STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

April 18, 2022

Michelle Jannenga
Thresholds
Suite 130
160 68th St. SW
Grand Rapids, MI 49548

RE: License #: AS410011488
Investigation #: 2022A0583014
Thresholds Chamberlain Group Home

Dear Ms. Jannenga:

Attached is the Special Investigation Report for the above referenced facility. Due to the physical plant violation 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.

A six-month provisional license is recommended for the physical plant violation. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410011488
Investigation #:	2022A0583014
Complaint Receipt Date:	02/22/2022
Investigation Initiation Date:	02/22/2022
Report Due Date:	03/24/2022
Licensee Name:	Thresholds
Licensee Address:	Suite 130 160 68th St. SW Grand Rapids, MI 49548
Licensee Telephone #:	(616) 340-3788
Administrator:	William Griffin
Licensee Designee:	Michelle Jannenga
Name of Facility:	Thresholds Chamberlain Group Home
Facility Address:	2819 Chamberlain Ave, SE Grand Rapids, MI 49508-1511
Facility Telephone #:	(616) 247-6831
Original Issuance Date:	10/08/1980
License Status:	REGULAR
Effective Date:	03/04/2022
Expiration Date:	03/03/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was not properly supervised while taking a bath and suffered first and second-degree burns.	No
The facility’s hot water was not maintained within the range of 105 to 120 degrees Fahrenheit.	Yes

III. METHODOLOGY

02/22/2022	Special Investigation Intake 2022A0583014
02/22/2022	APS Referral
02/22/2022	Contact – Telephone call APS Staff Bryan Kahler
02/22/2022	Contact - Telephone call Licensee Designee Michelle Jannenga
02/22/2022	Special Investigation Initiated - Letter Melissa Gekeler, Network 180 Recipient Rights
02/22/2022	Contact – Telephone call APS Staff Bryan Kahler
02/22/2022	Contact - Telephone call Licensee Designee Michelle Jannenga
02/22/2022	Contact - Letter Licensee Designee Michelle Jannenga
02/22/2022	Contact - Telephone call Grand Rapids Police Department Major Case Team Detective Sean Wolf
02/22/2022	Contact - Telephone call Abby Simmons Spectrum Health Social Worker
02/24/2022	Contact - Letter Spectrum Hospital Health Information Management Staff Lynsey Johnson
03/10/2022	Contact - Letter

	Grand Rapids Police Department Major Case Team Detective Sean Wolf
03/22/2022	Contact - Letter Grand Rapids Police Department Major Case Team Detective Sean Wolf
03/22/2022	Inspection Completed On-site Licensee Designee Michelle Jannenga, Administrator William Griffin, Staff Quenetta Williams
03/22/2022	Contact - Telephone Greg Lutz, Thresholds Maintenance Technician
03/22/2022	Contact - Letter Licensee Designee Michelle Jannenga
04/03/2022	Contact - Letter Licensee Designee Michelle Jannenga
04/04/2022	Inspection Completed On-site Staff Quenetta Williams
04/07/2022	Contact - Letter Grand Rapids Police Department Major Case Team Detective Sean Wolf
04/08/2022	Contact - Telephone call Staff Mahogany Johnson
04/18/2022	Exit Conference Licensee Designee Michelle Jannenga

ALLEGATION: Resident A was not properly supervised while taking a bath and suffered first and second-degree burns.

INVESTIGATION: On 02/22/2022 I received complaint allegations via email from Adult Protective Services (APS) staff Bryan Kahler. Mr. Kahler confirmed he was assigned to investigate the allegations. The complaint alleged that 54-year-old Resident A resides at the Thresholds Chamberlain Group Home due to mental illness and physical limitations. On 02/21/2022 facility staff contacted emergency personnel due to Resident A displaying signs of a cardiac event; however, when emergency medical personal arrived Resident A displayed first and second degree burns to his body as well as cardiac distress. The complaint alleged that on 02/21/2022 facility staff assisted Resident A with his bath by running the bath water

and then leaving Resident A alone in the bathroom. The complaint alleged that facility staff returned five minutes later and observed Resident A displaying trouble breathing and not responsive. The complaint alleged that emergency personal were contacted and arrived at the facility and started cardiopulmonary resuscitation and while doing so, observed the skin on Resident A's back began peeling off. Resident A was transported to the Spectrum Hospital Emergency Department and medical personal concluded that Resident A had been immersed in scalding hot water as evidenced by the burns on his back.

