RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

January 15, 2019

Robin Deerfield
Thresholds
Post Office Box 68327
Grand Rapids, MI 49516-8327

RE: License #: AL410007103
Investigation #: 2019A0583012
Gladiola Home

Dear Ms. Deerfield:

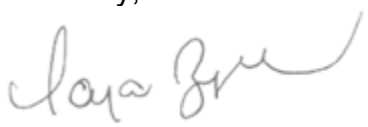
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2019A0583012
Complaint Receipt Date:	12/20/2018
Investigation Initiation Date:	12/20/2018
Report Due Date:	01/19/2019
Licensee Name:	Thresholds
Licensee Address:	1225 Lake Drive SE Grand Rapids, MI 49506
Licensee Telephone #:	(616) 466-5259
Administrator:	Robin Deerfield
Licensee Designee:	Robin Deerfield
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:	08/12/2018
Expiration Date:	08/11/2020
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A presented with unexplained bruises on her inner thigh and there are concerns Resident B may have caused the injuries because the two residents do not interact well together.	No
Additional Findings	Yes

III. METHODOLOGY

12/20/2018	Special Investigation Intake 2019A0583012
12/20/2018	Special Investigation Initiated - Letter Recipient Rights, Melissa Gekeler
12/20/2018	APS Referral
01/02/2019	Contact - Face to face Staff Caryn Bauman
01/02/2019	Contact - Telephone Licensee Designee Robin Deerfield
01/03/2019	Contact – Face to Face Home Manager Kimberly Brown, Staff Tamika Foster, Assistant Home Manager Angela Davis, Resident B
01/07/2019	Contact - Telephone Relative 1
01/07/2019	Contact - Telephone Sue Fox
01/07/2019	Contact - Telephone Donique Kosters
01/10/2019	Contact - Document Chelsea Towns, Adult Protective Services
01/10/2019	Contact - Telephone Relative 1
01/11/2019	Contact - Telephone Sue Fox

01/14/2019	Exit Conference Licensee Designee, Robin Deerfield

ALLEGATION: Resident A presented with unexplained bruises on her inner thigh and there are concerns Resident B may have caused the injuries because the two residents do not interact well together.

INVESTIGATION: On 12/20/2018 I received emailed allegations from Recipient Rights, Melissa Gekeler. The allegations stated the following: *"(Resident A) attended respite at Gladiola home 11/30 - 12/2. On 12/2 during bath (Resident A's) mom noticed bruising on the inside of (Resident A's) inner thigh. She stated that "it looked like pinches". She also stated that there was a new girl (resident) in the home who didn't get along with (Resident A). (Resident A's) mother, (Relative 1), stated that she took pictures on her phone and has since lost those pictures due to needing a new phone. Gladiola staff called me about the situation and I called (Resident A's) mom/guardian to inquire."*

On 01/02/2019 I completed and unannounced onsite investigation at the facility. I interviewed staff, Caryn Bauman, privately. Ms. Bauman stated she works in the Gladiola "apartment" and doesn't know the names of "respite" residents that reside in the Gladiola Home.

On 01/02/2019 I interviewed Licensee Designee, Robin Deerfield, via telephone. Ms. Deerfield stated Resident A is a respite resident of the facility. Ms. Deerfield stated Resident A last resided at the facility from 11/30/2018 until 12/02/2018. Ms. Deerfield stated Home Manager, Kimberly Brown, verbally informed Ms. Deerfield that Resident A's legal guardian and parent, Relative 1, contacted Ms. Brown and reported Relative 1 noticed bruises on Resident A's inner thighs on 12/02/2018. Ms. Deerfield stated Relative 1 stated she reported the allegations to Resident A's case manager, Donique Kosters, and photographed the injuries. Ms. Deerfield stated Relative 1 stated staff, Tamika Foster, caused the injuries because Ms. Foster was the only staff to bathe Resident A during the 11/30/2018 until 12/02/2018 respite stay. Ms. Deerfield stated she spoke with Ms. Kosters regarding the allegations and Ms. Kosters stated Relative 1 did not report the injuries to her. Ms. Deerfield stated she has no knowledge of Resident A and Resident B not interacting appropriately together and she has no suspicions that Resident B caused the injuries. Ms. Deerfield stated Resident A is highly agreeable to Relative 1's wishes and Relative 1 often speaks for Resident A.

