GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

Lauren Gowman
Linden Square Assisted Living
650 Woodland Drive East
Saline, MI 48176

September 1, 2023

RE: License #: AH810334704
Investigation #: 2023A1022002
Linden Square Assisted Living

Dear Lauren Gowman:

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 authorized representative and a date.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH810334704
Investigation #:	2023A1022002
Complaint Receipt Date:	10/10/2022
Investigation Initiation Date:	10/11/2022
Report Due Date:	12/09/2022
Licensee Name:	Linden Square Assisted Living, LLC
Licensee Address:	950 Taylor Avenue Grand Haven, MI 49417
Licensee Telephone #:	(616) 846-4700
Administrator:	Jessica Richardson
Authorized Representative:	Lauren Gowman
Name of Facility:	Linden Square Assisted Living
Facility Address:	650 Woodland Drive East Saline, MI 48176
Facility Telephone #:	(734) 429-7600
Original Issuance Date:	06/21/2013
License **Status:**	REGULAR
Effective Date:	01/10/2023
Expiration Date:	01/09/2024
Capacity:	187
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The resident of concern (ROC) choked because he was given food that he was unable to swallow. He did not respond to first aid measures and was declared “brain dead.”	Yes

III. METHODOLOGY

10/10/2022	Special Investigation Intake 2023A1022002
10/11/2022	Special Investigation Initiated - Telephone Complainant interviewed by phone.
11/10/2022	Inspection Completed On-site
09/01/2023	Exit Conference

ALLEGATION:

The resident of concern (ROC) choked because he was given food that he was unable to swallow. He did not respond to first aid measures and was declared "brain dead."

INVESTIGATION:

On 10/11/2022, the Bureau of Community and Health Systems received a referral from Adult Protective Services (APS). The APS investigation status was marked as "denied." According to the referral, "[Name of resident of concern (ROC)] (53) is an adult who was diagnosed with Huntington's disease. [Name of ROC] resides at an assisted living home. On 10/06/2022, [name of ROC] was given a cheeseburger and choked on the cheeseburger. The assisted living home is aware that [name of ROC] has an issue with swallowing food. The staff attempted to do the Heimlich maneuver and contacted 911. It is unknown how long [name of ROC] went without CPR or any attempt to address [name of ROC] choking on the cheeseburger. It is believed that [name of ROC] was neglected due to the assisted living home being aware that [name of ROC] was at risk of choking when he ate food. [Name of ROC] is currently at the hospital and is brain dead due to lack of oxygen."

On 10/10/2022, the facility submitted an incident report (IR) that essentially described the same event, but the IR included in its description the facility's attempts at cardiopulmonary resuscitation (CPR) for the ROC. According to the IR, "On 10/06/2022, General East resident, [name of the ROC] was sent to University of Michigan Hospital due to choking and going unresponsive… [Name of the ROC] was walking through the life enrichment room towards the dining room at approximately 12:00 pm. Quality Assurance Coordinator, [name of Quality Assurance Coordinator] who was sitting in the east life enrichment room, observed him coughing as he was walking into the dining room. As resident [name of the ROC] entered the dining room, another resident [name of resident] began yelling: "Get that guy!" Med tech [name of Med tech] heard resident [name of resident] and approached him to see what was going on. At that time, resident, [name of the ROC] was observed by Med Tech, [name of Med Tech] spitting out food and then resident [name of the ROC] walked up to Med Tech [name of Med Tech] and grabbed her shoulders. Med Tech, [name of Med Tech] saw resident [name of the ROC]'s lips were blue and he appeared to be choking. At this time, approximately 12:04pm, Quality Assurance Coordinator [name of the Quality Assurance Coordinator], asked Med Tech, [name of Med Tech] if resident [name of the ROC] was okay. Simultaneously, Med Tech [name of Med Tech] turned resident [name of the ROC] around and began the Heimlich maneuver. Resident [name of the ROC] fell to his knees, so Med Tech, [name of Med Tech] and Quality Assurance Coordinator [name of the Quality Assurance Coordinator] laid resident [name of the ROC] on the dining room floor. RSA [name of caregiver] had come to assist and attempted to sweep the resident [name of the ROC]'s mouth unsuccessfully. Resident [name of the ROC]'s lips were still blue and he no longer was breathing. Quality Assurance Coordinator [name of

