GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 18, 2024

Laura Esese
Ascension Health III AFC
3640 Brambleberry Dr. NW
Comstock Park, MI 49321

RE: License #: AS410386016
Investigation #: 2024A0583014
Ascension Health III AFC

Dear Ms. Esese:

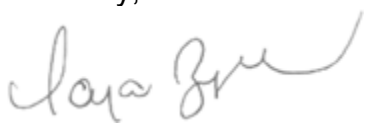
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS410386016
Investigation #:	2024A0583014
Complaint Receipt Date:	01/09/2024
Investigation Initiation Date:	01/09/2024
Report Due Date:	02/08/2024
Licensee Name:	Ascension Health III AFC
Licensee Address:	3640 Brambleberry Dr. NW Comstock Park, MI 49321
Licensee Telephone #:	(616) 856-9191
Administrator:	Laura Esese
Licensee Designee:	Laura Esese
Name of Facility:	Ascension Health III AFC
Facility Address:	1947 Millbank St SE Grand Rapids, MI 49508
Facility Telephone #:	(616) 805-4203
Original Issuance Date:	02/09/2017
License Status:	REGULAR
Effective Date:	08/09/2023
Expiration Date:	08/08/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Staff Dorothy Thompson verbally mistreated Resident A.	Yes
Staff Dorothy Thompson secluded Resident A in her bedroom.	Yes

III. METHODOLOGY

01/09/2024	Special Investigation Intake 2024A0583014
01/09/2024	Special Investigation Initiated - Letter
01/09/2024	APS Referral
01/10/2024	Inspection Completed On-site
01/10/2024	Contact - Face to Face Resident B
01/10/2024	Contact - Telephone call made Staff Dorothy Thompson
01/17/2024	Exit Conference Licensee Designee Laura Esese

ALLEGATION: Staff Dorothy Thompson verbally mistreated Resident A.

INVESTIGATION: On 01/09/2024 I received complaint allegations via email from Recipient Rights staff Melissa Gekeler. Ms. Gekeler stated that she recently received complaint allegations which alleged that staff Dorothy Thompson recently "kept yelling" at Resident A.

On 01/09/2024 I emailed the complaint allegations to adult protective services intake.

On 01/10/2024 I completed an unannounced onsite investigation at the facility and privately interviewed staff Best Uwitonze, Resident B, Resident C, and Resident D.

While onsite I visually verified the wellbeing of Resident A. I observed that Resident A is deaf and utilizes a Cochlear implant. Resident A was unable to engage in a conversation but presented as happy and well groomed.

Staff Best Uwitonze stated that staff Dorothy Thompson works independently on weekends and therefore the two staff do not work jointly. Ms. Uwitonze stated that she had no knowledge of the allegations.

Resident B stated that Resident A is deaf and requires the assistance of a Cochlear Implant. Resident B stated that Resident A often makes “loud noises” and has “screaming episodes”. Resident B stated that on multiple occasions Ms. Thompson has instructed Resident A to “shut up, shut up” in response to Resident A’s screaming episodes.

Resident C stated that Ms. Thompson tells Resident A to “be quiet” in response to Resident A’s loud noises. Resident C stated that she has never observed Ms. Thompson tell Resident A to “shut up”.

Resident D stated that Ms. Thompson has told Resident A to “shut up” in response to Resident A’s loud noises.

On 01/10/2024 I interviewed Resident E privately at the PACE Day Program. I observed that Resident E is deaf but can communicate in sentences, read lips, and utilize American Sign Language. I interviewed Resident E with the assistance of an American Sign Language interpreter. Resident E stated that she shares a bedroom with Resident A. Resident E stated that she has never observed staff Dorothy Thompson tell Resident A to “shut up”. Resident E stated that she has observed Ms. Thompson tell Resident A to “be quiet”.

On 01/10/2023 I interviewed staff Dorothy Thompson via telephone. Ms. Thompson stated that Resident A is deaf, utilizes a Cochlear Implant, and generates “loud noises for no particular reason”. Ms. Thompson stated that Resident A’s noises agitate other residents of the facility and therefore Ms. Thomson has placed her finger over her mouth and said, “quiet down”. Ms. Thompson denied telling Resident A to “shut up” at any time.

On 01/17/2024 I completed an Exit Conference with licensee designee Laura Esese via telephone. Ms. Esese stated she did not dispute the findings 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 Dorothy Thompson stated that Resident A’s “noises” agitate other residents of the facility and therefore Ms. Thompson has placed her finger over her mouth and said, “quiet down”. Ms. Thompson denied telling Resident A to “shut up” at any time.

	Resident B stated that Resident A often makes loud noises and has “screaming episodes”. Resident B stated that on multiple occasions Ms. Thompson has instructed Resident A to “shut up, shut up” in response to Resident A’s screaming episodes. Resident D stated that Ms. Thompson has instructed Resident A to “shut up” in response to Resident A’s “loud noises”. A preponderance of evidence indicates a violation of the applicable rule occurred. Staff Dorothy Thompson has instructed Resident A to “shut up”.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff Dorothy Thompson secluded Resident A in her bedroom.

INVESTIGATION: On 01/09/2024 I received complaint allegations via email from Recipient Rights staff Melissa Gekeler. Ms. Gekeler stated that she recently received complaint allegations which alleged that staff Dorothy Thompson locked Resident A in her bedroom all day.

On 01/10/2024 I completed an unannounced onsite investigation at the facility and privately interviewed staff Best Uwitonze, Resident B, Resident C, and Resident D.

Staff Best Uwitonze stated that she no knowledge of the allegations.