On 02/22/2022 I reviewed an email received from Recipient Rights staff Melissa Gekeler. The email was drafted and sent to my attention on 02/21/2022 at 6:16 pm. Ms. Gekeler reported she was assigned to investigate the same complaint allegations. Ms. Gekeler' s email contained a formal Recipient Rights Complaint Form and stated the following: *'Thresholds Director Jacquie Johnson contacted Office of Recipient Rights to report that this morning Mahogany Johnson, staff at Chamberlain AFC home drew a bath for recipient (Resident A). (Resident A) entered the tub and Mahogany Johnson left. A short while later she heard gurgling noises and upon entering the bathroom found the recipient in distress. She called 911 for assistance. He was transported to the ED and had second degree burns to his hands and feet. Treating emergency personnel stated the shock from the hot water stopped his heart and he remains on life support at the hospital.'*

On 02/22/2022 I interviewed APS staff Brian Kahler via telephone. Mr. Kahler reported that he was notified from Spectrum Hospital staff that Resident A died this morning (02/22/2022) at 9:00 AM.

On 02/22/2022 I interviewed Licensee Designee Michelle Jannenga via telephone. Ms. Jannenga stated on 02/21/2022 she was informed via telephone from Administrator William Griffin that Resident A was transported via ambulance to Spectrum Hospital due to "a possible seizure or cardiac arrest". Ms. Jannenga stated Mr. Griffin was not working at the facility at the time on the incident. Ms. Jannenga stated staff Mahogany Johnson and Quenetta Williams were working at the facility on 02/21/2022 "first shift" when the incident occurred. Ms. Jannenga stated it is her understanding from speaking with Mr. Griffin that Ms. Johnson ran Resident A's bathwater which was reported to be "lukewarm". Ms. Johnson assisted Resident A into the bathtub and allowed Resident A privacy to soak in the bathtub alone. Ms. Johnson stated approximately five minutes after exiting the bathroom Ms. Johnson overheard Resident A making "gurgling noises". Ms. Johnson was concerned Resident A was exhibiting seizure-like activity and contacted 911. Ms. Jannenga stated emergency personnel arrived and performed cardiopulmonary resuscitation before transporting Resident A to Spectrum Hospital. Ms. Jannenga stated a new facility staff named Quenetta Williams was the only other staff member working at the time of the incident. Ms. Jannenga stated the Grand Rapids Police Department visited the facility to investigate the incident. Ms. Jannenga stated the law enforcement incident number is 22-009685. Ms. Jannenga stated Resident A's bathing routine includes staff running Resident A's bathwater followed by staff

allowing Resident A approximately ten to fifteen minutes to relax in the bathtub alone. Ms. Jannenga explained Resident A enjoyed resting in the warm water for a short time before staff assisted Resident A with personal care and Resident A's Assessment Plan permitted staff to leave him unsupervised in the bathtub. Ms. Jannenga stated Resident A communicated with one-word responses such as yes or no.

On 02/22/2022 I received an email from Licensee Designee Michelle Jannenga. The email contained Resident A's Assessment Plan which was signed on 02/01/2022 and documented that Resident A "is verbal but uses single words, short phrases and physical cues to communicate needs". The Assessment Plan also stated Resident A "prefers baths" and "will wash himself but very slowly" and "needs physical assistance from staff to ensure he is cleaned thoroughly". The Assessment Plan also stated Resident A "is susceptible to hypo and hyperthermia". The Assessment Plan does not address a need for staff to monitor Resident A while soaking in the bathtub.

On 02/22/2022 I interviewed Detective Sean Wolf of the Grand Rapids Police Department Major Case Team via telephone. Detective Wolf stated he was assigned to investigate the current allegations. Detective Wolf stated that on 02/21/2022 the Grand Rapids Police Department's Forensic Unit visited the facility and tested water from the water heater which registered at 128.1 degrees Fahrenheit. Detective Wolf stated he will be contacting the medical examiner in an attempt to obtain an autopsy.

