GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 15, 2022

Cornelius Kuperus
David's House Ministries
2390 Banner Dr.
Wyoming, MI 49509

RE: License #: AS410314820
Investigation #: 2023A0583007
House 4

Dear Mr. Kuperus:

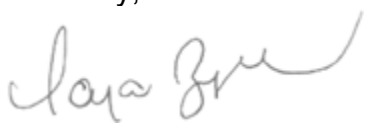
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS410314820
Investigation #:	2023A0583007
Complaint Receipt Date:	11/08/2022
Investigation Initiation Date:	11/09/2022
Report Due Date:	12/08/2022
Licensee Name:	David's House Ministries
Licensee Address:	2390 Banner Dr. Wyoming, MI 49509
Licensee Telephone #:	(616) 247-7861
Administrator:	Cornelius Kuperus
Licensee Designee:	Cornelius Kuperus
Name of Facility:	House 4
Facility Address:	2375 Banner Dr. SW Wyoming, MI 49509
Facility Telephone #:	(616) 247-7861
Original Issuance Date:	10/18/2012
License Status:	REGULAR
Effective Date:	04/18/2021
Expiration Date:	04/17/2023
Capacity:	3
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A's wheelchair was not safely restrained in the facility's vehicle which resulted in Resident A sustaining injuries.	Yes

III. METHODOLOGY

11/08/2022	Special Investigation Intake 2023A0583007
11/09/2022	Special Investigation Initiated - Letter Cornelius Kuperus, Licensee Designee
11/09/2022	Contact - Document Received Ruth Bonfiglio, Davids House Residential Services Administrator
11/09/2022	Inspection Completed On-site Staff Shawntell Rice, Resident A
11/14/2022	APS Referral
11/14/2022	Contact – Telephone Staff Lianna Cullin
11/15/2022	Exit Conference Cornelius Kuperus, Licensee Designee

ALLEGATION: Resident A's wheelchair was not safely restrained in the facility's vehicle which resulted in Resident A sustaining injuries.

INVESTIGATION: On 11/08/2022 an Incident Report was received via facsimile from Ruth Bonfiglio, David's House Residential Services Administrator. The incident report stated the following: *'(Resident A) had taken a fall backwards in his wheelchair while staff was making a left turn onto Lake, Michigan Drive in a DHM van to head towards Allendale to visit his dad's nursing home. Lianna pulled into a gas station immediately and went to take care of (Resident A). (Resident A) hit his head and it made a small cut'.* The Incident Report stated Resident A was transported to the Emergency Room via ambulance and was admitted with 'fractures' to his back.

On 11/09/2022 I received and reviewed an email from Licensee Designee Cornelius Kuperus which stated the following: *'I had our maintenance department look through the van as well to determine if there were any issues he could see with the straps.*

We also do this monthly. He discovered that the wrong straps were in the van. These straps were from one of our newer vehicles with a similar, yet slightly different latching mechanism. It would appear that the staff driving the van did not realize these were the wrong straps, so would've assumed she locked the resident down correctly as this strap still appeared to lock into place, but came lose while driving.

We are not sure how this happened but are taking steps to make sure it can't happen again. Presently, maintenance is working on finding a way to permanently label the straps in each van so that we will know if they get moved to another van by accident.

Obviously, this will also be included in all present and future trainings on how to strap down residents in our vans.'

On 11/09/2022 I completed an unannounced onsite investigation at the facility and interviewed staff Shawntell Rice and observed Resident A.

Ms. Rice stated that last Sunday she was working with staff Lianna Cullin. Ms. Rice stated around noon Ms. Rice transported Resident A in the facility van to visit Culvers and Resident A's father. Ms. Rice stated at approximately 1:26 PM Ms. Rice received a telephone call from Ms. Cullin and Ms. Cullin reported that after accelerating from a red light she heard a thud and Resident A yelled, "Ow". Ms. Cullin explained that she had secured Resident A, who was seated in his wheelchair, into the back of the van with security straps however the straps malfunctioned causing Resident A to fall backwards in his wheelchair. Ms. Rice stated she advised Ms. Cullin to telephone "911" and request medical assistance. Ms. Rice stated Ms. Cullin followed the advice and telephoned "911" for assistance. Ms. Rice stated Resident A was transferred to Spectrum Hospital for treatment. Ms. Rice stated Resident A was released from Spectrum Hospital with a diagnosis of a "Cervical Sprain". Ms. Rice stated staff often switch safety straps between the multiple vans owned by the facility and it was discovered that the vehicle Ms. Cullin was driving had the wrong straps designed for that vehicle.

I observed Resident A's wellbeing. Resident A was lying in his bed wearing a cervical collar. Resident A was unable to complete an interview as a result of his developmental disability.

On 11/14/2022 I emailed complaint allegations to Adult Protective Services Centralized intake.

On 11/14/2022 I completed an interview with staff Lianna Cullin via telephone. Ms. Cullin stated that on 11/06/2022 she drove Resident A "around 11:30 AM to Culvers" in the facility van. Ms. Cullin stated that after eating lunch at Culvers she assisted Resident A into the van and made sure to secure Resident A's wheelchair into the van with safety straps. Ms. Cullin stated that Resident A was seat belted into his wheelchair inside the van. Ms. Cullin stated that she stopped at a red light and then

turned left when she heard a “thud”. Ms. Cullin stated she heard Resident A yell “ow” and observed Resident A was seated in his wheelchair, however the wheelchair had fallen backwards inside the vehicle. Ms. Cullin stated she telephoned 911 after pulling off the road. Ms. Cullin stated emergency personal traveled to the scene and transported Resident A to the hospital via ambulance. Ms. Cullin stated Resident A was diagnosed with a cervical strain and back fractures and was admitted to the hospital. Ms. Cullin stated Resident A was subsequently discharged back to the facility. Ms. Cullin stated maintenance staff later discovered that the wrong safety strap had been used in the vehicle on 11/06/2022 which caused the strap to become loose while transporting Resident A. Ms. Cullin stated the incorrect strap has been replaced with the correct strap for the vehicle.

On 11/15/2022 I completed and Exit Conference with Licensee Designee Cornelius Kuperus. Mr. Kuperus stated he agreed with the finding and would submit an acceptable corrective action plan.

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:	On 11/06/2022 Resident A was transported in the facility vehicle by staff Lianna Cullin. Resident A was seat belted in the vehicle into his wheelchair which was secured by safety straps. While driving, Resident A’s wheelchair became unsecured and Resident A fell backwards causing fractures to Resident A’s back and a sprain to his cervical spine. It was later discovered that the wrong safety strap was utilized to secure Resident A’s wheelchair inside of the vehicle. A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

11/15/2022

Toya Zylstra Date
Licensing Consultant

Approved By:

11/15/2022

Jerry Hendrick Date
Area Manager