GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 31, 2022

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

RE: License #: AL410007103
Investigation #: 2022A0583029
Gladiola Home

Dear Ms. Jannenga:

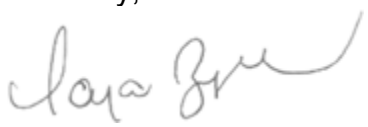
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL410007103
Investigation #:	2022A0583029
Complaint Receipt Date:	05/18/2022
Investigation Initiation Date:	05/18/2022
Report Due Date:	06/17/2022
Licensee Name:	Thresholds
Licensee Address:	Suite 130 160 68th St. SW Grand Rapids, MI 49548
Licensee Telephone #:	(616) 340-3788
Administrator:	Kimberly Brown
Licensee Designee:	Michelle Jannenga
Name of Facility:	Gladiola Home
Facility Address:	3210 Gladiola Avenue, SW Wyoming, MI 49519-3225
Facility Telephone #:	(616) 538-3067
Original Issuance Date:	12/01/1976
License Status:	REGULAR
Effective Date:	08/12/2020
Expiration Date:	08/11/2022
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was restricted from using the telephone.	No
Facility staff stripped Resident A's bedroom of all her personal items and refused to allow Resident A access to said items.	Yes
Facility staff restricted Resident A to her bedroom.	Yes
Additional Findings	No

III. METHODOLOGY

05/18/2022	Special Investigation Intake 2022A0583029
05/18/2022	Contact - Document Received Recipient Rights Michelle Richardson
05/18/2022	Special Investigation Initiated - On Site Recipient Rights Michelle Richardson, Staff Shanita Davis, Staff Darisha Stovall, Resident A, Resident B
05/18/2022	Contact - Document Received Licensee Designee Michelle Jannenga
05/19/2022	Contact - Document Received Licensee Michelle Jannenga
05/20/2022	APS Referral
05/26/2022	Contact – Telephone Denise Heugel, Network 180
05/31/2022	Exit Conference Licensee Designee Michelle Jannenga

ALLEGATION: Resident A was restricted from using the telephone.

INVESTIGATION: On 05/18/2022 complaint allegations were received from Network 180 Recipient Rights. The complaint alleged that Resident A was restricted from telephone use by facility staff after Resident A exhibited acting out behaviors.

On 05/18/2022 I completed an unannounced onsite investigation at the facility. Network 180 Recipient Rights staff Michelle Richardson accompanied the onsite visit and was present for all interviews. I interviewed staff Shanita Davis, Darisha Stovall, Resident A, and Resident B privately with Ms. Richardson.

Staff Shanita Davis stated she had limited information to provide regarding the complaint allegations because she does not work directly with Resident A and has not been educated regarding Resident A's care needs. Ms. Davis stated she did work at the facility on 05/14/2022 and observed that Resident A left the facility without staff permission "for ten minutes" after Resident A walked down the street but "was never out of sight". Ms. Davis stated Resident A returned to the facility after ten minutes and Ms. Davis stated she had limited information regarding Resident A's subsequent behaviors or assessed consequences thereafter. Ms. Davis stated she does not know if Resident A's access to the telephone was restricted as a result of Resident A's negative behaviors.

Staff Darisha Stovall stated she was subsequently informed by facility staff that Resident A left the facility's premises without permission on 05/14/2022 for a short time and returned that same day. Ms. Stovall stated Resident A displayed acting out behaviors following the 05/14/2022 incident which included Resident A slamming doors, spitting, and throwing items. Ms. Stovall stated she worked at the facility on 05/16/2022 at approximately noon and observed Resident A again displaying behaviors such as throwing items because Resident A was upset that she was not permitted to shower when she wanted to. Ms. Stovall stated Resident A was asked to "calm down" in her bedroom. Ms. Stovall stated Resident A was not restricted from telephone use.

I attempted to interview Resident A privately in her bedroom however Resident A presented as easily distracted and did not answer the question of whether she was denied telephone access by Ms. Stovall.

Resident B stated she did not know if Resident A's telephone access was restricted.

