GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 20, 2023

Dawn Noordijk
Heritage Homes Inc
Bldg 200, Suite 205
400 136th Avenue
Holland, MI 49424

RE: License #: AM700009394
Investigation #: 2023A0464024
HH-Harrison Ave Group Home

Dear Ms. Noordijk:

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,

Megan Aukerman, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 438-3036

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
This report contains quoted profanity

I. IDENTIFYING INFORMATION

License #:	AM700009394
Investigation #:	2023A0464024
Complaint Receipt Date:	02/22/2023
Investigation Initiation Date:	02/22/2023
Report Due Date:	04/23/2023
Licensee Name:	Heritage Homes Inc
Licensee Address:	Bldg 200, Suite 205 400 136th Avenue, Holland, MI 49424
Licensee Telephone #:	(616) 403-1466
Administrator:	Dawn Noordijk
Licensee Designee:	Dawn Noordijk
Name of Facility:	HH-Harrison Ave Group Home
Facility Address:	342 Harrison Avenue Holland, MI 49423
Facility Telephone #:	(616) 396-3657
Original Issuance Date:	02/05/1987
License Status:	REGULAR
Effective Date:	07/16/2021
Expiration Date:	07/15/2023
Capacity:	8
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Facility staff Bethany James is verbally abusive and pinched Resident A's arm.	Yes
On 02/18/2023 Resident A got his wheelchair stuck in a snowbank and facility staff left Resident A outside for over forty-five minutes.	Yes

III. METHODOLOGY

02/22/2023	Special Investigation Intake 2023A0464024
02/22/2023	Special Investigation Initiated - Telephone Dawn Noordijk, Licensee Designee
02/22/2023	APS Referral Centralized Intake, DHHS
02/22/2023	Contact - Document Received Brianna Fowler, ORR
02/28/2023	Contact-Face to face Brianna Fowler (ORR), Bethany James (Staff), Charlotte Austin (Staff), and Tina Millisor (Administrative Staff)
03/07/2023	Inspection Completed-Onsite Resident A Brianna Fowler, ORR
03/15/2023	Contact-Document received Brianna Fowler, ORR
03/20/2023	Exit Conference Dawn Noordijk, Licensee Designee

ALLEGATION: Facility staff Bethany James is verbally abusive and pinched Resident A's arm.

INVESTIGATION: On 02/22/2023, I received a complaint from the Office of Recipient Rights (ORR). The complaint alleged that on 02/18/2023, Resident A went outside the facility to vape. Resident A's wheelchair got stuck in a snowbank and facility staff were unable to get him out. Staff left Resident A outside for over forty-five minutes. The complaint also alleged facility staff; Bethany James treats

Resident A poorly. She is verbally abusive and pinched his arm around Thanksgiving.

On 02/22/2023, I exchanged emails with licensee designee, Dawn Noordijk. She stated staff, Bethany James and Charlotte Austin have been suspended until the investigation is complete.

On 02/22/2023, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral per policy.

On 02/23/2023, I exchanged emails with Ottawa County Recipient Rights worker, Brianna Fowler to coordinate the investigation.

On 02/28/2023, I met with Ms. Fowler and Heritage Homes Administrative staff, Tina Millisor to interview facility staff. We interviewed Charlotte Austin, individually. Ms. Austin stated she regularly works with staff Bethany James. Ms. Austin stated Resident A got his wheelchair stuck in the snow on 02/18/2023. When Ms. Austin went to tell Ms. James, he was stuck and she needed help, Ms. James said; “damnit Ben”. Ms. Austin feels it was loud enough for other residents to hear. Ms. Austin confirmed Ms. James has made other inappropriate comments regarding Resident A. Ms. Austin stated Ms. James frequently jokes about Resident A’s weight and being fat. Ms. Austin stated Resident A and Ms. James joke around with each other, but Ms. Austin feels Ms. James “takes it too far” sometimes. Ms. Austin has heard Ms. James talk to Resident A about his weight and being healthy. She has told him he needs a purpose otherwise he should just go ahead and die. Ms. Austin stated Ms. James has made similar comments to other staff about Resident A. Ms. Austin denied Ms. James has ever physically hurt Resident A; specifically pinching his arm. She denied witnessing any other staff physically hurt Resident A.