On 01/03/2019 I completed on onsite investigation at the facility. I interviewed Home Manager Kimberly Brown, Staff Tamika Foster, and Resident B each privately.

Ms. Brown stated Resident A is a respite resident that last resided at the facility 11/30/2018 until 12/2/2018. Ms. Brown stated Ms. Foster was the sole staff that

bathed Resident A while she was at the facility 11/30/2018 until 12/2/2018. Ms. Brown stated Relative 1 telephoned her on 12/10/2018 and reported Resident A presented with bruises on her “groin”. Ms. Brown stated she informed Relative 1 that Ms. Foster was the only staff to bathe Resident A while she was residing at the facility. Ms. Brown stated she overheard Relative 1, through the telephone, ask Resident A “was it Ms. Foster”? Ms. Brown stated she heard Resident A state “yeah”. Ms. Brown stated Relative 1 stated she wanted Resident A to continue to reside at the facility despite the injuries Relative 1 stated she viewed.

Ms. Foster stated she bathed Resident A twice while she resided at the facility 11/30/2018 until 12/2/2018. Ms. Foster stated she did not view or cause bruises on Resident A’s thighs and buttocks. Ms. Foster stated she did not wash Resident A’s “private areas” while she bathed her. Ms. Foster stated she has not observed Resident A and Resident B to not get along and she has no concerns Resident B caused Resident A’s injuries.

Resident B stated she did not abuse Resident A in any manner. Resident B stated she enjoys the time she spends with Resident A.

On 01/07/2019 I interviewed Relative 1 via telephone. Relative 1 stated she is the mother and legal guardian of Resident A. Relative 1 stated Resident A completed a respite stay 11/30/218 until 12/02/2018 at the facility. Relative 1 stated on 12/3/2018, while bathing Resident A, Relative 1 observed Resident A displayed small bruises on her inner thighs and buttocks. Relative 1 described Resident A’s injuries as “looked like they just pinched her down the line” on her thighs and buttocks. Relative 1 stated she asked Resident A whom perpetrated the injuries and Resident A stated, “she did it”. Relative 1 stated she asked Resident A if staff at the facility caused Resident A’s injuries and Resident A said “yes”. Relative 1 stated she asked Resident A for the name of the staff at the facility that Resident A alleged caused the injuries, however Resident A could not provide the name. On 12/3/2018, Relative 1 stated she displayed Resident A’s injuries to Community Living Support staff, Sue Fox. On 12/5/2018, Relative 1 stated she informed Resident A’s case manager, Donique Kosters, of Resident A’s injuries in person during a home visit. Relative 1 stated after she informed Ms. Kosters of the injuries, Relative 1’s cell phone broke for 5 days and she was unable to call the facility. On 12/10/2018, Relative 1 stated she telephoned facility Home Manager, Kimberly Brown and explained Resident A’s injuries. Relative 1 stated Ms. Brown informed Relative 1 that staff Tamika Foster was the only staff to bathe Resident A. Relative 1 stated she subsequently asked Resident A if Ms. Foster caused the injuries and Resident A stated Ms. Foster did cause her injuries. Relative 1 stated she photographed Resident A’s injuries however she lost the photographs when her phone broke. Relative 1 stated she did not report the injuries to law enforcement. Relative 1 stated Resident A stated Resident B is “mean” to her, but she does not believe Resident B caused the injuries.

01/07/2018 I interviewed Donique Kosters via telephone. Ms. Kosters stated she is the case manager of Resident A. Ms. Kosters stated facility staff contacted her and reported Relative 1 had concerns Resident A returned from the facility with bruises on her thighs. Ms. Kosters stated Relative 1 did not report the allegations to her on 12/5/2018. Ms. Kosters stated she telephoned Relative 1 on 12/18/2018 and Relative 1 stated Resident A displayed bruises Relative 1 believed were due to abuse by staff. Ms. Kosters stated Relative 1 reported Resident B was "mean" to Resident A. Ms. Kosters stated she has not viewed Resident A's injuries or interviewed her.

