GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 14, 2023

Cornelius Kuperus
David's House Ministries
2390 Banner Dr.
Wyoming, MI 49509

RE: License #: AS410314820
Investigation #: 2023A0583041
House 4

Dear Mr. Kuperus:

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 #:	AS410314820
Investigation #:	2023A0583041
Complaint Receipt Date:	08/30/2023
Investigation Initiation Date:	08/31/2023
Report Due Date:	09/29/2023
Licensee Name:	David's House Ministries
Licensee Address:	2390 Banner Dr., Wyoming, MI 49509
Licensee Telephone #:	(616) 284-4388
Administrator:	Cornelius Kuperus
Licensee Designee:	Cornelius Kuperus
Name of Facility:	House 4
Facility Address:	2375 Banner Dr. SW, Wyoming, MI 49509
Facility Telephone #:	(616) 247-7861
Original Issuance Date:	10/18/2012
License Status:	REGULAR
Effective Date:	04/18/2023
Expiration Date:	04/17/2025
Capacity:	3
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Facility residents are not receiving adequate care.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/30/2023	Special Investigation Intake 2023A0583041
08/31/2023	Special Investigation Initiated - Telephone
09/01/2023	APS Referral
09/01/2023	Inspection Completed On-site
09/01/2023	Contact – Telephone Ed Wilson, Recipient Rights
09/01/2023	Contact – Telephone Home Manager Shonquetta Sneed
09/01/2023	Contact – Telephone Staff Kelly Williams
09/01/2023	Contact – Telephone Staff Candice Maksymowski
09/03/2023	Contact – Email Licensee Designee Casey Kuperus
09/04/2023	Contact – Email Administrator Ruth Bonfigilio
09/05/2023	Contact – Onsite Resident A, Resident B, Resident C
09/07/2023	Contact – Email Administrator Ruth Bonfigilio
09/08/2023	Contact – Email Administrator Ruth Bonfigilio
09/08/2023	Contact – Telephone

	Staff Candice Maksymowski
09/08/2023	Contact – Telephone Staff Kelly Williams
09/14/2023	Exit Conference Licensee Designee Casey Kuperus

ALLEGATION: Facility residents are not receiving adequate care.

INVESTIGATION: On 08/29/2023 I received the above complaint allegation from the BCAL online reporting system. The complaint alleged that staff Candice Maksymowski, “had gone to sleep and didn't change or reposition the residents until 5:30 am and the shift started at 11pm”. The complaint further alleged that, “a male resident got up very wet and Candice told him to get back in his room”.

On 09/01/2023 I referred the complaint allegation to Adult Protective Services Centralized Intake.

On 09/01/2023 I completed an unannounced onsite investigation at the facility and interviewed Licensee Casey Kuperus, staff Mary Kubiak, and staff Amber Sneed. I observed the wellbeing of Resident A, Resident B, and Resident C.

Licensee Designee Casey Kuperus stated he had no knowledge of third shift staff sleeping and it is expected that staff remain awake and provide resident care as needed during third shift. Mr. Kuperus stated that the facility is staffed with “one to two staff” every third shift which is typically from 11:00 PM until 7:00 AM.

Staff Mary Kubiak stated she has worked at the facility for approximately one week and has no knowledge of staff sleeping or residents not receiving adequate personal care on third shift.

Staff Amber Sneed stated she has worked at the facility for approximately one month and has never observed indications that residents are not receiving adequate personal care. Ms. Sneed stated she typically starts her shift at 6:30 AM and has always observed third shift staff awake upon Ms. Sneed’s entrance to the facility.

I attempted to interview Resident A however it was difficult to understand Resident A due to her developmental disabilities.

I attempted to interview Resident B however Resident B was under Covid 19 restriction preventing the interview. I observed Resident B asleep in his personal bedroom.

I observed the wellbeing of Resident C who appeared appropriately groomed and dressed. A formal interview was not completed with Resident C due to his lack of verbal skills.

On 09/01/2023 I emailed the complaint allegation to Network 180 Recipient Rights Ed Wilson.