the Quality Assurance Coordinator] began chest compressions in an attempt to dislodge the food and Med Tech [name of Med Tech] called for help over the walkie-talkie to east dining room as well as for someone to call 911. Administrator, [name of administrator] called 911 at approximately 12:06pm. Med Tech, [name of Med Tech #2] ran to the east dining room upon hearing the call for help and to call 911. Upon entering the east dining room, Med Tech [name of Med Tech #2] observed the resident [name of the ROC] unresponsive with blue lips. Med Tech [name of Med Tech #2] yelled: "We have to do the Heimlich!" someone else yelled: "[Name of Med Tech #2] do it!" Quality Assurance Coordinator [name of Quality Assurance Coordinator] okayed it due to Med Tech's size and strength, hoping he could dislodge the food. Med Tech, [name of Med Tech #2] lifted resident [name of the ROC] and attempted the Heimlich maneuver with 5 abdominal thrusts without success so Quality Assurance Coordinator [name of the Quality Assurance Coordinator] instructed Med Tech [name of Med Tech #2] to lay resident back down. Resident [name of the ROC] was then laid back on the floor and chest compressions were started by Quality Assurance Coordinator [name of the Quality Assurance Coordinator]. Shift Supervisor [name of the shift supervisor] called for RSC [name of caregiver #2] via that walkie-talkie. Upon arrival to the east dining room, RSC [name of caregiver #2] observed resident [name of the ROC] on the dining room floor with Quality Assurance Coordinator [name of the Quality Assurance Coordinator] performing chest compressions. RSC [name of caregiver #2] ran to obtain a mouth barrier and returned to resident [name of the ROC]. Clinical Coordinator [name of the Clinical Coordinator] was assisting Quality Assurance Coordinator [name of the Quality Assurance Coordinator] and attempted two breaths upon [name of the Quality Assurance Coordinator]'s instructions. The two breaths were unsuccessful and Quality Assurance Coordinator [name of the Quality Assurance Coordinator] continued with chest compressions. Huron Valley EMTs arrived to facility at approximately 12:15pm and took over CPR. Huron Valley EMTs left with resident, [name of the ROC] at approximately 12:30pm. Shift Supervisor, [name of the shift supervisor] notified POA/son via phone at approximately 12:20pm… Upon further investigation by Administrator [name of administrator], it was found that resident [name of the ROC] was served a whole hamburger for lunch."

On 10/11/2022, I interviewed the complainant by phone. The complainant stated that his father, the ROC had been at the facility only a short time, maybe since the late summer of 2022. The complainant stated that he had been present when the ROC was assessed for care. The complainant went on to say that both he and other family members who were in attendance for the assessment emphasized the need for the ROC to receive a modified textured diet due to his inability to swallow. According to the complainant, the ROC had a swallowing evaluation prior to his move-in to the facility which indicated he needed his food pureed with a food thickening agent added in order for him to eat it safely. The complainant went on to say that the ROC's judgement was impaired, especially when it came to which foods he was safely able to eat.

On 11/10/2022, at the time of the onsite visit, I interviewed the administrator, the wellness director, the culinary supervisor (current) and the corporate regional quality assurance (QA) coordinator, who had been in the facility on the day that the ROC was served the inappropriate food, choked, and was sent to the hospital. According to the administrator and the QA coordinator, on that day, the ROC was in the general assisted living dining area as residents were coming in for the noon meal. The ROC was impatient to be served and started to yell, asking for food. The ROC's impatient behavior was irritating to the other residents waiting for their food. The administrator went on to say that Med Tech #2 decided to intervene to prevent this situation from escalating and went into the kitchen to ask for the ROC's meal. According to the culinary supervisor, the food service procedure for the general assisted living dining room was for the culinary supervisor to be informed by a caregiver which resident was ready for their meal and the culinary supervisor would put the resident's food on the plate. The administrator then went on to say that the culinary supervisor (former) was out of the kitchen when Med Tech #2 requested the ROC's meal, and then acknowledged that only the culinary supervisor was aware of the ROC's diet and food texture modification requirements. The culinary employee in the kitchen complied with Med Tech #2's request for food for the ROC but gave Med Tech #2 a hamburger on a bun rather than a "minced and moist" modified texture hamburger and bun as specified on the ROC's service plan.

When the administrator was asked to explain why the culinary employee was not aware of the ROC's modified texture diet that was part of his service plan, the administrator explained that the culinary supervisor was responsible to inform the culinary employees of special diet orders by listing the resident's name and special diet order on a "white (dry erase) board" kept in the kitchen. According to a follow-up IR dated 10/30/2022, the "diet boards in the kitchen had not been updated since early September with the residents' special diets. Head chef, [name of former culinary supervisor] had received a written disciplinary counseling regarding his work performance on 9/7/2022 and was spoken to specifically about updating the diet boards on September 29th." The administrator went on to say that the former culinary supervisor was terminated from employment following this incident.

Review of the ROC's service plan indicated that he required little assistance from care staff to complete activities of daily living, other than reminders to use the toilet. He was at high risk for falling as he had an unsteady gait and had a diet order for a minced and moist diet, with all meat to be cut up.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following:

	(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.
ANALYSIS:	The facility had previously identified that the diet order board was not being kept up to date but this deficiency was not immediately corrected. The ROC was served food that did not conformed to his diet order as specified on his service plan. He was served food he could not swallow.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR), the facility administrator and the resident services coordinator on 09/01/2023. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the status of the license.

09/01/2023

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

08/31/2023

_____

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section