



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 6, 2025

Daniel Sherman
Riversbend Rehabilitation Inc
3707 Katalin Ct.
Bay City, MI 48706

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| RE: License #: | AS090297500 |
| Investigation #: | Amended 2026A0123006 Westwood |

Dear Daniel Sherman:

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.

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.

This report was amended to add clarification on which nursing staff authored the nurse progress notes received on 12/16/2025. The clarified information is in the last paragraph of page 14, in the second, third, and sixth sentences of the paragraph.

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) 643-7960.

Sincerely,

A handwritten signature in cursive script, appearing to read "Shamidah Wyden".

Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

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|---------------------------------------|---|
| License #: | AS090297500 |
| Investigation #: | 2026A0123006 |
| Complaint Receipt Date: | 11/12/2025 |
| Investigation Initiation Date: | 11/14/2025 |
| Report Due Date: | 01/11/2026 |
| LicenseeName: | Riversbend Rehabilitation Inc |
| Licensee Address: | 3707 Katalin Ct. Bay City, MI 48706 |
| Licensee Telephone #: | (989) 284-7267 |
| Administrator: | Daniel Sherman |
| Licensee Designee: | Daniel Sherman |
| Name of Facility: | Westwood |
| Facility Address: | 4762 Westview Bay City, MI 48706 |
| Facility Telephone #: | (989) 671-2148 |
| Original Issuance Date: | 10/08/2008 |
| License Status: | REGULAR |
| Effective Date: | 04/08/2025 |
| Expiration Date: | 04/07/2027 |
| Capacity: | 4 |
| Program Type: | PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED |

II. ALLEGATION(S)

| | Violation Established? |
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| On 08/19/2025, Resident A's safety and protection were not ensured when Resident A had a medical emergency. | No |
| Additional Findings | Yes |

III. METHODOLOGY

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| 11/12/2025 | Special Investigation Intake 2026A0123006 |
| 11/14/2025 | Special Investigation Initiated - Letter Email sent to Complainant 1 requesting additional information. |
| 11/17/2025 | Contact - Document Received Email received from Complainant 1 clarifying name and address of facility. |
| 11/18/2025 | Inspection Completed On-site I conducted an unannounced on-site at the facility. |
| 11/18/2025 | Contact - Telephone call made I interviewed LD Dan Sherman. |
| 12/03/2025 | Contact - Telephone call made I left a voicemail requesting a return call from Chelsea Carrick, RN. |
| 12/03/2025 | Contact - Telephone call made I made an attempted call to Relative 1. |
| 12/03/2025 | Contact - Telephone call made I attempted a call to Relative 2. I left a voicemail. |
| 12/03/2025 | Contact - Telephone call received I interviewed Relative 1. |
| 12/03/2025 | Contact - Telephone call received I received a voicemail from Chelsea Carrick, RN. |
| 12/03/2025 | Contact - Telephone call made |

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| | I interviewed Chelsea Carrick, RN. |
| 12/03/2025 | Contact - Telephone call made I attempted a call to staff Kaley Smith. |
| 12/03/2025 | Contact - Telephone call made I made an attempted call to staff Jehremy Avalos. |
| 12/09/2025 | Contact- Documentation Received I received requested documentation via fax. |
| 12/15/2025 | Inspection Completed On-site I conducted a follow-up on-site at the facility. |
| 12/16/2025 | Contact- Telephone call made Follow-up call with Chelsea Carrick, RN. |
| 12/16/2025 | Contact- Document Sent I sent an email to Dr. Kevin Ginnebaugh, MD. |
| 12/16/2025 | Contact- Telephone call made I left a voicemail requesting a return call from Laura Pfenninger, M.A. |
| 12/16/2025 | Contact- Telephone call received I spoke with Dr. Kevin Ginnebaugh, MD. |
| 12/16/2025 | Contact- Telephone call received I received a voicemail from Laura Pfenninger, M.A. |
| 12/16/2025 | Contact- Document received Requested documentation received via fax. |
| 12/17/2025 | Contact- Telephone call made I interviewed Laura Pfenninger, M.A. |
| 12/17/2025 | Contact- Telephone call made Follow-up call to home manager Janessa Hoffman. |
| 12/17/2025 | Contact- Telephone call made Attempted call to Bay County Medical Examiner. |
| 12/17/2025 | Contact- Document Sent Email sent to Bay County Medical Examiner requesting a call back. |
| 12/19/2025 | Contact- Document Sent |

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| | Email sent to Complainant 1. |
| 12/19/2025 | Contact- Document Received Email received from Complainant 1. |
| 01/05/2026 | Exit Conference I spoke with licensee designee Dan Sherman. |

ALLEGATION: On 08/19/2025, Resident A's safety and protection were not ensured when Resident A had a medical emergency.

INVESTIGATION: On 10/31/2025, the Bureau of Community and Health Services received an online complaint regarding the allegations above. I was assigned the complaint for investigation on 11/14/2025. The complaint noted that Resident A was eating a peanut butter and jelly sandwich, as Relative 1 was visiting, and 20 minutes after Relative 1 left the facility, Relative 1 received a call that Resident A was not breathing. The complaint also noted that nurse Chelsea Carrick, RN stated that it may have been the PICC line (peripherally inserted central catheter) Resident A had that may have caused a blood clot to the heart, Resident A was known to have an issue with swallowing, a previous choking event while sitting in a recliner, and at the time of this choking, Riversbend did not have a LifeVac. It should be noted that a LifeVac is not required in AFC homes.

On 11/18/2025, I conducted an unannounced on-site at the facility. I interviewed staff Alex Burgett. Staff Burgett stated that he was not working at the facility on the day that Resident A passed away. Staff Burgett was the only staff in the home upon arrival, and no residents were present. Staff Burgett called home manager Janessa Hoffman to report to the home.