On 02/22/2022 I interviewed Abby Simmons Spectrum Health Social Worker via telephone. Ms. Simmons stated that Resident A was admitted to the Spectrum Emergency Department on 02/21/2022. Ms. Simmons stated the Spectrum Health Burn Team was involved with Resident A's medical treatment. Ms. Simmons stated medical records indicate Resident A suffered from second degree burns to his bilateral feet and buttocks and first degree burns to his arms. Ms. Simmons stated medical records indicate 15% of Resident A's total body surface area sustained burns. Ms. Simmons stated Resident A has a history of epilepsy. Ms. Simmons stated medical records indicate cardiopulmonary resuscitation was performed on Resident A by emergency personnel however Resident A was unresponsive upon arrival to the Emergency Department. Ms. Simmons stated Resident A passed away on 02/21/2022 however the medical records do not identify a definitive cause of death.

On 02/24/2022 I received Resident A's Medical Records from Spectrum Hospital Health Information Management staff Lynsey Johnson via email. Resident A's medical record completed by treating Emergency Department Physician Jennifer Bach DO on 02/21/2022 stated the following information:

'Patient was brought in by EMS with reports of AFC staff helping him with a bath, then hearing him with agonal respirations about 10 minutes later. At that time CPR was immediately started, he underwent approximately 30 minutes of CPR and

received 2 rounds of epinephrine when EMS arrived and had subsequent return of spontaneous circulation. Patient arrives with a supraglottic airway in place, no spontaneous respirations. Pulses are weak peripherally. Pupils are fixed and dilated. He does also have numerous areas of second-degree burn on the bilateral feet and ankles, sacral area and perineum, bilateral hips, and on the majority of his dorsal body surface. Unclear whether not he was submerged, but patient's face did not have any burns. Airway was exchanged for endotracheal tube, see procedure note. This was done without medications, patient was not requiring any sedation. After this an arterial line was placed in the right radial artery for accurate blood pressures as we were having trouble getting blood pressure readings on the monitor, and manual pressures were low as well. After this a right internal jugular central venous access line was placed due to need for multiple pressors. Patient was unresponsive during the entirety of his resuscitation, he is significantly acidotic on his lab work. Chest x-ray showing good tube placement and line placement, no evidence of pneumothorax. He was then taken directly to CT scan which upon real-time review did show a moderate-sized pneumothorax on the right likely secondary to CPR and multiple rib fractures. He also did have a liver laceration noted. Preparations were made for chest tube placement which was performed with repeat chest x-ray for verification.

Patient's mother is at bedside, she is patient's legal guardian. She is aware of his poor prognosis and of the concerns regarding his presentation today with burns being present. APS has been contacted by social Work, police are present at bedside and were taking photographs in the emergency department. Due to Michigan law patient's mother is not able to change his code status at this time, although expect to have extremely poor prognosis and is unlikely to survive this event based on his presentation to the emergency department. Social work will be in contact and will start pursuing the appropriate legal process to change code status as CPR would likely be futile in this instance. Patient is admitted to intensive care unit in critical condition. Critical care time was required due to the life threatening nature of this patient's condition and I spent 80 minutes performing critical care exclusive of any procedure time.

CHIEF COMPLAINT:

CARDIAC ARREST

Assessment/Plan

DIAGNOSIS at time of disposition:

1. *Cardiac arrest (HCC)*
2. *Multiple fractures of ribs, bilateral, initial encounter for closed fracture*
3. *Second degree burns of multiple sites*
4. *Closed traumatic fracture of ribs of right side with pneumothorax*
5. *Cardiogenic shock (HCC)*

MEDICAL DECISION MAKING:

This patient has a past medical history of developmental delay, as well as epilepsy who presents from his AFC home. The report from EMS that the patient was placed in a bathtub at his AFC home and roughly 10 minutes later staff heard agonal breathing and found the patient without pulses. CPR was immediately started and

