GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 23, 2022

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

RE: License #: AL410007103
Investigation #: 2023A0583008
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
Report contains explicit language

I. IDENTIFYING INFORMATION

License #:	AL410007103
Investigation #:	2023A0583008
Complaint Receipt Date:	11/14/2022
Investigation Initiation Date:	11/14/2022
Report Due Date:	12/14/2022
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:	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:	08/12/2022
Expiration Date:	08/11/2024
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Facility staff physically and verbally mistreated Resident A.	Yes

III. METHODOLOGY

11/14/2022	Special Investigation Intake 2023A0583008
11/14/2022	APS Referral
11/14/2022	Special Investigation Initiated - On Site
11/17/2022	Contact – Telephone Staff Shara Scott
11/17/2022	Contact – Telephone Staff Shanita Davis
11/17/2022	Contact – Telephone Staff Kiyla Sims
11/22/2022	Exit Conference Licensee Designee Michelle Jannenga

ALLEGATION: Facility staff physically and verbally mistreated Resident A.

INVESTIGATION: On 11/14/2022 I received a complaint allegation from Adult Protective Services Staff Rodney Allen via email. The complaint alleged the following:

'(Resident A) was physically assaulted by Unknown Caregiver. Unknown Caregiver punched (Resident A) in the face, which has cause (Resident A) swollen lips and a laceration on the inside of her bottom lip. Unknown Caregiver also choked (Resident A), which caused (Resident A) to have difficulty breathing. (Resident A) is also having pain in her neck, back and throat when she swallows. (Resident A) fled from the Gladiola Home AFC Home following the physical assault by Unknown Caregiver. (Resident A) was met by an EMS at that time and transported to U of M Health West. A Gladiola Home AFC Home staff member was not present at that time to give EMS information about (Resident A). When (Resident A) arrived at Gladiola Home AFC Home, she had blood on her shirt and hands'.

On 11/14/2022 I completed an unannounced onsite investigation at the facility and privately interviewed Administrator Cornelia Buggs, Resident A, and Resident B. Adult Protective Services Staff Rodney Allen was present during all interviews.

Ms. Buggs reported that she did not work on 11/13/2022 which is the date the incident occurred. Ms. Buggs stated she was informed second hand that Resident A was agitated most of the weekend because she was not able to visit her brother for the weekend. Ms. Buggs stated Resident A verbally threatened peers as a result of her agitation. Ms. Buggs stated she was informed that Resident A verbally and physically assaulted staff Shanita Davis necessitating staff Shara Scott and Kiylah Sims to assist Ms. Davis with physically managing Resident A. Ms. Buggs stated Resident A sustained a laceration to her lip, cracked tooth, and cervical pain during the incident. Ms. Buggs stated Resident A fled the facility after the incident and contacted police for assistance. Ms. Buggs stated Resident A was transported by emergency personnel to the University of Michigan West Hospital where she was treated for her injuries. Ms. Buggs stated that Resident A returned to the facility at approximately 11:00 PM that same day. Ms. Buggs stated Resident A has continued to “bother peers” and threaten other residents since her return.

Resident A stated she that on 11/12/2022 she was “in a mood” and argued with staff and peers up until the 11/13/2022 altercation. Resident A acknowledged that on 11/13/2022 she “made fun of” staff Shanita Davis’ deceased mother which caused Ms. Davis to “charge” at Resident A. Resident A stated Ms. Davis “touched me with her hands first” and subsequently called Resident A “a B and Mfer”. Resident A stated the altercation took place in the dining room area of the facility by the stairwell. Resident A stated staff Shara Scott heard the commotion and attempted to intervene physically. Resident A stated she “punched” Ms. Davis and Ms. Scott during the incident and Ms. Scott “punched” Resident A in the mouth causing Resident A to sustain a bruised and lacerated lip and bruises to her face. Resident A then stated “everyone was punching everyone” during the incident. Resident A stated staff Kiyla Sims also heard the commotion and grabbed Resident A’s clothing. Resident A stated the altercation subsided and she fled the facility “without shoes on”. Resident A stated she walked to Family Fare located on 32nd and Burlingame where she telephoned 911. Resident A stated the Wyoming Police and an ambulance arrived. Resident A stated she was taken via ambulance to the hospital where she was treated for a laceration to her lips, cracked tooth, and various bruises and abrasions. Resident A stated she was discharged back to the facility later that same day. Resident A stated she did not believe other residents observed the incident.

I observed that Resident A had a broken front tooth, black eye, and scratches to her neck that she attributed to the incident.