During this on-site, home manager Janessa Hoffman arrived at the facility. I interviewed Staff Hoffman. Staff Hoffman stated that she was present the day Resident A passed away. Staff Hoffman stated that Resident A had a PICC line due to having an antibiotic resistant urinary tract infection (UTI), and the day Resident A passed away was the last day of the UTI treatment. Staff Hoffman stated Resident A had returned to the facility from an antibiotic infusion treatment. Resident A had lunch, and Relative 1 was at the facility visiting with Resident A. Resident A was holding a bite of peanut butter and jelly sandwich in his mouth. Staff Kaley Smith had the bite of sandwich put in a cup, swabbed and cleared Resident A's mouth, and had Resident A sip something to drink. Resident A was then in the living room sitting forward. Staff Hoffman stated that she was sitting in the van about to transport another resident to therapy when staff Kaley Smith ran out to tell Staff Hoffman that Resident A was not breathing. Staff Hoffman stated that Resident A had no pulse, was not breathing, and did not show signs of choking. Staff Hoffman stated that staff had been keeping an eye on Resident A because Resident A was not acting his normal self. She stated that they had to contact Relative 1 to come back to the home about 20 minutes after Relative 1 had initially left. Staff Hoffman stated that the

facility does have a LifeVac. She stated that Staff Smith pulled the solo cup out of the trash that day and showed the food that she had Resident A spit out. Staff Hoffman stated the family did not opt to have an autopsy completed, but they wished they would have, as they all wanted to know how Resident A passed away. She stated that staff attended the end of life celebration, and all of the staff took the loss hard.

During this on-site, Staff Hoffman pointed out the facility's LifeVac, sitting in a box above the file cabinet in the home's medication room. I took a photo of the LifeVac.

During this on-site, I took photos of documentation from Resident A's file. Resident A's *AFC-Resident Information and Identification Record* notes that Resident A moved into the facility on 10/13/2008.

An *AFC Licensing Division- Incident/Accident Report* dated 08/19/2025 at 12:30 pm states the following:

"[Resident A] had just finished eating lunch- holding last bite of food in his mouth. Staff (Kaley) cued [Resident A] to spit out the bite and he did. Took a drink and staff moved him from the table to the living room with a blanket to watch tv. Moments later, staff noticed [Resident A] was not breathing. Kaley immediately called 911 and Jehremy and home supervisor (Janesa) began CPR until emergency services arrived. Efforts ineffective, emergency services took over care. No known cause of death."

The incident report notes that Relative 1 and Chelsea Carrick, RN were contacted via phone.

A copy of Resident A's *Health Care Appraisal* dated 10/13/2024 notes that Resident A was on a regular diet, had a TBI (traumatic brain injury), and used a wheelchair. The health care appraisal was completed by Andrew Delano, RN, BSN.

On 11/18/2025, I interviewed licensee designee Dan Sherman via phone. LD Sherman stated that all of the facilities they own are each equipped with a LifeVac. LD Sherman stated that to his knowledge Relative 1 sat with Resident A while Resident A had lunch. Staff checked and cleared Resident A's mouth. Relative 1 left the facility, then 20 minutes later staff had to call Relative 1 to come back to the facility. LD Sherman stated that staff did CPR right away. Resident A was a longtime resident, and the loss was crushing to the staff as Resident A was loved. LD Sherman stated he does not believe there was any wrongdoing, and the family did not do an autopsy. LD Sherman stated that he wanted to know what happened to Resident A. LD Sherman stated that staff Jehremy Avalos did CPR right away, and the nurse, Chelsea Carrick, RN ran over to the facility as well.

On 12/03/2025, I interviewed Relative 1 via phone. Relative 1 is Resident A's guardian. Relative 1 stated that according to an autopsy completed by a private pathologist named Dr. Spitz, Resident A choked to death. Relative 1 stated they did

not think the staff provided proper care or supervision to Resident A, and staff should have been watching Resident A more carefully. I requested a copy of the death certificate and autopsy report from Relative 1. Relative 1 stated that Relative 3 has that information and it was turned over to an attorney. Relative 1 stated that Resident A had been eating a peanut butter and jelly sandwich at the table and some other stuff. There were no staff at the table with Resident A paying attention. Relative 1 stated that it was their understanding that someone was to watch Resident A and make sure that Resident A was not holding anything in his mouth. Relative 1 stated that Resident A had a swallow study completed in the past, but all food was eaten by mouth. Relative 1 stated that staff were supposed to have things in bite size pieces for most of the things Resident A ate. Relative 1 stated the peanut butter and jelly sandwich was not in bite size pieces. Relative 1 stated that Resident A had a PICC line for an infusion of antibiotics that was for 14 days because of a urinary tract infection. Relative 1 stated that when arriving back to the facility after receiving the call about Resident A, Resident A was lying in bed and was deceased. Resident A had gone from the table/lounge chair to the bed. Relative 1 denied seeing any food on Resident A's face or around Resident A's mouth at this time. Relative 1 stated that about 15-20 minutes after leaving the facility, is when the call was received from staff that Resident A had quit breathing. Relative 1 stated that Resident A had a traumatic brain injury and had lived at the facility for over 17 years. Resident A could carry a conversation if you initiated it. Resident A did not express any concerns about his care to Relative 1. Relative 1 denied knowing when Resident A last had a choking incident and stated *"we weren't there all the time. They didn't always tell us."*

