



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 30, 2025

Teresa Wendt
HGA Non-Profit Homes Inc.
917 West Norton
Muskegon, MI 49441

RE: License #:	AS610012194
Investigation #:	2026A0356005
	Lilac Street Home

Dear Ms. Wendt:

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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in cursive script that reads "Elizabeth Elliott". The signature is written in black ink and is positioned below the word "Sincerely,".

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610012194
Investigation #:	2026A0356005
Complaint Receipt Date:	10/27/2025
Investigation Initiation Date:	10/27/2025
Report Due Date:	12/26/2025
LicenseeName:	HGA Non-Profit Homes Inc.
Licensee Address:	917 West Norton Muskegon, MI 49441
Licensee Telephone #:	(231) 728-3501
Administrator:	Teresa Wendt
Licensee Designee:	Teresa Wendt
Name of Facility:	Lilac Street Home
Facility Address:	1901 Lilac Street Muskegon, MI 49442-6542
Facility Telephone #:	(231) 788-3750
Original Issuance Date:	09/26/1980
License Status:	REGULAR
Effective Date:	07/20/2024
Expiration Date:	07/19/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A died unexpectedly in the facility.	No
Additional Findings	Yes

III. METHODOLOGY

10/27/2025	Special Investigation Intake 2026A0356005
10/27/2025	APS Referral Resident death, unexpected.
10/27/2025	Special Investigation Initiated - Telephone Teresa Wendt-Licensee Designee.
11/25/2025	Inspection Completed On-site
11/25/2025	Contact - Face to Face Teresa Wendt, Licensee Designee, Wendy Boltze, DCW, Damaris Hughes, HGA supervisor.
11/25/2025	Contact - Document Received facility documents.
12/02/2025	Contact-Telephone call made Precious Wyrick, Relative #1 (left message on voice mail), Ms. Boltze (for correct number for Ms. Wyrick), Linda Wagner, Health West Office of Recipient Rights, Tasha Kuklewski, Health West ORR.
12/04/2025	Contact-Document Received Medical documents, ORR documents from Tasha Kuklewski.
12/16/2025	Contact-Telephone call made Precious Wyrick. No answer.
12/16/2025	Contact-Document received Text from Ms. Wyrick.
12/16/2025	Telephone call made Trinity Health, Marie Pritchard, NP, spoke to RN, Julie Johnson. Best suggestion refer to speech pathologist reports.

12/22/2025	Telephone call made Precious Wyrick, DCW.
12/23/2025	Telephone call made Interviewed Relative #1 Cheyenne Kaufman, speech and language pathologist, Health West, left voice mail message.
12/29/2025	Exit conference-Jessica Carter, Administrator, as approved by Licensee Designee, Teresa Wendt.

ALLEGATION: Resident A died unexpectedly in the facility.

INVESTIGATION: On 10/22/2025, I received an Incident Report (IR) dated 10/21/2025, 7:17p.m. the IR named Wendy Boltze as the employee assigned to Resident A. The location of the incident was documented as the kitchen table. The IR documented the following information; *'(Resident A) was at the kitchen table having cheesecake for snack when he stood up and started acting/trying to take his pants and brief off. I (Wendy Boltze) stood up to see what was wrong and I noticed right away he looked dusky around his mouth. I reached around to do the Heimlich maneuver but he started twisting due to not liking to be restrained in any fashion, so I tried to put him in the sitting position, but he tried standing, I sat him again, went behind him when he went limp and bent forward onto his lap, Precious Wyrick called 911 at 7:18p.m. as I was trying to help, the 911 dispatcher said to get him to the floor, I did this and immediately began CPR, I then swiped his mouth to remove anything possibly present and continued CPR (cardio pulmonary resuscitation) until EMS (Emergency Medical Service) arrived and took over at 7:25p.m. approximately. At this point I contacted the CEO, talked with EMS and the EMS gentleman said I had his airway clear and that maybe he suffered a heart attack. EMS continued working on (Resident A) for 30 minutes before calling TOD (time of death) and that they did everything they could and the physician at the hospital told them to call it. I then called back the CEO of HGA as instructed, notified (Relative #1) at 8:10p.m. as instructed, I then spoke with Officer Benedict with the Muskegon Township Police Department and told him everything written above. He said there will be an autopsy but reassured me I did everything correctly and timely but that sometimes the lack of oxygen can cause the heart to misfire and that I could call if I needed anything. They took (Resident A) out at 9:02p.m.'*

