GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

March 12, 2024

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

RE: License #: AM410278667
Investigation #: 2024A0583015
Plainfield Group Home

Dear Ms. Jannenga:

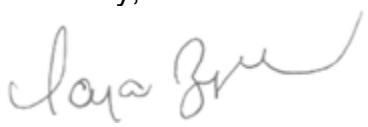
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 #:	2024A0583015
Complaint Receipt Date:	01/22/2024
Investigation Initiation Date:	01/23/2024
Report Due Date:	03/23/2024
Licensee Name:	Thresholds
Licensee Address:	Suite 130, 160 68th St. SW Grand Rapids, MI 49548
Licensee Telephone #:	(616) 466-5242
Administrator:	Debra Barrington
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:	10/26/2023
Expiration Date:	10/25/2025
Capacity:	8
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A has unexplained bruises and rib fractures.	Yes
Additional Findings.	Yes

III. METHODOLOGY

01/22/2024	Special Investigation Intake 2024A0583015
01/22/2024	Contact – Telephone Adult Protective Services Staff Emily Graves
01/22/2024	Contact – Text Message Adult Protective Services Staff Emily Graves
01/23/2024	Special Investigation Initiated - On Site
01/23/2024	Contact – Email Adult Protective Services Staff Emily Graves
01/23/2024	Contact – Telephone Licensee Designee Michelle Jannenga
01/24/2024	Contact – Telephone Case Manager Ashton Byrne
01/24/2024	Contact – Telephone Public Guardian Cheryl Masselkowski
01/24/2024	Contact – Facsimile Administrator Debra Barrington
01/25/2024	Inspection Completed On-site
01/30/2024	Contact – Facsimile Corewell Health Medical Records
01/30/2024	Contact – Onsite GRPD Staff Umutesi Uwera
02/01/2024	Contact – Email Corewell Health Social Worker Kendra Martin LLMSW

02/02/2024	Contact – Onsite GRPD Staff Angela Davis, Staff Lien Lee
02/05/2024	Contact – Telephone Facility maintenance staff, Rick Yost
02/06/2024	Contact – Telephone Staff Cecile Uwamahoro
02/20/2024	Contact – Email Detective Briana Pierson
02/22/2024	Contact – Telephone Adult Protective Services Staff Emily Graves
02/28/2024	Contact – Email Detective Briana Pierson
03/12/2024	Exit Conference Licensee Designee Michelle Jannenga

ALLEGATION: Resident A has unexplained bruises and rib fractures.

INVESTIGATION: On 01/22/2024 I received the above complaint allegation via telephone from Adult Protective Services staff Emily Graves. Ms. Graves stated that on 01/22/2024 Resident A arrived at the Corewell Health Emergency Department with substantial injuries suspicious of abuse including multiple rib fractures in various stages of healing. Ms. Graves explained that one rib fracture was estimated to be "acute" which indicates the injury occurred recently "as in one to four days prior". Ms. Graves explained that multiple rib fractures were estimated to be "subacute" injuries meaning that the injuries occurred "five to fourteen days prior and other rib fractures". Ms. Graves stated Resident A also had extensive bruising all over her body. Ms. Graves stated Resident A is developmentally disabled and non-verbal. Ms. Graves stated that Resident A has been admitted inpatient the Corewell Health Hospital.

Later in the day on 01/22/2024 Ms. Graves text messaged photographs of Resident A's injuries. I examined the photographs which showed Resident A's face, chest, torso, abdomen, back, arms, legs, and feet contained numerous bruises in various stages of healing. I observed a large bruise on Resident A's right upper arm which appeared to wrap around her arm. The bruise was square in the center and appeared suspicious of the use of a restraint. I observed an area of bruising to Resident A's lower front waist also linear in nature and suspicious of restraint use.

On 01/23/2024 I completed an unannounced onsite investigation at the facility and privately interviewed Administrator Debra Barrington, staff Angela Davis, and staff Karen Gaddis.

While onsite I reviewed Resident A's Assessment Plan for AFC Residents, signed 07/25/2023. It states Resident A requires "full assistance" with bathing, grooming, and personal hygiene and indicates Resident A has "very limited mobility and requires staff assistance to walk." The Assessment Plan also document documents that Resident A "can crawl, but due to her weak ankles she struggles walking". The Assessment Pan states Resident A is able to communicate her needs through physical cues, pointing, and some noises and that Resident A masturbates in front of others.

