GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2019

Kathy Patterson
New Hope Group Home, LLC
3671 Senora Ave. SE
Grand Rapids, MI 49508

RE: License #: AS410381260
Investigation #: 2019A0464059
New Hope Group Home LLC 60

Dear Ms. Patterson:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 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 (616) 356-0183.

Sincerely,

Megan Aukerman, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 438-3036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410381260
Investigation #:	2019A0464059
Complaint Receipt Date:	09/04/2019
Investigation Initiation Date:	09/04/2019
Report Due Date:	11/03/2019
Licensee Name:	New Hope Group Home, LLC
Licensee Address:	3671 Senora Ave. SE Grand Rapids, MI 49508
Licensee Telephone #:	(419) 439-1218
Administrator:	Kathy Patterson
Licensee Designee:	Kathy Patterson
Name of Facility:	New Hope Group Home LLC 60
Facility Address:	3660 Senora Ave. SE Grand Rapids, MI 49508
Facility Telephone #:	(419) 439-1218
Original Issuance Date:	05/27/2016
License Status:	REGULAR
Effective Date:	11/27/2018
Expiration Date:	11/26/2020
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has a history of swallowing objects. On 08/24/2019, Resident A swallowed thumb tacks. There is concerns regarding the supervision of Resident A by facility staff.	No
On 08/24/2019, Resident A swallowed thumb tacks and facility staff did not seek medical treatment until 08/28/2019.	No
Additional Findings	Yes

III. METHODOLOGY

09/04/2019	Special Investigation Intake 2019A0464059
09/04/2019	Special Investigation Initiated - Telephone Jennifer Morgan, ORR
09/05/2019	APS Referral DHHS, Centralized Intake
09/17/2019	Inspection Completed-Onsite Jennifer Morgan (ORR), Nathanael Bieszka (Administrator), Resident A and Abby Crossen (Staff)
09/17/2019	Contact-Document received Resident A's Medical Records
10/25/2019	Exit Conference Kathy Patterson, Licensee Designee

ALLEGATION: Resident A has a history of swallowing object. On 08/24/2019, Resident A swallowed thumb tacks. There is concerns regarding the supervision of Resident A by facility staff.

INVESTIGATION: On 09/04/2019, I received a complaint from Ionia County Office of Recipient Rights (ORR). The complaint alleged Resident A has a history of swallowing objects. On 08/24/2019, Resident A told staff she swallowed thumb tacks. Facility staff did not seek medical attention for Resident A until 08/28/2019. There is concern Resident A is not being appropriately supervised.

On 09/04/2019, I spoke with Ionia County ORR worker, Jennifer Morgan, to coordinate the investigation.

On 09/05/2019, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral per policy.

On 09/17/2019, Ms. Morgan and I completed an onsite inspection at the facility. We interviewed facility administrator, Nathanael Bieszka. Mr. Bieszka stated he was previously informed Resident A has a history of attention seeking behaviors and will make threats of self-harm. However, Resident A has not swallowed objects since moving into the facility. Mr. Bieszka stated on 08/24/2019, Resident A informed staff she swallowed thumb tacks, however there was no evidence suggesting she actually had. Mr. Bieszka stated Resident A was taken to the doctor on 08/28/2019 and there were no concerns. Mr. Bieszka stated Resident A is case managed through the Right Door for Hope, Recovery and Wellness. Mr. Bieszka stated Resident A does not have a behavior plan, however Resident A's case manager is working on completing one.

Ms. Morgan and I then interviewed staff person, Abby Crossen. Ms. Crossen stated she was the staff person scheduled on 08/24/2019. Ms. Crossen stated between 6:00 AM and 6:30 AM Resident A came to her and told her "I have to tell you something bad, I swallowed thumb tacks". Ms. Crossen asked Resident A to show her where they were, Resident A then pointed to the cork board in the living room. Ms. Crossen did not see any thumb tacks. Ms. Crossen stated it was not possible for Resident A to swallow thumb tacks from there, because Ms. Crossen had removed all of them prior to Resident A taking them. Ms. Crossen stated she asked Resident A how she was feeling. Resident A stated she felt fine. Ms. Crossen stated she called Mr. Bieszka who advised Ms. Crossen to keep an eye on Resident A. Ms. Crossen stated she then completed an incident report. Ms. Crossen stated a few days later, she was advised by Resident A's case manager to take Resident A to the hospital. Ms. Crossen took Resident A to the hospital on 08/28/2019. There was no evidence suggesting Resident A had swallowed thumb tacks. Ms. Crossen stated she was told that Resident A has attention seeking behavior, a history of swallowing objects and a history of making self- harming statements, however Ms. Crossen denied Resident A has ever demonstrated any of these behaviors while living at the facility.

Ms. Morgan and I then interviewed Resident A privately. Resident A stated she recently went to the hospital and had x-rays and the doctors told her she was fine. When asked why, Resident A stated she swallowed thumb tacks. Resident A stated she does not know why she swallowed them, but staff told her she could not do things like that because she could get seriously ill. Resident A stated she felt fine after swallowing the tacks. Resident A denied she has done anything like this before while living at the facility.

