GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 28, 2023

Nathanael Bieszka
9844 Snow Ridge Ave. SE
Grand Rapids, MI 49508

RE: License #: AS410344357
Investigation #: 2023A0583040
New Hope Group Home

Dear Nathanael Bieszka:

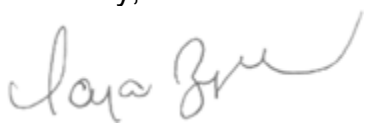
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410344357
Investigation #:	2023A0583040
Complaint Receipt Date:	08/21/2023
Investigation Initiation Date:	08/21/2023
Report Due Date:	09/20/2023
Licensee Name:	Nathanael Bieszka
Licensee Address:	9844 Snow Ridge Ave. SE Grand Rapids, MI 49508
Licensee Telephone #:	(419) 439-1218
Administrator:	Kathy Patterson
Name of Facility:	New Hope Group Home
Facility Address:	3671 Senora Ave. SE Grand Rapids, MI 49508
Facility Telephone #:	(419) 439-1218
Original Issuance Date:	06/02/2014
License **Status:**	REGULAR
Effective Date:	12/01/2022
Expiration Date:	11/30/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED, AGED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Facility staff failed to provide adequate care and supervision.	Yes

III. METHODOLOGY

08/21/2023	Special Investigation Intake 2023A0583040
08/21/2023	Special Investigation Initiated - On Site
08/22/2023	Contact – Email Administrator Kathy Patterson
08/22/2023	APS Referral
08/22/2023	Contact – Email Jennifer Morgan, The Right Door
08/22/2023	Contact – Telephone Staff Tamila Pratt
08/22/2023	Contact – Telephone Staff Martellus Ballard
08/22/2023	Contact – Telephone Staff Becky Bout
08/22/2023	Contact – Telephone Administrator Kathy Patterson
08/22/2023	Contact – Telephone Public Guardian Angie Starkey
08/28/2023	Exit Conference Licensee Nathanael Bieszka

ALLEGATION: Facility staff failed to provide adequate care and supervision.

INVESTIGATION: On 08/22/2023 I received an Incident Report via facsimile. I observed that the incident report, signed 08/17/2023, stated that on 08/17/2023 Resident A choked to death. The Incident Reported further stated that Resident A had eaten lunch and proceeded to choke on his food. The Incident Report stated

staff Tamila Pratt performed the Heimlich Maneuver and CPR until emergency medical staff arrived at the facility and took over life saving measures. The Incident Report stated Resident A was pronounced dead at 1:20 PM on 08/17/2023 at the facility.

On 08/21/2023 I completed an unannounced onsite investigation at the facility and interviewed administrator Kathy Patterson, Resident B, and Resident C.

Administrator Kathy Patterson stated that at approximately 12:30 PM on 08/17/2023 she was enroute to the facility and telephoned staff Tamila Pratt. Ms. Patterson stated Ms. Pratt answered the telephone call and immediately stated that Resident A appeared to be choking. Ms. Patterson stated she directed Ms. Pratt to put the telephone on speaker phone and perform the Heimlich Maneuver. Ms. Patterson stated she then instructed Ms. Pratt to perform Cardiopulmonary Resuscitation and instructed Resident B to use the facility's landline telephone and call "911". Ms. Patterson stated she arrived at the facility within minutes and observed Ms. Pratt performing Cardiopulmonary Resuscitation on Resident A in the bathroom. Ms. Patterson stated she immediately took over Cardiopulmonary Resuscitation efforts until emergency medical personnel arrived and took over life saving measures. Ms. Patterson stated emergency medical personnel worked on Resident A for approximately twenty-five minutes before pronouncing him deceased at 1:20 PM.