On 09/01/2023 I interviewed Home Manager Shonquetta Sneed via telephone. Ms. Sneed stated Resident A has been diagnosed with a pressure wound on her buttocks which requires facility staff to reposition Resident A “every two hours” while Resident A is sleeping. Ms. Sneed stated staff are required to check Resident A every two hours during the night and change Resident A’s adult briefs if they are wet. Ms. Sneed stated staff are required to change Resident C’s adult briefs if Resident C comes out of his bedroom “wet” during third shift. Ms. Sneed stated staff are required to drain Resident B’s catheter bag third shift if it is observed as full. Ms. Sneed stated that she typically works from 6:00 AM until 4:00 PM and has not observed indications that staff are sleeping third shift or not providing adequate resident care. Ms. Sneed stated that the facility staffs third shift with one staff.

On 09/01/2023 I interviewed staff Kelly Williams via telephone. Ms. Williams stated that staff Candice Maksymowski trained Ms. Williams third shift from approximately 10:30 PM until 6:30 AM on 06/29/2023, 06/30/2023, and 06/31/2023. Ms. Williams stated that Ms. Williams and Ms. Maksymowski were the only staff working during the third shift. Ms. Williams stated that at approximately 11:30 to midnight Ms. Maksymowski slept in the facility’s living room on the couch or chair. Ms. Williams stated that Ms. Maksymowski told Ms. Williams that, “you can lay back too”. Ms. Williams stated Ms. Maksymowski did change Resident B’s catheter before going to sleep but instructed Ms. Williams not to change Resident A’s adult brief or reposition Resident A. Ms. Williams stated that Ms. Maksymowski woke up at approximately 6:00 AM, before first shift staff arrived at the facility.

On 09/01/2023 I interviewed Home Manager Shonquetta Sneed via telephone. Ms. Sneed stated she works first shift and has never observed staff Candice Maksymowski sleeping when Ms. Sneed arrives to the facility at approximately 6:30 AM daily. Ms. Sneed stated that she recently spoke with the previous house manager who informed Ms. Sneed that staff are no longer required to rotate Resident A every two hours at night because Resident A’s bed sore has healed.

On 09/01/2023 I interviewed staff Candice Maksymowski via telephone. Ms. Williams stated that she generally works from 10:30 PM until 6:30 AM and has worked at the facility for approximately three years. Ms. Maksymowski stated that approximately one year ago she was “caught sleeping” while working third shift at the facility “on accident”. Ms. Maksymowski stated there have been recent instances when she has closed her eyes for a couple minutes. Ms. Maksymowski stated that the facility’s expectation is that staff are awake during their shifts. Ms. Maksymowski stated that she does not reposition Resident A every two hours while

she is asleep because it hinders Resident A's rest and Resident A's bedsore has healed. Ms. Maksymowski stated she changes Resident B's catheter nightly.

On 09/03/2023 I received an email from Licensee Designee Casey Kuperus which contained Resident B and Resident C's Assessment Plans for AFC Residents. Resident B's Assessment Plan, signed 05/01/2023, states "(Resident B) is becoming frustrated with being unable to remember things. It is reported that Resident B will swear at staff, threaten to drink bleach and threaten to run away. Resident B has never ever drank bleach or run away". Resident C's Assessment Plan, signed 02/27/2023, states "(Resident C) needs to be monitored to prevent elopement, not with the purposes of evading staff, but if anything catches his attention he will walk/run to the desired item or person without alerting staff or assessing safety. For this reason, (Resident C) requires alarms on the doors as part of his behavior plan".

On 09/04/2023 I received an email from Administrator Ruth Bonfiglio which contained Resident A's Assessment Plan for AFC Residents. Resident A's Assessment Plan, signed 06/04/2023, states Resident A requires assistance with toileting and "(Resident A) requires total hands-on assistance from staff for toileting to provide support with transferring with a Hoyer lift, changing briefs, wiping, & washing hands. (Resident A) wears adult briefs that need to be changed several times throughout the day and night. (Resident A) is toileted at least 4 times per day. Staff should support (Resident A) with using the bathroom or changing her adult brief at least once every night as well in order to prevent skin breakdown that result from (Resident A) laying in her incontinence. (Resident A) has presented problems with this in the past".