On 12/03/2025, I interviewed Riversbend Rehabilitation, Inc. nurse Chelsea Carrick, RN. Nurse Carrick stated that she was not present at the facility when the event transpired, but she did report to the facility that day. She stated that she received a call at 12:31 pm that day. She stated that when she arrived, EMS were giving full code CPR, and was attempting to intubate Resident A. She stated that another EMS worker called a medical director to get the okay to stop all life saving measures. EMS also called the medical examiner who did not think an autopsy was warranted, but the family had the final say. The EMS workers were either from Medstar or MMR. The fire department was there as well. Nurse Carrick stated she does not know the cause of death. She stated that she only speculated that maybe it had to do with Resident A's PICC line. It was Resident A's last infusion, and PICC lines are associated with blood clots. She stated that after staff fed Resident A lunch, Resident A was in the living room sitting with another resident. Staff walked by and found Resident A to be unresponsive. Staff had been in the kitchen area cleaning up and putting away the food just prior. She stated that she thinks there may be only one incident report about a prior choking incident. She stated that she believes staff Jehremy Avalos did CPR initially, and EMS took over when they arrived. Nurse Carrick stated that Resident A did not have a swallow study on file that she is aware of since she began working in 2022. Resident A was on a regular diet and was able to communicate. She stated that you could hear if Resident A was coughing and clearing his throat, because Resident A could do that on his own. She denied that any of Resident A's family expressed any concern to her directly. She stated that

staff were distraught, as they had worked with Resident A for many years. Nurse Carrick stated that each of their facilities is equipped with a LifeVac. She stated that a speech and language pathologist provided them with LifeVacs. She stated that per Resident A's records, a speech therapist named Laura Pfenninger, M.A., CCC-SLP recommended that Resident A complete a MBS (*modified barium swallow study*), but the swallow study was declined in March 2025 by Relative 1. I requested additional documentation from Nurse Carrick during this call.

On 12/04/2025, I received a copy of Resident A's *Feeding and Swallowing Guidelines* for Resident A, dated 01/29/2025. It is signed by speech-language Pathologist Laura Pfenninger, M.A., CCC, SLP. Some of what the guidelines state are the following:

- *1:1 supervision and assist to feed as needed (you must be sitting with him during all meals and snacks)*
- *Sit at 90 degrees upright from hips*
- *Take a drink following 2-3 bites of food*
- *Small bites, ¼ size teaspoon for meat, and ½ teaspoon for all other food. Cut food into bite size pieces*
- *Check for pocketing of food in cheeks throughout meals & at the end of meals.*

On 12/09/2025, I emailed Complainant 1 requesting any documentation such as a death certificate or autopsy report. The same day, I received a copy of an autopsy report via email dated 10/23/2025. In the email, Complainant 1 noted that Gephart Funeral Home picked Resident A's body up from the facility and asked the family of Resident A if they wanted an autopsy to be conducted, but the family was denied by the Bay County Medical Examiner according to Gephart Funeral Home. The family contacted Dr. Spitz who completed the autopsy.

The autopsy report dated 08/22/2025 was conducted by Michigan Forensics-Forensic Pathology and Toxicology located out of Grosse Pointe Farms, Michigan. The report is signed by forensic pathologist Kevin Ginnebaugh, M.D. on 10/23/2025. The final diagnoses listed for Resident A are:

Choking

- *Food bolus with complete occlusion of the proximal trachea and distal bronchi and bronchioles*

Hypertensive and atherosclerotic cardiovascular disease-

- *Concentric biventricular hypertrophy*
- *Biventricular dilation*
- *Cystic nephrosclerosis*
- *Coronary and aortic atherosclerosis*

Nephrolithiasis

Blunt impact injuries

- *Ischemic infarction of the left basal ganglia and left parietal lobe of the brain, remote*
- *Encephalomalacia*
- *Abrasions and contusions of skin, minor*

The opinion Kevin Ginnenbaugh, M.D. wrote is as follows:

“Based on the autopsy findings and the information currently available to me, it is my opinion that [Resident A] died as a result of choking. A remote infarction of the brain and hypertensive and atherosclerotic cardiovascular disease were contributory conditions. A review of medical records would allow for further correlation of the autopsy findings with the clinical course and history. Additional opinions may be generated if such a review is requested.”

On 12/09/2025, I received requested documentation from Chelsea Carrick, RN. A copy of a *Dysphagia Update* written by speech and language pathologist Laura Pfenninger, M.A., CCC- SLP dated 03/18/2025 states the following:

“This clinician spoke with [Resident A’s] guardian, [Relative 1], to update him on reported issues from the staff regarding [Resident A’s] difficulty with various food. I stated that [Resident A] has been coughing and occasionally choking on various foods, with one instance over the weekend with baked beans where [Resident A] required back blows to clear, and the next step would be to have a Modified Barium Swallow (MBS) study completed to provide recommendations for any possible diet changes and/or mealtime modifications that can be made to allow for safer oral intake. [Relative 1] stated that he does not think that is necessary at this time and that staff just need to make sure that his food is cut into small pieces and that they are sitting with him at all times to stop him from choking before it happens. I stated that he is 1:1 supervision and they are to be sitting with him during all meals and snacks but he questioned if that is actually happening. I stated that I would review this with the staff and that he could sign a waiver stating he would like to decline the recommended MBS study for [Resident A] but [Relative 1] stated that he would not be signing anything since he does not believe that the staff are following their jobs during mealtime. After the phone call, I reached out to the home supervisor and she stated that they are always within arm’s reach of him and they provide both verbal and hand-over-hand cues for bite-size and pacing as needed. She stated that it appears to be a timing issue of when he takes in a breath that sometimes causes him to cough/choke. I stated that if needed they could continue to pulse his food in a blender if he is having difficulty (so it’s finely chopped but not pureed) and to contact me with any further concerns or if they notice a pattern of food he is having difficulty with and we would possibly make modifications to his diet as needed.”