Resident B stated that on 08/17/2023 residents were served lunch by staff Tamila Pratt which consisted of "hot dogs". Resident B stated he observed Resident A walk away from the dining table to the bathroom while "choking". Resident B stated he informed Ms. Pratt that Resident A was choking, and Ms. Pratt performed the Heimlich Maneuver and CPR on Resident A while Ms. Patterson was on speaker phone. Resident B stated Ms. Patterson instructed him to call 911 on the facility's landline telephone and Resident B did so. Resident B stated Ms. Patterson arrived at the facility before emergency medical personnel and continued doing CPR on Resident A. Resident B stated emergency medical personnel arrived at the facility and transported Resident A to the hospital. Resident B stated Ms. Pratt and Ms. Patterson were calm throughout the incident. Resident B stated that he has never observed Resident A choke on his food in the past.

Resident C stated that on 08/17/2023 residents were served lunch by staff Tamila Pratt which included hot dogs on buns. Resident C stated he observed Resident A "choking on the hotdog" and Resident A subsequently went into the bathroom where Ms. Pratt performed CPR. Resident C stated he telephoned 911 on his cellular telephone after Ms. Pratt directed him to do so. Resident C stated Ms. Patterson arrived at the facility and performed "CPR" until emergency personnel arrived.

On 08/22/2023 I interviewed staff Tamila Pratt via telephone. Ms. Pratt stated she has worked at the facility approximately one year. Ms. Pratt stated that on 08/17/2023 around 12:00 PM, she prepared lunch for residents which included a hotdog on a bun, chips, and a fruit. Ms. Pratt stated that while residents were eating

lunch at the facility's dining table, she sat on the living room couch "doing paperwork" and observing residents eating lunch. Ms. Pratt stated Resident A appeared to have eaten his entire lunch and walked to the bathroom. Ms. Pratt stated Resident B informed Ms. Pratt that, "I think something is wrong with (Resident A)". Ms. Pratt stated she walked to the bathroom and simultaneously received a phone call from Administrator Kathy Patterson, who was on her way to the facility. Ms. Pratt stated she told Ms. Patterson she was going to hang up the telephone because Resident A appeared to be choking. Ms. Pratt stated Ms. Patterson told Ms. Pratt to place the telephone on "speaker phone" and start the Heimlich maneuver. Ms. Pratt stated she placed the telephone on "speaker phone" and attempted to do the Heimlich maneuver on Resident A however Resident A attempted to push Ms. Pratt away. Ms. Pratt stated Resident A became "limp" and Ms. Pratt helped lower Resident A to the bathroom floor where she started Cardiopulmonary Resuscitation. Ms. Pratt stated, "(Resident B) or (Resident C)" telephoned 911 on the facility's landline and the 911 operator assisted Ms. Pratt with counting rescue breaths and compressions. Ms. Pratt stated Ms. Patterson arrived at the facility "within a couple minutes" of Resident A choking and Ms. Patterson took over Cardiopulmonary resuscitation efforts. Ms. Pratt stated emergency medical personal arrived at the facility "within five minutes" after they were telephoned, and emergency medical personal took over life saving measures. Ms. Pratt stated she directed residents out of the facility while emergency medical personnel performed life saving measures. Ms. Pratt stated emergency medical personnel located a piece of hot dog inside Resident A's airway and he was pronounced deceased at the facility at approximately 1:20 pm.

On 08/22/2023 I received an email from Administrator Kathy Patterson. The email included Resident A's Assessment Plan for AFC Residents which was signed on 01/13/2023 and Resident A's Healthcare Appraisal which was signed on 03/09/2023. Resident A's Assessment Plan for AFC Residents stated Resident A required staff assistance with Eating/Feeding in the form of "assistance w/ cutting food into small bite size pieces". Resident A's Healthcare Appraisal was completed by Nurse Practitioner Elizabeth Stob and indicated Resident A has a history of stroke, bi-polar disorder, left side weakness, multiple dental caries, and missing teeth.

On 08/22/2023 I emailed the complaint allegations to Adult Protective Services Centralized Intake.

On 08/22/2023 I emailed the complaint allegations to Jennifer Morgan of The Right Door.