On 09/05/2023 I completed an onsite investigation at the facility and interviewed Resident A and Resident B with assistance of staff Sheryl Chase.

Resident A stated that staff Candice Maksymowski works at the facility third shift. Resident A stated she has a history of skin break down (bed sore) on her buttocks that is currently healed but flares up if Resident A is not repositioned often enough or left in wet adult briefs too long. Resident A stated she sometimes urinates through her nightly adult brief. Resident A stated Ms. Maksymowski does not check her adult brief every two hours and does not reposition her. Resident A stated that she would not be as wet in the mornings if her adult brief was changed more often during the nights. Resident A stated that although her bed sore is healed, she would like to be repositioned every two hours to reduce the chance of a reoccurrence.

Resident B stated that he is typically asleep when Ms. Maksymowski arrives to the facility third shift and therefore, he does not know if Ms. Maksymowski sleeps at the facility.

On 09/07/2023 I received and reviewed an email from Administrator Ruth Bonfiglio which stated, "(Resident A's) IPOS historically indicates we turned (Resident A) every 2 hours when she had an open wound, however since (Resident A) does not

have an open wound, and we currently do not have documentation from a physician that it is medically required, (Resident A) is currently being adjusted when staff change (Resident A’s) brief at night. (Resident A’s) IPOS states (Resident A’s) briefs are to be changed at least once every night to prevent skin breakdown”.

On 09/07/2023 I received an email from Administrator Ruth Bonfiglio which contained Resident A’s Individual Plan of Service. The IPOS was signed 02/28/2023 and states Resident A, “wears adult briefs that need to be changed several times throughout the day and night. (Resident A) is toileted at least 4 times. Staff should support (Resident A) by using the bathroom or changing her adult briefs at least once every night as well in order to prevent skin breakdown that can result from resident a lying in her incontinence.”

On 09/08/2023 I received an email from Administrator Ruth Bonfiglio which stated, “(Resident A’s) bedsore was gone 6.29-30, 2023” and “(Resident A) was discharged from the wound clinic February 2, 2021”. The email further stated that, “(Resident A’s) last appointment at the wound clinic was October 4, 2022 as a follow up appointment” and “(Resident A) is currently not being seen at the wound clinic nor does (Resident A) have an open wound”.

On 09/08/2023 I interviewed staff Candice Maksymowski via telephone. Ms. Maksymowski stated that she does check Resident A’s adult brief every two hours while Resident A is sleeping third shift and if the adult brief is wet Ms. Maksymowski will change said adult brief.

On 09/08/2023 I interviewed staff Kelly Williams via telephone. Ms. Williams stated that Resident C did come out of his bedroom during one the evenings between 06/29/2023 and 06/31/2023 and Resident C was directed by staff Candice Maksymowski to go back to his bedroom. Ms. Williams stated that during the incident Resident C did not appear to be wet. Ms. Williams stated that during the evenings of 06/29/2023 through 06/31/2023 Ms. Maksymowski did not check Resident A's adult briefs and thus did not change Resident A’s wet adult briefs.

On 09/14/2023 I completed an Exit Conference with Licensee Designee Casey Kuperus via telephone. Mr. Kuperus stated he did not dispute the findings of the Special Investigation and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A stated that staff Candice Maksymowski works at the facility third shift. Resident A stated she has a history of skin

	break down on her buttocks that is currently healed but flares up if she is not repositioned often enough. Resident A stated Ms. Maksymowski does not check her adult brief every two hours and does not reposition her during third shift. Staff Candice Maksymowski stated that she does check Resident A's adult brief every two hours while Resident A is sleeping third shift and if the adult brief is wet Ms. Maksymowski changes her brief. Staff Kelly Williams stated that during the evenings of 06/29/2023 through 06/31/2023 staff Candice Maksymowski slept from 11:30 PM until 6:00 AM and did not check or change Resident A's adult briefs. Resident A's Assessment Plan states she requires total hands-on assistance from staff for toileting to provide support with transferring with a Hoyer lift, changing briefs, wiping, & washing hands. Resident A wears adult briefs that need to be changed several times throughout the day and night and is toileted at least 4 times per day. Staff should support Resident A with using the bathroom or changing her adult brief at least once every night as well in order to prevent skin breakdown that result from Resident A laying in her incontinence. A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. Staff Candice Maksymowski did not check and change Resident A's adult briefs third shift between 06/29/2023 and 06/31/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Staff Candice Maksymowski mistreated Resident C.

