GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 18, 2023

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

RE: License #: AM410278667
Investigation #: 2023A0583043
Plainfield Group Home

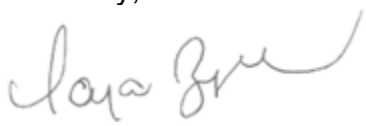
Dear Ms. Jannenga:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 #:	AM410278667
Investigation #:	2023A0583043
Complaint Receipt Date:	09/12/2023
Investigation Initiation Date:	09/12/2023
Report Due Date:	10/12/2023
Licensee Name:	Thresholds
Licensee Address:	Suite 130 160 68th St. SW Grand Rapids, MI 49548
Licensee Telephone #:	(616) 455-0960
Administrator:	Michelle Jannenga
Licensee Designee:	Michelle Jannenga
Name of Facility:	Plainfield Group Home
Facility Address:	2860 Plainfield NE Grand Rapids, MI 49505
Facility Telephone #:	(616) 361-0838
Original Issuance Date:	04/10/2007
License Status:	REGULAR
Effective Date:	10/26/2021
Expiration Date:	10/25/2023
Capacity:	8
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A sustained extensive abdominal bruising.	No
Additional Findings	Yes

III. METHODOLOGY

09/12/2023	Special Investigation Intake 2023A0583043
09/12/2023	Special Investigation Initiated - Telephone Relative 1 and Relative 2
09/13/2023	Inspection Completed On-site
09/14/2023	Contact - Telephone call received Relative 1
09/14/2023	Contact - Document Received Michelle Janenga
09/15/2023	APS Referral
09/15/2023	Contact – Telephone Staff Lien Lee
09/18/2023	Exit Conference Licensee Designee Michelle Jannenga

ALLEGATION: Resident A sustained extensive abdominal bruising.

INVESTIGATION: On 09/12/2023 the above complaint allegation was received via email from Network 180 Recipient Rights Staff Melissa Gekeler. Ms. Gekeler stated that she received a complaint on 09/12/2023 which stated Resident A was picked up on Sunday Sept. 3 for the day and late in the day Resident A was observed to be, “bruised from her neck to her waist”. The complaint further stated that the most predominant bruising was observed on her right side and Resident A’s, “whole right breast was terribly bruised, under her arm, down rib cage”.

On 09/12/2023 I interviewed Relative 1 and Relative 2 jointly via speaker phone per their request. Relative 1 and Relative 2 reported Resident A is a non-verbal female who requires “total care” and resides at the Plainfield Group Home. Relative 1 and Relative 2 reported that they are co-guardians of Resident A. Relative 1 and

Relative 2 reported that on 09/03/2023 they arrived at the facility and spoke with staff Debra Barrington. Relative 1 and Relative 2 stated that Ms. Barrington reported a small red mark was observed by facility staff on Resident A's right breast. Relative 1 and Relative 2 reported that Ms. Barrington stated the red mark was unremarkable and staff had no idea how the mark originated. Relative 1 and Relative 2 reported that on 09/03/2023 they picked up Resident A from the facility and transported her to their home. Relative 1 stated that on 09/03/2023 at 5:00 PM she assisted Resident A with using the bathroom and in doing so observed extensive bruising on her right breast and abdominal region. Relative 1 and Relative 2 stated they transported Resident A back to the facility on 09/03/2023 later in the evening. Relative 1 stated she telephoned staff Debra Barrington and questioned the origination of Resident A's abdominal bruising. Relative 1 stated Ms. Barrington informed her that she had no idea the red mark transitioned into bruising. Relative 1 and Relative 2 reported that they photographed Resident A's injuries on 09/10/2023. Relative 1 in Relative 2 stated that Resident A has not received medical treatment or X rays to determine if she has fractures to her abdominal area. Relative 1 and Relative 2 both stated that today they requested facility staff help Resident A schedule and receive X rays of the bruises. Relative 1 and Relative 2 stated that facility staff have scheduled the X rays to be completed by a traveling medical company.