On 08/22/2023 I interviewed staff Tamila Pratt via telephone. Ms. Pratt stated that on 08/17/2023 she served Resident A a hotdog on a bun which was whole and not cut. Ms. Pratt stated that she was "not sure" if she had read Resident A's Assessment Plan for AFC Residents because she didn't understand the difference between the State of Michigan Assessment Form and The Right Door's Plan of Service. Ms. Pratt stated that Resident A had a difficult time eating some items as

evidenced by choking but Resident A was always able to clear the food from his throat without staff assistance. Ms. Pratt stated she would always cut tough items such as “meat” for Resident A and other residents. Ms. Pratt stated that she didn’t remember if anyone told that Resident A’s food needed to be “cut up every meal”. Ms. Pratt stated she felt adequately trained to provide resident care.

On 08/22/2023 I interviewed Kathy Patterson via telephone. Ms. Patterson stated Resident A suffered from severe dental decay and refused dental treatment. Ms. Patterson stated that facility staff were required to cut “tougher” food that Resident A “could not chew”. Ms. Patterson stated facility staff are provided and required to read a copy of each resident’s Assessment Plan and staff meetings are held monthly to revisit each resident's current functioning and needs. Ms. Patterson stated she was certain staff had read Resident A’s Assessment Plan but stated staff only needed to cut “tough” food.

On 08/22/2023 I interviewed staff Martellus Ballard via telephone. Mr. Ballard stated staff are required to read each resident’s Assessment Plan for AFC Residents and staff meetings are held monthly to collectively discuss residents’ ongoing needs. Mr. Ballard stated that he was aware that staff are required to cut Resident A’s “difficult food”. Mr. Ballard stated that he would not cut soft foods such as apple sauce for Resident A, but Mr. Ballard stated he would cut “practically everything else”. Mr. Ballard stated Resident A required his food to be cut into small pieces because Resident A suffered from severe dental decay preventing him from chewing and displayed minor swallowing issues.

On 08/22/2023 I interviewed staff Becky Bout via telephone. Ms. Bout stated that she was required to read all of the resident’s Assessment Plans for AFC Residents. Ms. Bout stated Resident A’s Assessment Plan stated that staff were required to cut Resident A’s food “only when he requested it” and “at times he would ask” for staff assistance with cutting his food. Ms. Bout stated she never observed Resident A choke on his food and he “always ate fine”.

On 08/22/2023 I interviewed Resident A’s Public Guardian Angie Starkey via telephone. Ms. Starkey stated she has been appointed Resident A’s legal Guardian for approximately “one year”. Ms. Starkey confirmed that Resident A required staff assistance with cutting his food because, “he didn’t have any teeth” and “didn’t wear dentures”. Ms. Starkey stated she was unaware that on 08/17/2023 facility staff did not cut Resident A’s hotdog before serving it to Resident A. Ms. Starkey confirmed that Resident A required staff assistance with cutting the hot dog he was served on 08/17/2023.

On 08/28/2023 I completed an Exit Conference with Licensee Nathanael Bieszka via telephone. Mr. Bieszka stated he does not agree that a licensing violation transpired, and he would like time to consult with an attorney before accepting the issuance of a provisional license. Mr. Bieszka stated that all staff are educated to follow each resident’s Assessment Plan however in this case Mr. Bieszka believes

Resident A's Assessment Plan was incorrectly written. Mr. Bieszka stated Resident A only required staff assistance with cutting his food into small pieces upon Resident A's request rather than at all times, which is what should have been written into said Assessment Plan.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A's Assessment Plan for AFC Residents stated Resident A required staff assistance with Eating/Feeding in the form of "assistance w/ cutting food into small bite size pieces". Staff Tamila Pratt stated that on 08/17/2023 she served Resident A a hot dog on a bun which was whole and not cut. Ms. Pratt confirmed that Resident A subsequently died as a result of choking on the uncut hot dog. A preponderance of evidence was discovered during the course of the Special Investigation; Resident A's Assessment Plan for AFC Residents was not followed by facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license be modified to provisional status as a result of the above-cited quality of care violation.

08/28/2023

Toya Zylstra Date
Licensing Consultant

Approved By:

08/28/2023

Jerry Hendrick Date
Area Manager