GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 27, 2024

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

RE: License #: AS410360988
Investigation #: 2024A0583056
Mayfield

Dear Ms. Jannenga:

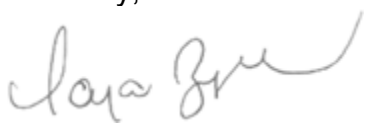
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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
Report contains profane language.

I. IDENTIFYING INFORMATION

License #:	AS410360988
Investigation #:	2024A0583056
Complaint Receipt Date:	09/19/2024
Investigation Initiation Date:	09/20/2024
Report Due Date:	10/19/2024
Licensee Name:	Thresholds
Licensee Address:	Suite 130 160 68th St. SW Grand Rapids, MI 49548
Licensee Telephone #:	(616) 466-5242
Administrator:	Joshua Hosack
Licensee Designee:	Michelle Jannenga
Name of Facility:	Mayfield
Facility Address:	3927 Mayfield NE Grand Rapids, MI 49525
Facility Telephone #:	(616) 361-5491
Original Issuance Date:	06/19/2014
License Status:	REGULAR
Effective Date:	12/18/2022
Expiration Date:	12/17/2024
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Residents perform manual labor for the benefit of staff.	No
Staff verbally mistreat residents.	Yes
Staff “rough house” with residents.	No
Residents enter the unlocked medication closet to retrieve items.	Yes
Staff serve residents spicy food.	No
Additional Findings	Yes

III. METHODOLOGY

09/19/2024	Special Investigation Intake 2024A0583056
09/20/2024	Special Investigation Initiated - Letter Licensee Designee Michelle Jannenga
09/20/2024	Contact - Document Sent Recipient Rights Michelle Gekeler
09/23/2024	Inspection Completed On-site
09/24/2024	APS Referral
09/27/2024	Exit Conference Licensee Designee Michelle Jannenga

ALLEGATION: Residents perform manual labor for the benefit of staff.

INVESTIGATION: On 09/19/2024 complaint allegations were received from the BCAL online reporting system. The complaint stated that residents are being exploited by facility staff as a result of performing “manual labor that directly benefited Thresholds”. The complaint further stated that, “the home manager and assistant manager took the 4 residents to the manager's private home to do his yardwork without pay and calling it volunteering”.

On 09/20/2024 I interviewed licensee designee Michelle Jannenga via telephone. Ms. Jannenga stated that she was aware that administrator Joshua Hosack transported residents to his personal residence to complete yard work. Ms. Jannenga stated that residents of the facility often volunteer as a group in the community. Ms. Jannenga stated that the staff exercised “poor judgement” in bringing residents to Mr. Hosack’s personal residence to do yard work as volunteering activity. Ms. Jannenga stated that the incident occurred in August 2024

during warm weather temperatures. Ms. Jannenga stated that to her knowledge, all residents agreed to the activity and were provided pizza and drinks after the activity.

On 09/20/2024 I emailed complaint the allegation to Network 180 Recipient Rights.

On 09/23/2024 I completed an unannounced onsite investigation at the facility and interviewed administrator Joshua Hosack, staff Marcus Holt, staff Sandy Koning, Resident A, Resident B, and Resident D.

While onsite I attempted to interview Resident C however he was easily distracted and appeared to lack the verbal and communication skills to complete an interview. Resident C was observed as clean and appropriately dressed.

Administrator Joshua Hosack stated that residents routinely participate in volunteering within the community. Mr. Hosack stated that in the beginning of August 2024 he asked Resident A, Resident B, Resident C, and Resident D if they wanted to help Mr. Hosack clean his yard and all four residents agreed to do so willingly. Mr. Hosack stated that staff Wallace Waalkes was also working on that day and agreed to stay at the facility with any resident who did not want to participate. Mr. Hosack stated all of the four residents voiced their willingness to participate. Mr. Hosack stated that he and Mr. Waalkes transported the four residents to Mr. Hosack's personal residence, and they all performed yard work such as removing grape vines and burning debris. Mr. Hosack stated that residents were provided breaks as needed and "sparkling water". Mr. Hosack stated that the temperature was warm, and they were gone from the facility approximately "three to four hours". Mr. Hosack stated that residents were all provided pizza after their work.

Staff Marcus Holt stated that he had no knowledge of the incident.

Staff Sandy Koning stated that she had no knowledge of the incident.