On 09/12/2023 I received a text message from Relative 1. The text message contained two photographs of Resident A's abdominal bruising. I observed the photographs displayed Resident A's bruises in multiple stages of healing located primarily on Resident A 's right breast and right abdominal area.

On 09/13/2023 I completed an unannounced onsite investigation at the facility. Recipient rights staff Melissa Gekeler was present during the onsite investigation. While onsite I interviewed staff Debra Barrington, Karen Gaddis, and Angela Davis. While onsite I visually verified the wellbeing of Resident A.

Staff Debra Barrington stated that facility staff Lien Lee showed Ms. Barrington a small red mark located on Resident A 's right breast on 09/02/2023. Ms. Barrington characterized Resident A's red mark as unremarkable and of unknown origin. Ms. Barrington stated that on 09/03/2023 Relative 1 and Relative 2 arrived at the facility and transported Resident A back to their home. Ms. Barrington stated Relative 1 and Relative 2 transported Resident A back to the facility that same day and made no mention of Resident A's abdominal bruising. Ms. Barrington stated Relative 1 and Relative 2 arrived at the facility on 09/06/2023 and transported Resident A back to their home. Ms. Barrington stated on 09/06/2023 she received a telephone call from Relative 1 questioning the origin of Resident A 's bruising. Ms. Barrington stated Resident A's red mark transitioned into extensive bruising between 09/02/2023 and 09/06/2023. Ms. Barrington stated Resident A does not appear to exhibit signs of pain therefore medical attention was not sought. Ms. Barrington stated she has never observed facility staff mistreat Resident A or harm her in any manner. Ms. Barrington denied she caused Resident A 's injuries. Ms. Barrington stated Resident A does utilize a hoyer lift however her injuries are not consistent with the misuse of

Resident A’s hoyer lift. Ms. Barrington stated Resident A utilizes a wheelchair which consists of a chest plate and straps and Resident A favors her right side while sitting in the wheelchair. Ms. Barrington stated that given the location of Resident A 's bruising it appears Resident A wheelchair straps and faceplate may have caused Resident A’s chest bruising. Ms. Barrington stated that Resident A has been scheduled for X rays of her abdominal area today.

Staff Karen Gaddis stated she has worked at the facility for less than one month. Ms. Gaddis stated Ms. Barrington informed her of Resident A’s abdominal bruising approximately a week ago. Ms. Gaddis stated Resident A 's abdominal injuries appear consistent with her wheelchair straps and plate being too tight as Resident A favors her right side while sitting in the wheelchair. Ms. Gaddis stated she has never observed facility staff mistreat Resident A in any manner and denied that she has harmed Resident A either indirectly or directly.

Staff Angela Davis stated that on 09/02/2023, while changing Resident A, she observed a red line type mark on Resident A 's right breast. Ms. Davis stated she next observed Resident A’s red mark again on 09/04/2023 which had transitioned into extensive bruising around Resident A 's right breast and abdominal region. Ms. Davis stated Resident A’s injuries appear consistent with her wheelchair straps and chest plate being placed too tight given the location of her injuries and her pattern of sitting rigidly on the right side of her wheelchair. Ms. Davis denied harming Resident A and denied she has observed other staff physically harm Resident A.

Resident A was observed sitting in her wheelchair which contains straps and a chest plate for safety. Resident A does sit rigidly to the right of her wheelchair and thus a new left side pad was added to the wheelchair. Resident A’s bruising to her abdominal area appeared to be healing.

On 09/14/2023 I received a telephone call from Relative 1. Relative 1 stated that she previously misspoke, and she did not observe any type of red mark or bruising on Resident A on 09/03/2023. Relative 1 stated that she actually observed Resident A’s abdominal bruising on 09/06/2023.

