GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 14, 2024

DeElla Johnson
Andrews & Johnson Inc
P.O. Box 457
Genesee, MI 48437

RE: License #: AS250345774
Investigation #: 2025A0576003
Andrews & Johnson #4

Dear DeElla Johnson:

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.
- 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 (517) 643-7960.

Sincerely,

Christina Garza, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 240-2478

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250345774
Investigation #:	2025A0576003
Complaint Receipt Date:	10/17/2024
Investigation Initiation Date:	10/18/2024
Report Due Date:	12/16/2024
Licensee Name:	Andrews & Johnson Inc
Licensee Address:	P.O. Box 457, Genesee, MI 48437
Licensee Telephone #:	(810) 938-8177
Administrator:	DeElla Johnson
Licensee Designee:	DeElla Johnson
Name of Facility:	Andrews & Johnson #4
Facility Address:	7404 N Bray Road, Mt Morris, MI 48458
Facility Telephone #:	(810) 686-2198
Original Issuance Date:	08/29/2013
License **Status:**	REGULAR
Effective Date:	02/25/2024
Expiration Date:	02/24/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A has a physician order for a ground diet. On 10/11/2024, Staff, Ceal Caves gave Resident A a full slice of pizza.	Yes

III. METHODOLOGY

10/17/2024	Special Investigation Intake 2025A0576003
10/17/2024	APS Referral
10/18/2024	Special Investigation Initiated - Letter Sent email to Michelle Salem, Office of Recipient Rights (ORR)
10/18/2024	Contact - Document Received Received email from Michelle Salem
10/29/2024	Inspection Completed On-site Interviewed Home Manager, Michelle Paige, Resident A, and Staff, Emily Morey
11/04/2024	Contact - Telephone call made Left messages for Staff, Ceal Caves and Melissa Shute to return my call
11/12/2024	Contact - Telephone call made Left messages for Staff, Ceal Caves and Melissa Shute to return my call
11/12/2024	Contact - Telephone call made Interviewed Staff, Melissa Shute
11/12/2024	Contact - Telephone call made Interviewed Licensee Designee, DeElla Johnson
11/12/2024	Exit Conference
11/14/2024	Contact - Telephone call received Interviewed Staff, Ceal Caves

ALLEGATION:

Resident A has a physician order for a ground diet. On 10/11/2024, Staff, Ceal Caves gave Resident A a full slice of pizza.

INVESTIGATION:

On October 18, 2024, I sent an email to Michelle Salem, Recipient Rights Officer (ORR) from Genesee County Community Mental Health regarding any updates she can provide regarding this investigation. Officer Salem reported Resident A was not harmed when she was provided with pizza that was not grounded. Resident A's nurse indicated that giving Resident A the piece of pizza (contrary to her physician order requiring a ground diet) placed her at risk of physical harm, i.e., choking and aspiration. The staff member that gave her the pizza acknowledged she knew the order and made the error.

On October 29, 2024, I conducted an unannounced on-site inspection at Andrews & Johnson #4 and interviewed the Home Manager, Michelle Paige. Manager Paige confirmed that the allegations are true. Manager Paige stated that Staff Melissa Shute and Emily Morey called her to report that Resident A was provided a slice of pizza and by the time the staff realized it only the crust was left. Manager Paige reported that Resident A has a doctor order that she is to have a ground diet due to failing a swallow evaluation. Staff, Ceal Caves is the staff member who provided Resident A the slice of pizza. The staff and clients were at a dance at CMH, and they had pizza for the clients. Staff Caves inadvertently gave Resident A the slice of pizza.

On October 29, 2024, I interviewed Staff, Emily Morey regarding the allegations. Staff Morey reported she has worked at the home since February 2024. Staff Morey explained that last month staff and residents were at a dance at GHS. While at the dance, Staff Morey was supervising another resident and when she came back to the table she saw Resident A with a pizza crust. Staff Morey told Staff Melissa Shute that Resident A had eaten the pizza. Resident A was okay, and they continued to monitor her. The residents and staff left the dance shortly after. Staff Melissa Shute told Staff Morey that Staff, Ceal Caves was the staff person who gave Resident A the slice of pizza. Staff Morey asked Staff Caves, and she confirmed she gave Resident A the piece of pizza.