While on site I reviewed Resident A health care appraisal signed by doctor Mark W. Bates on 10/12/23. This document noted that Resident A is "nonverbal" and has been diagnosed with an "Intellectual disability".

While on site I reviewed documents labeled as "Thresholds Incident Note to Agency" which stated that following:

- On 11/13/23 at 11:15 AM staff Angela Davis documented that Resident A "was walking to the dining area for lunch and while getting in her chair, (Resident A) fell knocking the chair over and hitting the back of her head causing a small cut".

- On 12/21/23 at 5:15 PM staff Angela Davis completed a report that stated that "everyone was at the table and (Resident A) had attempted to get up from the table and stumbled and somehow she bumped her face at the table". This document stated that Resident A "displayed some bruising on her cheek and her lip was bleeding".

- On 12/21/23 at 7:00 PM staff Angela Davis completed a report which stated that "staff heard a loud thump coming from the ladies hallway and observed (Resident A) was laying on the floor on her L side". This document stated that Resident A had bitten her lip and tongue which were "bleeding" and that staff cleaned up Resident A's face and applied ointment.

- On 01/01/2024 at 5:30 AM staff Lien Lee documented that she observed "a big bruise located on (Resident A's) lower side of her right breast". The origination of the bruise is not identified in the document.

- On 01/06/2024 at 6:45 AM facility staff noticed a black mark under Resident A's right eye. The origination of black mark is not identified in the document.

- On 01/14/24 at 6:30 AM staff Leanne Lee documented that Resident A was observed with “most of her index finger” bruised. There was no origination of the bruise identified in the document.

- On 01/19/24 at 2:30 PM staff Angela Davis stated that Resident A had bitten her tongue causing it to “bleed profusely for four hours straight and was throwing herself on to the floor”. Ms. Davis documented that she had telephoned “on call” who advised to “continue to monitor”.

Administrator Debra Barrington stated that she has worked at the facility since 2008 and Resident A has resided at the facility since 2019. Ms. Barrington stated that Resident A has been diagnosed with a developmental disability and is non-verbal. Ms. Barrington stated that Resident A has limited vision, utilizes a wheelchair, but can walk “short distances”. Ms. Barrington stated that Resident A exhibits self-harming behaviors as evidenced by “pinching” her body causing bruising. Ms. Barrington stated that Resident A always has bruises on her body due to walking into walls, pinching her own body, biting her tongue, purposefully and accidentally falling to the floor, falling out of chairs, and masturbating. Ms. Barrington stated that she has observed Resident A often walking into walls and other objects. Ms. Barrington stated that Resident A pinches her breast and chest area often which has historically and currently caused extensive bruising. Ms. Barrington stated that it was recently reported to her from staff Angela Davis that Resident A was sitting in a lazy boy chair that she flipped upside down and onto herself. Ms. Barrington stated that she is unsure of the exact date of the incident or if Resident A suffered injuries from the incident. Ms. Barrington stated that she often observes Resident A fall to the floor when she loses her balance. Ms., Barrington stated that Resident A masturbates causing scratches and bruising to her vaginal area. Ms. Barrington was shown the 01/22/2024 photographs taken by Adult Protective Services Investigator Emily Graves of Resident A’s current injuries and Ms. Barrington stated that the photographs were consistent with the level of bruises Resident A typically displays.

Ms. Barrington stated that facility staff typically complete one Incident Report per month to document Resident A’s consistent bruising, unless a significant injury or incident is observed by facility staff necessitating a separate Incident Report. Ms. Barrington stated that Resident A does not leave the facility often and does not participate in a day program. Ms. Barrington stated that from 01/16/2024 until 01/17/2024 all facility residents including Resident A spent the night in a local hotel due to professional bed bug treatment of the facility. Ms. Barrington stated that she was on vacation and did not work at the facility from 01/17/2024 until 01/21/2024. Ms. Barrington stated that she returned to the facility on 01/22/2024 at approximately 2:00 PM and staff Angela Davis reported that day that Resident A had been biting her tongue causing profuse bleeding. Ms. Davis stated to Ms. Barrington that she had informed Resident A’s primary care physician, Dr. Bates, of Resident A’s tongue injury and facility staff were directed to send Resident A to the emergency department for medical care. Ms. Barrington stated that she only observed Resident A briefly on 01/22/2024 because Ms. Davis was preparing Resident A to leave the

