GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 9, 2022

Jeffrey Shepard
Elder Ridge Manor II, LLC
PO Box 518
Stockbridge, MI 49285

RE: License #: AL330380274
Investigation #: 2022A0466063
Elder Ridge Manor II, LLC

Dear Mr. Shepard:

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 feel free to 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 (517) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330380274
Investigation #:	2022A0466063
Complaint Receipt Date:	09/12/2022
Investigation Initiation Date:	09/16/2022
Report Due Date:	11/11/2022
Licensee Name:	Elder Ridge Manor II, LLC
Licensee Address:	4101 Oakley Road Stockbridge, MI 49285
Licensee Telephone #:	(517) 851-7501
Administrator:	Jennifer Flores
Licensee Designee:	Jeffrey Shepard
Name of Facility:	Elder Ridge Manor II, LLC
Facility Address:	4101 Oakley Road Stockbridge, MI 49285
Facility Telephone #:	(517) 851-7501
Original Issuance Date:	04/06/2017
License Status:	REGULAR
Effective Date:	10/05/2021
Expiration Date:	10/04/2023
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION:

	Violation Established?
On 09/10/2022, Resident A choked and died after being provided food by direct care staff members that was too difficult for him to chew.	No
Additional Findings	Yes

III. METHODOLOGY

09/12/2022	Special Investigation Intake- 2022A0466063.
09/16/2022	Special Investigation-assigned to Julie Elkins from Leslie Herrguth.
09/16/2022	Contact - Document Sent to Ronald Cole, EMSA.
09/16/2022	Contact - Document Sent Deputy Scott Macomber.
09/16/2022	Special Investigation Initiated – Telephone call to assigned licensing consultant Rodney Gill.
09/16/2022	APS Referral- not required Resident passed away prior to Complaint being made.
09/19/2022	Inspection Completed On-site.
09/20/2022	Contact - Document Sent- FOIA request.
09/20/2022	Contact - Telephone call made to DCW Edwina Schmidt interviewed.
11/03/2022	Contact - Telephone call made to Jacke Randall, Senior CommUnity Care of Michigan (PACE), message left.
11/07/2022	Contact - Telephone call made to Jacke Randall, Senior CommUnity Care of Michigan (PACE), message left.
11/07/2022	Contact – Telephone call recevied from PACE dietitian Amanda Bowerman
11/07/2022	Exit Conference with licensee designee Jeffrey Shepard.

ALLEGATION: On 09/10/2022, Resident A choked and died after being provided food by direct care staff members that was too difficult for him to chew.

INVESTIGATION:
On 09/12/2022, Complainant reported Resident A asked for and was given a peanut butter sandwich on 09/10/2022 and the sandwich was cut in half. Complainant reported everything Resident A eats needs to be cut up. Complainant reported Resident A began choking and emergency medical service (EMS) was contacted but could not restart Resident A's heart. Complainant reported one direct care worker (DCW) did the Heimlich on Resident A and the other DCW called 911 as the food would not dislodge.

On 09/19/2022, I reviewed an *Incident/Accident Report* dated 9/10/2022 at 12:33 pm and authored by administrator Jennifer Flores and signed by licensee designee Jeffrey Shepard. In the "Explain what Happened" section of the report it stated, "[Resident A] asked staff for a peanut butter sandwich after his lunch, staff made it for him and cut in half (all [Resident A's] food is cut) he also had a drink with him. While eating his sandwich he began to choke." In the "Action taken by staff" section of the report it stated, "One staff administered the Heimlich maneuver while the other called 911. When staff was unable to dislodge the food debris they began CPR while waiting on EMS to arrive. EMS took over CPR, were able to find more debris, however, they were unable to restart his heart." In the "Corrective Measures" section of the report it stated, "None, staff followed emergency procedure as directed by EMS."