On 9/15/2023 I received an email from licensee designee Michelle Jannenga. The email contained medical documentation from Harmony Cares Medical Group. The medical documentation was dated 09/13/2023 and stated that an x-ray was completed on Resident A 's abdominal area which was noted as negative for fractures.

On 09/15/2023 I interviewed staff Lien Lee via telephone. Ms. Lee stated that on 09/02/2023, while undressing Resident A for a shower, she observed a red mark on Resident A’s right breast and very light bruising located under Resident A’s right breast. Ms. Lee stated she immediately showed staff Debra Barrington Resident A’s injuries. Ms. Lee stated that she observed Resident A's “area got worse over time” as evidenced by Resident A’s red mark progressing into widespread abdominal

bruising. Ms. Lee stated that based upon the location of the Resident A's abdominal bruising; she believes Resident A's bruising was caused by the chest plate and straps of Resident A's wheelchair.

On 09/18/2023 I completed an Exit Conference with Licensee Destinee Michelle Jannenga via telephone. Ms. Jannenga stated she agreed with the Special Investigation findings.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a Resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	On 09/02/2023 a red mark and light bruising were observed on Resident A's right breast. By 09/06/2023 Resident A's red mark progressed into significant abdominal bruising. All interviewed staff could not definitely identify the origination of Resident A's abdominal bruising but denied the injuries were due to abuse or neglect. A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate a violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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

INVESTIGATION: On 09/12/2023 I interviewed Relative 1 and Relative 2 jointly via speaker phone per their request. Relative 1 and Relative 2 reported Resident A is non-verbal and requires "total care". Relative 1 and Relative 2 reported that Resident A has extensive bruising to her abdominal area. Relative 1 in Relative 2 stated that Resident A has not received medical treatment or X rays to determine if she fractured her abdominal area. Relative 1 and Relative 2 both stated that today they requested facility staff help Resident A schedule and receive X rays of the bruises. Relative 1 and Relative 2 stated that facility staff have scheduled the X rays to be completed by a traveling medical company.

On 09/13/2023 I interviewed staff Debra Barrington at the facility. Ms. Barrington stated that facility staff Lien Lee showed Ms. Barrington a small red mark located on Resident A 's right breast on 09/02/2023. Ms. Barrington characterized Resident A's red mark as unremarkable and of unknown origin. Ms. Barrington stated Resident A's red mark transitioned into extensive bruising between 09/02/2023 and 09/06/2023. Ms. Barrington stated Resident A does not appear to exhibit signs of pain therefore medical attention was not sought. Ms. Barrington stated that Resident A has been scheduled for X rays of her abdominal area today.

On 9/15/2023 I received an email from licensee designee Michelle Jannenga. The email contained medical documentation from Harmony Cares Medical Group dated 09/13/2023. This documentation stated that an x-ray was completed on Resident A's abdominal area which was noted as negative for fractures.

A 09/15/2023 file review indicates that on 01/03/2023 the facility was found to have violated R 400.14310 (4) due to facility staff failing to seek timely medical care for a resident who sustained an arm fracture.

On 09/18/2023 I completed an Exit Conference with Licensee Destinee Michelle Jannenga via telephone. Ms. Jannenga stated she would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14310	**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:	On 09/02/2023 at least two facility staff noted that Resident A had a small red mark located on her right breast. Between 09/02/203 and 09/06/2023 Resident A's red mark transitioned into extensive abdominal bruising requiring the need for x-rays to rule out fractures. X-rays were not completed until 09/13/2023. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a violation of the applicable rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation 2023A0583013 01/03/2023**

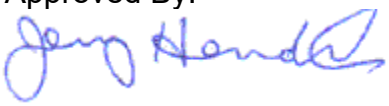
IV. RECOMMENDATION

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

09/18/2023

Toya Zylstra — Date
Licensing Consultant

Approved By:



09/18/2023

Jerry Hendrick — Date
Area Manager