facility for medical treatment. Ms. Barrington stated that in her brief interaction with Resident A on 01/22/2024, she did not observe anything out of the ordinary. Ms. Barrington stated that there are times when staff work independently at the facility. Ms. Barrington stated that she has not observed any facility staff display aggression or frustration towards Resident A or any other resident of the facility. Ms. Barrington stated that she has no knowledge regarding how Resident A sustained rib fractures. Ms. Barrington stated that she has never observed any facility resident display aggressive behavior towards Resident A or any other resident of the facility.

Staff Angela Davis stated that she has worked at the facility for approximately three years. Ms. Davis stated that she worked at the facility on 01/22/2023 from 7:00 AM until 3:30 PM. She stated that Resident A has recently been biting her tongue which is not uncommon, but on 01/22/2024 Resident A's tongue biting behaviors escalated. Ms. Davis stated that she telephoned Dr. Bates' medical staff and informed the medical team that Resident A's tongue biting appeared severe. Ms. Davis stated that she was directed to arrange for Resident A to be seen at the Corewell Health Emergency Department and therefore Resident A was sent there for medical treatment. Ms. Davis stated that Resident A "always has bruises" from "falls and trips". Ms. Davis stated that Resident A often scratches her vaginal area, pinches around her breasts, and throws herself to the floor. Ms. Davis stated that she recently observed Resident A fall in the bathroom and "flip out of a lazy boy chair". Ms. Davis stated that she did not observe any injuries immediately after the bathroom and chair incidents. Ms. Davis stated that Resident A has not appeared to be in any pain recently except after Resident A bit her tongue and "winced". Ms. Davis stated that she did recently notice Resident A "walking funny" therefore Ms. Davis checked Resident A's new shoes which had caused a callous. Ms. Davis was shown the 01/22/2024 photographs of Resident A's injuries and stated that the photographs appear consistent with Resident A's normal level of bruising. Ms. Davis stated that she has not observed any facility staff display aggression or frustration towards Resident A or any other resident of the facility. Ms. Davis stated that she has no knowledge regarding how Resident A sustained rib fractures. Ms. Davis stated that she has never observed any facility resident display aggressive behavior towards Resident A or any other resident of the facility.

Staff Karen Gaddis stated that she has worked at the facility since August 2023. Ms., Gaddis stated that she worked at the facility yesterday but did not change Resident A's clothing. Ms. Gaddis stated that she did change Resident A's briefs and clothing last week and observed Resident A's bruises under her breasts which Ms. Gaddis identified as normal for Resident A. Ms. Gaddis explained that Resident A "grabs her own breasts" routinely which causes bruising in the area. Ms. Gaddis stated that last week she changed Resident A's adult briefs and observed a large bruise on her side. Ms. Gaddis stated that she was not concerned about the bruising because Resident A "runs into things and falls and throws herself down". Ms. Gaddis stated that she has not observed any "big falls" recently, but Resident A did bite her tongue recently causing the need for an emergency department visit. Ms. Gaddis was shown the 01/22/2024 photographs of Resident A's injuries and Ms.

Gaddis stated that the bruising around Resident A's breasts were consistent with the level of bruising she typically displays in the chest area. Ms. Gaddis stated that she did not remember observing the bruising to Resident A's feet, back, and arms previously. Ms. Gaddis stated that she has no knowledge regarding how Resident A sustained rib fractures. Ms. Gaddis stated that she has never observed any facility staff or resident to display aggressive behavior towards Resident A or any other resident of the facility.

On 01/23/2024 I received and reviewed an email from Adult Protective Services Investigator Emily Graves. The email included the following: *'This morning I visited with (Resident A) today at Butterworth. She had bruising over the entirety of her body. She is being followed by a social worker named Kendra and her RN is Kristy Half. When her nurse tech assisted me in getting pictures of the bruising, (Resident A) was grunting and groaning with pain. Her face was grimacing. (Resident A) is not on any medications that would cause her to bruise easily. A body scan was performed and she has bilateral chronic rib fractures on the 8th -11th ribs. She has an acute rib fracture on her 11th rib that is new.'*

On 01/23/2024 I interviewed Licensee Designee Michelle Jannenga via telephone. Ms. Jannenga stated that she was Resident A's case manager until 2009. Ms. Jannenga stated that Resident A has a history of running into walls because of impaired vision and has a history of self-masturbation. Ms. Jannenga stated that Resident A "always grunts and scrunches her face up". Ms. Jannenga stated that she was informed from facility staff that Resident A recently began "pinching herself". Ms. Jannenga stated Resident A has "thyroid issues" necessitating the administration of medication and has a history of aspiration pneumonia.

