GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 3, 2023

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

RE: License #: AM410278667
Investigation #: 2023A0583013
Plainfield 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 #:	AM410278667
Investigation #:	2023A0583013
Complaint Receipt Date:	12/12/2022
Investigation Initiation Date:	12/12/2022
Report Due Date:	01/11/2023
Licensee Name:	Thresholds
Licensee Address:	Suite 130 160 68th St. SW Grand Rapids, MI 49548
Licensee Telephone #:	(616) 466-5242
Administrator:	Michelle Jannenga
Licensee Designee:	Michelle Jannenga
Name of Facility:	Plainfield Group Home
Facility Address:	2860 Plainfield NE Grand Rapids, MI 49505
Facility Telephone #:	(616) 361-0838
Original Issuance Date:	04/10/2007
License Status:	REGULAR
Effective Date:	10/26/2021
Expiration Date:	10/25/2023
Capacity:	8
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A sustained a broken arm.	No
Additional Findings	Yes

III. METHODOLOGY

12/12/2022	Special Investigation Intake 2023A0583013
12/12/2022	APS Referral
12/12/2022	Special Investigation Initiated - Letter Licensee Designee Michelle Jannenga
12/12/2022	Contact - Document Sent Recipient Rights Ed Wilson
12/12/2022	Contact – Email APS Drew Blackall
12/13/2022	Contact – Onsite
12/14/2022	Contact – Email APS Drew Blackall
12/28/2022	Contact - Telephone Staff Lien LE
12/29/2022	Contact - Telephone Staff Joyce Walton
01/03/2023	Exit Conference Licensee Designee Michelle Jannenga

ALLEGATION: Resident A sustained a broken arm.

INVESTIGATION: On 12/12/2022 complaint allegations were received from Adult Protective Services via email. The complaint allegations stated the following: *'(Resident A) is 77 and lives in a group home. (Resident A) had a TBI as a child, has cerebral palsy, and is nonverbal. (Resident A's) sister Therese is her legal guardian. (Resident A) came to the ER yesterday after having a stroke. (Resident A) was discovered to have a broken arm. (Resident A) is wheelchair bound, and cannot*

move at baseline. There is also no record of (Resident A) falling yet she has a newly broken arm'.

On 12/12/2022 I received an email from Adult Protective Services staff Drew Blackall. Mr. Blackall stated the complaint allegations was sent to the Grand Rapids Police Department for their review and the complaint allegation was assigned to Mr. Blackall for Adult Protective Services investigation. Mr. Blackall stated Adult Protective Services on-call staff completed an interview with Relative 1 via telephone. Relative 1's interview with Adult Protective Services staff stated the following: *'Spoke with Relative 1 by phone, confirmed that she is client guardian. Spectrum Butterworth is likely keeping (Resident A) for a few days for monitoring and tests post stroke. Guardian states that this is a Thresholds home, and that (Resident A) has lived here for 10 years. The guardian is very happy with the home, feels that broken arm was an accident from a hoyer transfer. Guardian states that she has already been in contact with a Thresholds manager Marcia English regarding the accident. Guardian states that Thresholds maintains excellent communication and she has no concerns. Guardian was thanked for her time, explained that she may get a follow up call from APS or licensing.'*

On 12/12/2022 I emailed the complaint allegation to Recipient Rights Ed Wilson.

On 12/13/2022 I completed an unannounced onsite investigation at the facility. Adult Protective Services staff Drew Blackall was present during the onsite and present for all interviews. Mr. Blackall stated the complaint allegation was screened out for formal investigation by the Grand Rapids Police Department. I privately interviewed Administrator Marcia English, staff Angela Davis, Debra Barrington, Carolyn Evans, and Resident B.

