GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 12, 2021

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

RE: License #: AS340398815
Investigation #: 2021A0583041
Thompson

Dear Ms. Patterson:

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,

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 #:	AS340398815
Investigation #:	2021A0583041
Complaint Receipt Date:	07/28/2021
Investigation Initiation Date:	07/28/2021
Report Due Date:	08/27/2021
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:	Thompson
Facility Address:	9625 Thompson Road Lake Odessa, MI 48849
Facility Telephone #:	(419) 439-1218
Original Issuance Date:	04/29/2019
License Status:	REGULAR
Effective Date:	10/29/2019
Expiration Date:	10/28/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff Abby Cnossen smokes marijuana and drinks alcohol while providing care for residents.	Yes
Facility staff allow residents to feed Resident A her liquid diet.	Yes
Staff Abby Cnossen is abusive towards residents.	Yes
Staff Abby Cnossen takes residents' medications.	No
Additional Findings	Yes

III. METHODOLOGY

07/28/2021	Special Investigation Intake 2021A0583041
07/28/2021	Special Investigation Initiated - Letter Adult Protective Services Staff Vicki Pohl
07/29/2021	Contact - Document Sent Adult Protective Services Staff Vicki Pohl
07/29/2021	Contact - Telephone call made Carrie Brennan
07/30/2021	Contact - Telephone call made Carrie Brennan
07/30/2021	Contact - Telephone call made Staff Mark Bieska
07/30/2021	Inspection Completed On-site Staff Abby Cnossen, Licensee Designee Kathy Designee, Staff Nathan Bieszka, Resident B, Resident C, Resident D, Resident E, Resident F
08/02/2021	Contact - Email Licensee Designee Kathy Patterson
08/05/2021	Contact - Email Jennifer Morgan Ionia CMH
08/052021	Contact - Telephone Jennifer Morgan Ionia CMH
08/05/2021	Contact - Telephone Relative 1
08/09/2021	Contact - Telephone

	Relative 1
08/12/2021	Exit Conference Licensee Designee Kathy Patterson

ALLEGATION: Staff Abby Cnossen smokes marijuana and drinks alcohol while providing care for residents.

INVESTIGATION: On 07/28/2021 I received allegations via email from Adult Protective Services Staff Vicki Pohl. Ms. Pohl stated she received the complaint allegations on 06/29/2021. Ms. Pohl stated the complaint alleged that staff Abby Cnossen smokes marijuana and drinks alcohol while providing care for residents.

On 07/30/2021 I interviewed Carrie Brennan via telephone. Ms. Brennan stated she is engaged to staff Mark Bieszka and visited the facility from approximately 05/09/2021 until 05/14/2021. Ms. Brennan stated staff Abby Cnossen resides in the lower level of the facility. Ms. Brennan stated while visiting the facility, she often observed Mr. Bieszka and Ms. Cnossen drink alcohol together at the facility while Ms. Cnossen provided care to residents. Ms. Brennan stated Ms. Cnossen often smelled “cinnamon” in Ms. Cnossen’s cup that Ms. Brennan believed had been filled with “fire ball” which she explained to be 66 proof alcohol. Ms. Brennan stated Ms. Cnossen provided care to residents while Ms. Cnossen drank the “fireball” and Mr. Bieszka was also drinking at the time but not providing care to residents. Ms. Brennan stated while she visited the facility, she often observed Ms. Cnossen “smoke marijuana out of a bowl” and “smoke marijuana with a vaping pen” while providing care for residents.

On 07/30/2021 I interviewed staff Mark Bieszka via telephone. Mr. Bieszka stated he has consumed alcohol with Ms. Cnossen at the facility while Ms. Cnossen provided care to residents on multiple occasions. Mr. Bieszka stated Ms. Cnossen became “intoxicated nearly every time” she drank alcohol at the facility. Mr. Bieszka stated he has observed Ms. Cnossen smoke marijuana at the facility while providing care to residents.

On 0730/2021 I completed an unannounced onsite investigation at the facility and privately interviewed Licensee Designee Kathy Patterson, staff Nathan Bieszka, staff Abby Cnossen, Resident B, Resident C, Resident D, Resident E, and Resident F.