We then interviewed staff Bethany James. Ms. James stated she and Resident A have a relationship where they joke with each other. She stated Resident A has a very sarcastic personality. Ms. James stated Resident A is supposed to be working on weight loss, but still eats very unhealthily. Ms. James stated she has had conversations with Resident A about how he needs to be healthy and take care of himself. Ms. James stated she did tell Resident A he was getting bigger and needed to be aware of what he is putting in his body. Ms. James denied telling Resident A he needed to just go into hospice and die. Ms. James stated she has vented to her coworkers about Resident A, but it has always been in the office with the door closed. Ms. James acknowledged her voice carries and other residents could have overheard her comments. Ms. James denied she has ever caused physical harm to Resident A. She denied she has ever pinched Resident A and stated she would never harm a resident.

I then reviewed written statements provided by staff, Tiffany Knighten and Misty Wilson. Both staff stated there was an incident when they were talking with Ms.

James during shift change. Ms. James stated, “she was sick of (Resident A’s) shit. He could just die, and she wouldn’t even care”. Both staff stated they were in the office when Ms. James made the statement. Ms. Knighten and Ms. Wilson stated there was another incident on 02/13/2023, where Ms. James was upset with Resident A and told them “(Resident A) should just move out and die”.

On 03/07/2023, Ottawa County Recipient Rights worker, Brianna Fowler completed an onsite inspection at the facility. Resident A was interviewed, privately. Resident A stated he likes Ms. James, but sometimes she takes things too far. Resident A stated Ms. James frequently talks about his weight and has told him, “I don’t care if you have to go into hospice”. Ms. James has told Resident A that he and Resident B are very needed. She has also told him that taking him to the bathroom is the worst part of her job. Resident A stated around Thanksgiving time Ms. James pinched him several times under his arm. Resident A denied anyone else saw Ms. James pinch him. Resident A was observed to have no marks or bruises.

On 03/15/2023, I exchanged emails with Ms. Fowler. She indicated she would also be citing regarding the rights complaint, for dignity and respect.

On 03/20/2023, an exit conference was completed with licensee designee, Dawn Noordijk. She was informed of the investigation findings and recommendations. Ms. Noordijk stated Ms. James employment has been terminated.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	On 02/22/2023, a complaint was received alleging facility staff Bethany James is verbally abusive towards Resident A and pinched his arm. Staff, Charlotte Austin, Tiffany Knighten and Misty Wilson all reported witnessing staff Bethany James make inappropriate statements towards and about Resident A. All three denied witnessing Ms. James pinch Resident A.

	Ms. James confirmed she has spoke with Resident A regarding his weight and "vented" about Resident A to other staff. Ms. James denied pinching Resident A. Resident A reported Ms. James talks about his weight and going into hospice care. Resident A disclosed Ms. James pinched him under his arm; however, there were no witnesses. Based on the investigative findings, there is sufficient evidence to support the rule violation that Ms. James does not treat Resident A with dignity and respect.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 02/18/2023, Resident A got his wheelchair stuck in a snowbank. Facility staff left Resident A outside for over forty-five minutes.

