GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 11, 2023

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

RE: License #: AS250263541
Investigation #: 2024A0779007
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 #:	2024A0779007
Complaint Receipt Date:	11/03/2023
Investigation Initiation Date:	11/06/2023
Report Due Date:	01/02/2024
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 is to get the medication Alendronate weekly, on Saturdays. Resident A was given this medication two days in a row on 10/28 and 10/29/23.	No
Additional Findings	Yes

III. METHODOLOGY

11/03/2023	Special Investigation Intake 2024A0779007
11/06/2023	Special Investigation Initiated - Telephone Spoke to recipient rights investigator, Matt Potts.
11/06/2023	APS Referral Complaint was referred to APS.
11/08/2023	Inspection Completed On-site
11/18/2023	Contact - Telephone call made Interview conducted with staff person, Ojanae Hairston.
11/29/2023	Contact - Telephone call made Spoke to administrator, Jennifer Soto.
11/29/2023	Contact - Telephone call made Interview conducted with staff person, La' nija Broach.
12/07/2023	Exit Conference Held with administrator, Jennifer Soto.

ALLEGATION:

Resident A is to get the medication Alendronate weekly, on Saturdays. Resident A was given this medication two days in a row on 10/28 and 10/29/23.

INVESTIGATION:

On 11/6/23, a phone conversation took place with recipient rights officer, Matt Potts, who confirmed that he is investigating the same allegations. Matt Potts stated that he had already spoken to staff person Ojanae Hairston who admitted that she simply made a mistake and grabbed the wrong medication. He stated that staff Hairston claims that she did not pass the medication to Resident A and put the pill back into the bubble pack.

On 11/8/23, an on-site inspection was conducted. Resident A was viewed to be clean, well-groomed, and appeared to be doing fine. Due to Resident A's cognitive deficiencies, he was not able to be interviewed.

On 11/8/23, staff person, Breonna Slaughter, stated that she passed Resident A's Alendronate medication on 10/28/23 and that when she worked again on 10/30/23, she noticed the mistake. Staff Slaughter stated that she noticed that another pill of Alendronate had been punched out from Resident A's bubble pack and that Staff Hairston had signed the medication administration record (MAR) indicating that she had passed the med on 10/29/23. She stated that the pill was missing from the bubble pack and has not been found.

Resident A's MAR and the bubble pack for Alendronate has been reviewed. It was confirmed that the pill is missing and that the MAR has Staff Hairston's initials on it for 10/29/23. The initials on the MAR give the appearance that Staff Hairston had passed the Alendronate medication on 10/29/23.

On 11/8/23, a phone interview was conducted with staff person, Ojanae Hairston. She stated that it was her first time passing meds on 1st shift and that she was not familiar with that particular medication. Staff Hairston stated that she popped the pill from Resident A's Alendronate bubble pack and initialed the MAR, but then realized she had made a mistake. Staff Hairston claimed that she did not pass the medication and tried to put the pill back into the bubble pack. She stated that she did not notice that the pill got lost and that she should have put tape on the bubble pack to ensure the pill would stay. Staff Hairston denied that she gave Resident A the Alendronate medication on 10/29/23.

On 11/29/23, a phone conversation took place with administrator, Jennifer Soto, who confirmed that the alleged missing pill of Alendronate was never found. She stated that the second staff that worked with Staff Hairston on 10/29/23 was La 'nija Broach, but that she is no longer employed at this home. Administrator Soto reported that Staff Broach was the med checker/counter for that shift and should have gone behind Staff

Hairston and checked all medications. Administrator Soto stated that Staff Broach had confirmed Staff Hairston's version of events related to the Alendronate medication.

On 11/29/23, a phone interview was conducted with staff person, La'nija Broach. She confirmed that she worked with Staff Hairston on 10/29/23. Staff Broach claims that she did not go behind Staff Hairston and check/count meds that day and that she did not know that she was supposed to. Staff Broach stated that she does not know if Staff Hairston passed the Alendronate medication to Resident A or not. She stated that she does remember Resident A acting differently or anything other than normal that shift.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Staff person, Ojanae Hairston, admits that she punched a pill from Resident A's bubble pack of Alendronate on 10/29/23, but she denies that she gave the pill to Resident A. The staff that worked with Staff Hairston that shift, La'nija Broach, stated that she does not know if Staff Hairston passed the Alendronate medication to Resident A or not. Staff Broach stated that she does remember Resident A acting differently that shift. Due to Resident A's cognitive deficiencies, he could not be interviewed and can't say whether he was given the medication. There was no known witness to the medication passing. There was insufficient evidence found to prove that Resident A was given a second dose of the Alendronate medication on 10/29/23.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/8/23, Staff Hairston admitted that initialed Resident A's MAR, indicating that she had passed Resident A's Alendronate medication on 10/29/23, when she did not actually pass the medication. She admitted that she did not go back and correct the MAR, indicating that the medication was not passed.

On 11/29/23, Administrator Soto stated that Staff Hairston should have circled her initials on the MAR and wrote on the back of the MAR that the med was not passed.

Administrator Soto stated that all medication passers have learned that during their medication training.

Resident A's MAR has been reviewed. It was confirmed that Staff Hairston's initials are on the Alendronate section of the MAR for 10/29/23. The initials on the MAR give the appearance that Staff Hairston had passed the Alendronate medication on 10/29/23.

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:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	The initials on the MAR for Resident A gives the appearance that Staff Hairston had passed the Alendronate medication on 10/29/23. Staff Hairston stated that she did not pass the medication to Resident A on 10/29/23 and did not go back and correct the MAR. There was sufficient evidence found to warrant the violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/7/23, an exit conference was held with administrator, Jennifer Soto. Jennifer Soto was informed of the outcome of this investigation and that a corrective action plan is required.

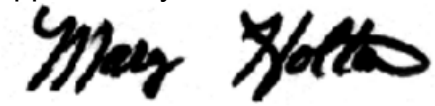
IV. RECOMMENDATION

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

12/11/2023

Christopher Holvey — Date
Licensing Consultant

Approved By:



12/11/2023

Mary E. Holton — Date
Area Manager