On 12/09/2025, I received requested documentation from Chelsea Carrick, RN. A copy of a *Dysphagia Update* written by speech and language pathologist Laura Pfenninger, M.A., CCC- SLP dated August 2025 states the following:

“08-05-2025: This clinician spoke with the Riversbend nurse Andrew and he stated that [Resident A’s] psychiatrist, Dr. Wierserma, had recommended him to be evaluated for VitalStim therapy due to him holding his food. It was discussed with the nurse that he can be evaluated however, VitalStim therapy would not address him holding his food but rather it could target a swallowing dysfunction. The nurse stated that he has a UTI and it was discussed that potentially any loss of appetite or confusion, including holding food, could be secondary to the UTI.”

“08-06-2025: This clinician spoke with the Westwood staff Colleen and she shared that he had not started his medication for his UTI but she shared that he had been holding food at times, refusing to eat, and his weight has been fluctuating. She stated that he started holding food and sometimes refusing to eat at the beginning of July, which there was speculation that was when his UTI may have started.”

“08-18-2025: This clinician spoke with Madison the OT (occupational therapist) about [Resident A] and she then referenced the weight logs and stated that [Resident A] has lost about 20 pounds since last month. This clinician had asked if she had any suggestions to help with him holding his food if it’s not related to the UTI and she did not have any suggestions but stated she thought that it may be secondary to apraxia/motor planning.”

“This clinician then called Westwood where [Resident A] lives and spoke with Colleen again. She stated that tomorrow is his last day of his medications through the PICC line but things were not improving like we had hoped with him eating more/not holding food. She stated that he is continuing to refuse meals at times, holding food at times, and also holding his medications in his mouth at times and not swallowing. She stated that sometimes he won’t eat at all. When that happens sometimes they will try a protein drink and he will drink it and other times he won’t. She stated that yesterday he ate 100% of his breakfast and only 50% of his lunch. Then stated sometimes he won’t eat his breakfast and then he’ll eat 50% of his lunch. When asked about his blood sugars, she stated that he hasn’t needed insulin much, so far he only needed it 3x this month and his blood sugars have been under 100. She stated that he didn’t want to drink yesterday, and he wouldn’t swallow and was holding the drink in his mouth. Stated that he is taking an hour to eat his meal. He weighed 182 last month and 166 this month. She stated that he is coughing at times, on drinks especially and that they continue to thicken his drinks to a nectar consistency and sometimes thicker if he is having trouble. It was discussed that if his parents agreed to it, an MBS could be ordered and if deemed appropriate, VitalStim therapy could be initiated to address any swallowing dysfunctions identified on the MBS which would possibly address the coughing at times that occurs during oral intake and to possibly get him to be able to safely drink thin liquids again. This clinician stated that treatment would begin once the MBS study results were received if his parents agreed to both the MBS and VitalStim therapy. It was stated that this clinician would call the nurse and recommend the possibility of him being evaluated for a PEG/feeding-tube to address him holding food/refusing to eat.”

“This clinician then called the other SLP and she also did not have any suggestion on how to resolve the issue of him not eating and holding his food. She also stated that VitalStim would not address this issue of him not eating and holding his food but they could attempt to rub his throat but this would not be a functional way to initiate a swallow for him throughout a whole meal to sustain adequate oral intake. She also agreed with this clinician that it may be time for him to be evaluated for a PEG/feeding tube since things weren’t resolved from him being treated for the UTI.”

“This clinician then called the director of rehab with the recommendations for [Resident A] which were the following: he should be evaluated to determine if a PEG-tube/feeding tube should possibly be placed. It was also stated that if his parents agreed to it, that he should complete an MBS study to determine any swallowing dysfunctions, any possible changes with his current diet, and to determine if VitalStim would be appropriate. It was discussed that his parents refused this clinician’s last recommendation in March of 2025 for him to complete an MBS to determine if any diet modifications should be made or any new strategies could be implemented during meals to assist with safety. The director stated he did not want this clinician to call his family but would contact the nurse to update her on the situation so she could call the family with the clinician’s recommendations. He stated that this clinician could follow up with the nurse to update her on his situation as well.”

“This clinician received a text message from the nurse Chelsea that [Resident A] was scheduled for a head CT scan September 4th. This clinician called her immediately after to update her with all the above information and she stated she was going to call his family with the above recommendations that were discussed with the director of rehab.”

“08-19-2025- After the news of [Resident A’s] passing on August 19th, this clinician did reach out to the nurse and she stated that she was able to speak with [Resident A’s] [Relative 1] around 4:30 on the previous day and he was open to the idea of [Resident A] getting an MBS and possibly participating in VitalStim therapy because he has also noticed changes with [Resident A]. She also stated that it may be time to consider doing a PEG/feeding tube due to him holding food.”

On 12/15/2025, I conducted an unannounced follow-up on-site at the facility. I conducted the following interviews with staff Kaley Smith, staff Jehremy Avalos, Resident B, and staff Colleen Bullock:

I interviewed staff Kaley Smith. Staff Smith stated that she has worked in the facility for about five years. Staff Smith stated that on 08/19/2025, Resident A was eating lunch at the kitchen table. Resident A was not his normal self that week. Resident A had a PICC line, and she thought he may have been tired from the medication/UTI infection. She stated that it was Resident A’s last day of antibiotics. Staff Smith stated that Resident A, when sick, would not chew food well, would hold food in his mouth, and not eat well. Staff Smith stated that she was sitting with Resident A, while