lasted for approximately 30 minutes. EMS arrived while CPR was ongoing and provided epinephrine x2 and achieved Ross get about 30 minutes of CPR time. Patient on arrival was hypotensive and continued to be unresponsive. Reports from EMS state that the patient did have areas of burns to his bilateral feet as well as bilateral thighs. By the time they arrived at the AFC home, the water was drained from the bathtub entirely and they are unsure if the patient was ever submerged or how hot the water was. They were told that the water was not too hot. On initial examination, the patient's pupils are fixed and dilated. Patient has bilateral lung sounds. IV access was established, pads were applied to the chest and back, and labs were drawn. Initial blood pressure showed the patient be hypotensive. Also on exam the patient has areas of sloughing of skin to bilateral feet is significant erythema and blistering. Additionally he has erythema to the skin of bilateral wrists, hands as well as the posterior aspect of bilateral thighs. This is concerning for a burn injury from the margin in the water in the patient's bathtub. While in the Trauma Bay I spoke with the guardian of the patient to his mother who was updated of the patient's condition. She did not have any paperwork or advanced directives at that time. The patient's mother plans to come to the emergency department as soon as she can. Initial labs show the patient to be acidotic with a venous pH is 7.17 and lactic acid of 7.7. Electrolytes do appear within normal limits with no major derangements. Patient was provided IV fluids as well as rectal Tylenol as he was noted to be febrile. In the the Trauma Bay, the patient's I-gel airway was exchanged for any ET tube. Additionally an arterial line was placed in the right radial artery an a triple-lumen central line was placed in the right IJ. both replaced the ultrasound with direct visualization of the line going into the vessel for both procedures, please see the procedure notes for all 3 procedures. While in the Trauma Bay, the patient continued to be hypotensive and norepinephrine, and vasopressin were initiated, but he additionally required phenylephrine to attempt to maintain MAPs. Following this once moderately stabilized, the patient was taken to the CT scanner for further advanced imaging of the head, abdomen and pelvis. CT angiogram was ordered to evaluate for possible PE contributing to the patient's cardiac arrest. On realtime review of CT scan there is a moderate sized pneumothorax on the right and preparations were made for emergent chest tube. A call was also placed to the intensive care unit regarding the patient's condition, they agreed to accept the patient for further management. Additionally there are bilateral rib fractures and associated area of likely hematoma to the left lobe of the liver with no active bleeding appreciated. A right-sided chest tube was placed in the mid axillary line just superior to the nipple line above the rib at this pace. Chest x-rays performed to confirm placement. Following this the patient was admitted to the intensive care unit in critical condition. The forensics police team was in the emergency department photographed the patient's areas of burns. The mother was at bedside and updated of patient's overall poor condition and prognosis. The patient was transferred to the intensive care unit for ongoing treatment and care. Social work was involved to help determine the patient's code status as they work conflicting reports relating as to whether the patient was full code or do not resuscitate, and as a developmentally delayed patient, his mother is not able to change code status without legal involvement.'

I reviewed Resident A's discharge medical record completed by treating Spectrum Health Hospital Physician Connor McCalmon, MD on 02/22/2022 which stated the following information:

'(Resident A) is a 54 y.o. male with a history of cerebral palsy, autism, seizures, who presented from AFC with cardiac arrest. History was provided by his mother, as well as chart review and verbal handoff from the ED. He was bathing in hot water at the AFC, it was unclear whether he was being directly supervised during this time and staff found him unresponsive. EMS responded and CPR was initiated. Two rounds of epinephrine were given, no shocks were administered contrast was achieved after 20 minutes of resuscitation of presumed PEA arrest. Upon arrival to Butterworth Emergency department, he was hypothermic, hypotensive requiring vasopressors, unresponsive, and was intubated. Pupils were fixed and dilated. The posterior of his torso, arms, and feet showed weeping bullous burns. Thoracic imaging noted pneumothorax, and chest tube was placed. He was started antibiotics admitted to the intensive care unit. While in the intensive care unit, he experienced further hemodynamic instability, and pressor requirements further increased. His mother who had guardianship of him was present at the time of adMs.ion. Efforts were made to change code status to do not resuscitate via the court petition in accordance with family wishes. Over the course of the day, pressor requirements further increased. Two-Physician assessment was performed noting medical futility in CPR and shocks, and his code status was changed to DNR. Aggressive medical supportive care was continued with vasopressors and ventilation.

On the morning of 02/22/2022, the MICU team was called to the bedside by nursing due to very low blood pressures on arterial line and flattened monitored wave forms. Death was pronounced at 0853. Family was present at the bedside at time of death. Medical examiner was contacted by Attending Physician.'

On 03/10/2022 I received an email from Detective Sean Wolf of the Grand Rapids Police Department. Detective Wolf stated he had not interviewed staff Mahogany Johnson as a result of Ms. Johnson retaining an attorney. Detective Wolf stated he has interviewed other facility staff that were working on 02/21/2022 and a facility maintenance staff. Detective Wolf stated he was awaiting documents from the facility which could take a couple of weeks to obtain.

On 03/22/2022 I received an email from Detective Sean Wolf of the Grand Rapids Police Department. Detective Wolf stated he had not interviewed staff Mahogany Johnson as a result of Ms. Johnson's attorney not returning Detective Wolf's requests to schedule the interview.

