GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 23, 2021

Michelle Jannenga
Thresholds
Post Office Box 68327
Grand Rapids, MI 49516-8327

RE: License #: AS410094885
Investigation #: 2021A0583018
Roth 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.
- 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 #:	AS410094885
Investigation #:	2021A0583018
Complaint Receipt Date:	02/22/2021
Investigation Initiation Date:	02/22/2021
Report Due Date:	03/24/2021
Licensee Name:	Thresholds
Licensee Address:	1225 Lake Drive SE Grand Rapids, MI 49506
Licensee Telephone #:	(616) 466-5242
Administrator:	Michelle Jannenga, Designee
Licensee Designee:	Michelle Jannenga
Name of Facility:	Roth Group Home
Facility Address:	99 Roth Street, SE Grand Rapids, MI 49548-7728
Facility Telephone #:	(616) 281-1788
Original Issuance Date:	06/13/2001
License Status:	REGULAR
Effective Date:	12/17/2019
Expiration Date:	12/16/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Facility staff failed to provide Resident A's guardian with an Incident Report when Resident A was hiospitalized.	Yes

III. METHODOLOGY

02/22/2021	Special Investigation Intake 2021A0583018
02/22/2021	Special Investigation Initiated - Telephone Relative 1
02/22/2021	APS Referral
02/23/2021	Exit Conference Licensee Designee Michelle Jannenga

ALLEGATION: Facility staff failed to provide Resident A's guardian with an Incident Report when Resident A was hospitalized.

INVESTIGATION: Note that an on-site inspection was not conducted as a part of this investigation due to the current COVID-related concerns and the nature of the allegation.

On 02/23/2021 I received complaint allegations from the BCAL online reporting system. The complaint allegations stated Resident A's legal guardian, Relative 1, did not receive an Incident Report after Resident A was hospitalized due to an assault perpetrated by another resident.

On 02/23/2021 I interviewed Relative 1 via telephone. Relative 1 stated he is the legal guardian of his brother, Resident A. Relative 1 stated on 01/17/2021 he received a telephone call from facility staff indicating Resident A had been struck in the eye by another resident necessitating the need for medical treatment. Relative 1 stated Resident A was admitted to the Mercy Health Emergency Department for medical treatment on 01/17/2021 and discharged that same day. Relative 1 stated facility staff provided adequate supervision of Resident A prior to and during the physical assault, however Relative 1 did not receive a written Incident Report regarding the incident.

On 02/23/2021 I completed an Exit Conference with Licensee Designee Michelle Jannenga. Ms. Jannenga confirmed Relative 1 was not provided with a written Incident Report from facility staff regarding the 01/17/2021 physical assault of Resident A. Ms. Jannenga confirmed Resident A required and received medical

treatment from the Emergency Department at Mercy Health on 01/17/2021. Ms. Jannenga stated she would complete an acceptable Corrective Action Plan and agreed with the Special Investigation findings.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.**
ANALYSIS:	Ms. Jannenga confirmed Resident A required and received medical treatment from the Emergency Department at Mercy Health on 01/17/2021 and Relative 1 was not provided with a written Incident Report. Evidence was discovered through this investigation which would indicate a violation of the applicable rule has occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

02/23/2021

Toya Zylstra Date
Licensing Consultant

Approved By:

02/23/2021

Jerry Hendrick Date
Area Manager