01/10/2018 I received an email from Adult Protective Services Worker, Chelsea Towns. The email contained Ms. Towns' 12/21/2018 at 3:00 pm face-to-face interview with Resident A that occurred at the MOKA day center. I reviewed the interview which states the following: *"Contact was made with (Resident A) at MOKA. (Resident A) was observed to be dressed appropriately. (Resident A) held onto ASW's arm during the interview. (Resident A) stated she is doing good today and likes MOKA. ASW asked what she likes about MOKA and (Resident A laughed but did not answer. ASW asked if (Resident A) goes to Thresholds,(Resident A) said "yeah." ASW asked (Resident A) if she likes Thresholds and she said "yeah." ASW asked (Resident A) if she's had any bruises recently, and (Resident A) said "yes." ASW asked (Resident A) how she got the bruises and (Resident A) said "I don't know." ASW asked (Resident A) if anyone is mean to her or hurts her, (Resident A) said "No." ASW asked (Resident A) if she feels safe at home, and she said "Yes." (Resident A) asked ASW if she uses paper to write notes, laughed, and grabbed ASW's hand and walked to the bus. (Resident A) said "Thank you!" and got onto the bus*."

On 01/10/2019 I interviewed Relative 1 via telephone. Relative 1 stated she could not locate photographs of Resident A's injuries on her cell phone.

On 01/11/2019 I interviewed Community Living Support staff, Susan Fox. Ms. Fox stated on 12/03/2018 Relative 1 asked Ms. Fox to view Resident A's injuries Relative 1 suspected were sustained while Resident A was at the facility. Ms. Fox stated Resident A was only wearing a t-shirt and underwear while Relative 1 showed Ms. Fox Resident A's legs. Ms. Fox stated she did not view multiple bruises on Resident A's inner thighs. Ms. Fox stated she viewed one "small very faint bruise" that Ms. Fox stated appeared accidental as it was located by Resident A's knee. Ms. Fox stated she informed Relative 1 that Ms. Fox did not see what Relative 1 was seeing in terms of multiple bruises. Ms. Fox did not ask Resident A how she sustained the small bruise on her knee.

On 01/14/2019 I completed an Exit Conference with Licensee Designee Robin Deerfield. She stated she agreed with the findings.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	During a 12/21/2018 interview completed by Adult Protective Services staff, Chelsea Towns, Resident A stated she did not know how she sustained bruises, but that no one hurts her. Staff Tamika Foster and Resident B deny causing Resident A 's injuries. Relative 1 stated she viewed Resident A's bruises on her inner thigh and buttocks and photographed the injuries. Relative 1 stated she no longer has the photographs. CLS Staff, Susan Fox, stated she did not view multiple bruises on Resident A's inner thighs. There is insufficient evidence to substantiate violation of R 400.15308 (1).
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Staff are not competently trained to perform tasks related to all facility residents' personal care, supervision, and protection.

INVESTIGATION: On 01/02/2019 I completed and unannounced onsite investigation at the facility. I interviewed staff, Caryn Bauman, privately. Ms. Bauman stated she works in the Gladiola "apartment" and that she didn't know the names of "respite residents that reside in the Gladiola Home. Ms. Bauman stated she did not believe Gladiola Home staff were at the facility. Ms. Bauman attempted to locate Gladiola Home staff as she stated she did not know their schedules. Ms. Bauman was not able to locate Gladiola Home staff or residents. Ms. Bauman explained "I do not work on this side of the facility" and because of this she was not aware of the whereabouts of the staff and residents that reside on the house side of the facility.

On 01/02/2019 I interviewed Licensee Designee Robin Deerfield. Ms. Deerfield stated staff should be trained by Ms. Brown, Home manager, regarding the care needs of every resident in the facility. Ms. Deerfield stated staff should be operating the home as one program, rather than the Gladiola Home and Gladiola Apartment separately.

On 01/03/2019 I completed on onsite investigation at the facility. I interviewed Home Manager Kimberly Brown, Staff Tamika Foster, and Assistant Home Manager Angela Davis each privately.