Staff Abby Cnossen stated she has never ingested alcohol or smoked marijuana while providing care for residents. Ms. Cnossen denied drinking alcohol at the facility with Mark Bieszka. Ms. Cnossen stated she does smoke marijuana and drink alcohol in her personal time away from the facility.

Licensee Designee Kathy Patterson and staff Nathan Bieszka both stated they have never observed Ms. Cnossen drink alcohol or smoke marijuana while providing care to residents.

Residents B, C, D and E each stated they have never observed Ms. Cnossen consume alcohol or smoke marijuana while working at the facility or while providing resident care.

Resident F stated she has observed Ms. Cnossen and staff Mark Bieszka drink alcohol together at the facility “while they were working together”. Resident F stated she observed the alcohol was in “a cup” and Ms. Cnossen called the alcohol her “powerful juice”. Resident F stated Ms. Cnossen admitted the two staff were drinking alcohol together. Resident F stated she doesn’t remember the exact date of the incident, but it occurred within the past few months. Resident F stated she didn’t know if Ms. Cnossen or staff Mark Bieszka drank to intoxication. Resident F stated she has never observed Ms. Cnossen smoke marijuana at the facility.

On 08/12/2021 I completed an Exit Conference with Licensee Designee Kathy Patterson via telephone. Ms. Patterson stated she agreed with the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.
ANALYSIS:	Staff Mark Bieszka stated he has consumed alcohol with Ms. Cnossen at the facility while Ms. Cnossen provided care to residents on multiple occasions. Mark Bieszka stated Ms. Cnossen became “intoxicated nearly every time” she drank alcohol at the facility. Mark Bieszka stated he has observed Ms. Cnossen smoke marijuana at the facility while providing care to residents. Carrie Brennan stated she visited the facility from approximately 05/09/2021 until 05/14/2021. Ms. Brennan stated she observed staff Abby Cnossen provide care to residents while Ms. Cnossen drank alcohol and smoked marijuana at the facility.

	Resident F stated she has observed Ms. Cnossen and staff Mark Bieszka drink alcohol together at the facility “while they were working together”. Staff Abby Cnossen stated she has never ingested alcohol or smoked marijuana while providing care for residents. Residents B, C, D and E each stated they have never observed Ms. Cnossen consume alcohol or smoke marijuana while working at the facility or while providing resident care. There is sufficient evidence to substantiate violation of the applicable rule. A preponderance of evidence exists to substantiate Staff Abby Cnossen drank alcohol while providing care to facility residents therefore she is not suitable to provide resident care.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Facility staff allow residents to feed Resident A her liquid diet.

INVESTIGATION: On 07/28/2021 I received allegations via email from Adult Protective Services staff Vicki Pohl. Ms. Pohl stated the complaint alleged that staff Abby Cnossen allowed facility residents to feed Resident A her liquid diet. Ms. Pohl stated Resident A no longer resides at the facility and passed away on 07/07/2021 at a skilled nursing facility due to complications of aspiration pneumonia.

On 07/30/2021 I interviewed Carrie Brennan via telephone. Ms. Brennan stated while visiting the facility from 05/09/2021 until 05/14/2021, she observed multiple residents feed Resident A her prescribed liquid diet of oatmeal. Ms. Brennan stated staff Abby Cnossen reported she did not like Resident A and refused to feed Resident A her prescribed liquid diet.

On 07/30/2021 I interviewed staff Mark Bieszka via telephone. Mark Bieszka stated Resident A was prescribed a liquid diet of oatmeal as a result of her swallowing deficiencies. Staff Mark Bieszka stated Resident A lacked the ability to feed herself due to arm mobility issues and was unable to verbally communicate her needs. Staff Mark Bieszka stated Ms. Cnossen allowed Resident B to feed Resident A her liquid diet because Ms. Cnossen reported she “couldn’t stand it and it grossed her out”. Staff Mark Bieszka stated he had observed Resident B give Resident A “heaping tablespoons” of oatmeal and Resident A would “cough occasionally” while Resident B fed Resident A.

On 07/30/2021 I completed an unannounced onsite investigation at the facility and privately interviewed Licensee Designee Kathy Patterson, staff Nathan Bieszka, Abby Cnossen, Resident B, Resident C, Resident D, Resident E, and Resident F.

