GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 3, 2025

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

RE: License #:	AS250263541
Investigation #:	2025A1039014
	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,

Martin Gonzales, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250263541
Investigation #:	2025A1039014
Complaint Receipt Date:	03/05/2025
Investigation Initiation Date:	03/05/2025
Report Due Date:	05/04/2025
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:	12/21/2024
Expiration Date:	12/20/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A is blind and non-verbal and was found outside the facility barefoot by a UPS delivery man.	Yes

III. METHODOLOGY

03/05/2025	Special Investigation Intake 2025A1039014
03/05/2025	Special Investigation Initiated - Letter Emailed referral source regarding the allegations.
03/05/2025	APS Referral Case was assigned to APS worker Rickie Miles for investigation.
03/06/2025	Contact - Document Received Received email from GHS ORR Shepard concerning APS worker investigating the case.
03/11/2025	Inspection Completed On-site Interviewed the Administrator, Home Manager and Resident A.
03/24/2025	Contact - Document Sent Sent email to APS worker Rickie Miles.
03/24/2025	Contact - Document Sent Sent email to ORR Patricia Shepard.
03/25/2025	Contact - Document Received APS worker Rickie Miles informed me that she substantiated her investigation.
03/28/2025	Contact - Telephone call made Completed phone interview with Direct Care Worker Marteva Mahan.
04/03/2025	Exit Conference Completed with Licensee Designee.
04/03/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A is blind and non-verbal and was found outside the facility barefoot by a UPS delivery man.

INVESTIGATION:

On 03/05/2025, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that on 02/24/2025, Resident A is blind and non-verbal and was found outside the facility barefoot by a UPS delivery man.

On 03/06/2025, I received an email from Genesee Health Systems Office of Recipient Rights (ORR) worker Patricia Shepard. ORR Shepard confirmed that she was aware of the allegations and that she had the same information and did not have any additional information to add. ORR Shephard stated that she was unaware of who the Adult Protective Services Worker was on the investigation.

On 03/11/2025, I completed an unannounced onsite investigation at the Embury Home. I interviewed the following people: Administrator Jennifer Soto, Home Manager Aisha Lyons and Resident A.

On 03/11/2025, I interviewed Administrator Jennifer Soto at a table in the living room. Administrator Soto stated that she was aware of the allegations and that the incident did occur. Administrator Soto stated that she was not present at the time of the incident but that she received a call from staff informing her that Resident A was found outside of the home unsupervised by a UPS worker who was dropping off deliveries to the home. Administrator Soto stated that adult protective services showed up to the home and did an investigation also because of the incident that occurred. Administrator Soto stated that she contacted the Home Manager Aisha Lyons about the situation to obtain the details and contacted the Office of Recipient Rights to inform them of the situation that occurred. Administrator Soto stated that they currently have five residents and that they are all nonverbal. Administrator Soto stated that from what she is aware, that the staff on duty had line of site on Resident A while she was cooking food in the kitchen and then Resident A must have wondered off and went out the front door and sat down in the driveway where he was found by the UPS driver. Administrator Soto stated that Resident A was not harmed, and he was outside for approximately five minutes. Administrator Soto stated that the home is working on getting alarms for the doors. Administrator Soto stated that the Home Manager counseled the staff that was on duty about the line of sight and safety of the residents.

On 03/11/2025, I interviewed Home Manager (HM) Aisha Lyons at a table in the living room. HM Lyons stated that she was aware of the allegations but was not present at the time the incident occurred. HM Lyons stated that the incident did occur and that it was reported to the Office of Recipient Rights. HM Lyons stated that her understanding of the incident was that a staff member was in the kitchen making the residents food.

Resident A was in the kitchen with the staff member and while the staff was cooking. Resident A left the kitchen and went outside before the staff member noticed and a UPS driver came to the door and alerted the staff that Resident A was outside in the driveway. HM Lyons stated that neither the home nor the staff have had a resident leave the facility in the past. HM Lyons stated that the Administrator and the Licensee Designee were informed, and they spoke with staff about the level of care that residents need to receive and possible ways to make the home safer as the residents are non-verbal or limited verbally. HM Lyons stated that Resident A was not harmed and that the home is looking at putting alarms on the doors to alert them if they are opened.

HM Lyons provided me with Resident A's Health Care Appraisal, Genesee Health System face sheet and the Assessment Plan. The assessment plan notes that Resident A is non-verbal, blind, can understand simple direction and needs assistance with walking/mobility.

On 03/11/2025, I had a face-to-face meeting with Resident A in the living room. Staff led Resident A into the room. Resident A appeared neat and clean but is unable to speak and is blind. Resident A is diagnosed with the following: Intellectual disability and unspecified communication disorder. I attempted to engage in simple conversation with Resident A, but he was unable to respond back verbally but was able to smile.

On 03/24/2025, I received an email from Genesee Health Systems Office of Recipient Rights (ORR) worker Patrica Shepard. ORR Shepard informed me that she would be substantiating on her investigation concerning Resident A and Embury Home.

On 03/24/2025, I receive an email from Department of Health and Human Services Adult Protective Services (APS) Worker Rickie Miles. APS Miles informed me that he would be substantiating on his investigation concerning Resident A and Embury Home.

On 03/28/2025, I completed a phone interview with Direct Care Worker (DCW) Marteva Mahan. DCW Mahan stated that she is aware of the allegations and that she was the staff that was working the day the incident occurred. DCW Mahan stated that this has never happened before and that Resident A has never attempted to leave the home before. DCW Mahan stated that she was making food in the kitchen and that Resident A was sitting on the floor in the kitchen while she was making food and that it could have not been more than a couple minutes and she heard someone at the door. DCW Mahan answered the door and it was a UPS driver stating that a resident was in the driveway alone. DCW Mahan stated that she is unsure how Resident A got outside without her seeing but that she contacted the House Manager and informed her of the situation. DCW Mahan stated that there have been no further incidents since that occurred.

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:	It was alleged that Resident A is blind and non-verbal and was found outside the facility barefoot by a UPS delivery man. I interviewed the DHHS Adult Protective Services Worker, GHS Office of Recipient Rights Worker, Administrator, House Manager, Direct Care Worker and had a face-to-face meeting with Resident A. I reviewed Resident A's health appraisal, GHS face sheet and assessment plan. Upon completion of my investigation it was determine that there was a preponderance of evidence to conclude that R 400.14305 was violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 04/03/2025, I completed an exit conference with Licensee Designee Bethany Mays. I informed LD Mays of the results of my investigation and that a corrective action plan would be needed for the rule violation.

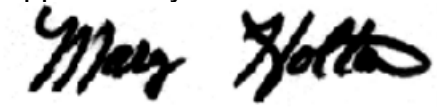
IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend the status of the license remain the same.

04/03/2025

Martin Gonzales Licensing Consultant	Date

Approved By:



04/03/2025

Mary E Holton Area Manager	Date