GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 31, 2022

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

RE: License #: AL410007104
Investigation #: 2023A0583005
Thresholds Eastern Group Home

Dear Ms. Jannenga:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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

Sincerely,

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

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410007104
Investigation #:	2023A0583005
Complaint Receipt Date:	10/26/2022
Investigation Initiation Date:	10/27/2022
Report Due Date:	11/25/2022
Licensee Name:	Thresholds
Licensee Address:	Suite 130 160 68th St. SW Grand Rapids, MI 49548
Licensee Telephone #:	(616) 340-3788
Administrator:	Michelle Jannenga
Licensee Designee:	Michelle Jannenga
Name of Facility:	Thresholds Eastern Group Home
Facility Address:	4707 Eastern Avenue, SE Grand Rapids, MI 49508-7537
Facility Telephone #:	(616) 249-1531
Original Issuance Date:	01/10/1977
License Status:	REGULAR
Effective Date:	02/06/2021
Expiration Date:	02/05/2023
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff failed to seek timely medical care for Resident A.	Yes

III. METHODOLOGY

10/26/2022	Special Investigation Intake 2023A0583005
10/27/2022	Special Investigation Initiated - Letter Licensee Designee Michelle Jannenga
10/27/2022	APS Referral
10/27/2022	Contact – Email Licensee Designee Michelle Jannenga
10/27/2022	Contact – Telephone Amanda Erspamer, case manager
10/27/2022	Inspection completed onsite
10/31/2022	Exit Conference Licensee Designee Michelle Jannenga

ALLEGATION: Staff failed to seek timely medical care for Resident A.

INVESTIGATION: On 10/26/2022 complaint allegation was received from the Adult Protective Services Centralized Intake Unit but was screened out for formal Adult Protective Services investigation. The complaint alleged that Resident A was, "having health issues on 10/12/22" which included, "increased falls, not using her left arm and crying while sitting on the toilet". The complaint further alleged that Resident A, "was taken to the hospital on the next day and staff reported that she had been acting like this for weeks". The complaint stated that Resident A has a history of, "stroke and lost the ability to swallow" which has caused, "all liquids were going to her lungs". The complaint alleged that Resident A's, "symptoms went unaddressed for weeks".

On 10/27/2022 I completed an interview with Resident A's case manager, Amanda Erspamer, via telephone. Ms. Erspamer stated that Resident A has a legal guardian, communicates with sounds, and displays limited cognition. Ms. Erspamer stated facility staff, "didn't seek medical care for (Resident A) in a timely manner". Ms. Erspamer stated facility staff informed Ms. Erspamer that Resident A, "had been

declining for a month" as evidenced by excessive fatigue, increased falls, lack of independent ADLS, and crying. Ms. Erspamer stated she has observed Resident A on 09/15/2022 and Resident A "appeared normal". Ms. Erspamer stated staff reported Resident A had been physically declining but would have periods in which she would return to her baseline over the past month. Ms. Erspamer stated that on 10/12/2022 at 03:00 PM she spoke with staff Tami Mitchell who stated Resident A had suffered, "four falls in the past month, increased unsteady gait, resistance to using the commode independently, and beer colored urine". Ms. Erspamer stated Resident A has a history of Urinary Tract Infections and therefore she instructed Ms. Mitchell to transport Resident A to the Emergency Department that evening. Ms. Erspamer stated staff transported Resident A to the Emergency Department on 10/13/2022 and Resident A was admitted to Spectrum Hospital. Ms. Erspamer stated hospital staff performed a swallow study and it was determined that Resident A was suffering from dysphagia. Ms. Erspamer stated hospital staff recommended Resident A be discharged to a nursing home with hospice services due to the dysphagia diagnosis. Ms. Erspamer stated hospital staff also performed an MRI which indicated signs that Resident A had suffered a stroke, although a date of the stroke could not be confirmed. Finally, Ms. Erspamer stated blood tests for Resident A indicated high levels of protein which are being evaluated for a cause.

On 10/28/2022 I completed an unannounced onsite investigation at the facility and interviewed staff Marcus Holt, Tami Jackson, Tami Mitchell, and Christina Likely.

Staff Marcus Holt stated "a couple days prior to 10/12/2022" staff Christina Likely informed Mr. Holt that Resident A, "was not acting like herself" as evidenced by extra fatigue and difficulty drinking fluids. Mr. Holt stated he visually observed Resident A and saw nothing visually concerning. Mr. Holt stated he does not regularly work at the facility therefore he is not aware of Resident A's normal baseline functioning. Mr. Holt stated he informed staff Tami Jackson to contact Resident A's case manager Amanda Erspamer, primary care physician, and guardian to inform them of Resident A's change in status.