On 03/22/2022 I completed an announced onsite inspection at the facility and interviewed Licensee Designee Michelle Jannenga, Administrator William Griffin, and staff Quenetta Williams.

While onsite I noted that the bathroom in which the incident occurred was in the process of being remodeled. The bathtub/shower were demolished. While onsite I

checked the water temperature of the kitchen faucet which measured 100 degrees Fahrenheit.

Resident interviews could not be completed given the pervasive developmental disabilities of facility residents.

Licensee Designee Michelle Jannenga stated Resident A was diagnosed with Autism and a seizure disorder. Ms. Jannenga stated Resident A sustained one seizure while at the facility in 2014 necessitating the administration of prescription Tegretol. Ms. Jannenga stated Resident A has not suffered a second seizure. Ms. Jannenga stated Resident A had the ability to answer simple questions with a "yes" or "no". Ms. Jannenga stated Resident A exhibited the ability to get in and out of the bathtub unassisted. Ms. Jannenga stated Resident A's typical bathing routine consisted of facility staff assisting Resident A with undressing himself in the bathroom while staff ran Resident A's bathwater. Ms. Jannenga stated facility staff leave the bathroom for ten or fifteen minutes while Resident A soaks in the warm bath water. Ms. Jannenga stated after Resident A is done soaking in the warm bath water facility staff help Resident A wash and Resident A subsequently transfers himself out of the bathtub. Ms. Jannenga stated although Resident A's hands were "contracted, it could be possible" for Resident A turn on the water himself. Ms. Jannenga stated staff Mahogany Johnson and Quenetta Williams both worked the morning of 02/21/2022 and Ms. Johnson was assigned the task of bathing Resident A. Ms. Jannenga stated Ms. Johnson was placed on leave since the 02/21/2022 incident and has retained a personal attorney. Ms. Jannenga stated Ms. Johnson has not completed an interview with law enforcement. Ms. Jannenga stated Ms. Johnson has always been observed to be a quality and caring staff.

Administrator William Griffin stated that on 02/21/2022 at approximately 08:00 AM Ms. Johnson telephoned Mr. Griffin and placed the call on "speaker phone". Mr. Griffin stated Ms. Johnson reported that she had been assisting Resident A with his morning bath when she observed Resident A to be making "strange noises". Mr. Griffin stated he instructed Ms. Johnson to contact "911" and Mr. Griffin stated he was "on my way" to the facility. Mr. Griffin stated he arrived at the facility at approximately 08:15 AM and observed Resident A was located on the floor of his bedroom. Mr. Griffin stated emergency medical personnel from the local fire department and ambulance company were performing chest compressions on Resident A and an unknown emergency medical personal sated "we don't have a heartbeat". Mr. Griffin stated he observed Resident A's feet appeared "pinkish" in color before emergency medical staff transported Resident A to the hospital. Mr. Griffin stated he observed the water from the bathtub had been drained. Mr. Griffin stated he spoke briefly with Ms. Johnson after Resident A was transported to the hospital and Ms. Johnson stated she had drawn Resident A's bath water which she described as being "okay" in temperature. Mr. Griffin stated Ms. Johnson reported Resident A was left alone in the bathtub to soak for a short time before Ms. Johnson checked on Resident A who was observed making "strange sounds". Mr. Griffin stated Resident A's typical bathing routine consisted of Resident A undressing

himself in the bathroom while staff ran Resident A's bathwater. Mr. Griffin stated staff leave the bathroom for ten or fifteen minutes while Resident A soaks in the warm bath water. Mr. Griffin stated after Resident A is done soaking in the warm bath water staff help Resident A wash and Resident A subsequently transfers himself out of the bathtub. Mr. Griffin stated Resident A possessed the verbal skills to scream "owie" if he was experiencing pain. Mr. Griffin stated he has always observed Ms. Johnson to follow agency policies and exhibited a very "enthusiastic" demeanor when interacting with residents. Mr. Griffin stated he was impressed with the level of care she provided. Mr. Griffin stated he had worked at the facility on 02/20/2002 and did not observe the water as excessively hot.