On 01/24/2024 I interviewed Ashton Byrne via telephone. Ms. Byrne stated that she has been Resident A's case manager for approximately four years. Ms. Byrne stated that she recently observed photographs of Resident A's current injuries. Ms. Byrne stated she has "never seen (Resident A) look like that". Ms. Byrne stated that she last observed Resident A in-person in approximately November 2023 and online during a TEAMS meeting on 01/12/2024. Ms. Byrne stated that during the 11/2023 in person visit Resident A did not present with obvious signs of distress or bruising. Ms. Byrne stated that during the 01/12/2024 online TEAMS meeting Ms. Byrne observed healing bruising to Resident A's face. Ms. Byrne stated that she received an Incident Report from facility staff approximately 01/2024 indicating that Resident A had fallen from a table causing bruises to her face and lip. Ms. Byrne stated that in the past Resident A has presented with "a few minor bruises" which were explained by incident reports authored by facility staff. Ms. Byrne stated that Resident A is legally blind and bumps into walls. Ms. Byrne stated that Resident A will place her hands down her pants to masturbate and has caused scratches in her vaginal area. Ms. Bryne stated that she has no documentation or personal observations to indicate that Resident A pinches herself. Ms. Byrne stated that facility staff have recently reported that Resident A has been biting her own tongue. Ms. Byrne stated that she has observed Resident A as "always happy" and

“humming” during in-person visits. Ms. Byrne stated that she has received no Incident Reports and has no personal observations that would explain the extent of Resident A’s current injuries.

On 01/24/2024 I interviewed Cheryl Masselkowski via telephone. Ms. Masselkowski stated that she has been Resident A’s legal guardian since 2007. Ms. Masselkowski stated that Resident A does bite her own tongue and masturbates causing the need for a medicated cream for irritation. Ms. Masselkowski stated that Resident A is typically a “happy” individual that has a history of biting her tongue when “something is wrong”. Ms. Masselkowski stated that Resident A has been observed to have a “bruise here or there” but not to the extent she presented with on 01/22/2024. Ms. Masselkowski stated that she has never observed Resident A pinch herself and Ms. Masselkowski has never received an Incident Report from the facility staff stating Resident A exhibits such behavior. Ms. Masselkowski stated that she has received “minimal incident reports” from facility staff regarding Resident A sustaining bruises. Ms. Masselkowski stated that she last observed Resident A in person on 12/06/2024 and observed the bruising to her face.

On 01/24/2024 I received a facsimile from Administrator Debra Barrington. The facsimile contained the facility’s “Home Staff Schedule Worksheet” from January 15 2024, until January 28 2024. I observed that staff Angela Davis worked at the facility independently on 01/19/2024 from 4:00 PM until 8:00 PM.

On 01/25/2024 I completed an unannounced onsite inspection at the facility and privately interviewed Administrator Debra Barrington and staff Karen Gaddis. Adult Protective Services Investigator Emily Graves and Grand Rapids Police Detective Briana Pierson were present during all interviews.

While onsite I observed Resident A’s shared bedroom. I observed a bungy cord hanging on a mirror next to Resident A’s bed and a gait belt located in a dresser drawer next to Resident A’s bed. I observed Resident A’s metal frame displayed areas of scratches and missing paint.

Administrator Debra Barrington reaffirmed that Resident A pinches herself around her breast area and bumps into walls causing multiple and consistent bruising to her body. Ms. Barrington stated that Resident A regularly bites her tongue and has been observed to throw herself to the floor purposefully. Ms. Barrington stated that recent bruising documented on Resident A’s foot were “not noticed until now” by Ms. Barrington and she had no explanation to the origination of the bruises. Ms. Barrington stated that third shift staff have been reporting that Resident A has been getting out of her bed and wandering around the facility up to six times a night. Ms. Barrington stated that she had never observed the bungy cord located in Resident A’s bedroom and denied using it as a restraint. Ms. Barrington stated that the gait belt located in Resident A’s bedroom belonged to her roommate and denied using the belt as a restraint.