On 09/19/2022, I conducted an unannounced investigation and I interviewed DCW Shelby Higgins who reported she started working at the facility on 08/09/2022. DCW Higgins reported she was on shift on 9/10/2022 when Resident A choked on a peanut butter sandwich and passed away. DCW Higgins reported DCW Edwina Schmidt was on shift with her. DCW Higgins reported Resident A liked to eat fast and was always reminded to slow down. DCW Higgins reported there was a sign posted by where he sat to eat his meals that said, "eat slowly." DCW Higgins reported that on 09/10/2022, Resident A had finished his lunch and he heard another resident ask for a peanut butter sandwich, so he asked for one also. DCW Higgins reported Resident A did not have any dietary restrictions nor was he prescribed a special diet including having his food cut into smaller pieces. DCW Higgins reported Resident A always asked for additional portions and because he ate his food so fast, direct care workers cut up his food into bite size pieces. DCW Higgins reported she made Resident A a peanut butter sandwich, per his request, using only one piece of bread since he had already eaten his lunch. DCW Higgins reported she cut the half of sandwich down the middle and then cut it across three times making six small bite size pieces of the sandwich. DCW Higgins reported Resident A always reported he was hungry and had no impulse control around food. DCW Higgins reported Resident A did not have any teeth and Programs of All-

Inclusive Care for the Elderly (PACE) had been working on getting him dentures for the past two years. DCW Higgins reported Resident A did not have any trouble eating without teeth. DCW Higgins reported on the day of the incident she heard suddenly heard DCW Schmidt yelling Resident A's name and then DCW Schmidt started doing the Heimlich maneuver on Resident A. DCW Higgins reported she called 911 who told her to put Resident A on the floor and then she started chest compressions as directed by 911. DCW Higgins reported DCW Schmidt tried to get the food out of Resident A's mouth but reported Resident A's mouth would not open. DCW Higgins reported Resident A put his hands on his chest while he was choking. DCW Higgins reported the police were the first to arrive and had an automated external defibrillator (AED) machine with them. DCW Higgins reported EMS arrived shortly thereafter and took over the chest compressions. DCW Higgins reported EMS worked on Resident A for a long time, probably 20 minutes, to clear his airway but were unsuccessful. DCW Higgins reported she helped get the other residents out of the dining area. DCW Higgins reported that EMS could not resuscitate Resident A and Resident A passed away.

On 09/19/2022, I interviewed Kaylie Shepard who reported that she has been the manager of the facility since 05/16/2020. DCW Kaylie Shepard reported that on 09/10/2022, DCW Higgins and DCW Schmidt were on duty at the facility. DCW Kaylie Shepard reported that she was in the backyard gardening when she recevied a call from administrator Jennifer Flores about Resident A choking so she went into the facility and saw all residents and DCWs in the dining room. DCW Kaylie Shepard reported she helped get the residents out of the dining area as Resident A was being given Cardiopulmonary resuscitation (CPR) and she wanted to secure the area. DCW Kaylie Shepard reported the local Sherriff was the first responder on scene and he arrived while DCW Higgins was giving Resident A CPR. DCW Kaylie Shepard reported the Sherriff took over CPR for DCW Higgins when he arrived. DCW Kaylie Shepard reported once EMS arrived they were able to get some food/debris out of Resident A's airway but it was not enough to clear the airway. DCW Kaylie Shepard reported Resident A was not on any physician prescribed special diet or any food restriction including Resident A's food to be cut into bite sized pieces. DCW Kaylie Shepard reported DCWs cut up Resident A's food because he liked to eat so fast, they did not want him to choke. DCW Kaylie Shepard reported Resident A had seen a dietitian through PACE because of multiple choking episodes. DCW Kaylie Shepard reported that this was the second time that the facility had called 911 for Resident A choking with the first time occurring at the Halloween party in 2021. DCW Kaylie Shepard reported the PACE dietitian gave Resident A the sign which sat by him while he ate that reads, "Eat Slowly."