Resident A was eating. Staff Smith stated that Relative 1 came to the facility while Resident A was eating. Resident A had a peanut butter jelly sandwich and some soup. When Relative 1 arrived, Resident A was eating a second bite of the sandwich. Relative 1 said to Resident A, "*eat your food, [Resident A].*" Staff Smith stated that Relative 1 passed through to drop off some paperwork and did not sit down with Relative 1 to eat. Relative 1 was only in the home for a couple of minutes. Staff Smith stated that she was right at the table with Resident A, helping Resident A eat. Staff Smith stated that she initially had Resident A's sandwich cut in half at first, then started cutting the sandwich up more while Resident A was holding the third bite in his mouth. She stated that Resident A held the third bite in his mouth for about five minutes and did not take any more bites of the sandwich after that. She stated that after Relative 1 left, she had Resident A spit out the third bite into a cup. She stated that she was watching Resident A eat the whole time. Staff Smith stated that staff were told to be at the table with Resident A because Resident A had been acting very tired that whole week, and not himself. Resident A had been sleeping a lot more. Staff Smith stated that she does not recall leaving the table while Resident A was eating, but if she did it was only to the kitchen island that is right next to the dining room table. She stated that after Resident A spit the third bite of peanut butter and jelly sandwich into the cup, Resident A had something to drink, then sat at the table for about two minutes with Resident B. She stated that Resident A was not very talkative generally but would say a few words and nod. She stated that Resident A at that time was staring while holding his mouth open, at Resident B. After about three minutes, she moved Resident A to the living room, gave Resident A a neck pillow, and blanket. She stated that Resident A did not make any sounds or anything, just closed his eyes after she gave Resident A the neck pillow. Resident A looked ready for his regular nap and looked fine at this time. Staff Smith stated that she walked to the kitchen, and within about a minute, Staff Jehremy Avalos said, "*does he look pale to you?*" After she saw Resident A, Staff Smith stated that she ran to the office to call 911 and ran out to the garage to get home manager Janessa Hoffman. She stated that Staff Hoffman ran in to assist Staff Avalos. Staff Smith stated that Staff Avalos and Staff Hoffman did CPR immediately. Staff Avalos had started CPR before she ran to get Staff Hoffman. Staff Smith stated that the EMT's arrived, and suctioned Resident A, but nothing came out. She stated that the EMT's stated Resident A's airway was clear. Staff Smith stated that she pulled the last bite of peanut butter and jelly sandwich out of the trash to show nurse Chelsea Carrick, RN. Staff Smith stated that she does not know what happened to Resident A. Staff Smith stated that Resident A's parents had their own dietary guide they wanted staff to follow, and she believes that at the time Resident A passed away, she believes his liquids were thickened. Staff Smith stated that Resident A's parents always refused swallow study tests and did not want Resident A on a pureed diet. She stated that it was recently put in Resident A's plan a couple months prior for staff to not go into another room while Resident A eats. She stated that it was her understanding that staff had to stay within line-of-sight. Resident A could put food to mouth on his own, but if Resident A gave up halfway, staff assisted with feeding. Staff Smith stated that the only issue she recalled was Resident A not swallowing the third bite of peanut butter and jelly sandwich, but that was not abnormal. She stated that she thinks Resident A chewed

the first two bites pretty good without struggling. Resident A was taking his time chewing it slowly. When asked if Resident A had any noticeable bruising that day, Staff Smith stated that a bruise was noticed on the back of the leg, and Staff Hoffman had reported it to the nurse, and staff were instructed to keep monitoring it. She stated that she is not sure if Resident A bruised easily, and that Resident A usually never had a lot of bruises. She stated that she could not recall if it was on a physician's order to cut Resident A's food up into bite sized pieces, but the directions to do so came from the speech therapist, and it would change often. She stated that they would cut up food when Resident A was sick, and Resident A's parents were against pureed food. Staff Smith stated that she does not know what happened to Resident A and wishes that an autopsy would have been conducted. She stated that the family was appreciative and told staff they did everything they could in the situation, so to have any investigation now is shocking.

I interviewed staff Jehremy Avalos. Staff Avalos stated that he has worked with the company for about 11 to 12 years, and in this facility for about four months. Staff Avalos stated that on 08/19/2025, he got Resident A up for the day and ready for a medical appointment for Resident A's PICC line meds. Resident A appeared fine, and there were no signs of distress. Staff Avalos stated Resident A had breakfast before or after the appointment. Nothing alarming happened during this time. Staff Avalos stated that he left the facility again at lunchtime to do transports and was gone during the lunch hour. When he arrived back at the facility (he couldn't recall exact time), he walked through the living room, and saw Resident A's lips were white/blue, said to staff Kaley Smith "*he looks very pale, what's going on here?*" He stated that he saw Resident A was not breathing, tilted Resident A's wheelchair back almost flat, and began chest compressions. Staff Avalos stated that was his first instinct. Staff Avalos stated that Staff Smith had jumped up, looked at Resident A, then ran to get staff Janessa Hoffman. Staff Avalos stated that one of the other staff called 911, but he did not know which one because he was doing CPR on Resident A. Staff Avalos stated that everything happened so fast, EMTs arrived and took over. Staff Avalos stated that he had to leave the facility again to do transports. Staff Avalos stated that Resident A was pretty independent with eating/feeding, but he'd assist Resident A at times. Resident A's food was always cut up in small bites, and Resident A was also on thick-it. Staff Avalos denied there was any significant bruising on Resident A. He stated that the EMT's took Resident A out of the wheelchair, and placed Resident A onto the floor, but believes the EMTs were very careful in doing so. Staff Avalos stated that Resident A had a big wheelchair that tilted almost completely flat. Staff Avalos stated that Resident A did not have any diet restrictions and was not on pureed foods. Staff Avalos stated that Resident A did eat a lot of peanut butter in oatmeal, or on waffles and bananas. He stated that Resident A did not eat too many peanut butter and jelly sandwiches. He stated that Resident A could tell staff what he wanted to eat, and Resident A never really argued about the home's menu. Staff Avalos stated that Resident A's food guidelines for bite size pieces hung on the refrigerator.