Staff Karen Gaddis reaffirmed that Resident A loses balance and falls “straight to the floor” often causing bruises. Ms. Gaddis stated that she has observed Resident A bite her tongue and often presents with bruises on her breast area and vaginal area. Ms. Gaddis stated that she had never observed the bungy cord located in Resident A’s bedroom and denied using it as a restraint. Ms. Gaddis stated that the gait belt located in Resident A’s bedroom belonged to her roommate and denied using it as a restraint.

While onsite I observed the Grand Rapids Police Department Forensic Unit confiscate the bungy cord and gait belt located in Resident A’s bedroom.

On 01/30/2024 I received a facsimile from Corewell Health Medical Records Department. The facsimile contained Resident A’s medical records which indicated that Resident A had been treated by the Corewell Health Emergency Department on 01/22/2024 and was initially sent to the Emergency Department by staff Angela Davis due to an escalation of tongue biting. The documentation indicated that Resident A presented on 01/22/2024 “covered in bruises head to toe” and was admitted to Corewell Health Hospital for further medical treatment. While Resident A was hospitalized, further testing indicated that Resident A had sustained numerous rib fractures in various stages of healing which facility staff attributed to falling and self-harm. The documentation indicated that Resident A’s injuries were concerning for non-accidental trauma.

On 01/30/2024 I observed an in-person interview of staff Umutesi Uwera at the Grand Rapids Police Department facilitated by Detective Briana Pierson. I observed via live video. Ms. Uwera stated that she has observed Resident A pinch herself but has never observed Resident A sustain injuries from the behaviors. Ms. Uwera stated that she has observed Resident A throw herself to the floor but has never observed Resident A sustain injuries from the behaviors. Ms. Uwera stated that she has observed the gait belt located in Resident A’s bedroom dresser and stated the gait belt belongs to a Resident B. Ms. Uwera stated that she has never observed facility staff restrain Resident A. Ms. Uwera stated that she has never observed the bruising on Resident A’s upper right arm and chest and stated that Resident A’s upper arm injury “looks like something was placed around her arm”.

On 02/01/2024 I received an email from Corewell Health Social Worker Kendra Martin LLMSW. The email stated that Resident A’s treating hospital internist, Dr. Alexander Cobb, stated that Resident A has been diagnosed with an acute displaced left 11 rib fracture, subacute left 8-11 rib fractures, and chronic right 4-9 rib fractures. Dr. Alexander stated that an acute rib fracture is dated as occurring within 0-4 days after injury, subacute is dated as occurring within 5-14 days after injury, and chronic is dated as occurring more than 15 days after injury. Dr. Cobb reported that Resident A’s injuries are “still suspicious of suspected physical abuse and/or non accidental trauma based off imaging and photos reviewed on imaging as well as documentation by trauma teams”. Dr. Cobb further denied observing or

receiving reports that Resident A had fallen, woken up during the night, or has bitten her tongue while hospitalized.