On 11/25/2025, I interviewed Teresa Wendt, Licensee Designee. Ms. Wendt stated staff immediately called 9-1-1 and Ms. Boltze began CPR. Ms. Wendt stated before she began CPR, Ms. Boltze attempted the Heimlich Maneuver on Resident A. Ms. Wendt stated the cause of death for Resident A has been determined as choking.

On 11/25/2025, I interviewed DCW (Direct Care Worker) Wendy Boltze at the facility. Ms. Boltze has been on staff for two years and works 1st shift usually but this

incident occurred on 2nd shift. Ms. Boltze stated she gave Resident A a snack that was cheesecake, an inch wide down to a sliver, in a pie shape. Ms. Boltze stated she took the crust off the cheesecake even though the crust was a crumble and not a thick crust. Ms. Boltze stated she served Resident A only the “pudding” part of the cheesecake, Resident A was eating the cheesecake under her supervision, but he vomited and cheesecake was present. Ms. Boltze stated Resident A then stood up at the table and began to take his pants off and pull his brief off. Ms. Boltze stated she was sitting right at the table with Resident A and she noticed that it was “dusky” around his mouth, so she tried to administer the Heimlich Maneuver twice, but he was fighting it. Ms. Boltze stated she instructed DCW Precious Wyrick to call 9-1-1. She got Resident A to sit down and he slumped forward, began to turn blue but she continued to administer the Heimlich Maneuver. Ms. Boltze stated, the dispatcher instructed Ms. Wyrick and Ms. Boltze to move Resident A to the floor and Ms. Boltze stated she began CPR (Cardiopulmonary Resuscitation) until EMS (Emergency Medical Services) arrived and took over Resident A’s care. Ms. Boltze stated before Resident A sat back down at the table, he grabbed another piece of cheesecake and shoved it in his mouth, Ms. Boltze stated she swiped it out of his mouth. Ms. Boltze stated Resident A acted normal, as he usually did prior to quickly standing straight up at the table, which was unusual because he normally would bend over the table and get up slowly. That is when she (Ms. Boltze) knew something was wrong. Ms. Boltze stated EMS said that she had gotten Resident A’s airway clear and possibly he had gone into cardiac arrest. Ms. Boltze stated Resident A was pronounced dead at the facility at 8:04p.m. Ms. Boltze stated staff were always at the table with Resident A because he was a choke hazard.

On 11/25/2025, I reviewed the Health Care Appraisal (HCA) for Resident A, signed by Marie Ritchard, NP (nurse practitioner), dated 02/28/2024. The HCA documented Resident A’s DOB (date of birth) as 08/19/1959 and his diagnosis as ‘severe intellectual disability, autism, scoliosis of the T spine, diabetes, OCD (obsessive compulsive disorder) and seizure disorder.’ The HCA documented a special diet for Resident A and explained the special diet as ‘pureed, thickened liquids, diabetic.’

On 12/04/2025, I reviewed the Muskegon Township police report dated 10/21/2025 at 19:18 (7:18p.m.)-10/21/2025, 21:08 (9:08p.m.). The report is a death investigation by Ofc. Arthur Benedict and documented the following information; *‘I was dispatched to the listed address for a medical emergency. The original call stated a 64 year old (Resident A’s DOB is 08/19/1959 making him 66 rather than 64 as documented in this police report) male was choking. He was unresponsive and not breathing. Due to other calls for service, my response was delayed, and I arrived at the scene roughly an hour after the original call. The incident was reported on 10/21/25 around 1918hrs. Upon arrival I entered the residence and located the deceased (Resident A) on the floor in the living room area just to the West of the dinner table. (Resident A) was located face up. There was what appeared to be food down by his feet (cheesecake). The table in the living room was off center as if someone pushed it. (Resident A) was pronounced deceased at 2004hrs. (8:04p.m.)’*

