GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 7, 2021

Nancy Jagelewski
1195 Stuve Ranch Rd.
Barton City, MI 48705

RE: License #: AF010278112
Investigation #: 2021A0360025
Maple Grove AFC

Dear Ms. Jagelewski:

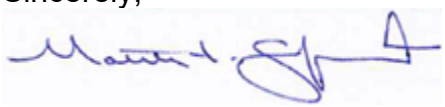
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (989) 732-8062.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
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931 S Otsego Ave
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(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF010278112
Investigation #:	2021A0360025
Complaint Receipt Date:	05/19/2021
Investigation Initiation Date:	05/20/2021
Report Due Date:	06/18/2021
Licensee Name:	Nancy Jagelewski
Licensee Address:	1195 Stuve Ranch Rd. Barton City, MI 48705
Licensee Telephone #:	(989) 736-0828
Administrator:	Nancy Jagelewski
Licensee Designee:	N/A
Name of Facility:	Maple Grove AFC
Facility Address:	1195 Stuve Ranch Road Barton City, MI 48705
Facility Telephone #:	(989) 736-0828
Original Issuance Date:	12/08/2005
License Status:	REGULAR
Effective Date:	06/12/2020
Expiration Date:	06/11/2022
Capacity:	6
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A died from a choking incident on 1/9/2021. Staff on duty did not know what to do when Resident A was choking.	No
Additional Findings	Yes

III. METHODOLOGY

05/19/2021	Special Investigation Intake 2021A0360025
05/20/2021	Special Investigation Initiated - On Site
05/20/2021	Inspection Completed On-site licensee Nancy Jagelewski, staff Kim Basner, HHM John Jagelewski
05/20/2021	Contact - Telephone call made Relative 1-A
05/24/2021	Contact - Document Received Nancy Jagelewski
05/26/2021	Contact - Document Received Nancy Jagelewski
06/03/2021	Contact - Telephone call made Melodi Suszek, HOM left message
06/04/2021	Contact - Telephone call made Melodi Suszek, HOM left message
06/08/2021	Contact - Telephone call made Sherry Reynolds HOM supervisor
06/09/2021	Contact - Telephone call received Sherry Reynolds, Melodi Suszek, HOM
06/09/2021	Contact - Telephone call made Nancy Jagelewski
06/09/2021	Contact - Telephone call received Kim Basner
06/10/2021	Exit Conference with Licensee Nancy Jagelewski

07/07/2021	Exit Conference with Licensee Nancy Jagelewski

ALLEGATION: Resident A died from a choking incident on 1/9/21. Staff on duty did not know what to do when Resident A was choking.

INVESTIGATION: On 5/19/2021 I received complaint information through the LARA online incident reporting system and opened a special investigation.

On 5/20/2021 I conducted an unannounced on-site inspection at the home. The licensee Nancy Jagelewski stated on 1/9/2021 Resident A died after a choking incident in the home. She stated Resident A was 88 years old, on Hospice services and had a Do Not Resuscitate order. She stated she was not home at the time of the choking incident. She stated one of her staff, Kim Basner was working that day. She stated her husband John Jagelewski was also present in the home during the incident. Ms. Jagelewski stated Resident A did not have any history of choking or coughing during eating. She stated Resident A did not have any special diet or puree orders. She stated Resident A did not require any direct supervision while eating. Ms. Jagelewski provided me with a copy of Resident A's most recent written assessment plan dated 11/18/2019. The written assessment plan noted no special dietary needs or direct supervision while eating however it documented that Resident A "tries not to eat, covers up food with napkin." She stated she did not complete an incident report regarding Resident A's death. She provided me with a copy of Resident A's Do Not Resuscitate Order dated 11/15/2019. Ms. Jagelewski stated her staff, Kim Basner is a licensed CNA and previously worked in a nursing home and is very familiar with how to appropriately handle an emergency.