Staff Abby Cnossen stated Resident A “moved out the end of May” 2021 and transferred to a “hospital due to suspicions of pneumonia, fluid in her lungs, and aspiration”. Ms. Cnossen stated Resident A left the hospital after a diagnosis of pneumonia and transitioned to a Skilled Nursing facility where Resident A passed away. Ms. Cnossen stated Resident A was prescribed a liquid diet of oatmeal per her physician. Ms. Cnossen stated she informed Licensee Designee Kathy Patterson that she “did not enjoy” feeding Resident A her liquid diet and that “it’s grose”. Ms. Cnossen stated she allowed Resident B and Resident E to feed Resident A her liquid diet daily. Ms. Cnossen stated she always supervised Resident B and Resident E when they fed Resident A. Ms. Cnossen stated she had gone days without feeding Resident A herself and instead allowed Resident B and Resident E to feed Resident A. Ms. Cnossen stated she had oberved Resident B attempt to feed Resident A “large bites” but Ms. Cnossen stated she would always redirect Resident B. Ms. Cnossen stated “one day” she observed Resident A “choke” while Resident B fed Resident A her liquid diet. Ms. Cnossen stated she intervened during the feeding and Resident A appeared appropriate afterwards.

Licensee Designee Kathy Patterson and staff Nathan Bieszka both stated they allowed Resident B and Resident E to feed Resident A her liquid diet with supervision. Licensee Designee Kathy Patterson and staff Nathan Bieszka both stated they have never observed Resident A choke while being fed by Resident B or Resident E.

Resident B stated he fed Resident A her “oatmeal” because Ms. Cnossen “doesn’t like to feed her”. Resident B stated he had “no idea” why Ms. Cnossen did not like to feed Resident A her food.

Resident C stated Resident B fed Resident A her liquid diet with staff supervision daily. Resident C stated that on one occasion she observed Resident A choke while being fed by Resident B. Resident C stated Ms. Cnossen “patted” Resident A “on the back” while Resident A was choking.

Resident D stated Resident B fed Resident A her liquid diet with staff supervision daily. Resident D stated he fed Resident A her liquid diet occasionally with staff supervision.

Resident E stated Resident B fed Resident A her liquid diet with staff supervision daily. Resident E stated “once or twice” she fed Resident A her liquid diet with staff supervision.

Resident F stated Ms. Cnossen “got anyone she could” to feed Resident A her liquid diet including Resident B, Resident D, and Resident E. Resident F stated Ms. Cnossen supervised Resident B, Resident D, and Resident E while they fed Resident A.

On 08/02/2021 I received via email a copy of Resident A's Assessment Plan for AFC Residents from Licensee Designee Kathy Patterson. I reviewed the document is signed 01/01/2021 and states Resident A required assistance with Eating/Feeding.

On 08/12/2021 I completed an Exit Conference with Licensee Designee Kathy Patterson via telephone. Ms. Patterson stated she agreed with the findings and would submit an acceptable Corrective Action 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:	Licensee Designee Kathy Patterson, staff Nathan Bieszka, Abby Cnossen, and Staff Mark Bieszka each reported residents were allowed to feed Resident A her liquid diet. Resident B, Resident C, Resident D, Resident E, and Resident F each reported residents were allowed to feed Resident A her liquid diet. Resident A's Assessment Plan for AFC Residents indicates Resident A required assistance with eating/feeding. There is sufficient evidence to substantiate violation of the applicable rule. Facility staff allowed residents to feed Resident A her liquid diet.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff Abby Cnossen is abusive towards residents.

INVESTIGATION: On 07/28/2021 I received allegations via email from Adult Protective Services Staff Vicki Pohl. Ms. Pohl stated the complaint alleged that Staff Abby Cnossen is abusive towards facility residents.