INVESTIGATION: On 02/28/2023, Ms. Fowler, Ms. Millisor and I interviewed Ms. Austin. Ms. Austin stated Resident A always goes outside after breakfast time to vape nicotine. Ms. Austin stated 02/18/2023 was no different than any other morning. Resident A ate breakfast, then put a sweatshirt and coat on and went outside to vape. Ms. Austin stated Resident A typically stays outside for several minutes to vape. Ms. Austin stated on 02/18/2023, it was cold out, but the sun was shining. Resident A then drove his motorized wheelchair to the end of the driveway, turning onto the sidewalk to vape. Ms. Austin saw that Resident A got his motorized wheelchair stuck in the snow. Ms. Austin went outside to assist Resident A. Ms. Austin stated she was unable to free Resident A's wheelchair from the snow, so she went inside to seek help from Ms. James. Ms. Austin and Ms. James decided they did not want to leave the residents inside the facility unattended, therefore Ms. James went outside to try to assist Resident A, while Ms. Austin stayed inside with the other residents, watching from the doorway.

A few minutes later, Ms. James came back into the facility stating she was unable to get Resident A's wheelchair out of the snow and Resident A did not want her to call Emergency Medical Services (EMS). Ms. James informed Ms. Austin Resident A stated he was calling his grandmother. Ms. James then went and got a blanket to give Resident A, while he waited for family. Ms. Austin stated she and Ms. James were inside and Resident A was outside for about thirty minutes until his mom arrived. Resident A's mother was able to get Resident A unstuck and brought him back into the facility.

Ms. Fowler, Ms. Millisor and I then interviewed Ms. James. Ms. James stated on 02/18/2023, in the morning, she was cleaning resident bathrooms, when Ms. Austin came in and informed her Resident A got his wheelchair stuck in a snowbank. Ms. Austin told Ms. James she was unable to get Resident A out of the snowbank. Ms. James stated Ms. Austin stayed inside while Ms. James went outside to try and free

Resident A's wheelchair. Ms. James stated she was unable to do so. Ms. James asked Resident A if she could call EMS to assist with freeing his chair and Resident A informed her, he did not want her to and that he already contacted his mother. His mother was on her way. Ms. James states she went and got Resident A a blanket to keep him warm while he waited. Ms. James stated Resident A's mother arrived ten minutes later. Resident A's mother was able to get Resident A unstuck and brought him into the facility. Ms. James stated Resident A's mother was screaming, swearing, and yelling at she and Ms. Austin for leaving Resident A outside. Ms. James stated Resident A usually stays outside longer than what he was when he goes out to vape, therefore they thought he was fine to wait outside.

On 03/07/2023, an onsite inspection was completed by Ms. Fowler. She interviewed Resident A, privately. Resident A stated on 02/18/2023, he went outside to vape. Resident A stated he took the corner too sharply in his motorized wheelchair and ended up getting stuck in the snowbank. Resident A stated Ms. James and Ms. Austin came out separately to try to help, but they were unable to get him unstuck. Resident A stated he called his mom to come help. Staff gave him a blanket to use until his mom arrived. Resident A stated he feels he was stuck outside for approximately twenty minutes before his mom arrived. Resident A stated while he was waiting outside, he tried to call the facility phone on three separate occasions, but no one answered.

On 03/20/2023, an exit conference was completed with licensee designee, Dawn Noordijk. She was informed of the investigation findings and recommendations. Ms. Noordijk stated a corrective action plan would be submitted.

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 02/22/2023, a complaint was received alleging facility staff left Resident A out in the cold for over forty-five minutes. Facility staff Charlotte Austin, and Bethany James both stated that on 02/18/2023, Resident A went outside to vape nicotine and got his motorized wheelchair stuck in a snowbank. Both staff confirmed Resident A was waiting outside, unattended for several minutes until his mother arrived to assist. Ms. Austin and Ms. James confirmed they did not call Emergency Medical Services to assist with getting Resident A unstuck.

	Resident A reported he was outside for approximately twenty minutes until his mother came to help. Resident A stated while waiting, he called the facility on three separate occasions, and no one answered the phone. Based on the investigative findings, there is sufficient evidence to support a rule violation that facility staff failed to ensure Resident A's safety, by leaving him unattended in the cold.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

03/20/2023

Megan Aukerman Date
Licensing Consultant

Approved By:

03/20/2023

Jerry Hendrick Date
Area Manager