GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 18, 2022

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

RE: License #: AL410007105
Investigation #: 2023A0583006
Thresholds Benson 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 #:	AL410007105
Investigation #:	2023A0583006
Complaint Receipt Date:	10/31/2022
Investigation Initiation Date:	10/31/2022
Report Due Date:	11/30/2022
Licensee Name:	Thresholds
Licensee Address:	Suite 130 160 68th St. SW Grand Rapids, MI 49548
Licensee Telephone #:	(616) 340-3788
Administrator:	Michelle Jannenga
Licensee Designee:	Michelle Jannenga
Name of Facility:	Thresholds Benson Home
Facility Address:	840 Benson Avenue, NE Grand Rapids, MI 49503-1702
Facility Telephone #:	(616) 459-1205
Original Issuance Date:	01/17/1977
License Status:	REGULAR
Effective Date:	11/01/2022
Expiration Date:	10/31/2024
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Facility staff physically assaulted Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

10/31/2022	Special Investigation Intake 2023A0583006
10/31/2022	APS Referral
10/31/2022	Special Investigation Initiated - Telephone APS Drew Blackall
10/31/2022	Contact - Telephone call made Relative 1
10/31/2022	Contact – Telephone Licensee Designee Michelle Jannenga
11/03/2022	Contact – Telephone Staff Mark Evenhouse
11/04/2022	Contact – inspection completed onsite Resident A, Resident B
11/04/2022	Contact – Telephone Staff Mark Evenhouse
11/04/2022	Contact – Telephone Resident C
11/16/2022	Contact – Telephone Staff Elijah Kitur
11/18/2022	Exit Conference Licensee Designee Michelle Jannenga

ALLEGATION: Facility staff physically assaulted Resident A.

INVESTIGATION: On 10/31/2022 complaint allegations were received from Adult Protective Services Staff Drew Blackall via email. Mr. Blackall reported that he is

assigned to investigate the complaint allegations. Mr. Blackall stated it was alleged Resident A was physically assaulted by staff Mark Evenhouse. The complaint further alleged that Mr. Evenhouse, “twisted (Resident A’s) arm behind his back and slammed him to the floor” causing Resident A to sustain a sore arm and a knot on his forehead that is about the size of a quarter.

On 10/31/2022 I received an email from Adult Protective Services Staff Drew Blackall. The email contained Mr. Blackall’s interview notes with Relative 1 who was identified as Resident A’s sister and legal guardian. The interview notes stated the following: *‘Relative 1 reported (Resident A) was at Butterworth Hospital last night. Relative 1 noted that the doctor found (Resident A) had a “possible concussion” from the physical assault that occurred in the home.’*

On 10/31/2022 I interviewed Relative 1 via telephone. Relative 1 stated she is the legal guardian and sister of Resident A who resides at the facility. Relative 1 stated that on 10/28/2022 she was contacted by Resident A’s case manager, Jordan Hougan, and he reported that while visiting the facility he observed Resident A had a band aid on his forehead. Mr. Hougan reported to Relative 1 that Resident A stated he had been slammed on the ground and had his arm twisted behind his back by staff Mark Evenhouse. Relative 1 stated that she visited the facility on 10/30/2022 and observed a bruise and skin abrasion on Resident A’s forehead. Relative 1 stated she transported Resident A to the emergency department, and he was diagnosed with a “possible concussion and sore arm”. Relative 1 stated Resident A reported Mr. Evenhouse caused the injuries by slamming him to the ground and twisting his arm. Relative 1 stated she transported Resident A back to the facility on 10/30/2022 at approximately 11:00 PM and spoke with Mr. Evanhouse. Relative 1 stated Mr. Evanhouse reported Resident A broke into facility’s lower level office and began “smashing cellphones” and subsequently “attacked” Mr. Evenhouse necessitating Mr. Evenhouse to physically restrain Resident A. Relative 1 stated Mr. Evanhouse reported that he didn’t restrain Resident A until Resident A attacked him.

On 11/03/2022 I received and reviewed an email from Relative 1. The email contained a photograph of Resident A’s forehead injury. The injury appeared to be a small contusion with abrasion. The email contained a Spectrum Health After Visit Summary dated 10/30/2022 which stated Resident A was diagnosed with “injury of head” and “right should pain, unspecified chronicity”.

On 11/04/2022 I completed an unannounced onsite investigation at the facility and interviewed Resident A and Resident B privately.

Resident A presented with a small healing abrasion on his right temple. Resident A stated, “Mark pushed me”. Resident A could not provide further details as a result of his developmental disability.

Resident B stated he did not observe the incident that transpired between staff Mark Evenhouse and Resident A. Resident B stated Mr. Evenhouse treats him with

dignity and respect and he has never observed Mr. Evenhouse mistreat Resident A or any other resident residing at the facility.