Contact with Precious Wyrick: I first spoke with employee Precious outside the home. Precious explained tonight they gave (Resident A) a snack which was a piece of cheesecake. Precious mentioned that (Resident A) likes to eat his food fast. While eating, (Resident A) stood up which was not normal. Precious stated Wendy recognized that (Resident A) was possibly choking so she performed the Heimlich maneuver. The Heimlich maneuver did not work so he was put in a chair. Once in the chair, (Resident A) started to turn blue. 911 was called and they were directed to put (Resident A) on the ground and begin CPR. They let first responders take over when they arrived.

Contact with Wendy Boltze: Next I spoke with employee Wendy. Wendy also confirmed they gave (Resident A) a snack tonight and showed me the box from the garbage which was cheesecake. While (Resident A) was eating, he stood up and attempted to take his pants off. Wendy stated this was not normal for (Resident A) so it caught her attention. Wendy examined (Resident A) further and found him to be possibly choking on the food. Wendy attempted to get behind (Resident A) so she could perform the Heimlich maneuver, but (Resident A) would not let her. She explained that (Resident A) does not like anyone handling him or controlling him so he spun around on Wendy. Wendy stated after the attempted Heimlich she had (Resident A) sit down in a chair. She tried to do the Heimlich in the chair, but (Resident A) kept on trying to get up. Wendy told me when (Resident A) was in the chair, he began to turn blue and eventually slumped over. Wendy stated 911 was called and they were directed to place (Resident A) on the ground to begin CPR. Wendy stated she did finger swipe his mouth, but it appeared to be vomit. CPR was continued until first responders arrived.

Outcome: ME (Medical Examiner) Brad Walters was on scene and conducted his examination. Brad stated (Resident A) would be taken in for an autopsy due to the situation surrounding his death.

Supplemental Narrative By Arthur Benedict, 11/12/25 23:26

Information: I followed up with Medical Examiner Brad Walters who worked this case with me. Brad stated the autopsy ruled (Resident A's) death as a accidental choking. If needed, the autopsy report can be requested through the medical examiner's office. This case can be closed due to the results of the autopsy being accidental choking. Nothing further at this time.

Disposition: Closed'

On 12/04/2025, I reviewed the Western Michigan School of Medicine, Medical Examiner and Forensic Services report. The Pathologist documented on the report was Patrick Hansma, DO, investigator, Brad Walters, D-ABMDI. The report is dated 10/23/2025 and documented the date of Resident A's death as 10/21/2025. The report documented, 'in consideration of the postmortem external and radiographic examination findings, and the known circumstances surrounding the death of (Resident A) the cause of death is choking and the manner of death is accident.'

On 12/22/2025, I interviewed Ms. Wyrick via telephone. Ms. Wyrick reiterated information she reported to Ms. Kuklewski, Ms. Wyrick stated she called 9-1-1 immediately when Ms. Boltze asked her to and that Ms. Boltze attempted the Heimlich maneuver on Resident A and began CPR as soon as the 9-1-1 operator instructed her to.

On 12/29/2025, I conducted an exit conference with Jessica Carter, Administrator, via telephone, as approved by Licensee Designee, Teresa Wendt. Ms. Carter stated she agreed with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
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:	An IR documented on 10/21/2025, Resident A began to choke while eating at the facility and later died because of this incident. Based on investigative findings, staff at the facility called 9-1-1 and immediately began life saving measures by performing the Heimlich Maneuver and CPR upon the sudden adverse change in Resident A's health condition and therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING

INVESTIGATION: On 10/21/2025, Resident A choked on cheesecake and died unexpectedly in the facility.

On 11/25/2025, I interviewed Teresa Wendt, Licensee Designee. Ms. Wendt stated Resident A's special diet is documented as pureed, thickened liquids on the Health Care Appraisal.

