	Exit Conference Held with administrator, Jennifer Soto.
11/29/2023	APS Referral Complaint was referred to APS centralized intake.

ALLEGATION:

Resident A has a physician order for nectar thick liquids, which the home has not been providing.

INVESTIGATION:

On 10/23/23, a phone conversation took place with recipient Rights investigator, Michelle Salem, who confirmed that she is investigating the same allegations. She stated that she had already spoken to Resident A, who said that staff have not been thickening his liquids recently and have never thickened his water. Investigator Salem

reported that she had spoken to several staff at this home, and they all reported that they have never been told to thicken Resident A's water. Investigator Salem stated that the GHS Occupational Therapist (OT) was at this home on 10/16/23 and could not find any thickener in the home. She stated that the OT said that there was a risk of aspiration without the thickener.

On 10/26/23, an on-site inspection was conducted, and resident A was interviewed. Resident A stated that he does not like the Thick-it being put in his liquids. Resident A confirmed that staff have been thickening all his liquids, except water.

On 10/26/23, staff person, Britttany Slaughter, stated that staff were not aware that Resident A needed the Thick-it put in his water and that they were not trained to do that. Staff Slaughter stated that Resident A was getting the Thick-It in all other liquids he drank, but not water.

On 10/26/23, assistant manager, Shatoria McDaniel, confirmed that the home had run out of the Thick-it powder sometime over the weekend and that there was none in the home the morning of 10/16/23. She stated that she was not told by staff that they had run out of it or that they were running low. Manager McDaniel stated that the old home manager was the one who ordered the Thick-it when needed and that staff did not even know where to get it from. She stated that she went and got more Thick-it during the afternoon on 10/16/23.

During the on-site inspection on 10/26/23, the home provided a physician order and prescription for Thick-it powder. The physician order stated that Resident A is to receive nectar thick liquids.

On 11/29/23, a phone conversation took place with OT, Michelle McKnown, who stated that she was at this home the morning of 10/16/23 and witnessed the staff give Resident A orange juice and water without thickening it first. She stated that that there was no Thick-it present in the home at that time. OT McKnown confirmed that Resident A is to be receiving Thick-it in all liquids, including water.

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: **(a) Medications.**
ANALYSIS:	It was confirmed that there is a physician order in place stating that Resident A is to receive nectar thick liquids and that the

	home has a prescription for Thick-it powder for Resident A. Occupational therapist, Michelle McKnown, was at this home on 10/16/23 and witnessed the staff give Resident A orange juice and water without thickening it first. OT McKnown stated that there was no Thick-it powder present in the home on the morning of 10/16/23. Staff persons, Shatoria McDaniel, and Brittany Slaughter confirmed that the home had run out of Thick-it and did not have any in the home the morning of 10/16/23. They both confirmed that they had not been putting Thick-it in Resident A's water and claimed that they were not aware that they were supposed to. There was sufficient evidence found to prove that this home was not properly following the physician order that was in place to provide Resident A with nectar thick liquids.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/26/23, an on-site inspection was conducted, and Resident A's medication administration record (MAR) form was reviewed. The MAR indicated that the home had a prescription for Thick-it powder and that all liquids were to be to nectar like consistency. There was a total of seven days, during the month of October 2023, where staff failed to initial the MAR indicating that they had used the Thick-it powder in Resident A's liquids. Assistant manager, Shatoria McDaniel, stated that all of Resident A's liquids, except water on some occasions, were being thickened on those days in question.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**

ANALYSIS:	It was confirmed that this home had a prescription to use Thick-it powder in Resident A's liquids. Although it appears that the Thick-it was used, there was a total of seven days, during the month of October 2023, where staff failed to initial the MAR indicating that they had used the Thick-it powder in Resident A's liquids.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/29/23, an exit conference was held with administrator, Jennifer Soto. She was informed that a written corrective action plan is required.

IV. RECOMMENDATION

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

Christopher A. Holvey 11/29/23

Christopher Holvey Date
Licensing Consultant

Approved By:

Mary Holton 11/30/23

Mary E. Holton Date
Area Manager