I interviewed Resident B outside on the porch of the facility. Resident B stated that on the day Resident A passed away (08/19/2025), Resident B was sitting about two feet from Resident A in the living room. Resident B stated they do not know how Resident A passed away. Resident B stated that it was an emotional experience, as Resident B lived with Resident A for four years. Resident B stated that it happened after lunch time. Resident B looked over at Resident A and thought Resident A had something in his mouth, and Resident B had asked Resident A if Resident A had any pills in his mouth. Resident B stated that Resident A's eyes glazed over. The first responders arrived, and one was taking their time outside smoking a cigarette. Resident B reported not remembering exactly which staff were present that day but did remember Staff Smith and Staff Hoffman being present. Resident B stated that after Resident A died, Resident A was placed in his bed. Resident B reported thinking that Resident A died of natural causes. Resident B stated that Resident A was not coughing or making any noises. Resident B reported believing staff did all they could, and no one fell short that day. Resident B stated that the funeral home came with the hearse. Resident B stated that Resident A was not very social and did not talk much. Resident B stated that Resident A had a choking incident a while ago, and Staff Smith gave Resident A the Heimlich maneuver. Resident B reported feeling safe, and needs are being met. Resident B reported sitting at the table with the other residents, and that staff would usually be at the counter or kitchen within line of sight. Resident B stated that Resident A did not show any signs of choking that day.

I interviewed staff Colleen Bullock. She stated that she is a stand-in supervisor. She stated that she worked with Resident A for about 12 years. She stated that back in February 2024, she went to the hospital once with Resident A. While in the hospital, Resident A aspirated on Nystatin mouth wash. She stated that Resident A's parents were there, and one of them said "*they're going to want a swallow study now.*" Staff Bullock stated that Resident A's parents refused swallow studies multiple times, so every time there was a concern, she would document it. She stated that Resident A was seen in the hospital for thrush in February 2024, went to Mid-Michigan for blood cultures and a rapidly developing infection, then went to McClaren hospital and that's when Resident A aspirated. Staff Bullock showed me an incident report noting the hospital visit that occurred on 02/29/2024. She stated that this incident was also noted in their doctor's book. On this incident report, it does indicate that Relative 1 was notified at 12:25 pm on 02/29/2024 of the incident.

During this on-site, I observed the residents present in the home. They were clean and appropriately dressed. No issues were noted.

On 12/16/2025, I made a follow-up call to Chelsea Carrick, RN. She confirmed that the feeding and swallowing guidelines from January 2025 written by speech-language pathologist Laura Pfenninger, M.A., CCC, SLP, was the most updated guideline for Resident A. She stated that she was not sure if softer foods like peanut butter and jelly sandwiches had to be cut to bite size or not. She stated that any coughing episodes by Resident A would not be missed. It would be audible and visible. She denied having any knowledge of any bruising until she was notified of a

bruise behind Resident A's leg. Nurse Carrick stated that she had called Resident A's primary care physician about one to two days before Resident A passed away. Resident A had been holding medication in his mouth, not swallowing foods, and holding foods more frequently. Resident A had also experienced rapid weight loss. She stated that a message was left for the PCP regarding a CT scan to rule out neurological issues. The message was left on 08/18/2025. Resident A's last physician's appointment was on 07/28/2025, and a urinalysis was ordered. She stated that it was coordinated for Resident A to receive a PICC line on 08/06/2025, and Resident A received the first dose of medication that day.

On 12/16/2025, I spoke with forensic pathologist, Dr. Kevin Ginnebaugh, M.D from Michigan Forensics. Dr. Ginnebaugh conducted the autopsy on Resident A. Dr. Ginnebaugh stated that there was food in Resident A's windpipe from the lungs up to the throat. He stated that it was blocking any air you'd want to breath and is seen in anyone that chokes or aspirates. Dr. Ginnebaugh stated that the condition Resident A had (brain injury) would predispose someone to choking. He stated that it is possible to not show signs of choking, but he was not present, and that based on the autopsy, Resident A choked. Dr. Ginnebaugh stated that Resident A's rib fractures were consistent with CPR, and that for any bruises, he just had to document the abrasion, but they were not relevant or concerning. Dr. Ginnebaugh stated that nephrolithiasis is kidney stones. The blunt impact injuries noted in the report are from a car accident from a long time ago. Encephalomalacia is an old injury, and Resident A had hypertension and heart issues as well.

On 12/16/2025, I received a copy of *Progress Notes* dated for July and August 2025 from Chelsea Carrick, RN. The progress notes are authored by Chelsea Carrick, RN and Andrew Delano, RN-BSN. Progress notes from Andrew Delano, RN-BSN dated 07/10/2025 stated that Resident A had an appointment with Shawn McNally, NP for follow-up. Staff discussed with the nurse practitioner about Resident A pocketing food, "*being off and more out of it lately*". A physical exam was completed. On 07/28/2025, Andrew Delano, RN-BSN noted that Resident A had an appointment with Shawn McNally, NP for a hospitalization follow-up. A conversation was held about Resident A holding on to medications, food, and water in his mouth. It was discussed Resident A may have a UTI. An UA (urinalysis) was ordered, and a follow-up appointment was scheduled for 09/16/2025 at 9:15 am. On 07/30/2025 a skin assessment was completed, and no issues were noted. On 08/18/2025, Chelsea Carrick, RN, noted that she made a call to Resident A's nurse practitioner's office due to Resident A still holding food and refusing to swallow more frequently. She stated that the thought was that it was due to the UTI, but Resident A's last dose of antibiotic is 08/19/2025. Resident A's Relative 1 was contacted regarding rapid weight loss, concerns were expressed and that Relative 1 was informed a CT scan was ordered to rule out neurological issues. On 08/19/2025, Nurse Carrick noted she received a call at 12:31 pm about Resident A being found unresponsive in his wheelchair. Staff initiated CPR and called 911 at 12:29 pm. She noted that when arriving at the facility, she observed EMS doing CPR on the living room floor. An advanced directive was provided to EMS after a dose of *Epi* was given around 12:42

pm, then all life saving measures were stopped. She noted the time of death was around 12:46 pm. Gephart Funeral Home arrived around 2:10 pm and picked Resident A's body up.