Resident A stated that on an unknown date in August 2024; Mr. Hosack asked Resident A if he wanted to visit Mr. Hosack's personal residence to perform yard work. Resident A stated that he willingly agreed to do so, and three other residents willingly agreed to do as well. Resident A stated that while at Mr. Hosack's personal residence, Resident A "pulled ivy" and "cut branches". Resident A stated that the temperature during the outing was "very hot" and he was at Mr. Hosack's personal residence for approximately "4 to 5 hours". Resident A stated that he was provided breaks and water as needed. Resident A stated that he was provided pizza after completing the yard work. Resident A stated that he wished he hadn't agreed to do the yard work but "didn't speak up" to say no.

Resident B stated that on an unknown date in August of 2024, Mr. Hosack asked Resident B if he wanted to do yard work at Mr. Hosack's personal residence. Resident B stated that he enjoys volunteering in the community and willingly agreed

to do so. Resident B stated that the temperature on the date of the incident measured “90 something” and residents were at Mr. Hossack’s personal residence “more than two hours”. Resident B stated that he and other residents did yard work such as removing vines and all residents were provided water and breaks as needed. Resident B stated that he did not feel obligated to participate in the outing and to his knowledge all other residents agreed to do so willingly. Resident B stated that he was provided pizza after the yard work was completed.

Resident D stated that he willingly agreed to help Mr. Hosack complete yard work at Mr. Hosack’s personal residence on an unknown date in August 2024. Resident D stated that he trimmed branches and burned debris under the supervision of Mr. Hosack. Resident D stated that the temperate that day was warm and Resident D was provided water as needed. Resident D stated that he was provided pizza after the yard work was completed.

On 09/24/2024 I emailed complaint the allegation to Adult Protective Services Centralized Intake.

On 09/25/2024 I interviewed staff Wallace Waalkes via telephone. Mr. Waalkes stated that he participated in the August 2024 excursion to administrator Joshua Hosack’s personal residence. Mr. Waalkes stated that Mr. Hosack, Resident A, Resident B, Resident C, Resident D, and Mr. Waalkes participated. Mr. Waalkes stated that each resident went willingly. Mr. Waalkes stated that they were gone from approximately 1:30 PM until 4:00 PM and the weather was described as “mildly warm”. Mr. Waalkes stated that the residents completed yard work at Mr. Hosack’s personal residence which included weeding, removing branches, and picking up crab apples. Mr. Waalkes stated that all of the residents were provided with water and breaks and were ultimately rewarded with pizza. Mr. Waalkes stated that the excursion was voluntary, and every resident was given the opportunity not to participate.

On 09/27/2024 I completed an Exit Conference via telephone with licensee designee Michelle Jannenga. Ms. Jannenga stated that she agreed with the Special Investigation findings.

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:	Resident A stated that on an unknown date in August 2024, Mr. Hosack asked Resident A if he wanted to visit Mr. Hosack’s personal residence to perform yard work. Resident A stated

	that he willingly agreed to do so, and three other residents willingly agreed to do so as well. Resident B stated that on an unknown date in August of 2024, Mr. Hosack asked Resident B if he wanted to do yard work at Mr. Hosack's personal residence. Resident B stated that he enjoys volunteering in the community and willingly agreed to do so. Resident D stated that he willingly agreed to help Mr. Hosack complete yard work at Mr. Hosack's personal residence on an unknown date in August 2024. A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate a violation of the applicable rule. Resident A, Resident B, Resident C, and Resident D each stated that they voluntarily participated in the August 2024 excursion and each resident stated that they were provided water and breaks as needed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff verbally mistreat residents.

INVESTIGATION: On 09/19/2024 complaint allegations were received from the BCAL online reporting system. The complaint stated that staff are verbally mistreating residents by, "yelling at them, calling them names, making rude comments to or about the residents".

On 09/23/2024 I completed an unannounced onsite investigation at the facility and interviewed administrator Joshua Hosack, staff Marcus Holt, staff Sandy Koning, Resident A, Resident B, and Resident D.

Administrator Joshua Hosack, staff Marcus Holt, and staff Stacy Konning each reported that they have never verbally mistreated any residents and have never observed other staff do so.

Resident A and Resident D both reported that they have never been verbally mistreated by staff and have never observed other residents verbally mistreated by staff. Resident A and Resident D both stated that the reported allegation was not true.