I then interviewed Mr. Jagelewski. He stated he was not currently certified in CPR or first aid but has received training in the past. He stated on 1/9/2021 at about 12:30 p.m. Ms. Basner noticed Resident A choking on a piece of watermelon that had been served during lunch. He stated he was up in the attic putting in some insulation when he heard Resident B calling for him. He stated Ms. Basner immediately started the Heimlich maneuver and he called 911. He stated Resident A was blue in color, but he also attempted the Heimlich and Resident A spit up some chunks of watermelon and seemed to begin breathing. He stated although Resident A had spit up some watermelon and appeared to start breathing it was very labored. He stated several police agencies responded and attempted to clear her airway while waiting for the ambulance to arrive but were unsuccessful. He stated he provided Resident A's medical information to the first responders.

While at the home on 5/20/2021 I interviewed Resident B. Resident B stated she was eating lunch at the table with Resident A when she began choking. She stated Ms. Basner immediately started to do the Heimlich. She stated she yelled for Mr. Jagelewski to come help. She stated Mr. Jagelewski also came to help and

attempted the Heimlich. She stated it was only a couple of minutes until emergency responders arrived at the home.

While at the home 5/20/2021 I interviewed the staff person Kim Basner. Ms. Basner stated she typically works one day a week at the home. She stated on 1/9/2021 all the residents were sitting at the table eating lunch when Resident A started to cough. She stated she watched Resident A and kept encouraging her to cough. She stated she could tell Resident A was unable to breath, so she immediately started the Heimlich maneuver. She stated Resident B got up from the table and called for Mr. Jagelewski. She stated Mr. Jagelewski called 911 and helped to give Resident A the Heimlich. She stated Resident A spit up some watermelon, but they were unable to clear her airway. She stated emergency responders showed up within minutes and they also could not clear her airway. Ms. Basner stated she has had extensive training in CPR and first aid, and she is a licensed CNA which requires training in the Heimlich, CPR and first aid. She stated she has worked in nursing homes in the past and is very familiar with responding to medical emergencies like choking incidents. She stated there was no delay between Resident A choking and her starting emergency treatment.

On 5/20/2021 I contacted Resident A's daughter; Relative 1-A. Relative 1-A stated she lives out of state but has been in regular communication with Resident A's hospice nurses. She stated she last visited the home in December 2020. She stated she was unaware of any special diets or direct supervision requirements while her mother is eating. She stated she had noticed that her mother would cough a lot while eating and had trouble with thick liquids. She stated the licensee has historically provided very good care for her mother, but she had become concerned with the level of care over the past year with COVID-19. She stated she was not familiar with Ms. Basner or how she responded to her mother's choking incident.

On 5/24/2021 Ms. Jagelewski sent me an incident report describing what occurred on 1/9/2021. It stated, *"Kim prepared sandwiches, chips, and cut up watermelon for lunch everyone was eating, (Resident A) started choking Kim immediately asked (Resident A) if she was OK (Resident A) couldn't respond. Kim started the Heimlich maneuver and told (Resident B) to get John. (Resident B) hollered upstairs "John, (Resident A) is choking." John called 911 while coming down from upstairs. Kim said a little piece of watermelon came out and (Resident A's) color started to come back. Then she was losing color again so they wheeled her away from the table and John picked her up and did the Heimlich again, (Resident A) spit up more watermelon and was breathing on her own again there was some gasping with her breathing. Deputy Franklin arrived as did the first responders a DNR officer, 2 more deputies and 2 ambulances. Kim and John were asked to step aside and the EMT's took over (Resident A's) care. She was breathing when she left on the stretcher. Mary Jo RN HOM met ambulance at the hospital. She called to say (Resident A) died on the way there."* It was noted that persons contacted on 1/9/2021 included Hospice of Michigan and Relative 1-A but not licensing.

On 5/25/2021 I contacted the licensee Nancy Jagelewski and requested verification of Ms. Basner's CNA credentials.

On 5/26/2021 Ms. Jagelewski provide me with a screenshot of the State of Michigan Nurse Aid Registry Verification Report for Ms. Basner. I then searched the State of Michigan Nurse Aid Registry and verified that Ms. Basner was certified as a nurse aid on 3/21/2002 and her certification is valid until 3/31/2022.