Administrator Marcia English stated Resident A has resided at the facility since 2011 and her guardian is Relative 1. Ms. English stated Resident A has a "very quiet voice" and is generally hard to understand. Ms. English stated Resident A requires the assistance of a "hoyer" lift for transfers operated by one staff. Ms. English stated that on 11/28/2022 Resident A complained of "arm pain" but could not identify the cause. Ms. English stated Resident A does suffer from joint pain on a consistent basis. Ms. English stated that on 11/28/2022 she observed no indications of injury. Ms. English stated that on 11/29/2022 she observed a large bruise on Resident A's left arm the size of a baseball. Ms. English stated she asked Resident A how she sustained the bruise and Resident A stated she didn't know. Ms. English stated she contacted Resident A's physician from Harmony Care, formerly Visiting Physicians, on 12/05/2022 who subsequently visited the facility on 12/08/2022 and evaluated Resident A's injury. Ms. English stated Resident A's physician ordered an x-ray and completed a blood draw while at the facility. Ms. English stated between 11/29/2022 and 12/05/2022 Resident A did not appear to be in excessive pain, did use the fractured arm, and was visited by Relative 1 who did not observe Resident A in pain. Ms. Cross stated on 12/09/2022 staff from Harmony Care telephoned the facility and reported that Resident A's blood testing results were concerning, and Resident A

required a trip to the Emergency Department. Ms. Cross stated Resident A was transported to the Emergency Department and was admitted due to signs of a stroke. Ms. Cross stated an x-ray was performed while Resident A was inpatient which revealed a fractured left arm. Ms. Cross stated Resident A does move her arms a lot while in the Hoyer lift, but Ms. Cross has no direct knowledge of the cause of Resident A's fractured arm.

Staff Angela Davis stated she has worked at the facility for three years. Ms. Davis stated Resident A "complains regularly of join pain" and on 11/28/2022 Resident A complained that her arm hurt. Ms. Davis stated she gave Resident A Tylenol PRN on 11/28/2022 for her pain. Ms. Davis stated she did not observe any noticeable injuries to Resident A's arm on 11/28/2022. Ms. Davis stated that on 11/29/2022 Administrator Marcia English showed Ms. Davis a dark bruise on Resident A's left arm the size of a "baseball". Ms. Davis stated she asked Resident A how she sustained the injury and Resident A started "I don't know". Ms. Davis stated she noticed Resident A's arm was "looser than the other arm" but Resident A continued to use the left arm for daily activities such as holding her cup to drink. Ms. Davis stated Resident A requires the use of a "hoyer" for transfers and sometimes her arm gets caught in the "hoyer" but that has not occurred lately to Ms. Davis' knowledge. Ms. Davis stated she has no direct knowledge of the origination of Resident A's fractured arm.

Staff Debra Barrington stated she has worked at the facility for fifteen years. Ms. Barrington stated on 11/29/2022 Administrator Marcia English informed Ms. Barrington that Resident A had a bruise to her arm. Ms. Barrington observed the bruise to be a large circular bruise. Ms. Barrington asked Resident A how she sustained the injury and Resident A stated, "I don't know". Ms. Barrington stated Resident A denied pain associated with the bruise. Ms. Barrington stated Resident A has gotten her arm stuck in her clothing while being transferred in a Hoyer lift because Resident A moves her arms, however Ms. Barrington has not observed this behavior recently. Ms. Barrington stated she does not know how what caused Resident A's injury.

Staff Carolyn Evans stated she has worked at the facility for "fourteen years". Ms. Evans stated she observed Resident A's arm with a large baseball sized bruise to her left arm on or around 11/29/2022. Ms. Evans stated Resident A reported it "hurt a little" and Resident A "didn't answer how it happened". Ms. Evans stated Resident A periodically catches her arm in her clothing while being transferred via a Hoyer lift but Ms. Evans has no direct knowledge of the origination of Resident A's injury.

Resident B stated she has resided at the facility for approximately nine months. Resident B stated Resident A was currently at the hospital, but Resident B was unaware of the reason why. Resident B stated Resident A displayed no signs of pain prior to the hospitalization and staff have been kind and patient regarding their interactions with Resident A. Resident B stated she was happy with the care she is provided.

On 12/14/2022 I received an email from Adult Protective Services staff Drew Blackall. The email contained Mr. Blackall's interview with Resident A that occurred on 12/13/2022 and an interview with Relative 1 that occurred on 12/14/2022. I reviewed the interview with Resident A stated the following: *'Contact was made with (Resident A) at Spectrum Health Butterworth Hospital, room 4825. (Resident A) was observed laying in her hospital bed, motionless. (Resident A's) eyes were opened and she visually traced APS enter the room. (Resident A's) well-being verified.*

Aps notified (Resident A) of the reason for the visit. It is reported (Resident A) is non-verbal. Aps addressed (Resident A) and asked her how she was doing. Aps gave (Resident A) ample time for response and none was provided. No information was obtained. No injuries were observed on (Resident A) at this time as she was covered with a blanket. She appeared calm and all of her needs met at this time.