On 12/17/2025, I spoke with speech and language pathologist Laura Pfenninger, M.A., CCC, SLP. Laura Pfenninger stated that all foods that Resident A consumed should have been cut into bite sized pieces. She stated that she was just informed yesterday that Resident A had been eating a peanut butter jelly sandwich. She stated that in the past, the family did not always want staff to follow the guidelines, stating that Staff Hoffman recalled a time when the family did not want Resident A's sloppy joes to be cut into bite sized pieces. Laura Pfenninger stated that she only worked with Resident A twice in 2025. In March 2025 she recommended that Resident A have a swallow study completed. She stated that Relative 1 refused to sign the waiver noting the refusal. She stated that she does not have the ability to tell what is going on without a swallow study. She stated that Resident A required 1 to 1 supervision while eating, and that staff assist as needed with feeding if Resident A did not bring the fork to his mouth. Resident A would get stuck, and staff would have to provide guidance. Laura Pfenninger stated that she was going to start working with Resident A again after a swallow study was completed, as Relative 1 agreed to one right before Resident A passed away. She stated that she was going to start Vital stem therapy for swallow dysfunction, if the swallow study showed that there were issues. She stated that she thought that Resident A may have been experiencing dementia-like symptoms due to the UTI, because sometimes with a UTI, it causes confusion, a person will refuse to eat and hold food in their mouth. She stated that she believes Resident A had an antibiotic resistant UTI and needed special medication for it. She stated that she was told that the EMT's did try to suction Resident A and nothing came out. Laura Pfenninger stated that staff were supposed to follow the guidelines she set. She stated that she does not know if the family may have verbally changed it or complained at some point since she set the guidelines. Resident A had a regular diet with a few modifications. The guidelines were posted on the refrigerator. She stated that if Resident A was biting from a sandwich (and not bites), they should have reached out to her first.

On 12/17/2025, I made an unsuccessful attempt to contact Dr. William R. Morrone, DO, the medical examiner for Bay County. A phone call attempt was made, and an email was sent. There was no response.

On 12/19/2025, I received a copy of Resident A's *Certificate of Death* from Complainant 1. It notes the date of death as 08/19/2025. The actual or presumed time of death is noted as unknown. The time pronounced dead is 12:47 military time. The cause of death listed is sudden death due to multiple factors, *essential hypertensive heart disease, diabetes mellitus type 2- with complication, and age and gender matched gross decline in ADL with organic brain decline (wheelchair bound)*. The manner of death is noted as natural. The death certificate is dated 08/20/2025 and signed by Dr. William R. Morrone, DO.

On 01/05/2025, I conducted an exit conference with licensee designee Dan Sherman via phone. He stated that he did not have any additional comments. I informed him of the findings and conclusion.

| APPLICABLE RULE | |
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| R 400.689 | Resident health care. |
| | (3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately. |
| ANALYSIS: | <p>On 11/18/2025, I conducted an unannounced on-site at the facility. I interviewed home manager Janessa Hoffman. She stated that after lunch Resident A was in the living room, Staff Smith ran out to the garage to tell her that Resident A was not breathing. Staff Hoffman pointed out the LifeVac facility had. She stated that Resident A did not show signs of choking, and they did not know the cause of death.</p> <p>Staff Hoffman provided an <i>AFC Licensing Division-Incident/Accident Report</i> dated 08/19/2025. It notes that moments after being situated in the living room after lunch, staff noticed Resident A was not breathing. Staff Jehremy Avalos and Staff Hoffman immediately began CPR until emergency services arrived. Staff Kaley Smith called 911.</p> <p>On 11/18/2025, I spoke with licensee designee Daniel Sherman. Daniel Sherman stated that staff did CPR right away.</p> <p>On 12/03/2025, I spoke with Resident A's guardian, Relative 1. Relative 1 stated that about 15-20 minutes after leaving the facility, is when the call was received from staff that Resident A had quit breathing.</p> <p>On 12/03/2025, I interviewed Chelsea Carrick, RN. She stated that she received a call at 12:31 pm on 08/19/2025. She stated that when she arrived, EMS were giving full code CPR, and was attempting to intubate Resident A. She stated that another EMS worker called a medical director to get the okay to stop all life saving measures. She stated that she believes staff Jehremy Avalos did CPR initially, and EMS took over when they arrived.</p> <p>On 12/15/2025, I interviewed staff Kaley Smith, Staff Jehremy Avalos, and Resident B. They both stated that Staff Avalos noticed Resident A was not breathing. Staff Smith ran to get Staff Hoffman and called 911 immediately. Staff Avalos confirmed he</p> |

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| | initiated CPR right away. Staff Avalos stated the EMTs took over the CPR when they arrived at the facility. Resident B was interviewed and stated that Resident B stated that Resident A was not coughing or making any noises. Resident B reported believing staff did all they could, and no one fell short that day. Resident B reported that the first responders arrived to the home. There is no preponderance of evidence to substantiate a rule violation. |
| CONCLUSION: | VIOLATION NOT ESTABLISHED |

ADDITIONAL FINDINGS:

INVESTIGATION:

On 12/03/2025, I interviewed Relative 1 via phone. Relative 1 stated that staff were supposed to have things in bite size pieces for most of the things Resident A ate. Relative 1 stated the peanut butter and jelly sandwich was not in bite size pieces.