Resident B stated that approximately one year ago staff Wallace Waalkes verbally mistreated Resident B. Resident B stated that Mr. Waalkes said, "you're acting like a dick". Resident B stated that he replied to Mr. Waalkes by stating, "don't call me

that Wally" and then Mr. Waalkes subsequently responded by stating, "then don't act like a dick". Resident B stated that he had never reported the incident prior, and this is the only incident in which he was verbally mistreated by a staff member.

On 09/25/2024 I interviewed staff Wallace Waalkes via telephone. Mr. Waalkes stated that he has communicated to residents that they were "acting likes jerks" because "it usually helps them reflect" when "they are amped up". Mr. Waalkes was asked if he had communicated to Resident B that Resident B had been "acting like a dick" and Mr. Waalkes stated, "I might have" and then "I can't remember". Mr. Waalkes stated that he has never observed other staff members verbally mistreat residents.

On 09/27/2024 I completed an Exit Conference via telephone with licensee designee Michelle Jannenga. Ms. Jannenga stated that she agreed with the Special Investigation findings 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:	Staff Wallace Waalkes stated that he has communicated to residents that they were "acting likes jerks" because "it usually helps them reflect" when "they are amped up". Mr. Waalkes was asked if he had communicated to Resident B that Resident B had been "acting like a dick" and Mr. Waalkes stated, "I might have" and then "I can't remember". A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a violation of the applicable rule. Staff Wallace Waalkes verbally mistreats residents by communicating to them that they are "acting likes jerks".
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff "rough house" with residents.

INVESTIGATION: On 09/19/2024 complaint allegations were received from the BCAL online reporting system. The complaint stated that staff are “roughhousing with” residents with includes, “unwanted physical contact like pushing residents to fall onto the couch, sitting on top of them, tickling them”.

Administrator Joshua Hosack stated that he has tickled residents under their arms and “rough housed” with residents in a joking manner. Mr. Hosack stated that “rough housing” has included tickling and soft pushing all done in a joking manner. Mr. Hosack stated that all of the residents of the facility are males with various developmental disabilities. Mr. Hosack stated that he has never “rough housed” with residents causing injuries or in an angry manner. Mr. Hosack stated that other male staff have “rough housed” with residents but have never caused injury. Mr. Hosack stated that none of the resident have reported that the “rough housing” is unwelcome or uncomfortable for them.

Staff Marcus Holt stated that he had no knowledge of staff “rough housing” with residents.

Staff Sandy Konning stated that she has observed Mr. Hosack “pushing” and “laughing” with Resident D but that the incidents are always in a playful manner and Resident D has never voiced that it has made him uncomfortable.

Resident A stated that Mr. Hosack has “tickled” and “pushed me off the corner of a couch onto the couch”. Resident A stated that this was done in a playful manner and stated that “I didn’t mind” when it happened. Resident A further stated that he would “prefer” that Mr. Hosack not tickle and push him however Resident A has never told Mr. Hosack to stop the behaviors. Resident A stated that he does not feel uncomfortable by Mr. Hosack’s behavior but does not prefer it.

Resident B stated that Mr. Hosack has tickled him under his arm pits “just for fun”. Resident B stated that Mr. Hosack’s behaviors do not make him feel uncomfortable because it is being done in a playful manner.

Resident D stated that Mr. Hosack has tickled and pushed Resident D in a playful manner. Resident D stated that he is “okay” with Mr. Hosack engaging in these types of behaviors with Resident D because they are being done in a joking manner. Resident D stated that he does not feel uncomfortable by Mr. Hosack’s behavior.

On 09/27/2024 I completed an Exit Conference via telephone with licensee designee Michelle Jannenga. Ms. Jannenga stated that she agreed with the Special Investigation findings.

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:	Resident A stated that Mr. Hosack has "tickled" and "pushed me off the corner of a couch onto the couch". Resident A stated that this was done in a playful manner and stated that "I didn't mind" when it happened. Resident A further stated that he would prefer that Mr. Hosack not tickle and push him however Resident A has never told Mr. Hosack to stop the behaviors. Resident A stated that he does not feel uncomfortable by Mr. Hosack's behavior. Resident B stated that Mr. Hosack has tickled him under his arm pits "just for fun". Resident B stated that Mr. Hosack's behaviors do not make him uncomfortable because it is being done in a playful manner. Resident D stated that Mr. Hosack has tickled and pushed Resident D in a playful manner. Resident D stated that he is "okay" with Mr. Hosack engaging in these types of behaviors with Resident D because they are being done in a joking manner. A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate a violation of the applicable rule. Resident B and Resident D both reported that they are comfortable with administrator Joshua Hosack's "rough housing" because they are being done in a playful manner which does not make them feel uncomfortable.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents enter the unlocked medication closet to retrieve items.