Resident B stated Resident A had displayed agitation and anger from 11/12/2022 until the 11/13/2022 incident as evidenced by threatening Resident B and other peers. Resident B stated she observed portions of the 11/13/2022 incident from her

bedroom. Resident B stated the incident occurred in the dining room by the stair way. Resident B stated she heard Resident A make a comment regarding Ms. Davis' "dead momma". Resident B stated she then observed Ms. Davis run after Resident A and Ms. Davis yelled, "don't talk about my momma bitch". Resident B stated she then observed Resident A run after Ms. Davis and Resident B then closed her bedroom door and tried to disengage from observing the incident. Resident B stated that Resident A left the home after the incident. Resident B stated she was unsure if Resident A or staff were injured in the incident.

On 11/14/2022 I received and reviewed an email from Administrator Cornelia Buggs. The email contained Resident A's After Visit Summary from University of Michigan Health West dated 11/13/2022 and indicated Resident A was diagnosed with lacerations, tooth fracture, head injury, and cervical pain.

On 11/17/2022 I interviewed staff Shara Scott via telephone. Ms. Scott stated she worked at the facility on 11/13/2022 and at approximately 6:30 PM Resident A came into the dining room and was extremely agitated. Ms. Scott stated Resident A started screaming at staff Shanita Davis. Ms. Scott stated Resident A said something to Ms. Davis "like bitch, that's why your mom is dead". Ms. Scott stated Resident A then attacked Ms. Davis by hitting and punching her. Ms. Scott stated she attempted to separate the two individuals, but Resident A would not let go of Ms. Davis. Ms. Scott stated she did not punch Resident A and she did not observe Ms. Davis punch Resident A. Ms. Scott stated she and Ms. Davis did restrain Resident A to ground and staff Kiylah Sims heard the commotion and came to assist. Ms. Scott stated that by the time Ms. Sims arrived to the scene, Resident A had calmed, and she was allowed up. Ms. Scott stated Resident A subsequently left the facility on foot and called the police. Ms. Scott stated she sustained scratches from the incident. Ms. Scott stated she was not at the facility after Resident A returned later that day. Ms. Scott stated she did not observe injuries to Resident A after the incident occurred because it happened quickly, and Resident A fled right afterwards.

On 11/17/2022 I interviewed staff Shanita Davis via telephone. Ms. Davis stated that on 11/13/2022 Resident A was upset from the day before and throughout the day. Ms. Davis stated Resident A was upset regarding not having a weekend visit with her brother and then stated, "your dead mom is a bitch" and charged at Ms. Davis. Ms. Davis stated Resident A began "hitting me and I was putting my arms up to block her punches" which caused staff Shara Scott to attempt to physically separate Resident A from Ms. Davis. Ms. Davis stated during the incident she never cursed at Resident A however Resident A called Ms. Davis racial slurs. Ms. Davis stated she and Ms. Scott were able to physically manage Resident A to the ground and allowed Resident A up after she was calm which was a short time. Ms. Davis stated staff Kiyla Sims overheard the commotion and observed as Resident A was being allowed up from the ground. Ms. Davis stated Resident A fled the home after the incident and contacted the police. Ms. Davis stated she sustained scratches from the incident and was unaware of Resident A sustaining injuries. Ms. Davis stated

during the incident she did not punch Resident A and was only attempting to block Resident A's punches.

On 11/17/2022 I interviewed staff Kiyla Sims via telephone. Ms. Sims stated that on 11/13/2022 she worked at the facility but didn't see much of the incident. Ms. Sims stated that throughout the day Resident A was irritable and later in the evening Ms. Sims heard commotion from the other side of the facility. Ms. Sims stated she found that staff Shara Scott was trying to hold Resident A back from trying to get to staff Shanita Davis. Ms. Sims stated Resident A was cursing at Ms. Davis and after Resident A calmed down, she left the facility on foot. Ms. Sims stated she did not observe Ms. Davis or Ms. Scott punch Resident A or curse at her during the incident. Ms. Sims stated she observed Resident A was bleeding from her mouth as she fled the facility.

On 11/22/2022 I completed an Exit Conference via telephone with Licensee Designee Michelle Jannenga. Ms. Jannenga stated she agreed with the Special Investigation findings and would submit an acceptable Corrective Action Plan.

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:	Staff Shanita Davis, staff Shara Scott, and staff Kiyla Sims reported that Resident A assaulted staff verbally and physically on 11/13/2022. Each staff denied that Resident A was verbally or physically mistreated during the incident. Resident A presented with a cracked tooth, lip laceration, and other bruises from the incident. Resident A stated facility staff physically and verbally mistreated her. Resident B stated on 11/13/2022 she heard Resident A make a comment regarding Staff Shanita Davis' "dead momma" and then observed Ms. Davis run after Resident A and Ms. Davis yelled, "don't talk about my momma, bitch". A preponderance of evidence was discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

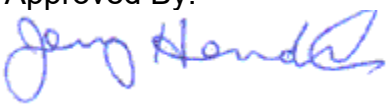
IV. RECOMMENDATION

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

11/22/2022

Toya Zylstra — Date
Licensing Consultant

Approved By:



11/23/2022

Jerry Hendrick — Date
Area Manager