On 02/02/2024 I observed an in-person interview via live video of staff Angela Davis at the Grand Rapids Police Department facilitated by Detective Briana Pierson. Ms. Davis stated that she had provided independent care of Resident A during the week preceding Resident A's 01/22/2024 emergency room visit. Ms. Davis stated that Resident A has recently attempted to the leave the facility, throws temper tantrums, and awakens multiple times at night. Ms. Davis stated that Resident A often walks into walls, purposefully throws herself to the floor, and bites her tongue causing injuries. Ms. Davis stated that on 01/19/2024 Ms. Davis was working independently. Ms. Davis stated that she assisted Resident A into the facility's reclining chair positioning Resident A's feet up and soon afterwards, she heard Resident A fall. Ms. Davis stated she immediately observed that Resident A had "flipped" the recliner chair upside down which landed on top of her. Ms. Davis stated that she checked Resident A for physical injuries and observed Resident A's tongue was bleeding. Ms. Davis stated that Resident A has a history of biting her tongue and recently, these behaviors have escalated. Ms. Davis stated that on 01/19/2024 Resident A had bitten her tongue constantly and her tongue was observed to have been "pouring out blood". Ms. Davis stated that she managed Resident A's tongue biting by applying pressure to the wound and on 01/22/2024 Ms. Davis received medical directions from Resident A's primary care physician to send Resident A to the emergency department for treatment. Ms. Davis stated that she had recently observed a large bruise on Resident A's right upper arm and bruising on Resident A's stomach on 01/18/2024 or 01/19/2024. Ms. Davis stated that the bruise on Resident A's upper right arm was "concerning", and she had "no idea" how she sustained it. Ms. Davis stated that the bruise appeared to look like something was placed around Resident A's upper arm thus causing the bruise. Ms. Davis stated that she had "no idea who could do that" to Resident A's upper arm. Ms. Davis acknowledged that Resident A does not stay seated in her wheelchair and had previously requested medical providers write a medical script for a seat belt which was denied. Ms. Davis stated that Resident A previously had a seat belt in her old wheelchair which kept her seated. Ms. Davis stated that she had previously observed the gait belt located in Resident A's bedroom dresser and reported that she believed it was used by a previous resident. Ms. Davis stated that the bruising on Resident A's waist appeared to have been caused by a strap, but Ms. Davis had no idea who would have caused the injury. Ms. Davis denied she caused any of Resident A's injuries and denied restraining Resident A in any manner.

On 02/02/2024 I observed and participated in an in-person interview of staff Lien Lee at the Grand Rapids Police Department facilitated by Detective Briana Pierson. Ms. Lee stated that she typically works third shift which can vary from 10:00 PM until 11:00 AM. Ms. Lee stated that residents are typically asleep when she arrives to the facility, and she typically gets residents dressed in the mornings before leaving. Ms. Lee stated that she completes Incident Reports for injuries she has observed on Resident A's body. Ms. Lee stated that she recently completed an Incident Report

for a bruised finger she observed on Resident A. Ms. Lee stated that she has not observed the extensive bruising to Resident A' s body documented by the 01/22/2024 photographs. Ms. Lee stated that she had not observed the bruising located on Resident A's upper arm and stomach and found the bruising to be "surprising". Ms. Lee stated that the week preceding Resident A's 01/22/2024 hospitalization; staff Cecile Uwamahoro dressed Resident A in the mornings. Ms. Lee stated that she has never observed Resident A bite her tongue, fall, or self-harm. Ms. Lee stated that Resident A does awaken during the night but is easily redirected back to her bed. Ms. Lee stated that she has observed the gait belt located in Resident A's dresser drawer previously. Ms. Lee stated that the previous facility's administrator, Marcia English, informed Ms. Lee that the gait belt belonged to Resident A and was used to secure Resident A in her wheelchair. Ms. Lee stated that Resident A's gait belt had been in her bedroom for over a year and she never observed the gait belt in use. Ms. Lee stated that she had observed the bungee cord found in Resident A's bedroom "months ago" located in her dresser drawer.

On 02/05/2024 I interviewed facility maintenance staff, Rick Yost, via telephone. Mr. Yost stated that he left the bungy cord observed in Resident A's bedroom at the facility on 01/16/2024. Mr. Yost stated that on 01/16/2024 he brought the bungy cord to the facility while delivering box springs. Mr. Yost stated that he doesn't remember which bedroom or where exactly he left the item in the facility.

On 02/06/2024 I interviewed staff Cecile Uwamahoro via telephone. Ms. Uwamahoro stated that she has worked at the facility for approximately two months and works third shift on weekends which varies from 9:00 PM until 11:00 AM Friday to Monday. Ms. Uwamahoro stated that on 01/19/2024 Ms. Uwamahoro arrived at the facility at approximately 8:00 PM before staff Lien Lee arrived. Ms. Uwamahoro stated that when she arrived at the facility staff Angela Davis was seated in the kitchen crying. Ms. Uwamahoro stated that Ms. Davis reported that she had had a "bad day" because she had worked independently, and Resident A had bitten her tongue causing severe bleeding. Ms. Uwamahoro stated that Ms. Davis informed Ms. Uwamahoro that Resident A had also been punching herself causing bruising. Ms. Uwamahoro stated that Ms. Davis asked Ms. Uwamahoro to observe Resident A's tongue. Ms. Uwamahoro stated that Ms. Uwamahoro observed that Resident A was dressed in her pajamas and was awake in her bed. Ms. Uwamahoro stated that she observed blood on Resident A's pajamas and Resident A's face was "bloody, bruised and her lip was big". Ms. Uwamahoro stated that she asked Ms. Davis to call the police to secure an ambulance for Resident A's injuries but Ms. Davis stated that her doctor was aware already and they needed to monitor Resident A's injuries. Ms. Uwamahoro stated that the following morning Ms. Uwamahoro assisted Resident A with getting dressed and observed multiple bruises over her chest, face, and arms. Ms. Uwamahoro stated that she believed that Resident A's injuries were due to Resident A physically harming herself as communicated by Ms. Davis the previous evening. Ms. Uwamahoro stated that she had worked at the facility third shift from 02/12/2024 – 02/15/2024 and was not assigned to dress Resident A however she did not observe bruises on Resident A's face during that time frame.