On 05/18/2022 I received an email from Licensee Designee Michelle Jannenga. The email contained Resident A's Assessment Plan for AFC home Residents which was signed 01/29/2022. The document indicates Resident A does not control aggressive behavior and "can become impulsive and aggressive at times". The document states Resident A "will hit others and destroy property" and "staff will help maintain a calm environment"

On 05/19/2022 I reviewed an email from Licensee Designee Michelle Jannenga. The email stated Resident A does not have a Behavior Support plan in place.

On 05/20/2022 I emailed complaint allegations to Adult Protective Service Centralized intake.

On 05/26/2022 I interviewed Janelle Huegel of Network 180. Ms. Huegel stated she visited the facility on 05/17/2022 and spoke with staff Darisha Stovall and Resident A. Ms. Huegel stated Ms. Stovall reported Resident A was not allowed to use the facility telephone because Resident A had displayed behaviors on 05/14/2022. Ms.

Huegel stated she did not ask Resident A if she was denied telephone use because Ms. Stovall “was right there”.

On 05/31/2022 I completed an Exit Conference with Licensee Designee, Michelle Jannenga. She stated she agreed with the findings.

APPLICABLE RULE	
R 400.15304	**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: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Janelle Huegel stated she visited the facility on 05/17/2022 and spoke with staff Darisha Stovall. Ms. Huegel stated Ms. Stovall reported Resident A was not allowed to use the facility telephone because Resident A had displayed acting out behaviors. Staff Darisha Stovall stated Resident A was not restricted from telephone use. Resident A presented as easily distracted and did not answer the question of whether she was denied telephone access by Staff Darisha Stovall. There is insufficient evidence to substantiate violation of the appliable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Facility staff stripped Resident A's bedroom of all her personal items and refused to allow Resident A access to said items.

INVESTIGATION: On 05/18/2022 complaint allegations were received from Network 180 Recipient Rights. The complaint alleged that Resident A's bedroom was stripped of her personal items by facility staff after Resident A exhibited acting out behaviors.

While onsite on 05/18/2022 staff Darisha Stovall stated that in response to Resident A's acting out behaviors, Ms. Stovall removed items from Resident A's bedroom including clothing, bedding, and all personal items and placed the items in the living room. Ms. Stovall stated Resident A's bedroom was left bare except for Resident A's bedframe and mattress. Ms. Stovall stated Resident A displayed the 05/16/2022 acting out behaviors at approximately 12:40 pm and her belongings were subsequently removed from her bedroom until Resident A "calmed down" at approximately 1:20 pm. Ms. Stovall stated she returned some of Resident A's belongings to her bedroom, such as a puzzle and bed linens at 1:20 pm but acknowledged that not all of Resident A's belongings have since been returned. Ms. Stovall acknowledged Resident A has been denied use of the personal items located in the living room since their removal from Resident A's bedroom.

While onsite I observed Resident A's personal items such as puzzles and clothing were located in bags in the facility living room. I observed Resident A's bedroom was sparsely furnished and contained bed linens on Resident A's bed and some clothing items.

Resident A stated staff Darisha Stovall "took stuff" out her bedroom. Resident A stated Ms. Stovall returned some items to Resident A's bedroom such as "cubbies" for "being good".

Resident B stated Staff Darisha Stovall took Resident A's "stuff" because Resident A had "behaviors". Resident B stated Ms. Stovall took all of Resident A's stuff and returned some of the items to Resident A's bedroom today.

On 05/26/2022 I interviewed Janelle Huegel of Network 180. Ms. Huegel stated she visited the facility on 05/17/2022 and spoke with staff Darisha Stovall and Resident A. Ms. Huegel stated Ms. Stovall reported she removed all of Resident A's personal items from her bedroom on 05/16/2022 in response to Resident A's acting out behaviors. Ms. Huegel stated she observed Resident A's bedroom was absent of all of Resident A's belongings except one puzzle. Ms. Huegel stated Resident A's bed was absent of linens. Ms. Huegel stated she observed Resident A's personal items located in the living room. Ms. Huegel stated during the 05/17/2022 visit Resident A did not talk about the complaint allegations nor did Ms. Huegel ask Resident A directly about the allegations.