APPLICABLE RULE	
R 400.1404	**Licensee, responsible person, and member of the household; qualifications.**
	(3) A licensee or responsible person shall possess all of the following qualifications: **(c) Be capable of appropriately handling emergency situations.**
ANALYSIS:	The complaint alleges Resident A died from a choking incident on 1/9/2021. Staff on duty did not know what to do when Resident was choking. Resident A was on Hospice and had a DNR order in place. Resident A died after a choking incident at the home on 1/9/2021. Resident A was being cared for and supervised by staff Kim Basner. Ms. Basner stated she witnessed Resident A coughing during lunch, immediately initiated emergency treatment by giving Resident A the Heimlich maneuver and called for additional help from the licensee's husband who immediately contacted 911. Mr. Jagelewski stated he heard Resident B call him because Resident a was choking. He immediately called 911 and assisted Ms. Basner with emergency care. Ms. Basner is a certified nurse aide and has been trained in how to appropriately handle emergency situations. Evidence obtained through this investigation indicates the licensee or responsible person was capable of appropriately handling emergency situations.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: While at the facility on 5/20/2021 I requested a copy of Resident A's written assessment plan. Ms. Jagelewski provided me with a copy of Resident A's most recent written assessment plan dated 11/18/2019. The written assessment plan noted no special dietary needs or direct supervision while eating however it documented that Resident A "tries not to eat, covers up food with napkin." Ms. Jagelewski denied that there were any special dietary needs or restrictions for Resident A.

On 5/24/2021 I requested and received a copy of Resident A's health care appraisal dated 5/12/2020. The health care appraisal was completed and signed by Hospice of Michigan Nurse Melodi Suszek. Under special dietary restrictions it was noted, "Soft diet as tolerated, thin liquids."

On 6/9/2021 I contacted the licensee, Nancy Jagelewski. She stated she was aware of the soft diet dietary restrictions on Resident A's health care appraisal. She stated she did not remember updating the written assessment plan after receiving the health care appraisal. She stated her husband John Jagelewski sent several documents with the ambulance on 1/9/2021 but she does not remember having updated the written assessment plan since 11/18/2019 and does not have a copy of a more recent written assessment plan.

APPLICABLE RULE	
R 400.1407	**Resident admission and discharge criteria; resident assessment plan; resident care agreement; house guidelines; fee schedule; physicians instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until a resident assessment plan is made and it is determined that the resident is suitable pursuant to the following provisions: **(a) The amount of personal care, supervision, and protection required by the resident is available in the home.** **(b) The kinds of services and skills required of the home to meet the resident's needs are available in the home.**
ANALYSIS:	Resident A's most recent assessment plan was dated 11/18/2019. It was not updated at least annually or after Resident A's special dietary restrictions changed in May 2020.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While at the facility on 5/20/2021 I interviewed the licensee; Nancy Jagelewski. Ms. Jagelewski stated Resident A did not have any history of choking or coughing during eating. She stated Resident A did not have any special diet or puree orders. She stated Resident A did not require any direct supervision while eating. Ms. Jagelewski provided me with a copy of Resident A's most recent written assessment plan dated 11/18/2019. The written assessment plan noted no special dietary needs or direct supervision while eating however documented that Resident A "tries not to eat, covers up food with napkin."

While at the facility on 5/20/2021 I interviewed staff Kim Basner. Ms. Basner stated she was not aware of any special dietary restrictions for Resident A. She stated on 1/9/2021 she served sandwiches, chips, and watermelon for lunch.

On 5/20/2021 I contacted Relative 1-A. She stated she was unaware of any special diets or direct supervision requirements while her mother is eating. She stated she had noticed that her mother would cough a lot while eating and had trouble with thick liquids.

On 5/24/2021 I requested and received a copy of Resident A's health care appraisal dated 5/12/2020 from Ms. Jagelewski. The health care appraisal was completed and signed by Hospice of Michigan Nurse Melodi Suszek. Under special dietary restrictions it was noted, "Soft diet as tolerated, thin liquids."

On 6/3/2021 I called and left a message with Hospice of Michigan Nurse Melodi Suszek.

On 6/4/2021 I called and left a message with Hospice of Michigan Nurse Melodi Suszek.

On 6/8/2021 I contacted Hospice of Michigan Nurse Supervisor Sherry Reynolds. Ms. Reynolds set up a phone conference with Ms. Suszek for 6/9/2021 at 9 a.m.