INVESTIGATION: On 09/19/2024 complaint allegations were received from the BCAL online reporting system. The complaint stated that staff are "having the residents enter the unlocked medication room or office unsupervised to grab items for the staff**".**

On 09/23/2024 I completed an unannounced onsite investigation at the facility and interviewed administrator Joshua Hosack, staff Marcus Holt, staff Sandy Koning, Resident A, Resident B, and Resident D.

Administrator Joshua Hosack and staff Marcus Holt both stated that they have never asked residents to enter the medication closet which is locked for resident safety and they have no knowledge of other staff allowing residents to access the medication closet.

Staff Sandy Konning stated that approximately “two months ago” she asked Resident B to enter the unlocked medication closet to pick up his medications which had been placed in a cup on a shelf inside the closet. Ms. Konning stated that she observed Resident B take his medications out of the closet and ingest them. Ms. Konning stated that she understood this was not appropriate and that the medication closet must be locked at all times that staff are not present and residents should be handed their medications directly from a staff member.

Resident A stated that staff Sandy Konning and Errol Spells leave the medication closet unlocked so that he and other residents can retrieve their preset medications from a cup located on a shelf inside the closet. Resident A stated that this has occurred on many occasions with the last incident occurring approximately one month ago.

Resident B stated that a staff member, whose name he did not want to disclose, allows him and other residents to enter the medication closet which was left unlocked. Resident B stated that his medications have been left sitting on a shelf in the closet in a cup and the unnamed staff directs Resident B to take his medications out of the cup and ingest them.

Resident D stated that staff Sandy Konning and Errol Spells place his medications into a cup with his initials and places the cup inside of the unlocked medication closet on a shelf. Resident D stated that Ms. Konning and Mr. Spells will leave the medication closet unlocked and then request Resident D to go into the closet and ingest his medications. Resident D stated that this has occurred on many occasions.

On 09/25/2024 I interviewed staff Errol Spells via telephone. Mr. Spells stated that he has never left the medication closet unlocked and has never allowed residents to retrieve their own medications from the medication closet.

On 09/27/2024 I completed an Exit Conference via telephone with licensee designee Michelle Jannenga. Ms. Jannenga stated that she agreed with the Special Investigation findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Resident A stated that staff Sandy Konning and Errol Spells leave the medication closet unlocked so that he and other residents can retrieve their preset medications from a cup located on a shelf inside the closet. Resident B stated that a staff member, whose name he did not want to disclose, allows him and other residents to enter the medication closet which was left unlocked. Resident B stated that his medications have been left sitting on a shelf in the closet in a cup and the unnamed staff directs Resident B to take his medications out of the cup and ingest them. Resident D stated that staff Sandy Konning and Errol Spells place his medications into a cup with his initials and place the cup inside of the unlocked medication closet on a shelf. Resident D stated that Ms. Konning and Mr. Spells leave the medication closet unlocked and then request Resident D go into the closet and ingest his medications. Staff Sandy Konning stated that approximately “two months ago” she asked Resident B to enter the unlocked medication closet to pick up his medications which had been placed in a cup on a shelf inside the closet. Ms. Konning stated she observed Resident B take his medications out of the closet and ingest them. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate violation of the applicable rule. Staff Sandy Konning and staff Errol Spells allow residents to enter the unlocked medication closet and retrieve their own medications for consumption.

CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff serve residents spicy food.

INVESTIGATION: On 09/19/2024 complaint allegations were received from the BCAL online reporting system. The complaint stated that staff are “making food more spicy because the staff eat the meals too”.

On 09/20/2024 I interviewed licensee designee Michelle Jannenga via telephone. Ms. Jannenga stated that to the best of her knowledge facility staff follow the posted menu and document substitutes as required. She stated that the facility utilizes a preplanned meal program which limits spicy food.

On 09/23/2024 I completed an unannounced onsite investigation at the facility and interviewed administrator Joshua Hosack, staff Marcus Holt, staff Sandy Koning, Resident A, Resident B, and Resident D.