On 07/30/2021 I interviewed Carrie Brennan via telephone. Ms. Brennan stated while visiting the facility from 05/09/2021 until 05/14/2021, she observed staff Abby Cnossen "verbally abuse" residents and saw bruising on residents that Ms. Brennan attributed to physical abuse perpetrated by Ms. Cnossen. Ms. Brennan stated Ms. Cnossen told her that Ms. Cnossen "hated" Resident A. Ms. Brennan reported she heard Ms. Cnossen state, "I can't stand" Resident A and "I hate the way (Resident A) looks". Ms. Brennan stated she heard Ms. Cnossen "yell" at Resident D and

Resident F to “shut up” and “stop complaining”. Ms. Brennan stated she never directly observed Ms. Cnossen physically abuse residents but did observe Resident F was “covered in bruises”. Ms. Brennan stated Resident F reported to Ms. Brennan that the cause of her bruises were due to Ms. Cnossen pinching her.
On 07/30/2021 I interviewed staff Mark Bieszka via telephone. Mr. Bieszka stated he observed staff Abby Cnossen verbally abuse residents. Mr. Bieszka stated he routinely observed Ms. Cnossen “yell” at resident after resident. Mr. Bieszka stated he “doesn’t remember” what Ms. Cnossen specifically said when she “yelled” at residents. He stated he did observe Ms. Cnossen refuse to feed Resident A her liquid diet because Ms. Cnossen stated she “couldn’t stand it” and “it grosed her out”. Mr. Bieszka stated he never observed Ms. Cnossen physically abuse residents although on an unknown date he did observe “fingerprints” on Resident A’s abdomen that he characterized as “unusual”.

On 07/30/2021 I completed an unannounced onsite investigation at the facility and privately interviewed Licensee Designee Kathy Patterson, staff Nathan Bieszka, Abby Cnossen, Resident B, Resident C, Resident D, Resident E, and Resident F.

Staff Abby Cnossen stated she has never verbally or physically abused any resident at any time. Ms. Cnossen stated she does not yell at residents and has never pinched any resident. Ms. Cnossen stated she did inform Licensee Designee Kathy Patterson in private that Ms. Cnossen found feeding Resident A her liquid diet “was grose” and she “didn’t enjoy it”.

Licensee Designee Kathy Patterson and staff Nathan Bieszka both stated they have never observed Ms. Cnossen abuse any resident of the facility physically or verbally. Licensee Designee Kathy Patterson and staff Nathan Bieszka both stated they have never observed indications of physical abuse on any residents.

Residents B stated Ms. Cnossen “gets on us when we don’t follow instructions” but denied Ms. Cnossen raised her voice or told residents to “shut up”. Resident B stated Ms. Cnossen has never physically abused him or any other resident to his knowledge. I did not observe Resident B to present with bruises on his arms or lower legs.

Resident C stated Ms. Cnossen has never verbally or physically abused her or any other resident to her knowledge. I did not observe Resident C to present with bruises on her arms or lower legs.

Resident D stated Ms. Cnossen has never verbally or physically abused him or any other resident to his knowledge. I did not observe Resident D to present with bruises on his arms or lower legs.

Resident E stated Ms. Cnossen has never verbally or physically abused her or any other resident to her knowledge. I did not observe Resident E to present with bruises on her arms or lower legs.

Resident F stated Ms. Cnossen “yells” at residents to “shut up” if Ms. Cnossen is “having a bad day”. Resident F stated Ms. Cnossen has never physically abused her or any other resident to her knowledge. I did not observe Resident F to present with bruises on her arms or lower legs.

On 08/12/2021 I completed an Exit Conference with Licensee Designee Kathy Patterson via telephone. Ms. Patterson stated she agreed with the findings and would submit an acceptable Corrective Action Plan.

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:	Carrie Brennan reported she heard Ms. Cnossen state, “I can’t stand” Resident A and “I hate the way (Resident A) looks”. Ms. Cnossen stated she heard Ms. Cnossen “yell” at Resident D and Resident F to “shut up” and “stop complaining”. Staff Abby Cnossen stated she did inform Licensee Designee Kathy Patterson in private that Ms. Cnossen found feeding Resident A her liquid diet “was grose” and she “didn’t enjoy it”. Staff Mark Bieszka stated he observed staff Abby Cnossen verbally abuse residents. Mr. Bieszka stated he routinely observed Ms. Cnossen “yell” at residents. Resident F stated Ms. Cnossen “yells” at residents to “shut up” if Ms. Cnossen is “having a bad day”. There is sufficient evidence to substantiate violation of the applicable rule. Ms. Cnossen verbally mistreated residents and therefore did not treat residents with dignity and respect.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff Abby Cnossen takes residents’ medications.