Contact was made with RN, Sarah. Sarah confirmed that (Resident A) has been non-verbal and provides no response. She reported that they continue to work with Resident A regarding her stroke and run testing to ensure she is stable at this time. There is no intention of discharge for today.'

The interview with Relative 1 stated the following: *'Contact was made with Relative 1, legal guardian, 616.206.2883. Relative 1 reported that she is very familiar with the situation and has been legal guardian for a long time. She indicated (Resident A) has been in the AFC placement for a "very, very long time." She reported that she has never had concern and (Resident A) has been doing well. She noted them as "kind and compassionate." Relative 1 reported she works and speaks often with Marcia English, the AFC Manager.*

Relative 1 reported that (Resident A) can be difficult to work with and does not always comply or help out others in her situation. Relative 1 indicated that (Resident A) will be difficult and cannot assist staff in her transfers. She is very stiff and rigid. Relative 1 reported that she is unsure of how (Resident A's) arm could have been broken, but did indicate a Hoyer lift is used and "things can happen." She indicated no direct knowledge of what happened or how the injury was obtained'.

On 12/28/2022 I interviewed staff Lien Le via telephoned. Ms. Le stated she has worked at the facility "over ten years". Ms. Le stated she has never observed staff become frustrated with Resident A and has not observed Resident A get injured in the Hoyer lift. Ms. Le stated she worked at the facility on 11/28/2022 and assisted Resident A with dressing. Ms. Le stated Resident A did not indicate she was in pain and no injuries were observed. Ms. Le stated that on 12/03/2022 she subsequently worked at the facility and was informed by coworkers that a bruise was observed on Resident A's arm. Ms. Le stated Resident A's injury was a "purple and black" bruise on Resident A's "whole left upper arm". Ms. Le stated Resident A did not appear to be pain and was able to continue using the arm without hesitation. Ms. Le stated Resident A is "hard to understand" therefore she did not ask Resident A directly how the injury occurred.

On 12/29/2022 I interviewed staff Joyce Walton via telephone. Ms. Walton stated she has worked at the facility “almost a year”. Ms. Walton stated on 11/28/2022 around 5:30 AM she observed a large bruise on Resident A’s left upper arm. Ms. Walton stated she immediately asked Resident A how she sustained the injury however Resident A didn’t say. Ms. Walton stated Resident A speaks very quietly and is often unable to be understood. Ms. Walton stated she immediately informed staff Debra Barrington and Administrator Marcia English of Resident A’s injury. Ms. Walton stated Resident A did not appear to be in pain however would not utilize the arm as she normally would. Ms. Walton explained that Resident A typically holds her cup but could not hold her cup after the injury. Ms. Walton stated on the next day she noticed Resident A’s arm was swollen. Ms. Walton stated she again informed Ms. Barrington and Ms. English of Resident A’s injury.

On 01/03/2023 I completed an Exit Conference with Licensee Designee Michelle Jannenga. Ms. Jannenga stated she agreed with the 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:	11/29/2022 facility staff observed a large bruise on Resident A’s upper left arm. Resident A was diagnosed with an arm fracture on 12/09/2022. The origination of the injury is unknown. A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate a violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING: Staff failed to seek timely medical care for Resident A.

INVESTIGATION: On 12/13/2022 I completed an unannounced onsite investigation at the facility. I privately interviewed Administrator Marcia English, staff Angela Davis, Debra Barrington, and Carolyn Evans.