On 6/9/2021 I received a call from Hospice of Michigan Nurse Supervisor Sherry Reynolds and Nurse Melodi Suszek. Ms. Suszek stated she completed Resident A's health care appraisal on 5/12/2020. She stated she noted Resident A's special dietary restrictions as "soft diet as tolerated, thin liquids." She stated it was reported to her by the licensee that Resident A was having trouble swallowing meat. She stated a soft diet means that Resident A should have been receiving food that is able to be cut up and mashed. She stated soft sandwich bread with the crust removed may be appropriate if it was mashed. She stated chips would not be appropriate. She stated watermelon would be fine if it were mashed and ripe. She stated hard to chew foods like steak would not be appropriate. She stated that "as tolerated" means the licensee should report any foods that Resident A is unable to tolerate so they can update the recommendation to a puree diet. She stated the licensee did not report

any coughing or choking concerns since the health care appraisal was completed in May 2020.

On 6/9/2021 I contacted the licensee; Nancy Jagelewski. She stated she was aware of the “soft diet as tolerated” note on Resident A’s health care appraisal but Resident A would fluctuate between eating fine and sometimes having more difficulty eating and sometimes would throw up. She stated she never allowed Resident A to eat hard to chew foods like steak but would serve her sandwiches and chips and watermelon as noted in the incident report on the day of her death. She stated they did not remove the crust from Resident A’s sandwiches, but they would cut them into 4 small squares and Resident A would eat everything but the crust. She stated they would also cut her watermelon in ½ inch by ½ inch squares but would not mash them. She stated Resident A ate cut up watermelon very often with no issues. She stated she would also provide Resident A with Cheetoh’s because they were her favorite. She stated Resident A also enjoyed McDonald’s hamburgers and seemed to eat them with no issues.

On 6/9/2021 I contacted the staff, Kim Basner. Ms. Basner again stated she was not aware of any special dietary restriction for Resident A. She stated on 1/9/2021 she served turkey or ham sandwiches with chips and cut up watermelon. She stated she cut up Resident A’s sandwich into 4 small squares but did not remove the crust.

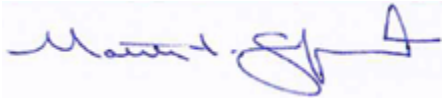
APPLICABLE RULE	
R 400.1419	**Resident nutrition.**
	(4) Special diets shall be prescribed only by a physician. A resident who has a special diet prescribed by a physician shall be provided such diet.

ANALYSIS:	Resident A's health care appraisal dated 5/12/2020 noted special dietary restrictions of "soft diet as tolerated, thin liquids." The licensee initially denied any special dietary restrictions for Resident A. It was not until it was pointed out on the health care appraisal that she acknowledged knowing about the soft diet. She did not update Resident A's written assessment plan and continued to provide Resident A with foods that were not in compliance with her special dietary restrictions. The staff Kim Basner denied any knowledge of any special dietary restrictions for Resident A. Hospice of Michigan nurse Melodi Suszek who completed the health care appraisal stated she documented the dietary restrictions after consultation with the licensee that Resident A was having difficulty swallowing meat. She stated any food served to Resident A should have been mashed. On 1/9/2021 Resident A was served a turkey or ham sandwich, chips, and watermelon, none of which were mashed. She choked while eating her lunch and died. There is a preponderance of evidence that Resident A's special dietary restrictions were not followed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/10/2021 and on 07/07/2021 I conducted an exit conference with the licensee Nancy Jagelewski. She did not concur with the findings of not adhering to Resident A's special dietary restrictions and failing to update her written assessment plan. She stated her understanding of the soft foods diet was that she could serve anything that Resident A wanted if she did not choke or cough on it. She stated she will submit a corrective action plan for approval for each rule violations.

IV. RECOMMENDATION

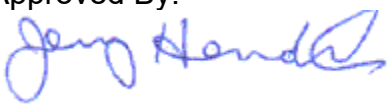
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



07/07/2021

Matthew Soderquist Date
Licensing Consultant

Approved By:



07/07/2021

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Jerry Hendrick Date
Area Manager