On 11/04/2022 I interviewed staff Mark Evenhouse via telephone. Mr. Evenhouse stated that he arrived at the facility at 11:00 AM on 10/23/2022. Mr. Evenhouse stated that Resident A was immediately “yelling at people” and Mr. Evenhouse couldn’t understand what had made Resident A upset. Mr. Evenhouse stated he asked Resident A “what was going on” many times, but Resident A could not articulate a response given his agitation and limited verbal skills. Mr. Evenhouse stated Resident A then “started attacking me” and was “punching, kicking, and scratching”. Mr. Evenhouse stated that at one point Resident A entered the main floor office and obtained keys to the lower level office which holds cellphones. Mr. Evenhouse stated Resident A took the keys into the lower level and obtained the phones that were in the lower level office. Mr. Evenhouse stated he followed Resident A to the lower level and observed Resident A take a phone from the lower level office and throw the phone in an attempt to break it. Mr. Evanhouse stated Resident A then proceeded upstairs and Mr. Evenhouse followed. Mr. Evenhouse stated Resident A subsequently attacked Mr. Evenhouse by grabbing, hitting, and punching Mr. Evenhouse in the living room. Mr. Evenhouse stated he and Resident A “started grappling” and both individuals fell to the floor and Mr. Evenhouse grabbed Resident A’s arms in an attempt to restrain him from hitting Mr. Evanhouse. Mr. Evenhouse stated that the altercation stopped after they fell to the ground and Mr. Evenhouse yelled “enough”. Mr. Evenhouse stated he sustained scratches to his face, neck, and nose as a result of Resident A attacking” him. Mr. Evanhouse stated he did not observe any injuries to Resident A. Mr. Evenhouse stated staff Elijah Kitur worked the evening of 10/23/2022 but did not directly observe the incident.

On 11/04/2022 I interviewed Resident C via telephone. Resident C reported he was present during the 10/23/2022 incident. Resident C stated Resident A, “went into the office and took house keys and then went downstairs and took a phone”. Resident C stated Resident A, “kept charging” at staff Mark Evenhouse. Resident C stated Resident A was, “hitting, kicking, and punching” Mr. Evenhouse and Mr. Evenhouse pushed Resident to the floor in “self-defense”. Resident C stated Mr. Evenhouse “walked away” after pushing Resident A to the floor and Resident C did not observe injuries to either individual. Resident C stated Mr. Evenhouse has always treated Resident C and other residents with dignity and respect and he has no concerns regarding Mr. Evenhouse’s treatment of residents.

On 11/16/2022 I interviewed staff Elijah Kitur via telephone. Mr. Kitur stated he worked on 10/23/2022 but did not observe the physical altercation between Mr. Evenhouse and Resident A. Mr. Kitur stated Mr. Evenhouse reported that Resident A assaulted him and Resident A stated Mr. Evenhouse “pushed” him. Mr. Kitur stated he did not observe injuries to Mr. Evenhouse or Resident A. Mr. Kitur stated he has never observed Mr. Evenhouse mistreat residents.

On 11/18/2022 I completed an Exit Conference with Licensee Designee Michelle Jannenga. She stated she agreed with the Special Investigation findings.

APPLICABLE RULE	
R 400.15305	**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 presented with a small healing abrasion on his right temple. Resident A stated, "Mark pushed me" but could not provide further details given his developmental disability. Staff Mark Evenhouse stated Resident A attacked him and was punching, kicking, and scratching him. In addition, Resident A accessed the main floor office and threw a phone in an attempt to break it. Mr. Evenhouse stated Resident A then proceeded upstairs and Mr. Evenhouse followed. Mr. Evenhouse stated he and Resident A "started grappling" and both individuals fell to the floor and Mr. Evenhouse grabbed Resident A's arms in an attempt to prevent him from hitting Mr. Evenhouse. Resident C reported he was present during the 10/23/2022 incident. Resident C stated Resident A went into the office and took a phone. Resident C stated Resident A kept "charging" at and was hitting, kicking, and punching Mr. Evenhouse. Resident C stated Mr. Evenhouse pushed Resident to the floor in "self-defense". A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: The facility failed to notify Relative 1 and LARA regarding an incident in which Resident A was physically restrained by facility staff.

INVESTIGATION: On 10/31/2022 I interviewed Relative 1 via telephone. Relative 1 stated she did not receive an Incident Report or any other type of notification of the 10/23/2022 incident within 48 hours of the incident.

On 10/31/2022 I completed a file review and observed that an Incident Report was not received regarding the 10/23/2022 incident.

On 10/31/2022 I received and reviewed an email from Licensee Designee Michelle Jannenga. The email stated that an Incident Report was completed on the date of the incident however the incident report was destroyed by Resident A before it was sent to LARA for review.

On 11/18/2022 I completed an Exit Conference with Licensee Designee Michelle Jannenga via telephone. Ms. Jannenga stated she agreed with the findings and will submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15311	**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: (a) The death of a resident. (b) Any accident or illness that requires hospitalization. (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. (d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.
ANALYSIS:	Relative 1 stated she did not receive an Incident Report or any other type of notification of the incident within 48 hours of the incident. A file review indicated that an Incident Report was not received by LARA regarding the incident. Licensee Designee Michelle Jannenga reported that an Incident Report was completed on the date of the incident however the incident report was destroyed by Resident A before it was sent to LARA for review.

	A preponderance of evidence was discovered during the Special Investigation to substantiation violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

11/18/2022

Toya Zylstra Date
Licensing Consultant

Approved By:

11/18/2022

Jerry Hendrick Date
Area Manager