On October 29, 2024, I interviewed Resident A who reported she has lived at her home for a long time. Resident A likes her home, and staff are nice to her. Resident A reported her food goes in the blender, and she eats and drinks with a spoon. Resident A confirmed she had a piece of pizza and stated no one chopped it up. Staff forgot to chop up the pizza. Resident A was okay after eating the pizza. Resident A denied any concerns with her home.

On October 29, 2024, I reviewed an order for Resident A. The order is dated for March 12, 2024, and authored by Adult Gerontology Acute Care Nurse Practioner, Angela M

Hanna. The order indicates Resident A is to have a ground diet and honey thick liquids. Resident A is to have liquids via teaspoon only and no cups or straws.

On November 4, 2024, and November 12, 2024, I left messages for Staff, Melissa Shute to return my call. On November 12, 2024, Staff Shute returned my call and the allegations were discussed. Staff Shute reported that Staff Ceal Caves gave Resident A a piece of pizza and by the time anyone noticed, Resident A had eaten all the pizza except the crust. Resident A was okay after eating the pizza. Staff Shute reported that Resident A is ordered a ground diet, and all the staff are aware of this requirement.

On November 4, 2024, and November 12, 2024, I left messages for Staff Ceal Caves to return my call. On November 14, 2024, Staff Caves returned my call, and she was interviewed regarding the allegations. Staff Caves reported that they were at a party, and she passed Resident A a piece of pizza. Staff Caves stated that it slipped her mind that Resident A is to follow a ground diet. Staff Caves explained that “there was a lot going on” and she knows that Resident A is to always have her food grounded. Staff Caves reported the incident was an accident. Staff Caves stated she apologized to Resident A for giving her the pizza and Resident A said it was okay and the pizza was good.

On November 12, 2024, I interviewed Licensee Designee, DeElla Johnson regarding the allegations. Licensee Designee Johnson confirmed the allegations are true and explained that staff and residents went to a GHS dance. All the residents were sitting together, and pizza and drinks were being given to the residents. Staff, Ceal Caves provided Resident A a slice of pizza. By the time another staff noticed Resident A was given a slice of pizza only the crust was left. Licensee Designee Johnson thinks Staff Caves forgot that Resident A is to have her food grounded per doctor order. Staff Caves may have been distracted by everything going on at the party. Licensee Designee Johnson reported that Staff Caves has worked at the home for over one year and is a good staff person.

On November 12, 2024, I conducted an exit conference with Licensee Designee, DeElla Johnson. I advised I would be requesting a corrective action plan for the cited rule violation. Licensee Designee Johnson reported that Staff Ceal Caves was provided retraining for resident food preparation. Licensee Designee Johnson also reviewed Resident A’s individual plan of service (IPOS) with all staff during a meeting.

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: **(b) Special diets.**

ANALYSIS:	It was alleged that Resident A is ordered to receive a ground diet, and she was provided a piece of pizza by staff that was not grounded. Upon conclusion of investigative interviews and a review of documentation, there is a preponderance of evidence to conclude a rule violation. Resident A has an order from Nurse Practioner Angela M Hanna that requires her diet to be grounded. In October 2024, Resident A was provided a slice of pizza that was not grounded by Staff Ceal Caves. Resident A, Staff Caves and 2 other staff confirmed Resident A was provided a slice of pizza that was not grounded at a party. There is a preponderance of evidence to conclude that staff did not follow the instructions of a health care professional with respect to Resident A's diet.
CONCLUSION:	**VIOLATION ESTABLISHED**

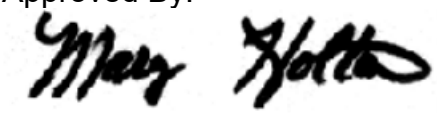
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in the license status is recommended.

11/14/2024

Christina Garza Date
Licensing Consultant

Approved By:



11/14/2024

Mary E. Holton Date
Area Manager