Administrator Marcia English stated that on 11/28/2022 Resident A complained of “arm pain” but could not identify the cause. Ms. English stated that on 11/28/2022 she observed no indications of injury. Ms. English stated that on 11/29/2022 she observed a “large bruise” on Resident A’s left arm the size of a baseball. Ms. English stated she asked Resident A how she sustained the bruise and Resident A

stated she didn't know. Ms. English stated she contacted Resident A's physician from Harmony Care, formerly Visiting Physicians, on 12/05/2022 who subsequently visited the facility on 12/08/2022 and evaluated Resident A's injury. Ms. English stated Resident A's physician ordered an x-ray and completed a blood draw while at the facility. Ms. English stated between 11/29/2022 and 12/05/2022 Resident A did not appear to be in excessive pain, continued to use the fractured arm, and was visited by Relative 1 who did not observe Resident A in pain. Ms. English stated on 12/09/2022 staff from Harmony Care telephoned the facility and reported that Resident A's blood testing results were concerning, and Resident A required a trip to the Emergency Department. Ms. English stated Resident A was transported to the Emergency Department and was admitted due to signs of a stroke. Ms. English stated an x-ray was performed while Resident A was inpatient which revealed a fractured left arm.

Staff Angela Davis stated that on 11/28/2022 Resident A complained that her arm hurt. Ms. Davis stated she gave Resident A "Tylenol PRN" on 11/28/2022 for her pain. Ms. Davis stated she observed no noticeable injuries to Resident A's arm on 11/28/2022. Ms. Davis stated that on 11/29/2022 Administrator Marcia English showed Ms. Davis a "dark" bruise on Resident A's left arm the size of a "baseball". Ms. Davis stated she asked Resident A how she sustained the injury and Resident A started "I don't know". Ms. Davis stated she noticed Resident A's left arm was "looser than the other arm" but Resident A continued to use the left arm for daily activities such as holding her cup to drink.

Staff Debra Barrington stated that on 11/29/2022 Administrator Marcia English informed Ms. Barrington that Resident A had a bruise to her arm. Ms. Barrington observed the bruise to be large and circular. Ms. Barrington asked Resident A how she sustained the injury and Resident A stated, "I don't know". Ms. Barrington stated Resident A denied pain associated with the bruise.

Staff Carolyn Evans stated she observed Resident A with a large baseball sized bruise to her left arm on 11/29/2022. Ms. Evans stated Resident A reported it "hurt a little" and that she "didn't answer how it happened".

On 12/28/2022 I interviewed Staff Lien Le via telephoned. Ms. Le stated she worked at the facility on 11/28/2022 and Ms. Le assisted Resident A with dressing. Ms. Le stated Resident A did not indicate she was in pain and no injuries were observed. Ms. Le stated that on 12/03/2022 she subsequently worked at the facility and was informed by coworkers that a bruise had been observed on Resident A's arm. Ms. Le stated she observed Resident A's injury was a "purple and black" bruise on Resident A's "whole left upper arm". Ms. Le stated Resident A did not appear to be pain and was able to continue using the arm without hesitation.

On 12/29/2022 I interviewed staff Joyce Walton via telephone. Ms. Walton stated she worked at the facility on 11/28/2022 and at approximately 5:30 am she observed a large bruise on Resident A's left upper arm. Ms. Walton stated she immediately

asked Resident A how she sustained the injury however Resident A “didn’t say”. Ms. Walton stated she immediately informed staff Debra Barrington and Administrator Marcia English of Resident A’s injury. Ms. Walton stated Ms. English “dismissed” Resident A’s injury. Ms. Walton stated Resident A did not appear to be in pain however would not utilize the arm as she normally would. Ms. Walton explained that Resident A typically holds her cup but could not hold her cup after the injury. Ms. Walton stated on the following day she noticed Resident A’s arm was swollen. Ms. Walton stated she again informed Ms. Barrington and Ms. English of Resident A’s injury. Ms. Walton stated Ms. English “brushed off” Resident A’s injury as not requiring medical attention.

On 01/03/2023 I completed an Exit Conference with Licensee Designee Michelle Jannenga via telephone. Ms. Jannenga stated she agreed with the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	On 11/28/2022 Resident A complained to facility staff of pain. On 11/29/2022 facility staff observed Resident A with a large bruise to her upper arm. Facility staff did not contact medical staff regarding Resident A’s injury until 12/05/2022 and Resident A did not receive a medical evaluation by a physician until 12/08/2022. Resident A was ultimately diagnosed with a left arm fracture on 12/09/2022. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/03/2023

Toya Zylstra Date
Licensing Consultant

Approved By:

01/03/2023

Jerry Hendrick Date
Area Manager