GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 15, 2024

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

RE: License #: AS410416497
Investigation #: 2024A0583031
Kendall East

Dear Ms. Jannenga:

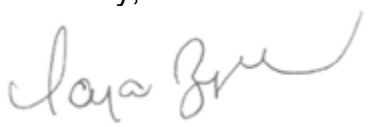
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS410416497
Investigation #:	2024A0583031
Complaint Receipt Date:	04/12/2024
Investigation Initiation Date:	04/12/2024
Report Due Date:	05/12/2024
Licensee Name:	Thresholds
Licensee Address:	Suite 130 160 68th St. SW Grand Rapids, MI 49548
Licensee Telephone #:	(616) 466-5242
Administrator:	Muaarijih Lyons
Licensee Designee:	Michelle Jannenga
Name of Facility:	Kendall East
Facility Address:	1740 Kendall St. SE Grand Rapids, MI 49508
Facility Telephone #:	(616) 455-0960
Original Issuance Date:	04/02/2024
License Status:	TEMPORARY
Effective Date:	04/02/2024
Expiration Date:	10/01/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Staff Susan Robinson physically struck Resident A.	Yes

III. METHODOLOGY

04/12/2024	Special Investigation Intake 2024A0583031
04/12/2024	APS Referral
04/12/2024	Special Investigation Initiated - Telephone Licensee Designee Michelle Jannenga
04/15/2024	Inspection Onsite Resident A, Resident B
04/15/2024	Exit Conference Michelle Jannenga

ALLEGATION: Staff Susan Robinson physically struck Resident A.

INVESTIGATION: On 04/12/2024 I received an email from Adult Protective Services staff Kevin Souser. Mr. Souser stated that Adult Protective Services received a complaint from Centralized Intake. Mr. Souser stated that the complaint alleged that on 04/11/2024, staff Susan Robinson hit Resident A on his upper left thigh “two or three times with an open hand”. The complaint stated that Ms. Robinson struck Resident A because Resident A had hit Ms. Robinson with an IPAD. The complaint stated that Resident A did not appear to be pain after the incident and there were no obvious signs of injury. The complaint stated that Ms. Robinson has been suspended from her employment due to the incident. Mr. Souser stated that he is investigating the complaint allegations.

On 04/11/2024 I spoke with Licensee Designee Michelle Jannenga via telephone. Ms. Jannenga stated that Resident A is non-verbal and requires “assistance with all ADLs”. Ms. Jannenga stated that on 04/11/2024 she was informed by staff Marcus Holt that staff Susan Robinson struck Resident A with an open hand two to three times on Resident A’s left upper thigh after Resident A hit Ms. Robinson with an IPAD. Ms. Jannenga stated that Mr. Holt and administrator Muaarijih Lyons observed the incident which occurred in the facility’s common living area. Ms. Jannenga stated that Resident A was observed by Mr. Holt and Ms. Lyons and did not present with any injuries from the incident. Ms. Jannenga stated that Ms. Robinson was asked to leave the facility immediately after the incident and will be formally terminated from employment.

On 04/12/2024 I interviewed staff Susan Robinson via telephone. Ms. Robinson stated that on 04/11/2024 she was working at the facility. Ms. Robinson stated that staff Marcus Holt, Resident A, and Resident B were all in the communal living area together. Ms. Robinson stated that Resident A hit Resident B on the head with an IPAD and Ms. Robinson intervened by attempting to move Resident A's hands. Ms. Robinson stated that Resident A then hit Ms. Robinson on her head with the IPAD. Ms. Robinson stated that she again tried to move Resident A's hands from hitting her. Ms. Robinson stated that at no time did she hit Resident A in any manner. Ms. Robinson stated that administrator Muaarijih Lyons was at the facility during the time of the incident but was not in the communal living room at the time of the incident. Ms. Robinson stated that Resident A and Resident B are both non-verbal. Ms. Robinson stated she has been suspended from the employment at the facility.

On 04/12/2024 I interviewed staff Marcus Holt via telephone. Mr. Holt stated that after lunch on 04/11/2024 he was seated in the communal living area with staff Susan Robinson, Resident A, and Resident B. Mr. Holt stated he was sitting on the "loveseat" next to Ms. Robinson and Resident A and Resident B were sitting together on the "couch". Mr. Holt stated that he heard Ms. Robinson say, "don't hit me" and then stand up and hit Resident A "two to three times with an open hand on Resident A's left upper thigh". Mr. Holt stated that he did not observe Resident A hit Ms. Robinson or Resident B with an IPAD. Mr. Holt stated that administrator Muaarijih Lyons heard the commotion in the communal living area and walked into the room as Ms. Robinson was standing over Resident A. Mr. Holt stated that he asked Ms. Robinson to leave the facility immediately after the incident occurred. Mr. Robinson stated that Resident A was immediately visually assessed by Mr. Holt and Ms. Holt and no injuries were observed on Resident A's left upper thigh.

On 04/12/2024 I interviewed administrator Muaarijih Lyons via telephone. Ms. Lyons stated that on 04/11/2024 she was working in her office when she overheard staff Susan Robinson yell "stop hitting". Ms. Lyons stated that she immediately walked into the common living area and observed Ms. Robinson and Resident A standing "face to face". Ms. Robinson stated that she then observed staff Marcus Holt tell Ms. Robinson, "you can't do that" and "I saw you hit him". Ms. Lyons stated that Ms. Robinson told Mr. Holt, "I'm sorry for what happened". Ms. Lyons stated that she asked Ms. Robinson if she was "okay" and Ms. Robinson did not respond. Ms. Lyons stated that she proceeded to speak with Mr. Holt privately and he informed Ms. Lyons that Ms. Robinson hit Resident A two to three times on his left upper thigh with an open hand. Ms. Lyons stated that Mr. Holt immediately suspended Ms. Robinson. Ms. Lyons stated that she has visually checked Resident A for injuries on 04/11/2024 and 04/12/2024 and he presents with no injuries.

On 04/15/2024 I completed an unannounced onsite investigation at the facility. While onsite I visually verified the welling of Resident A and Resident B. Resident A and Resident B were not interviewed as a result of their developmental disabilities rendering each of them non-verbal. I did not observe obvious signs of abuse on

Resident A and Resident B's arms and face. Both residents were observed with adequate hygiene.

On 04/15/2024 I completed an Exit Conference with Licensee Designee Michelle Jannenga via telephone. Ms. Jannenga stated that she agreed that a licensing violation had occurred. Ms. Jannenga stated that she would submit an acceptable Corrective Action Plan.

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:	Staff Marcus Holt stated that on 04/11/2024 he was seated in the communal living area with staff Susan Robinson, Resident A, and Resident B. Mr. Holt stated he was sitting on the "loveseat" next to Ms. Robinson and Resident A and Resident B were sitting together on the "couch". Mr. Holt stated that he heard Ms. Robinson say, "don't hit me" and then stand up and hit Resident A two to three times with an open hand on Resident A's left upper thigh. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a violation of the applicable rule. Staff Susan Robinson mistreated Resident A by physically hitting him.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

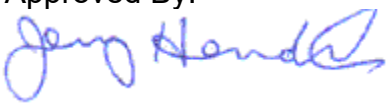
Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license status.

Toya Zylstra 04/15/2024

Toya Zylstra Date

Licensing Consultant

Approved By:



04/15/2024

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Jerry Hendrick Date
Area Manager