On 09/19/2022, I reviewed Resident A's record which documented that Resident A was admitted to the facility on 10/16/2017and was 65 years. Resident A's record contained a written *Assessment Plan for Adult Foster Care (AFC) Residents* that was dated 1/17/2019 and signed by Resident A and licensee designee Jeffrey Shepard. In the "eating/feeding" section of the report it stated, "staff to prepare and plan meals." In the" use of prosthesis" section of the report it stated, "top dentures,

waiting on bottoms to be made." In the "Special Diet" section of the report it stated, "no."

I reviewed Resident A's *Health Care Appraisal* which was dated 11/06/2020 and in the "Special Dietary Instructions" section of the report it said "none."

I reviewed Resident A's record and I did not find any documentation that Resident A had been seen by a dietitian or that were there any written instructions in the file from a dietitian regarding any food restrictions or special instructions.

On 09/20/2022, I interviewed DCW Schmidt who reported she started work at the facility at the end of July 2022. DCW Schmidt reported she worked with DCW Higgins on 09/10/2022 when Resident A choked on a peanut butter sandwich. DCW Schmidt reported Resident A had eaten his lunch and wanted a peanut butter sandwich because another resident had asked for one. DCW Schmidt reported DCW Higgins made Resident A peanut butter sandwich using one slice of bread. DCW Schmidt reported DCW Higgins told her that she thought that she cut the half of sandwich into four pieces. DCW Schmidt reported that Resident A shoves food into his mouth without chewing it and that is why there is a sign by him that reads, "Eat Slowly." DCW Schmidt reported that Resident A did not have any food restrictions or any special diets. DCW Schmidt reported she was administering noon medications when Resident A began choking. DCW Schmidt reported Resident A did not make any noise, she just saw his arm fall. DCW Schmidt reported DCW Higgins yelled that Resident A's lips are turning blue. DCW Schmidt and DCW Higgins reported trying the Heimlich maneuver but reported that it did not work. DCW Schmidt reported that Resident A was non-responsive. DCW Schmidt reported she tried to sweep Resident A's mouth but his mouth would not open, so DCW Higgins called 911. DCW Schmidt reported DCW Higgins started chest compressions per the direction of 911 until EMS arrived. DCW Schmidt reported during this time Resident A was not coughing or breathing.

On 11/07/2022, I interviewed PACE dietitian Amanda Bowerman who reported Resident A had a history of eating fast, being impulsive around food and choking. Dietitian Bowerman reported Resident A attended PACE twice a week and ate lunch there. Dietitian Bowerman reported Resident A had a choking incident on 8/5/2022 at PACE. Dietitian Bowerman reported Resident A did not have any physician ordered special diet and reported he had no dietary restrictions. Dietitian Bowerman reported PACE recommends food is cut up into small pieces for all PACE consumers. Dietitian Bowerman reported Speech Pathologist Roshani Jayasekara had seen Resident A on 09/07/2022 at the facility and conducted an assessment with him where he successfully ate four cookies in succession without choking or any other difficulty so no further action/restriction was taken. Dietitian Bowerman reported she saw Resident A at PACE on 09/06/2022 and reported he was doing well, he was eating more slowly and responding to the cueing that was provided to help him be less impulsive around food and Resident A had slowed down while he ate. Dietitian Bowerman reported Resident A did not have lower dentures as PACE

was having issues finding a dentist to get the dentures made. Dietitian Bowerman also noted administrator Flores did contact PACE on 06/01/2022 to inquire about Resident A's dentures and to report Resident A was having choking issues.