On 10/25/2019, I completed an exit conference with licensee designee, Kathy Patterson. She was informed of the investigation findings and recommendations.

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:	Facility administrator, Nathanael Bieszka and staff, Abby Crossen stated Resident A reported she swallowed thumb tacks on 08/24/2019. Both denied Resident A had done anything like this before moving into the facility. Ms. Crossen stated Resident A did not display any physical ramifications from swallowing the thumb tacks. Both stated Resident A was taken to the hospital and there was no physical evidence to suggest Resident A swallowed the thumb tacks. Mr. Bieszka stated Resident A is case managed through the Right Door for Hope, Recover and Wellness. Resident A does not have a behavior plan in place at this time. Resident A was interviewed privately and stated she did in fact swallow thumb tacks on 08/24/2019. Resident A denied she has done anything like this before, since moving into the facility. Resident A stated she was taken to the doctor and they told her she was fine. Based on the investigative findings, there is insufficient evidence to support a rule violation that staff failed to protect Resident A from harm.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: On 08/24/2019, Resident A swallowed thumb tacks and facility staff did not seek medical treatment until 08/28/2019.

INVESTIGATION: On 09/17/2019, Ms. Morgan and I completed an onsite inspection at the facility. We interviewed Mr. Bieszka and Ms. Crossen. Both denied witnessing Resident A physically swallow the thumb tacks. Ms. Crossen stated on 08/24/2019, Resident A told her she swallowed thumb tacks. Ms. Crossen stated she completed a physical assessment with Resident A, and Resident A stated she felt fine. Ms. Crossen then contacted Mr. Bieszka to inform him of the incident. Ms. Crossen was instructed to keep an eye on Resident A for any symptoms. If Resident A had any symptoms, she was to be taken into the hospital. Ms. Crossen then completed and incident report. Ms. Crossen stated the incident report was sent to Resident A's case manager as well as licensing. Ms. Crossen was informed by Resident A's case manager that Resident A should be taken to the hospital. Ms. Crossen stated she

took Resident A to Spectrum Health Hospital on 08/28/2019. The doctor completed a blood test and took a CT scan. The tests did not reveal any evidence that Resident A had swallowed thumb tacks. Ms. Crossen stated while at the hospital, Resident A was making statements of wanting to hurt herself. The hospital staff felt the statements were not concerning enough for admission; therefore, Resident A was discharged. The hospital provided a safety plan for any suicidal thoughts.

Ms. Morgan and I then interviewed Resident A privately. Resident A confirmed she swallowed thumb tacks, but stated she felt fine. Resident A stated she also went to the hospital, where she had an x-ray and the doctor told her she was fine.

On 09/17/2019, I received and reviewed Resident A's medical records from Spectrum Health Hospital-Pennock Emergency Room. Resident A was brought into the ER on 08/28/2019. Resident A saw physician assistant, Erica Nyman. Ms. Nyman ran blood tests and order a CT scan of Resident A's Abdomen and Pelvis. The results were normal. While at the ER, Resident A made statements of self-harm. The hospital discharged Resident A with a safety plan.

On 10/25/2019, I completed an exit conference with licensee designee, Kathy Patterson. She was informed of the investigation findings and recommendations.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	On 08/24/2019, Resident A reported to staff she swallowed thumb tacks. Staff person, Abby Crossen complete an assessment of Resident A and Resident A told her she felt fine. Ms. Crossen reported the incident to facility administrator, Nathanael Bieszka who advised Ms. Crossen to keep an eye of Resident A. He also advised her to seek medical attention for Resident A if needed. Resident A was taken to the hospital on 08/28/2019. Medical records documented blood work and a CT scan were completed. The results were normal and there were no reported concerns. Based on the investigative findings, there is insufficient evidence to support a rule violation that facility staff did not appropriate seek medical treatment.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITONAL FINDING: Resident A did not have a written assessment plan on file at the facility.

INVESTIGATION: On 09/17/2019, Ms. Morgan and I completed an onsite inspection at the facility. We interviewed Mr. Bieszka and Ms. Crossen. I asked to see Resident A's assessment plan. Staff were unable to locate Resident A's assessment plan. I looked through Resident A's facility records and was unable to locate the assessment plan. Ms. Crossen stated she did not think the assessment plan was completed yet. Mr. Bieszka and Ms. Crossen were advised to have the assessment plan completed as soon as possible.

On 10/25/2019, I completed an exit conference with licensee designee, Kathy Patterson. She was informed of the investigation findings and recommendations. Ms. Patterson stated the facility had the renewal inspection and all paperwork has been completed.

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 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:	On 09/17/2019, an onsite inspection was completed at the facility. Facility staff, Abby Crossen and facility administrator, Nathanael Bieszka were unable to locate Resident A's assessment plan. Ms. Crossen stated she did not think the assessment plan had been completed. Based on the investigative findings, there is sufficient evidence to support a rule violation that a current assessment plan was not on file for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

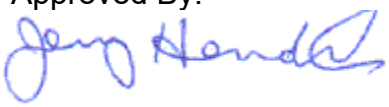
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the licensing status remain unchanged.

10/25/2019

Megan Aukerman Date
Licensing Consultant

Approved By:



10/25/2019

Jerry Hendrick Date
Area Manager