On 11/25/2025, I interviewed Ms. Boltze at the facility. Ms. Boltze stated she removed the crust from the cheesecake, and the cheesecake consistency was like "pudding." Ms. Boltze stated staff watched the amount of red sauce Resident A had with food, his food was pureed, and drinks were thickened with thicket but stated Resident A was not on a special diet.

On 11/25/2025, I reviewed the Health Care Appraisal (HCA) for Resident A, signed by Marie Ritchard, NP (nurse practitioner), dated 02/28/2024. The HCA documented

that Resident A required a special diet and explained the special diet as 'pureed, thickened liquids, diabetic.'

On 11/25/2025, I reviewed Resident A's assessment plan for AFC residents, signed by Relative #1, Malka Coleman-Fisher, (former) home manager, and Health West supports coordinator, Rashonna Dotson. The assessment plan documented that Resident A requires staff assistance with eating/feeding. The assessment plan described, '*(Resident A) can feed himself. Staff will prepare a soft mechanical diet and thickened liquids as prescribed. Staff will monitor for safety during meals.*' The assessment plan documented Resident A is on a special diet and described, '*staff will prepare a mechanical soft diet with honey thickened liquids per doctor's order.*'

On 11/25/2025, I reviewed Resident A's IPOS (Individual Plan of Service) through Health West effective 11/25/2024, by Madison Grunow, case manager. The IPOS documented Resident A has lived in this facility for 30 years and documented the following information:

- *(Resident A's) food preparation and monitoring while eating, due to dysphagia diagnosis, and following (Resident A's) safe swallowing guidelines per his most recent swallow study as of 11/25/2024. His current diet is IDDSI Level 4 pureed foods, and level 3 moderately thickened liquids. If there is an updated swallow study, it is the home's responsibility to update the case manager and follow up, to monitor (Resident A) for health and safety including following his safe swallowing guidelines written by the speech and language therapist.*
- *Safety Precautions: Line of sight supervision, (Resident A) is diagnosed with dysphagia and has a risk of choking and aspiration.*

On 12/02/2025, I interviewed Linda Wagner, Health West Office of Recipient Rights (ORR) supervisor. Ms. Wagner stated Resident A died from choking which caused cardiac arrest. Ms. Wagner stated Ms. Boltze did not follow Resident A's diet plan. Ms. Boltze took the crust off the cheesecake but that still did not meet the criteria for a level 4 pureed diet. Ms. Wagner stated Ms. Boltze thought cheesecake was a pudding type food which is what a level 4 pureed diet requires but cheesecake is not. Ms. Wagner stated Ms. Boltze was in-serviced on Resident A's dietary requirements by the Health West speech therapist, Precious Wyrick However, the other DCW on duty on 10/21/2025, had not been in-serviced on Resident A's special diet. Ms. Wagner added Ms. Wyrick was not responsible for Resident A on that date, Ms. Boltze was.

On 12/02/2025, I interviewed Tasha Kuklewski, Health West Office of Recipient Rights advisor. Ms. Kuklewski stated she conducted the investigation for Health West ORR. Ms. Kuklewski stated the cheesecake was not prepared to meet level 4 pureed per Resident A's special diet. Ms. Kuklewski stated Resident A could have cheesecake, but it was not prepared properly, and Ms. Boltze would not have had to remove the crust if it had been prepared to meet the level 4 pureed special diet. Ms. Kuklewski stated that Ms. Boltze was in-serviced on Resident A's special diet and

pureed instructions, but Ms. Wyrick was not in serviced. Ms. Kuklewski stated Ms. Wyrick was not in charge of caring for Resident A that day.