Ms. Brown stated she is in the process of training staff regarding all residents' Assessment Plans and needs. Ms. Brown stated the staff training has occurred during the last couple of meetings. Ms. Brown stated when staff are hired at the facility, they are hired to work on either the Gladiola House side or the Gladiola Apartment side. Ms. Brown stated residents may move freely from the house side to the apartment side. Ms. Brown stated each side of the facility has a separate home manager and separate staff schedules.

Ms. Foster stated she works mainly third shift and picks up occasional shifts on the Gladiola Home side of the facility. Ms. Foster stated during her third shift she completes bed checks on both sides of the facility however if she found a problem on the apartment side of the facility, she would contact the apartment home manager, "Cornelia" for assistance. Ms. Foster stated she is not familiar with the care need of residents that reside in the apartment but frequently sees residents that reside in the apartment "outside" of the home. Ms. Foster stated the two sides of the facility are "two separate programs". Ms. Foster stated when she works during the day shift, she works on the Gladiola Home side of the facility. Ms. Foster stated she is not familiar with the food preparation needs of the residents residing in the apartment. Ms. Foster stated there are two separate staff work schedules for each side of the facility.

Ms. Davis stated she is the Assistant Home Manager of the Gladiola Home side of the facility. Ms. Davis stated during staff meetings staff have talked about resident assessment plans for all facility residents. Ms. Davis stated the Gladiola Home and Gladiola Apartment have two separate staff work schedules. Ms. Davis stated staff are assigned to work at either the Gladiola Home or the Gladiola Apartment however residents can move freely throughout the facility.

On 01/14/2019 I completed an Exit Conference with Licensee Designee, Robin Deerfield. She stated she would complete an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to

	direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(d) Personal care, supervision, and protection.**
ANALYSIS:	On 01/02/2019, Staff Caryn Bauman stated she works in the Gladiola "apartment" and doesn't know the names of "respite" residents that reside in the Gladiola Home. Ms. Bauman stated "I do not work on this side of the facility" therefore she was not aware of the whereabouts of the staff and residents that reside on the house side of the facility. On 01/03/2019 Home Manager Kimberly Brown stated she is in the process of training staff regarding all residents' Assessment Plans and needs. Ms. Brown stated the staff training has occurred during the last couple of meetings. Ms. Brown stated when staff are hired at the facility, they are hired to work on either the Gladiola House side or the Gladiola Apartment side. On 01/03/2019 Staff Tamika Foster stated she works mainly third shift and picks up occasional shifts on the Gladiola Home side of the facility. Ms. Foster stated during her third shift she completes bed checks on both sides of the facility however if she found a problem on the apartment side of the facility, she would contact the apartment home manager, "Cornelia" for assistance. Ms. Foster stated she is not familiar with the care needs of residents that reside in the apartment but frequently sees residents that reside in the apartment "outside". Assistant Home Manager Angela Davis stated she is the Assistant Home Manager of the Gladiola Home side of the facility. Ms. Davis stated during staff meetings staff have talked about resident assessment plans for all facility residents. Ms. Davis stated the Gladiola Home and Gladiola Apartment have two separate staff work schedules. There is a preponderance of evidence to substantiate a violation of R 400.15204 (3) (d). Staff are not competent to perform assigned tasks, which shall include being competent in all of the following areas: personal care, supervision, and protection. Staff Caryn Bauman stated she is not familiar with all of the residents of the facility because she works in the Gladiola Apartment side of the facility. Staff Tamika Foster stated she works third shift and if there is a problem with residents in the apartment she calls the apartment home manager because she isn't familiar with the apartment residents. Home Manager

	Kimberly Brown and Assistant Home Manager Angela Davis stated staff are hired to work on either the Gladiola Home side or the Gladiola Apartment side of the facility and work separate schedules based upon which side of the facility they are working on.
CONCLUSION:	**VIOLATION ESTABLISHED**

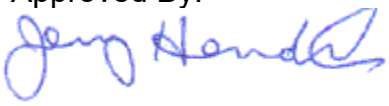
IV. RECOMMENDATION

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

01/15/2019

Toya Zylstra Date
Licensing Consultant

Approved By:



01/15/2019

Jerry Hendrick Date
Area Manager