Staff Quenetta Williams stated she began working at the facility on 02/14/2022. Ms. Williams stated on 02/21/2022 she worked at the facility from 07:00 AM until 03:00 PM with Ms. Johnson. Ms. Williams stated during the morning Ms. Williams was preparing breakfast in one the facility's kitchens while Ms. Johnson assisted Resident A with bathing. Ms. Williams stated she could hear running water coming from one of the facility bathtubs as Ms. Johnson assisted Resident A with bathing. Ms. Williams stated she overheard Ms. Johnson ask Resident A "is the water too hot" and then Ms. Williams overheard Resident A answer "no". Ms. Williams stated Ms. Johnson exited the facility bathroom and left Resident A to soak for approximately "five to ten minutes". Ms. Williams confirmed that Resident A's typical bathing routine consisted of staff leaving the bathroom for ten or fifteen minutes while Resident A soaks in the warm bath water. Ms. Williams stated after Resident A is done soaking in the warm bath water staff help Resident A wash and Resident A subsequently transfers himself out of the bathtub. Ms. Williams stated when Ms. Johnson entered the facility bathroom Ms. Johnson observed "something wrong" with Resident A and immediately alerted Ms. Williams. Ms. Williams stated she entered the bathroom immediately and observed Resident A was "breathing funny". Ms. Williams characterized Resident A's breathing as "like someone taking their last breath". Ms. Williams stated Ms. Johnson telephoned Mr. Griffin and placed the call on "speaker phone". Ms. Williams stated Mr. Griffin advised Ms. Williams and Ms. Johnson to immediately dial "911". Ms. Williams stated Ms. Johnson telephoned "911" and the emergency dispatcher advised the staff to let the water out of the bathtub and place a towel under Resident A's head. Ms. Williams stated she placed her hand in the bathtub's water while assisting Resident A and characterized the water temperate as "not hot". Ms. Williams stated she observed Resident A's skin that touched "in the water" appeared "red" in color. Ms. Williams stated emergency personnel arrived quickly. Ms. Williams stated emergency personnel moved Resident A from the bathtub to his bedroom floor and performed chest compressions. Ms. Williams stated Resident A was transported by ambulance to the hospital for further treatment.

On 03/22/2022 I interviewed Thresholds Maintenance Technician Greg Lutz via telephone. Mr. Lutz stated on the morning of 02/16/2022 Mr. Lutz checked the water temperature which registered approximately 90 to 100 degrees Fahrenheit therefore Mr. Lutz increased the water heater dial "1/16th of an inch". Mr. Lutz stated he did

not recheck the water temperature after increasing the dial. Mr. Lutz stated after the 02/21/2022 incident Mr. Lutz “turned the dial down”.

On 03/22/2022 I received an email from Licensee Designee Michelle Jannenga which included an attachment of Resident A’s Death Certificate. The document indicates a date of death as 02/22/2022 08:53 AM and the manner of death as “accident” (from options natural, accident, suicide, homicide, undetermined, and pending). The document describes how the injury occurred as “Deceased was burned by hot water while in bathtub” and the cause of death as “Medical complications of cutaneous thermal injury (scalding burns)”. The document confirms that no autopsy was performed.

On 04/03/2022 I received an email from Licensee Designee Michelle Jannenga which included an attachment with Resident A’s Individual Plan of Service, signed 05/01/2021. The document states “staff should know (Resident A’s) whereabouts in the home; specifically, within hearing distance as (Resident A) enjoys talking loudly and indicates where he is”. The document further states that Resident A “should be checked on every 30 minutes during the daytime” and “requires hands-on for all areas of his personal care”.

On 04/04/2022 I completed an unannounced onsite investigation at the facility and interviewed staff Quenetta Williams. Ms. Williams stated the facility completed a load of dishes in the dishwasher just prior to my arrival.

While onsite I checked the water temperature of the kitchen faucet which measured 100 degrees Fahrenheit.

On 04/07/2022 I received an email from Detective Sean Wolf of the Grand Rapids Police Department. Detective Wolf stated he is still attempting to coordinate an interview with staff Mahogany Johnson.

On 04/08/2022 I interviewed staff Mahogany Johnson via telephone. Ms. Johnson stated on 02/21/2022 she worked at the facility with Quenetta Williams from 7:00 AM until 3:00 PM. Ms. Johnson stated that when she arrived Resident A was awake and in the bathroom, sitting on the toilet with no clothing on in preparation for a bath. Ms. Johnson stated at approximately 7:30 AM she “rinsed the tub first” and “replaced the tub stopper” before running Resident A’s bath water. Ms. Johnson stated she felt the bath water as she filled the bathtub and the water “wasn’t hot at all” however Ms. Johnson stated she did not feel the water after turning the water off. Ms. Johnson stated she “filled” the bathtub “halfway up” before Resident A entered the bathtub unassisted. Ms. Johnson stated Resident A entered the bathtub and sat down in the water. Ms. Johnson stated Resident A did “not look uncomfortable” and did not indicate the water was too hot. Ms. Johnson stated after Resident A was seated in the bathtub Ms. Johnson asked Resident A “are you okay” and Resident A answered “yes”. Ms. Johnson stated she asked Resident A “are you sure” and Resident A answered “mom” which Ms. Johnson stated means “yes” for Resident A.