On 12/04/2025, I reviewed the Trinity Health speech and language pathologist, Christine Giberson, CCC-SLP's report dated 01/03/2024 documented the following information and recommendations for the special pureed diet; *'esophageal sweep revealed esophageal dysmotility with backflow up to the level of the pharynx. This occurred with both puree and moderately thickened liquid presentations. Patient present with moderate oral and pharyngeal dysphagia. No penetration or aspiration occurred during this study with puree and moderately thick liquids. Recommendations/Treatment, solid consistency: IDDSI Level 4 Pureed solid and liquid consistency: IDDSI Level 3 moderately thick liquid.'*

On 12/04/2025, I reviewed Level 4 puree instructions provided by Ms. Kuklewski that Ms. Boltze was in-serviced on. The instructions document that level 4 pureed diet foods *'are usually eaten with a spoon, they do not require chewing, have a smooth texture with no lumps, hold shape on a spoon, fall off a spoon in a single spoonful when tilted, are not sticky and liquid, such as sauces must not separate from solids.'* The document explained *'pureed food may be used if you are not able to bite or chew food or if your tongue control is reduced. Pureed foods only need the tongue to be able to move forward and back to bring the food to the back of the mouth for swallowing. It's important that puree foods are not too sticky because this can cause the food to stick to the cheeks, teeth, roof of the mouth or in the throat. Pureed foods are best eaten using a spoon.'* The document lists foods to avoid such as *'sticky or gummy food such as nut butter, overcooked oatmeal, porridge, edible gelatin, konjac containing jelly, sticky rice cakes.'*

On 12/04/2025, I reviewed Ms. Kuklewski's Health West Office of Recipient Rights investigative findings report dated 12/02/2025. Ms. Kuklewski's report documented an interview conducted with Madison Grunow, Health West case manager on 11/19/2025. Ms. Kuklewski documented the following information, *'(Resident A) had a diet order provided to us (Health West) in September 2024 (Christine Giberson, CCC-SLP) with pureed solids and moderately thickened liquids noted as the recommendation. In July 2025, Cheyenne (Kaufman) (our speech and language pathologist) completed a swallow evaluation and under her recommendations agreed with the order of pureed solids and moderately thickened liquids.'*

On 12/04/2025, I reviewed Ms. Kuklewski's ORR report interview with Speech and Language Pathologist, Cheyenne Kaufman, MS, CCC-SLP. Ms. Kaufman reported she saw the Lilac home (staff) for two IDDSI trainings due to poor attendance at the first scheduled day (trainings were on 03/20/2025 and 04/25/2025). Her report stated; *'I would consider cheesecake a Level 7 regular OR easy to chew due to it being a mixed/dual consistency, (since you have the crust layer, depending on the brand/preparation, the crust can be pretty hard to cut through with a fork or it can be moist enough where it is easily separated), cream cheese layer, and fruit sauce on top or incorporated into the cream cheese. Cheesecakes "as is" normally prepared*

would need to be modified to be considered pureed, but it is possible. A quick Google search indicated that you could put milk and some thickening agent into a blender with the cheesecake to prepare it into a pureed solid (thickener is needed when adding thin liquids as Level 4 specified that you cannot have separation of liquid/dripping with these consistency/liquids used must follow a person's liquid consistency requirements). If a blender was not available, if we were to scoop off the cream cheese layer onto a spoon sans crust, that falls more in line with pureed solid requirements (if it wasn't too thick/sticky/have chunks of fruit in it).'

On 12/04/2025, I reviewed Ms. Kuklewski's ORR report interview with DCW, Precious Wyrick. Ms. Wyrick reported the following information; *'she (Ms. Wyrick) worked second shift, 3:00p.m. to 11:00p.m. at the Lilac Home and had worked for HGA since August 2025. She reported that all (Resident A's) food and drinks were required to be pureed and thickened, and that his food "has to be blended." When asked to describe the difference between "pureed" and "blended," Precious Wyrick stated she did not think there was a difference, other than a thickening agent might be needed. Ms. Wyrick stated this was the first time since she had worked at Lilac that she was aware of cheesecake being served to (Resident A). She stated that evening Ms. Boltze was assigned to the kitchen, so Ms. Boltze prepared the cheesecake. Ms. Wyrick reported that the medication room is located off the back of the living room and is not in direct visual sight of the kitchen or dining table. She stated that whoever is on kitchen prepares meals and snacks and watches the recipients while they eat and Ms. Boltze "always watches the residents when they are eating." On the night of the incident, she was in the med room when Ms. Boltze called her into the kitchen for help with the computer, and "just a few moments later" (Resident A) began choking. Ms. Wyrick stated Ms. Boltze told her to call 9-1-1, and she placed the call at 7:18p.m., put the phone on speaker and the dispatcher gave CPR instructions to Ms. Boltze. Ms. Wyrick reported she had moved another recipient into the living room and the ambulance arrived shortly afterward. She stated she attempted to take over chest compressions, but that Ms. Boltze wanted to continue assisting (Resident A) until EMS arrived. When asked about how the cheesecake was prepared, Ms. Wyrick stated that Ms. Boltze would know more than she did, because Ms. Boltze had worked at the Lilac home for a long time. She recalled that Ms. Boltze removed the crust and described cheesecake as "not like a real solid food."*