Ms. Uwamahoro stated that she has never observed Resident A bite her tongue or pinch herself. Ms. Uwamahoro stated that she has never observed facility staff restrain or abuse any resident of the facility and has never done so herself.

On 02/20/2024 I received an email from Detective Briana Pierson. The email stated that Ms. Pierson had obtained approval to complete a polygraph for staff Angela Davis however Ms. Davis has refused to answer or respond to Ms. Pierson's telephone calls.

On 02/22/2024 I interviewed Adult Protective Services staff Emily Graves via telephone. Ms. Graves stated that Resident A had been discharged from Corewell Health Hospital and is currently at a "new adult foster care home". Ms. Graves stated that on 02/21/2024 she observed Resident A at her new facility. Ms. Graves stated that Resident A was observed with no bruises and facility staff stated that they have not observed Resident A fall or exhibit self-harm behaviors.

On 02/228/2024 I received an email from Detective Brianne Pierson. Detective Pierson reported that staff Angela Davis has refused a polygraph and has also refused to converse with Detective Pierson further.

On 03/12/2024 I completed an Exit Conference with Licensee Designee Michelle Jannenga. Ms. Jannenga stated she agreed with the findings and would accept the issuance of a Provisional License.

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:	Photographs taken of Resident A's face, chest, torso, abdomen, back, arms, legs, and feet displayed numerous bruises in various stages of healing. A large bruise on Resident A's right upper arm and lower front waist are suspicious of the use of a restraint. Resident A has been diagnosed with an acute displaced left 11 rib fracture, subacute left 8-11 rib fractures, and chronic right 4-9 rib fractures. The acute rib fracture is dated as occurring within 0-4 days after injury, subacute is dated as occurring within 5-14 days after injury, and chronic is dated as occurring more than 15 days after injury.

	Dr. Cobb reported that Resident A's injuries are "still suspicious" of suspected physical abuse and/or non accidental trauma "based off imaging and photos reviewed on imaging as well as documentation by trauma teams". Dr. Cobb further denied observing or receiving reports that Resident A had fallen, woken up during the night, and/or has bitten her tongue while hospitalized. Staff Angela Davis stated that she recently observed a large bruise on Resident A's right upper arm and bruising on Resident A's stomach on around 01/18/2024 or 01/19/2024. Staff Lien Lee stated that she has observed the gait belt located in Resident A's dresser drawer previously. Ms. Lee stated that the previous facility administrator, Marcia English, informed Ms. Lee that said gait belt belonged to Resident A and was used to secure Resident A into her wheelchair. Case manager Ashton Byrne stated that she has received no Incident Reports and has no personal observations that would explain the extent of Resident A's current injuries. Adult Protective Services Staff Emily Graves stated that Resident A had been discharged from Corewell Health Hospital and is currently at a new adult foster care home. Ms. Graves stated that on 02/21/2024 she observed Resident A at her new facility and observed no bruises. In addition, facility staff stated that they have not observed Resident A fall or exhibit self-harm behaviors. On 01/22/2024 Resident A presented to the Corewell Health Emergency Department with numerous rib fractures and bruises in various stages of healing. These injuries were deemed suspicious of abuse by medical personnel. An area of bruising located on Resident A's right upper arm appears consistent with the use of a restraint device and a gait belt was observed in the drawer next to Resident A's bed. Resident A has since been relocated to a new facility and staff at the current facility have reported that Resident A is not engaging in self-harming behaviors or falls. Resident A presents with no bruising at the current facility. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a violation of the applicable rule.

CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS: Facility staff failed to seek timely medical care for Resident A's injuries.

INVESTIGATION: On 02/02/2024 I observed via live video an in-person interview of staff Angela Davis at the Grand Rapids Police Department facilitated by Detective Briana Pierson. Ms. Davis stated that she had independently cared for Resident A during the week preceding Resident A's 01/22/2024 emergency room visit. Ms. Davis stated that Resident A bites her tongue causing injury. Ms. Davis stated that on 01/19/2024 she was working independently and Resident A had bitten her tongue constantly and Resident A's tongue was "pouring out blood". Ms. Davis stated that she managed Resident A's tongue biting by applying pressure to the wound and on 01/22/2024 Ms. Davis received medical directions from Resident A's primary care physician to send Resident A to the emergency department for treatment.

On 02/06/2024 I interviewed staff Cecile Uwamahoro via telephone. Ms. Uwamahoro stated that she has worked at the facility for approximately two months and works third shift on weekends which varies from 9:00 PM until 11:00 AM Friday to Monday. Ms. Uwamahoro stated that on 01/19/2024 Ms. Uwamahoro arrived at the facility at approximately 8:00 PM before staff Lien Lee arrived. Ms. Uwamahoro stated that when she arrived at the facility staff Angela Davis was seated in the kitchen crying. Ms. Uwamahoro stated that Ms. Davis reported that she had had a "bad day" because she had worked independently, and Resident A had bitten her tongue causing severe bleeding. Ms. Uwamahoro stated that Ms. Davis informed Ms. Uwamahoro that Resident A had also been punching herself causing bruising. Ms. Uwamahoro stated that Ms. Davis asked Ms. Uwamahoro to observe Resident A's tongue. Ms. Uwamahoro stated that Ms. Uwamahoro observed that Resident A was dressed in her pajamas and was awake in her bed. Ms. Uwamahoro stated that she observed blood on Resident A's pajamas and Resident A's face was "bloody, bruised and her lip was big".

A 03/12/2024 file review indicates that on 01/03/2023 (Special Investigation 2023A0583013) the facility was found to have violated R 400.14310 (4) due to facility staff failing to seek timely medical care for a resident who sustained an arm fracture. A Corrective Action Plan was received, approved, and verified. The Approved Corrective Action Plan consisted of training staff regarding the need to seek timely emergency medical treatment. The file review indicates that on 09/18/2023 (2023A0583043) the facility was found to have violated R 400.14310 (4) due to facility staff failing to seek timely medical care for a resident with observed abdominal bruising requiring the need for x-rays to rule out fractures. A Corrective Action was received, approved, and verified. The Approved Corrective Action Plan consisted of training staff regarding the need to seek timely medical treatment.

On 03/12/2024 I completed an Exit Conference with Licensee Designee Michelle Jannenga. Ms. Jannenga stated she agreed with the findings and would accept the issuance of a Provisional License.

APPLICABLE RULE	
R 400.14310	**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:	Staff Angela Davis stated that on 01/19/2024 Resident A had bitten her tongue constantly and her tongue was observed to have been “pouring out blood”. Ms. Davis stated that she managed Resident A’s tongue biting by applying pressure to the wound and on 01/22/2024. Ms. Davis received medical directions from Resident A’s primary care physician to send Resident A to the emergency department for treatment. Staff Cecile Uwamahoro stated that on 01/19/2024 she arrived at the facility at approximately 8:00 PM. Ms. Uwamahoro stated that Ms. Davis reported that Resident A had bitten her tongue causing severe bleeding. Ms. Uwamahoro stated that she observed blood on Resident A’s pajamas and Resident A’s face was “bloody, bruised and her lip was big”. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a violation of the applicable rule. On 01/19/2024 Resident A presented with a bloody tongue causing severe bleeding, bruised face, and swollen lip. Facility staff did not obtain medical treatment for these injuries until 01/22/2024.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigations 2023A0583043 09/18/2023, 2023A0583013 01/03/2023**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend that the license be modified to Provisional.

03/12/2024

Toya Zylstra Date
Licensing Consultant

Approved By:

03/12/2024

Jerry Hendrick Date
Area Manager