Administrator Joshua Hosack, staff Marcus Holt, and staff Sandy Konning each stated that staff follow the posted menu and do not purposefully flavor food in a spicy manner.

Resident A, Resident B, and Resident D each stated that staff follow the posted menu and do not purposefully flavor the food in a spicy manner.

On 09/27/2024 I completed an Exit Conference via telephone with licensee designee Michelle Jannenga. Ms. Jannenga stated that she agreed with the Special Investigation findings.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Administrator Joshua Hosack, staff Marcus Holt, and staff Sandy Konning each stated that staff follow the posted menu and do not purposefully flavor food in a spicy manner. Resident A, Resident B, and Resident D each stated that staff follow the posted menu and do not purposefully flavor the food in a spicy manner.

	A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate a violation of the applicable rule. Facility staff follow the posted menu and do not purposefully flavor the food in a spicy manner.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Staff Errol Spells sleeps while working at the facility independently.

INVESTIGATION: On 09/20/2024 I received an email from licensee designee Michelle Jannenga which I observed to contain Resident A, Resident B, Resident C, and Resident D's Assessment Plan for AFC Residents.

I observed that Resident A's Assessment Plan was signed one 03/01/2024 and indicates that Resident A is able to move independently within the community and "may lash out or lose control while at home with his family".
I observed that Resident B's Assessment Plan was signed 01/02/2024 and indicates that Resident B is not able to move independently within the community and requires staff assistance with controlling aggressive behavior.

I observed that Resident C's Assessment Plan was signed 12/30/2023 and indicates that Resident C is not able to move independently within the community, "can become aggressive at times", and "will sometimes walk around the house naked".

I observed that Resident D's Assessment Plan was signed 02/29/2024 and indicates that Resident D can move independently within the community and requires staff assistance with controlling his aggression.

On 09/23/2024 I completed an unannounced onsite investigation at the facility and interviewed administrator Joshua Hosack, staff Marcus Holt, staff Sandy Koning, Resident A, Resident B, and Resident D.

Staff Sandy Konning stated that she has observed staff Errol Spells sleeping on the facility's couch when she arrives to the facility to start her "6:00 PM" shift on Sundays. Ms. Konning stated that residents are awake when she arrives to the facility and Mr. Spells is asleep on the facility's couch. Ms. Konning stated that she has observed this occur on at least two occasions and she reported the incidents to administrator Joshua Hosack.

Resident A stated that staff Errol Spells has been observed to be sleeping on the living room couch while residents are awake and unattended. Resident A stated that these incidents occurred "one to two times" on Sundays from approximately "4:00 PM until 6:00 PM".

Resident B stated that staff Errol Spells works “most Sundays” first shift. Resident B stated that on multiple occasions Mr. Spells sleeps on the living room couch while residents are awake and unsupervised.

Resident D stated that staff Errol Spells sleeps on the living room couch “in the mornings” for “a long time” while residents are awake and unattended.

On 09/25/2024 I interviewed staff Errol Spells via telephone. Mr. Spells stated that he has never slept at the facility during waking hours. Mr. Spells stated that he is always awake while working and provides adequate resident care at all times.

On 09/27/2024 I completed an Exit Conference via telephone with licensee designee Michelle Jannenga. Ms. Jannenga stated that she agreed with the Special Investigation findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Staff Sandy Konning stated that she has observed staff Errol Spells sleeping on the facility’s couch when she arrives to the facility to start her “6:00 PM” shift on Sundays. Ms. Konning stated that residents are awake when she arrives to the facility and Mr. Spells is asleep on the facility’s couch. Resident A stated that staff Errol Spells has been observed sleeping on the living room couch while residents are awake and unattended. Resident A stated that these incidents occurred “one to two times” on Sundays from approximately “4:00 PM until 6:00 PM”. Resident B stated that staff Errol Spells works “most Sundays” first shift. Resident B stated that on multiple occasions Mr. Spells sleeps on the living room couch while residents are awake and unsupervised. Resident D stated that staff Errol Spells sleeps on the living room couch “in the mornings” for “a long time” while residents are awake and unattended. Staff Errol Spells stated that he has never slept at the facility during waking hours.

	A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate violation of the applicable rule. Staff Errol Spells sleeps on the facility's communal couch during waking hours while residents are unsupervised and unattended.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/27/2024

Toya Zylstra Date
Licensing Consultant

Approved By:

09/27/2024

Jerry Hendrick Date
Area Manager