Ms. Johnson stated she left Resident A in the bathtub alone with the bathroom door open to soak. Ms. Johnson stated she transitioned to the “other side of the house to assist another resident” while Resident A soaked in the bathtub. Ms. Johnson stated approximately “five minutes later” she returned to the bathroom to check on Resident A and observed Resident A “in a fetal position making a choking noise”. Ms. Johnson stated she called Ms. Williams into the bathroom for assistance. Ms. Johnson stated she telephoned Administrator William Griffin who advised Ms. Johnson to contact “911” immediately. Ms. Johnson stated she telephoned “911” and stayed on the telephone with “911” for approximately five to ten minutes before the fire department came. Ms. Johnson stated while waiting for emergency personnel to arrive, Ms. Johnson was advised by the “911” operator to drain the bath water. Ms. Johnson stated she drained the bath water and felt that the water “was not hot”. Ms. Johnson stated while waiting for emergency personnel to arrive Ms. Williams placed a towel under Resident A’s head. Ms. Jonson stated she “didn’t notice burns” to Resident A’s body. Ms. Johnson stated fire department personal arrived within minutes and a fire fighter “pulled” Resident A out of the bathtub and into Resident A’s bedroom where Cardiopulmonary Resuscitation was performed. Ms. Johnson stated after a short period of time Resident A was transported via ambulance to the hospital for further treatment. Ms. Johnson stated Resident A is able to verbalize pain and at no time during Resident A’s bathing did Ms. Johnson hear Resident A call out in pain. Ms. Johnson stated she has observed Resident A turn the bathtub water off but has never observed Resident A turn the bathtub water on. Ms. Johnson stated on 02/21/2022 she assisted Resident A with his bath according to the requirements of his assessed needs and denied negligence in any manner.

On 04/18/2022 I completed an Exit Conference via telephone with Licensee Designee Michelle Jannenga. Ms. Jannenga stated she agreed with the Special Investigation’s findings.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Licensee Designee Jannenga, Administrator Williams Griffin, staff Quenetta Williams, and Mahogany Johnson each stated Resident A’s typical bathing routine included facility staff allowing Resident A to soak in the bathtub unsupervised prior to staff assisting him with bathing.

	Resident A's Assessment Plan stated Resident A "will wash himself but very slowly" and "needs physical assistance from staff to ensure he is cleaned thoroughly". Resident A's Assessment Plan does not indicate that he required constant monitoring while in the bathtub. Resident A's Individual Plan of Service stated "staff should know Resident A's whereabouts in the home; specifically, within hearing distance as Resident A enjoys talking loudly and indicates where he is". The document further states that Resident A "should be checked on every 30 minutes during the daytime" and "requires hands-on for all areas of his personal care". This document does not indicate that Resident A requires one-on-one supervision or attention while in the bathtub. Staff Quenetta Williams stated on 02/21/2022 she worked at the facility from 07:00 AM until 03:00 PM. Ms. Williams stated during the morning Ms. Williams was preparing breakfast while staff Mahogany Johnson assisted Resident A with bathing. Ms. Williams stated she overheard Ms. Johnson ask Resident A "is the water too hot" and Resident A answer "no". Ms. Williams stated after Resident A was observed unresponsive, she placed her hand in the bathtub's water while assisting Resident A and characterized the water temperate as "not hot". Staff Mahogany Johnson stated she assisted Resident A with his bath according to the requirements of his assessed needs and denied negligence in any manner. On 02/21/2022 Resident A sustained medical complications of cutaneous thermal injury a result of hot bath water. However, Resident A's Assessment Plan and Individual Plan of Service do not indicate he required constant monitoring while soaking in the bathtub and he was typically left unsupervised for brief periods of times. A preponderance of evidence was not discovered during the investigation to substantiate a violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The facility's hot water was not maintained with the range of 105 to 120 degrees Fahrenheit.