APPLICABLE RULE	
R 400.15305	**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 direct care staff members knew Resident A ate his food too fast and were taking steps to modify the presentation of his food by cutting it up into smaller pieces as recommended by PACE. Further Resident A was evaluated by a PACE dietician and speech pathologist due to Resident A having multiple choking episodes which had resulted in the facility direct care staff members calling 911. Although the facility did not have documentation of the additional evaluations conducted, the evaluations were verified by PACE Dietitian Bowerman. The facility took Resident A's protection and safety into account by communicating with PACE and having Resident A evaluated to assure Resident A was provided with the care required therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	I reviewed Resident A's written *AFC Assessment Plan* and Resident A's *Health Care Appraisal* and neither documented any physician prescribed special diet including a requirement to cut Resident A's food into bite sized pieces. DCW Higgins and DCW Schmidt reported that Resident A did not have any physician prescribed special diet.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 09/19/2022, I conducted an unannounced investigation and I interviewed DCW Higgins who reported that she had been fingerprinted yet.

I reviewed the employee records of DCW Higgins and DCW Schmidt. DCW Higgins record documented that her date of hire was 08/09/2022 and DCW Schmidt's date of hire was 07/30/2022. DCW Higgins and DCW Schmidt's employee records contained a document that was labeled as "Employee File Checklist." The "background check/fingerprints" section of this document was left blank on both DCW Higgins and DCW Schmidt's form. Additionally, DCW Higgins and DCW Schmidt's employee records did not contain documentation that they had been fingerprinted and that they are eligible to work in an adult foster care.

On 09/19/2022, I interviewed Kaylie Shepard who reported that she provided me with all the documents that the facility has for DCW Higgins and DCW Schmidt.

On 09/20/2022, I interviewed DCW Schmidt who reported that she had not been fingerprinted. DCW Schmidt reported that administrator Flores sets that up but that she had not been to the facility recently. DCW Schmidt reported that she knows that this needs to be done but she is not sure when that will happen.

APPLICABLE RULE	
MCL 400.734	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislalture; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those

	fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	DCW Higgins and DCW Schmidt's employee records did not contain any documentation either direct care staff member had been fingerprinted as required. Both DCW Higgins and DCW Schmidt reported that they have not yet been fingerprinted. DCW Higgins and DCW Schmidt have had direct contact with residents and both should have been fingerprinted prior to the assumption of duties as a DCW.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 09/19/2022, I conducted an unannounced investigation and I interviewed DCW Higgins who reported that she was not trained in First Aid, CPR, personal care, supervision and protection, resident rights, safety and fire prevention and prevention and containment of communicable diseases

I reviewed the employee record of DCW Higgins. DCW Higgins employee record documented that her date of hire was 08/09/2022 and contained a document that was labeled as "Employee File Checklist." The "training log/CPR" section of the document was blank. DCW Higgins employee record also contained a document titled, *Employee Training Refresher Requirements*. This document had trainings that were labeled "at hire and every 2 years" or "at hire and annually." This document was completely blank. DCW Higgins employee record did not contain any documentation she had been trained in reporting requirements, First Aid, CPR, personal care, supervision and protection, resident rights, safety and fire prevention and prevention and containment of communicable diseases prior to the assumption of duties.

I reviewed DCW Schmidt's employee record which documented her date of hire was 7/30/2022. DCW Schmidt's employee record contained a document that was

labeled as “Employee File Checklist.” The “training log/CPR” section of the document was blank. DCW Schmidt’s employee record also contained a document titled, *Employee Training Refresher Requirements*. This document had trainings that were labeled “at hire and every 2 years” or “at hire and annually.” This document was completely blank. DCW Schmidt’s record did not contain any documentation that she had been trained in reporting requirements, First Aid, CPR, personal care, supervision and protection, resident rights, safety and fire prevention and prevention and containment of communicable diseases prior to the assumption of duties.

On 09/19/2022, DCW Higgins and Kaylie Shepard reported DCW Higgins performed CPR on Resident A on 09/10/2022 while he was choking. DCW Higgins reported she nor DCW Schmidt were trained in CPR.

On 09/19/2022, I interviewed Kaylie Shepard who reported she had provided me with DCW Higgins and DCW Schmidt’s complete employee records which contained all of the documents the licensee had for DCW Higgins and DCW Schmidt.