On 12/04/2025, I received a copy of Resident A's *Feeding and Swallowing Guidelines* for Resident A, dated 01/29/2025. It is signed by speech-language Pathologist Laura Pfenninger, M.A., CCC, SLP. Some of what the guidelines state are the following:

- *1:1 supervision and assist to feed as needed (you must be sitting with him during all meals and snacks)*
- *Sit at 90 degrees upright from hips*
- *Take a drink following 2-3 bites of food*
- *Small bites, ¼ size teaspoon for meat, and ½ teaspoon for all other food. Cut food into bite size pieces*
- *Check for pocketing of food in cheeks throughout meals & at the end of meals.*

On 12/15/2025, I conducted an unannounced follow-up on-site at the facility. I interviewed staff Kaley Smith and staff Jehremy Avalos. Staff Smith stated that on 08/19/2025, Resident A was eating lunch at the kitchen table. Staff Smith stated that she initially had Resident A's sandwich cut in half at first, then started cutting the sandwich up more while Resident A was holding the third bite in his mouth. She stated that Resident A held the third bite in his mouth for about five minutes and did not take any more bites of the sandwich after that. She stated that after Relative 1 left, she had Resident A spit out the third bite into a cup. She stated that she was watching Resident A eat the whole time. She stated that after Resident A spit the third bite of peanut butter and jelly sandwich into the cup, Resident A had something to drink, then sat at the table for about two minutes with Resident B.

I interviewed staff Jehremy Avalos. Staff Avalos stated that Resident A did not have any diet restrictions and was not on pureed foods. Staff Avalos stated that Resident A was pretty independent with eating/feeding, but he'd assist Resident A at times. Resident A's food was always cut up in small bites, and Resident A was also on thick-it. Staff Avalos stated that Resident A's food guidelines for bite size pieces hung on the refrigerator.

On 12/16/2025, I made a follow-up call to Chelsea Carrick, RN. She confirmed that the feeding and swallowing guidelines from January 2025 written by speech-language pathologist Laura Pfenninger, M.A., CCC, SLP, was the most updated guideline for Resident A. She stated that she was not sure if softer foods like peanut butter and jelly sandwiches had to be cut to bite size or not.

On 12/17/2025, I spoke with speech and language pathologist Laura Pfenninger, M.A., CCC, SLP. Laura Pfenninger stated that all foods that Resident A consumed should have been cut into bite sized pieces. She stated that she was just informed yesterday that Resident A had been eating a peanut butter jelly sandwich. Laura Pfenninger stated that staff were supposed to follow the guidelines she set. She stated that she does not know if the family may have verbally changed it or complained at some point since she set the guidelines. Resident A had a regular diet with a few modifications. The guidelines were posted on the refrigerator. She stated that if Resident A was biting from a sandwich (and not bites), they should have reached out to her first.

On 12/17/2025, I made a follow-up call to staff Janessa Hoffman, home manager. She stated that she cannot recall if staff were sitting at the table with Resident A, while Resident A was eating on 08/19/2025, but knows that they were watching Resident A eat. She stated that she could not recall if the peanut butter and jelly sandwich was cut into bite size pieces, as she did not prepare the meal. She stated that Resident A's feeding and swallowing guidelines were posted on the refrigerator. She stated that there is no set procedure for how often they review the guidelines with staff, but the staff present that day knew what the guidelines were.

On 01/05/2025, I conducted an exit conference with licensee designee Dan Sherman via phone. He stated that he did not have any additional comments. I informed him of the findings and conclusion.

| APPLICABLE RULE | |
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| R 400.689 | Resident health care. |
| | (1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional. |
| ANALYSIS: | On 11/18/2025, I interviewed staff Janessa who stated that Resident A showed no signs of choking on 08/19/2025. |

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| | <p>On 12/03/2025, I interviewed Relative 1 via phone. Relative 1 stated that staff were supposed to have things in bite size pieces for most of the things Resident A ate. Relative 1 stated the peanut butter and jelly sandwich was not in bite size pieces. Relative 1 stated there were no staff at the table with Resident A paying attention. Relative 1 stated that it was their understanding that someone was to watch Resident A and make sure that Resident A was not holding anything in his mouth.</p> <p>On 12/04/2025, I received a copy of Resident A's <i>Feeding and Swallowing Guidelines</i> written by speech and language pathologist Laura Pfenninger, M.A., CCC- SLP. It is dated 01/29/2025. The guidelines note that food is to be cut into bite sized pieces.</p> <p>On 12/15/2025, I interviewed staff Kaley Smith. Staff Smith stated that she initially had Resident A's peanut butter sandwich cut in half at first, then started cutting the sandwich up more while Resident A was holding the third bite in his mouth. Staff Smith stated that she was right at the table with Resident A, helping Resident A eat. Staff Smith stated that she does not recall leaving the table while Resident A was eating, but if she did it was only to the kitchen island that is right next to the dining room table.</p> <p>On 12/17/2025, I spoke with speech and language pathologist Laura Pfenninger, M.A., CCC, SLP. Laura Pfenninger stated that staff were supposed to follow the guidelines she set. She stated that if Resident A was biting from a sandwich (and not bites), they should have reached out to her first.</p> <p>There is a preponderance of evidence to substantiate a rule violation. During the course of the investigation, Staff Kaley Smith reported that she did not initially cut Resident A's peanut butter jelly sandwich into bite size pieces, as Resident A's feeding guidelines outlined.</p> |
| CONCLUSION: | VIOLATION ESTABLISHED |

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 3-4).



01/06/2026

Shamidah Wyden
Licensing Consultant

Date

Approved By:



01/06/2026

Mary E. Holton
Area Manager

Date