Staff Tami Jackson stated Resident A's baseline included ambulating with a walker, aspiration difficulties necessitating a pureed diet fed by staff, inability to verbally communicate, and limited cognition. Ms. Jackson stated she telephoned Resident A's public guardian, case manager, and primary care physician as instructed by Mr. Holt on 10/06/2022. Ms. Jackson stated that on 10/06/2022 she left Resident A's physician, Dr. Jeffrey Stevens, a message expressing concern regarding Resident A's status decline. Ms. Jackson stated no communication was exchanged regarding Resident A's decline after the 10/06/2022 message was left with Dr. Stevens until 10/10/2022 when staff Tami Mitchell called Dr. Stevens' office again. Ms. Jackson stated she did not know what Ms. Mitchell communicated with Dr. Stevens or his staff on 10/10/2022. Ms. Jackson acknowledged that Resident A had been declining over the past month however Resident A would have, "good and bad days". Ms. Jackson stated Resident A had been displaying more drooling, excessive fatigue, and was not eating well over the past month. Ms. Jackson stated that on

10/13/2022 she observed Resident A slouched over in her chair and it was agreed that she required an emergency room visit. Ms. Jackson transported Resident A to the emergency department at Spectrum Health where she was admitted.

Staff Tami Mitchell stated that Resident A had been declining over the past month and most significantly the two days preceding her 10/13/2022 hospitalization. Ms. Mitchell stated that on 10/12/2022 Resident A appeared more tired than normal, refused breakfast, and lost the ability to ambulate to the toilet. Ms. Mitchell stated she telephoned Dr. Stevens' office and was informed by his nurse that Resident A's symptoms did not appear to be consistent with a Urinary Tract Infection and did not warrant an emergency room visit unless Resident A appeared "worse". Dr. Stevens' nurse instructed staff to make an appointment for Resident A the following day unless Resident A appeared "worse".

Staff Christina Likely stated Resident A has been declining the month prior to her 10/13/2022 hospitalization. Ms. Likely stated she informed staff Marcus Holt of Resident A's decline which included excessive fatigue, combativeness, and excessive drooling on or about 10/06/2022. Ms. Likely stated at times Resident A would "perk up" but continued to decline overall. Ms. Likely stated that by 10/11/2022 staff were required to physically assist Resident A to the toilet because Resident A lacked the mobility to do so herself. Ms. Likely stated that by 10/13/2022 Resident A was excessively lethargic and required almost total care from staff.

On 10/28/2022 I reviewed an Incident Report received 10/17/2022 and authored by staff Tammy Jackson 10/13/2022. The Incident Report stated:

'(Resident A) seems to be declining. Staff had to have two person assist. (Resident A's) knees buckled, she needs total care. She has excessive drooling, her head is constantly down, she is less responsive. She stares off, and she has been falling more without any obstacles in her way (weak legs)'. The Incident Report stated Resident A was transported to Special Health Emergency Department.

On 10/31/2022 I completed an Exit Conference with Licensee Designee Michelle Jannenga via telephone. Ms. Jannenga stated she agreed with the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Case manager Amanda Erspamer stated that on 10/12/2022 at 3:00 PM she spoke with staff Tami Mitchell who stated Resident A had suffered four falls in the past month, unsteady gait,

	resistance to using the commode, and “beer colored urine”. Ms. Erspamer stated she instructed Ms. Mitchell to transport Resident A to the Emergency Department that evening. Ms. Erspamer stated staff transported Resident A to the Emergency Department on 10/13/2022 and Resident A was admitted to Spectrum Hospital. Staff Christina Likely stated Resident A had been declining the month prior her 10/13/2022 hospitalization. Ms. Likely stated that on 10/06/2022 she informed staff Marcus Holt of Resident A’s decline which included excessive fatigue, combativeness, and excessive drooling. Ms. Likely stated that by 10/11/2022 staff were required to physically assist Resident A to the toilet because Resident A lacked the mobility to do so herself. Ms. Likely stated that by 10/13/2022 Resident A was excessively lethargic and required almost total care from staff. There is a preponderance of evidence to substantiate a violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

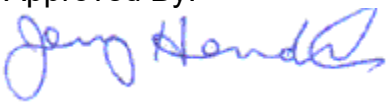
IV. RECOMMENDATION

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

10/31/2022

Toya Zylstra — Date
Licensing Consultant

Approved By:



10/31/2022

Jerry Hendrick — Date
Area Manager