GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 29, 2024

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

RE: License #: AS410011488
Investigation #: 2024A0340046
Thresholds Chamberlain Group Home

Dear Ms. Jannenga:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to 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,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS410011488
Investigation #:	2024A0340046
Complaint Receipt Date:	07/10/2024
Investigation Initiation Date:	07/12/2024
Report Due Date:	09/08/2024
Licensee Name:	Thresholds
Licensee Address:	Suite 130 160 68th St. SW Grand Rapids, MI 49548
Licensee Telephone #:	(616) 466-5242
Administrator:	Michelle Jannenga
Licensee Designee:	Michelle Jannenga
Name of Facility:	Thresholds Chamberlain Group Home
Facility Address:	2819 Chamberlain Ave, SE Grand Rapids, MI 49508-1511
Facility Telephone #:	(616) 247-6831
Original Issuance Date:	10/08/1980
License Status:	REGULAR
Effective Date:	10/22/2022
Expiration Date:	10/21/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 7/10/24 Resident A had a black and blue mark on his left cheek. It is unknown how he was injured.	No

III. METHODOLOGY

07/10/2024	Special Investigation Intake 2024A0340046
07/10/2024	APS Referral rec'd from APS
07/12/2024	Special Investigation Initiated - Telephone ORR Michael Kuik
07/29/2024	Inspection Completed On-site
08/14/2024	Contact – Telephone Call made Staff William Griffin
08/14/2024	Exit Conference Michelle Janninga – Designee

ALLEGATION: On 7/10/24 Resident A had a black and blue mark on his left cheek. It is unknown how he was injured.

INVESTIGATION: On 7/10/2024, I received a complaint from Adult Protective Services which stated that Resident A had a black and blue mark on his left cheek. The complaint further stated he came home from day programming angry and went to his room alone where he was heard screaming very loudly. There were no known incidents that would explain the cause of the injury.

On July 12, 2024, I was assigned this investigation. I contacted Michael Kuik from the Office of Recipient Rights and informed him of the allegation.

On July 29, 2024, I conducted an unannounced home inspection. Resident A was home at the time and agreed to speak with me privately in his room. After I explained who I was and why I was there, I asked Resident A about having an injury on his face. He stated he had hit himself when he was angry. I clarified that no one else caused the injury and he stated he caused the injury himself. There was still a faint discoloration on Resident A's face that was visible. Resident A did not want to speak any longer, so the interview was ended.

I reviewed the Incident Report that had been written the day of the incident, 7/8/24, by William Griffin. It stated that Resident A exited the bathroom and charged at Mr. Griffin attempting to bite him. Mr. Griffin redirected Resident A to his room. Resident A stated he "needed to go poop" and went back to the bathroom instead, where Mr. Griffin heard a sound like Resident A was hitting himself. When Resident A exited the bathroom, he had marks on his face.

Mr. Griffin gave Resident A some acetaminophen and a cold compress to apply to his face.

Another IR written by Mr. Griffin stated on 7/9/24 Resident A returned home from an outing and charged at staff Mr. Griffin attempting to bite him. Resident A also charged at another resident before being redirected and going to his room. He was then heard yelling, stomping, and displaying self-injurious behavior.

Mr. Griffin administered Tylenol and Olazapine PRN.

I reviewed Resident A's Assessment Plan. It was signed on 1/2/24 by Designee Michelle Jannenga. Under "Controls Aggressive Behavior" it states, "Better since Dr. Platner made med adjustments, noted behaviors including stomping on feet, biting, hair pulling, hitting, jabbing, tackling and SIB" (self-injurious behavior).

Under "Exhibits Self Injurious Behavior" it states, "has hit and bit himself, along with hitting head on pavement".

On August 14, 2024, I contacted Mr. Griffin to clarify what happened during these two incidents. Mr. Griffin confirmed that did not intervene when he heard Resident A hitting himself, but instead waited for him to calm down before administering PRN. I asked if he had checked on Resident A, opened the door, called out and asked what was going on, or attempted to redirect Resident A. Mr. Griffin stated he did not do any of these things. He did administer the ice pack and Tylenol afterward.

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:	The allegation was made that Resident A had bruising on his face and it was unknown how he sustained the injury. Resident A stated he hit himself because he was angry. Resident A did not want to discuss the subject any further.

	Mr. Griffin completed two IR's in two days describing Resident A having SIB and being upset. Mr. Griffin attended to Resident A after the SIB but did not intervene when Resident A was exhibiting SIB. There is not a preponderance of evidence that anyone else caused the injury, however nothing was done to attempt to redirect or protect Resident A from hurting himself.
CONCLUSION:	**VIOLATION ESTABLISHED**

On August 14, 2024, I conducted an exit conference with Designee Michelle Jannenga. I informed her of the allegation and that I did not find a rule violation. She agreed with my findings and had no further questions.

IV. RECOMMENDATION

I recommend no change to the current license status.

Rebecca Piccard August 29, 2024

Rebecca Piccard Date
Licensing Consultant

Approved By:

Jerry Hendrick

August 29, 2024

Jerry Hendrick Date
Area Manager