On 05/31/2022 I completed an Exit Conference with Licensee Designee, Michelle Jannenga. She stated she agreed with the findings and would complete an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15304	**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: **(j) The right of reasonable access to and use of his or her personal clothing and belongings.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Staff Darisha Stovall stated that in response to Resident A's acting out behaviors, Ms. Stovall removed items from Resident A's bedroom including clothing, bedding, and all personal items and placed them in the living room. Ms. Stovall stated Resident A's bedroom was left bare except for Resident A's bedframe and mattress. Ms. Stovall acknowledged Resident A has been denied use of the personal items since their removal from Resident A's bedroom. While onsite I observed Resident A's personal items such as puzzles and clothing were located in bags in the facility living room. A preponderance of evidence discovered during the Special Investigation supports violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Facility staff restricted Resident A to her bedroom.

INVESTIGATION: On 05/18/2022 complaint allegations were received from Network 180 Recipient Rights. The complaint alleged that Resident A was restricted from leaving her bedroom by facility staff after exhibiting acting out behaviors.

While onsite on 05/18/2022 staff Darisha Stovall stated that in response to Resident A's acting out behaviors on 05/16/2022, Ms. Stovall asked Resident A to "calm down" in her bedroom. Ms. Stovall stated Resident A calmed down in her bedroom

and was allowed to leave her bedroom within thirty minutes afterwards. Ms. Stovall stated Resident A has eaten meals out of her bedroom and moved freely through the facility since 05/16/2022.

Staff Shanita Davis stated she had limited information to provide regarding the complaint allegation because she does not work directly with Resident A but has observed Resident A moving freely throughout the facility today.

Resident A stated she was not allowed out her room by staff Darisha Stovall after her belongings were taken by Ms. Stovall. Resident A presented as being easily distracted and did not answer specific questions relating to time frames she was restricted to her bedroom.

Resident B stated Resident A was confined to her bedroom “for a long time” by staff Darisha Stovall. Resident B stated Resident A has been allowed out of her bedroom to eat meals.

On 05/26/2022 I interviewed Janelle Huegel of Network 180. Ms. Huegel stated she visited the facility on 05/17/2022 and spoke with staff Darisha Stovall. Ms. Huegel stated Ms. Stovall reported that Ms. Stovall restricted Resident A to her bedroom on 05/16/2022 due to Resident A’s acting out behaviors from 05/14/2022. Ms. Huegel stated Ms. Stovall stated she would not allow Resident A out of her bedroom “until she was good and ready”. Ms. Huegel stated Ms. Stovall reported she was only allowing Resident A out of her bedroom for meals. Ms. Huegel stated Resident A was confined to her bedroom during Ms. Huegel’s 05/17/2022 visit. Ms. Huegel stated during the visit Resident A did not talk about the complaint allegations nor did Ms. Huegel ask Resident A directly about the allegations.

On 05/31/2022 I completed an Exit Conference with Licensee Designee, Michelle Jannenga. She stated she agreed with the findings and would complete an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.**
ANALYSIS:	On 05/17/2022 Janelle Huegel stated staff Darisha Stovall reported that Ms. Stovall restricted Resident A to her bedroom on 05/16/2022 due to Resident A’s acting out behaviors. Ms.

	Huegel stated Ms. Stovall stated she would not allow Resident A out of her bedroom “until she was good and ready”. Ms. Huegel stated she observed Resident A was confined to her bedroom on 05/17/2022. Resident A stated she was not allowed out her room by staff Darisha Stovall after her belongings were taken from Ms. Stovall. Resident B stated Resident A was confined to her bedroom “for a long time” by Staff Darisha Stovall. A preponderance of evidence discovered during the Special Investigation supports violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

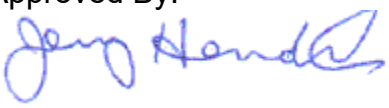
IV. RECOMMENDATION

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

05/31/2022

Toya Zylstra — Date
Licensing Consultant

Approved By:



05/31/2022

Jerry Hendrick — Date
Area Manager