INVESTIGATION: On 02/22/2022 I received complaint allegations via email from Adult Protective Services staff Bryan Kahler. Mr. Kahler confirmed he was assigned

to investigate the allegations. The complaint alleged that 54-year-old Resident A resides at the Thresholds Chamberlain Group Home due to mental illness and physical limitations. On 02/21/2022 facility staff contacted emergency personnel due to Resident A displaying signs of a cardiac event; however, when emergency medical personal arrived Resident A displayed first and second degree burns to his body as well as cardiac distress. The complaint alleged that on 02/21/2022 facility staff assisted Resident A with his bath by running the bath water and then leaving Resident A alone in the bathroom. The complaint alleged that facility staff returned five minutes later and observed Resident A displaying trouble breathing and not responsive. The complaint alleged that emergency personal arrived at the facility and started cardiopulmonary resuscitation and while doing so, observed the skin on Resident A's back began peeling off. Resident A was transported to the Spectrum Hospital Emergency Department and medical personal concluded that Resident A was immersed in scalding water as evidenced by the burns on his back.

On 02/22/2022 I interviewed Adult Protective Services staff Brian Kahler via telephone. Mr. Kahler reported that he was notified from Spectrum Hospital staff that Resident A died this morning at 9:00 AM.

On 02/22/2022 I interviewed Detective Sean Wolf of the Grand Rapids Police Department Major Case Team via telephone. Detective Wolf stated the Grand Rapids Police Department's Forensic Unit visited the facility and tested water from the water heater which registered at 128.1 degrees Fahrenheit**.**

On 02/22/2022 I interviewed Abby Simmons Spectrum Health Social Worker via telephone. Ms. Simmons stated that Resident A was admitted to the Spectrum Emergency Department on 02/21/2022. Ms. Simmons stated the Spectrum Health Burn Team was involved with Resident A's medical treatment. Ms. Simmons stated medical records indicate Resident A suffered from second degree burns to his bilateral feet and buttocks and first degree burns to his arms. Ms. Simmons stated medical records indicate 15% of Resident A's total body surface area sustained burns. Ms. Simmons stated Resident A has a history of epilepsy. Ms. Simmons stated medical records indicate cardiopulmonary resuscitation was performed on Resident A by emergency personnel however Resident A was unresponsive upon arrival to the Emergency Department. Ms. Simmons stated Resident A passed away on 02/21/2022 however the medical records do not identify a definitive cause of death.

On 03/22/2022 I received an email from Licensee Designee Michelle Jannenga. The email contained Resident A's Death Certificate. The document does indicate a date of death as 02/22/2022 08:53 AM. The document does indicate the manner of death as "accident" (from options natural, accident, suicide, homicide, undetermined, and pending). The document describes how the injury occurred as "Deceased was burned by hot water while in bathtub" and the cause of death as "Medical complications of cutaneous thermal injury (scalding burns)". The document confirms that no autopsy was performed.

On 04/18/2022 I completed an Exit Conference via telephone with Licensee Designee Michelle Jannenga. Ms. Jannenga stated she agreed with the Special Investigation findings. Ms. Jannenga stated she would submit an acceptable Corrective Action Plan and accept the issuance of a Provisional License.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(2) Hot and cold running water that is under pressure shall be provided. A licensee shall maintain the hot water temperature for a resident's use at a range of 105 degrees Fahrenheit to 120 degrees Fahrenheit at the faucet.
ANALYSIS:	Resident A's Death Certificate does indicate a date of death as 02/22/2022 08:53 AM. The document does indicate the manner of death as "accident" (from options natural, accident, suicide, homicide, undetermined, and pending). The document describes how the injury occurred as "Deceased was burned by hot water while in bathtub" and the cause of death as "Medical complications of cutaneous thermal injury (scalding burns)". Detective Sean Wolf of the Grand Rapids Police Department Major Case Team stated that on 02/21/2022 the Grand Rapids Police Department's Forensic Unit visited the facility and tested the water from the water heater which registered at 128.1 degrees Fahrenheit. A preponderance of evidence was discovered during the investigation to substantiate violation of the applicable rule. The facility's hot water temperature for Resident A's use on 02/21/2022 was above the acceptable range of 105 degrees Fahrenheit to 120 degrees Fahrenheit.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the issuance of a Provisional License for the above referenced physical plant violations.

04/18/2022

Toya Zylstra Date
Licensing Consultant

Approved By:

04/18/2022

Jerry Hendrick Date
Area Manager