INVESTIGATION: On 07/28/2021 I received allegations via email from Adult Protective Services staff Vicki Pohl. Ms. Pohl stated the complaint alleged that staff Abby Cnossen has also been observed by residents taking medications from the medication cart that belong to the residents.

On 07/30/2021 I interviewed Carrie Brennan via telephone. Ms. Brennan stated while visiting the facility from 05/09/2021 until 05/14/2021, Resident E alerted Ms. Brennan to “watch the med cabinet” because staff Abby Cnossen “takes what she wants”. Ms. Cnossen stated she has never observed Ms. Cnossen take residents’ medications.

On 07/30/2021 I interviewed staff Mark Bieszka via telephone. Mr. Bieszka stated he has never observed staff Abby Cnossen take residents’ medications.

On 0730/2021 I completed an unannounced onsite investigation at the facility and privately interviewed Licensee Designee Kathy Patterson, staff Nathan Bieszka, Abby Cnossen, Resident B, Resident C, Resident D, Resident E, and Resident F.

Staff Abby Cnossen stated she has unfettered access to residents’ medications which are located in the locked medication cart however she has never taken residents’ medications for personal use of any kind.

Licensee Designee Kathy Patterson and staff Nathan Bieszka both stated they complete weekly medication counts and have never observed a discrepancy regarding residents’ medications. Licensee Designee Kathy Patterson and staff Nathan Bieszka both stated they have never heard of or observed an issue regarding Ms. Cnossen obtaining residents’ medication for personal use.

Residents B, C, D, E, and F each stated they have never observed Ms. Cnossen utilize their medications for personal use. Residents B, C, D, E, and F each stated Ms. Cnossen administers their medications as prescribed to their knowledge.

While at the facility I reviewed the July 2021 Medication Administration Record indicated Residents B, C, D, E and F each received their medications as prescribed.

On 08/12/2021 I completed an Exit Conference with Licensee Designee Kathy Patterson via telephone. Ms. Patterson stated she agreed with the findings.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Residents B, C, D, E, and F each stated they have never observed Ms. Cnossen utilize their medications for personal use. Residents B, C, D, E, and F each stated Ms. Cnossen administers their medications as prescribed.

	Licensee Designee Kathy Patterson and staff Nathan Bieszka both stated they complete weekly medication counts and have never observed a discrepancy regarding residents' medications. Staff Abby Cnossen stated she has never taken residents' medications for personal use of any kind. While at the facility I reviewed the July 2021 Medication Administration Record indicated Residents B, C, D, E, and F each received their medications as prescribed. Residents and staff have not reported evidence indicating Staff Abby Cnossen has taken residents' medications for personal use.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING: Residents' medications were observed not in the original pharmacy-supplied containers.

INVESTIGATION: On 07/30/2021 I completed an unannounced onsite investigation at the facility and observed multiple medication tablets located in the back of the locked medication cart. I observed the tablets were not kept in the original pharmacy-supplied containers.

Staff Abby Cnossen stated she did not know which resident(s) the tablets belonged to. Ms. Cnossen stated she did not know why the tablets were not kept in the original pharmacy supplied container or for how long the tablets had been left in the back of the medication cart.

Licensee Designee Kathy Patterson and staff Nathan Bieszka both stated they complete weekly medication counts and have never observed there to be a discrepancy regarding residents' medications. Licensee Designee Kathy Patterson and staff Nathan Bieszka both stated that they did not know why the tablets were not kept in the original pharmacy supplied container or how long the tablets had been left in the back of the medication cart.

On 08/12/2021 I completed an Exit Conference with Licensee Designee Kathy Patterson via telephone. Ms. Patterson stated she agreed with the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**

	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	On 07/30/2021 I completed an unannounced onsite investigation at the facility and observed multiple medication tablets located in the back of the locked medication cart. I observed the tablets were not kept in the original pharmacy-supplied containers. There is sufficient evidence to substantiate violation of the applicable rule. Residents' medications were not kept in the original pharmacy-supplied containers.
CONCLUSION:	**VIOLATION ESTABLISHED**

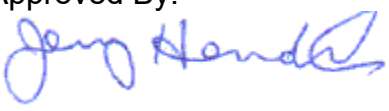
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

08/12/2021

Toya Zylstra Date
Licensing Consultant

Approved By:



08/12/2021

Jerry Hendrick Date
Area Manager