On 12/04/2025, I reviewed Ms. Kuklewski's ORR report that documented an interview with Relative #1 on 11/25/2025. *'Relative #1 reported that it was her understanding that staff had been trained on (Resident A's) needs and dietary requirements, noting (Resident A) had been on a pureed diet for many years. She added that over the years when staff brought (Resident A) to the family home, she did not question his care because he would reach out to the caregiver for comfort which reassured her. After reviewing the death certificate, she and her family were surprised to learn that (Resident A) had been given "cheesecake" and to her understanding, that it had not been prepared to his puree requirements.'*

On 12/04/2025, I reviewed Ms. Kuklewski's ORR report that documented a Health West training sign-in sheet dated March 20, 2025, showing that an IDDSI (International Dysphagia Diet Standardization Initiative) training took place at the facility. The training covered terminology, swallowing structures, phases of a swallow, symptoms of dysphagia, causes of untreated or poorly managed dysphagia, IDDSI framework, IDDSI levels modified diet, testing consistencies, other safety considerations, and caregiver questions. The instructor was Cheyenne Kaufman, MS, CCC-SLP. Ms. Boltze signed in as an attendee at the training. There is no record of Ms. Wyrick attending the training.

On 12/04/2025, I reviewed training documents for Ms. Boltze through Flex Training. Ms. Boltze was trained in Nutrition and Food safety on 02/20/2024 and again on 06/24/2025. In addition, Ms. Boltze attended an in-service on 03/20/2025 for the IDDSI training as documented in the aforementioned information.

On 12/04/2025, I reviewed training documents for Ms. Wyrick through Flex Training. Ms. Wyrick was trained on Nutrition and Food safety on 08/10/2025. Ms. Wyrick is not documented as attending the IDDSI training provided on 03/20/2025 by Ms. Kaufman.

On 12/16/2025, I interviewed Julie Johnson, RN, at Trinity Health medical group. Ms. Johnson spoke to Marie Pritchard, NP and the health care professional that completed the HCA for Resident A. Ms. Johnson reported that Ms. Pritchard's best suggestion for further insight into Resident A's pureed diet is to interview and/or refer to speech pathologist reports. Ms. Johnson stated the NP documented a special diet for Resident A as pureed but the speech and language pathologists conduct studies that narrow down how the food/liquids should be prepared.

On 12/22/2025, I interviewed Ms. Wyrick via telephone. Ms. Wyrick stated Ms. Boltze took the crust off the cheesecake that Resident A ate and to her knowledge, the cheesecake was not modified in any other way. Ms. Wyrick stated she knew Resident A was on a special diet and that his food needed to be pureed or blended. Ms. Wyrick stated she is trained as required by licensing, but she has not been in-serviced on specific resident's special diets nor was she in-serviced on Resident A's pureed, Level 4 diet, yet she stated she would be able to feed every resident in the facility if she oversaw meals but that she was handling medications and not feeding residents when this incident occurred.