Resident B stated that Resident A’s “loud noises” irritate staff Dorothy Thompson and on multiple occasions Ms. Thompson has directed Resident A to stay in her shared bedroom until Ms. Thompson directs Resident A to “come out”. Resident B stated that Resident A is typically directed to stay in her bedroom up to an hour. Resident B stated that approximately two weeks ago, Resident B was sitting in her bedroom when she overheard Ms. Thompson direct Resident A to go to Resident A’s bedroom. Resident B stated that the incident occurred after breakfast. Resident B stated that Resident A could be heard “yelling and crying” and was “jiggling her doorknob” to try to open the bedroom door. Resident B stated she heard Ms. Thompson tell Resident A to “shut up” and Ms. Thompson would not allow Resident A to open the door. Resident B stated that Resident A was told by Ms. Thompson to stay in her bedroom. Resident B stated Resident A stayed in her bedroom until shortly before lunch which was over an hour in duration.

Resident C stated that on multiple occasions Ms. Thompson has directed Resident A to go to her bedroom for “being bad”. Resident C stated that Resident A often makes loud noises which causes residents and Ms. Thompson to become agitated. Ms. Thompson stated that in response to Resident A making “loud noises”; Ms. Thompson directs Resident A to “cool down” in her bedroom and Ms. Thompson

“shuts the door”. Resident C stated that Resident A often “yells” in her bedroom until Resident A “cools off”. Resident C stated that she has never observed Ms. Thompson hold Resident A’s door closed. Resident C stated that Resident A “comes out when she is ready” and which lasts less than an hour.

Resident D stated that Ms. Thompson directs Resident A to stay in her bedroom due to “being bad” which Resident D charactered as making “loud noises”. Resident D stated that Resident A’s “loud noises" agitate residents and Ms. Thompson. Resident D stated that Resident A is directed to sit in her bedroom until she stops yelling which can last up to thirty minutes. Resident D stated that she has never observed Ms. Thompson hold Resident A’s door closed although Resident D stated Resident A is not permitted to leave her bedroom until Ms. Thompson tells Resident A she may do so.

On 01/10/2024 I interviewed Resident E privately at the PACE Day Program. Resident E stated that she shares a bedroom with Resident A. Resident E stated that on multiple occasions she has observed staff Dorothy Thompson direct Resident A to stay in her bedroom because Resident A made “noises”. Resident E stated that Ms. Thompson typically does not hold Resident A’s bedroom door shut but on one occasion within the past two weeks Resident E observed Ms. Thompson hold Resident A’s bedroom door shut. Resident E stated that she observed Resident A tried to open the door. Resident E stated that Ms. Thompson refused to allow Resident A to leave her bedroom and Resident A stayed in her bedroom for approximately an hour.

On 01/10/2023 I interviewed staff Dorothy Thompson via telephone. Ms. Thompson stated that Resident A’s noises agitate other residents. Ms. Thompson stated that on several occasions Ms. Thompson has directed Resident A to stay in her bedroom because another resident was agitated and threatened to assault Resident A. Ms. Thompson stated that she has always directed Resident A to go to her bedroom to deescalate situations. Ms. Thompson stated that Resident A has never been sent to her bedroom as a means of punishment and Resident A willingly goes to her bedroom. Ms. Thompson stated that she generally left Resident A’s bedroom door open during the incidents but on one occasion Ms. Thompson did close Resident A’s bedroom door. Ms. Thompson denied she held Resident A’s bedroom door shut.

On 01/17/2024 I completed an Exit Conference with licensee designee Laura Esese via telephone. Ms. Esese stated she did not dispute the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of

	the licensee, employees, or any person who lives in the home shall not do any of the following: **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.**
ANALYSIS:	Staff Dorothy Thompson stated that on several occasions she has directed Resident A to stay in her bedroom because another resident was agitated and threatened to assault Resident A. Ms. Thompson stated that she has always directed Resident A to go to her bedroom to deescalate situations. Ms. Thompson stated that Resident A has never been sent to her bedroom as a means of punishment and Resident A willingly goes to her bedroom. Ms. Thompson stated that she generally left Resident A's bedroom door open during the incidents but on one occasion Ms. Thompson did close Resident A's bedroom door. Ms. Thompson denied she held Resident A's bedroom door shut. Resident B stated that approximately two weeks ago she was sitting in bedroom when she overheard Ms. Thompson direct Resident A to go to Resident A's bedroom. Resident B stated that Resident A could be heard "yelling and crying" and was "jiggling her doorknob" to try to open the bedroom door. Resident B stated she heard Ms. Thompson tell Resident A to "shut up" and Ms. Thompson would not allow Resident A to open the door. Resident E stated that on multiple occasions she has observed staff Dorothy Thompson direct Resident A to stay in her bedroom. Resident E stated that Ms. Thompson typically does not hold Resident A's bedroom door shut but on one occasion within the past two weeks Resident E observed Ms. Thompson hold Resident A's bedroom door shut. Resident E stated that she observed Resident A try to open the door. Resident E stated that Ms. Thompson refused to allow Resident A to leave her bedroom and Resident A stayed in her bedroom for approximately an hour. A preponderance of evidence indicates that a violation of the applicable rule occurred. Staff Dorothy Thompson confined Resident A to her bedroom.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/17/2024

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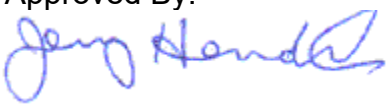
Toya Zylstra Date
Licensing Consultant

Approved By:



01/18/2024

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Jerry Hendrick Date
Area Manager