On 09/20/2022, I interviewed DCW Schmidt who reported that she had not been trained in First Aid, CPR, personal care, supervision and protection, resident rights, safety and fire prevention and prevention and containment of communicable diseases at any time even though she had been working with residents since the start of her employment. DCW Schmidt confirmed performing the Heimlich maneuver, which is an act of First Aid, on Resident A while he was choking and confirmed observing DCW Higgins performed CPR on Resident A on 09/10/2022 while he was choking. DCW Schmidt reported administrator Flores was supposed to schedule both her and DCW Higgins for training.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**

ANALYSIS:	DCW Higgins and DCW Schmidt both reported that they have not been trained in First Aid, CPR, personal care, supervision and protection, resident rights, safety and fire prevention and prevention and containment of communicable diseases. I reviewed DCW Higgins and DCW Schmidt's employee records. Neither record contained documentation that the DCWs were competent and trained in the above areas prior to the assumption of duties. Additionally, DCW Higgins, DCW Schmidt and Kaylie Shepard all reported both DCW Higgins and DCW Schmidt performed First Aid and CPR acts in attempt to stop Resident A from choking and help him breathe without training therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 09/19/2022, I conducted an unannounced investigation, and I reviewed the employee record of DCW Higgins whose date of hire was 08/09/2022. DCW Higgins employee record contained a document that was labeled as "*Employee File Checklist*" and the "Medical Clearance/TB" portion was left blank on the form. DCW Higgins employee record did not contain a *Medical Clearance* nor any documentation that she has been tested for communicable tuberculosis (TB).

DCW Edwina Schmidt's employee record documented her date of hire was 7/30/2022. DCW Schmidt's employee record contained a document that was labeled as "Employee File Checklist" and the "Medical Clearance/TB" portion was left blank on the form. DCW Higgins employee record did not contain a *Medical Clearance* nor any documentation that she has been tested for communicable tuberculosis.

On 09/19/2022, DCW Higgins reported that she has not completed a *Medical Clearance* or a TB test.

On 09/19/2022, I interviewed Kaylie Shepard who reported she had provided me with all of the documents the licensee has for DCW Higgins and DCW Schmidt.

On 09/20/2022, DCW Schmidt reported that she has not completed a *Medical Clearance* or a TB test.

APPLICABLE RULE	
R 400.15205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed

	by a licensed physician or his or her designee attesting to the physician's knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home. **(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.**
ANALYSIS:	DCW Higgins and DCW Schmidt both reported that they have not completed *Medical Clearances* or testing for communicable tuberculosis. DCW Higgins and DCW Schmidt's employee records did not contain documentation from a licensed physician attesting to the physician's knowledge of each employee's physical health nor each employee record contain evidence each employee had been tested for communicable tuberculosis.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 09/19/2022, I reviewed Resident A's record which contained a written *Assessment Plan for AFC Residents* that was dated 1/17/2019 and signed by Resident A and licensee designee Jeffrey Shepard. At the time of the unannounced investigation Resident A's record did not contain any updated written *Assessment Plan for AFC Residents* dated 2020, 2021, or 2022 nor did Resident A's record contain any documentation Resident A and/or his designated representative participated in the completion of an updated written *Assessment Plan for AFC Residents* during any of those years either.

On 09/19/2022, I interviewed Kaylie Shepard who reported all the documents for Resident A were provided in Resident A's resident record.

APPLICABLE RULE	
R 400.15301	**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 licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A's record contained a written *Assessment Plan for AFC Residents* that was dated 1/17/2019 that was signed by Resident A and licensee designee Jeffrey Shepard. At the time of the unannounced investigation Resident A's record did not contain any updated written *Assessment Plan for AFC Residents* for 2020, 2021, or 2022 or information Resident A and/or his designated representative participated in an updating his written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

11/07/2022

_____

Julie Elkins Date
Licensing Consultant

Approved By:

11/09/2022

_____

Dawn N. Timm Date
Area Manager