INVESTIGATION: On 09/01/2023 I interviewed staff Kelly Williams via telephone. Ms. Williams stated that staff Candice Maksymowski trained Ms. Williams at the facility third shift on 06/29/2023, 06/30/2023, and 06/31/2023. Ms. Williams stated Ms. Maksymowski slept on the living room couch or chair from 11:30 PM until 6:00 AM. Ms. Williams stated that during one of the training shifts Resident C entered the living room at approximately 1:00 AM and awoke Ms. Maksymowski. Ms. Williams stated she observed Ms. Maksymowski yell at Resident C to go back to bed and say "we are not doing this tonight." Ms. Williams stated Ms. Maksymowski pushed Resident C into his bedroom with her hands but did not leave marks or injuries. Ms. Williams stated all other residents were in bed during the incident.

On 09/01/2023 I interviewed Home Manager Shonquetta Sneed via telephone. Ms. Sneed stated she has never observed Ms. Maksymowski verbally or physically mistreat a resident of the facility.

On 09/01/2023 I interviewed staff Candice Maksymowski via telephone. Ms. Williams stated Resident C had come out of his bedroom during one of the evenings between 06/29/2023 to 06/31/2023. Ms. Maksymowski she calmly directed Resident C back into his bedroom and stated that she never mistreated Resident C while directing Resident C during the incident. Ms. Maksymowski denied she verbally mistreated Resident C or pushed Resident C. Ms. Maksymowski stated she has always verbally redirected Resident C back to his bedroom and gently assisted him back into his bedroom without incident. Ms. Maksymowski stated she has never mistreated residents of the facility.

On 09/05/2023 I completed an onsite investigation at the facility and interviewed Resident A and Resident B with assistance of staff Sheryl Chase.

Resident A stated that staff Candice Maksymowski works at the facility third shift. Resident A stated that she sleeps with her bedroom door open and has overheard Ms. Maksymowski become frustrated with Resident C for "mumbling" and for coming out of his bedroom at night. Resident A stated she has overheard Ms. Maksymowski exhibit an "angry voice" towards Resident C after he comes out of his bedroom at night. Resident A stated she has overheard Ms. Maksymowski instruct Resident C to "go back to your room" in an "angry tone".

Resident B stated that he is typically asleep when Ms. Maksymowski arrives to the facility third shift. Resident B stated he has never observed Ms. Maksymowski treat Resident B or any other resident in an unkind manner.

On 09/14/2023 I completed an Exit Conference with Licensee Designee Casey Kuperus via telephone. Mr. Kuperus stated he did not dispute the findings of the Special Investigation and would submit an acceptable Corrective Action Plan.

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:	Staff Kelly Williams stated that staff Candice Maksymowski trained Ms. Williams at the facility third shift on approximately 06/29/2023, 06/30/2023, and 06/31/2023. Ms. Williams stated she observed Ms. Maksymowski yell to Resident C to "go back to bed, we are not doing this tonight". Ms. Williams stated Ms.

	Maksymowski pushed Resident C into his bedroom with her hands but did not leave marks or injuries. Resident A stated that she has overheard Ms. Maksymowski exhibit an “angry” voice tone towards Resident C after he comes out of his bedroom at night. Resident A stated she has overheard Ms. Maksymowski instruct Resident C to “go back to your room” in an “angry tone”. Staff Candice Maksymowski reported that Resident C has come out of his bedroom during the evenings however Ms. Maksymowski stated that she has never mistreated Resident C while directing Resident C back into his bedroom. Ms. Maksymowski denied she verbally mistreated Resident C or pushed Resident C. A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule. Staff Candice Maksymowski verbally mistreated Resident C.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/14/2023

Toya Zylstra	Date
Licensing Consultant

Approved By:

09/14/2023

Jerry Hendrick	Date
Area Manager