On 12/23/2025, I interviewed Relative #1 via telephone. Relative #1 stated she did not agree with staff at the facility feeding Resident A cheesecake that was not modified to the pureed diet that he was on. Relative #1 stated she is "furious" and feels like Resident A was "murdered" in this facility. Relative #1 stated she wondered why Resident A's food was not pureed as the doctor and the speech and language pathologist ordered, which is pureed foods and honey thick liquids. Relative #1 stated in all the reports she has read, everything from the doctor and speech and language pathologists says Resident A's food was to be pureed and honey thick

liquids. Relative #1 stated she was under the impression that Resident A was not to eat anything that was not pureed. Relative #1 stated Resident A had been on a pureed diet for years, at least back to 2017, possibly longer and she does not agree with Resident A being fed cheesecake that was not pureed. Relative #1 stated if all other food Resident A ate was pureed, the cheesecake should have been pureed also.

On 12/29/2025, I interviewed DCW Davona Roberson via telephone. Ms. Roberson stated she was not working in this facility until November 2025, and she was trained on food and nutrition through Health West. She has also been trained on resident IPOS (individual plan of service) documents. Ms. Roberson stated there currently is a resident in the facility that has a special pureed diet, and she has been trained how to prepare this resident's food.

On 12/29/2025, I conducted an exit conference with Jessica Carter, Administrator, via telephone, as approved by Licensee Designee, Teresa Wendt. Ms. Carter stated management for HGA is in the process of retraining all staff on special diets and food preparation for the residents. Ms. Carter stated all staff at this facility, including Ms. Boltze and Ms. Wyrick, were trained on Resident A's special diet, but staff that are not yet IDDSI trained do not prepare food for residents with special dietary needs. Ms. Carter stated staff at this facility reported they have always followed Resident A's special pureed diet and are not sure why Resident A's snack was not prepared by Ms. Boltze per his special dietary instructions. Ms. Carter stated she understands the information, analysis, and conclusion of this applicable rule and will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.663	Nutrition; adoption by reference.
	(5) A resident who has a prescribed diet by an appropriately licensed health care professional shall be provided that diet.
ANALYSIS:	<p>An IR documented on 10/21/2025, Resident A began to choke while eating at the facility and later died because of this incident.</p> <p>The HCA documented a special diet for Resident A and explained the special diet as 'pureed, thickened liquids, diabetic.'</p> <p>Ms. Kaufman, speech and language pathologist, reported she considered cheesecake a Level 7 diet rather than a level 4 pureed diet as Resident A was required to have.</p> <p>Ms. Kaufman reported cheesecake as normally prepared would need to be modified to be considered pureed.</p>

	<p>Training transcripts show Ms. Boltze was trained in Nutrition and Food safety on 02/20/2024 and 06/24/2025. Ms. Boltze attended an in-service on 03/20/2025 for the IDDSI training as documented in the aforementioned information.</p> <p>Although staff Wendy Boltze was properly trained regarding Resident A's needs relating to food preparation, there is a preponderance of evidence to show that Resident A's documented special diet was not followed on 10/21/2025 when Resident A was given a slice of cheesecake (minus the crust) that was not pureed according to his special diet. A violation of this applicable rule is established.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDING

INVESTIGATION: On 11/25/2025, I reviewed Resident A's assessment plan for AFC residents, signed by Relative #1, Malka Coleman-Fisher, (former) home manager, and Health West supports coordinator, Rashonna Dotson. The assessment plan was dated 04/16/2024 and was more than one year old by the date of my review.

On 12/29/2025, I conducted an exit conference with Jessica Carter, Administrator via telephone, as approved by Teresa Wendt, Licensee Designee. Ms. Carter stated she understands the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.685	Resident admission; resident assessment plan; resident care agreement; health care appraisal.
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	<p>On 11/25/2025, I reviewed Resident A's assessment plan, and the assessment plan was dated 04/16/2024.</p> <p>The assessment plan was not updated annually as the rule requires and therefore, a violation of this applicable rule is established.</p>

CONCLUSION:	VIOLATION ESTABLISHED
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IV. RECOMMENDATION

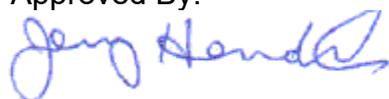
Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.



12/30/2025

Elizabeth Elliott Date
Licensing Consultant

Approved By:



12/30/2025

Jerry Hendrick Date
Area Manager