GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 4, 2026

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

RE: License #: AS410094885
Investigation #: 2026A0579029
Roth Group Home

Dear Michelle 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.

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) 356-0100.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W., Unit 13
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410094885
Investigation #:	2026A0579029
Complaint Receipt Date:	04/02/2026
Investigation Initiation Date:	04/03/2026
Report Due Date:	06/01/2026
Licensee Name:	Thresholds
Licensee Address:	Suite 130, 160 68th St. SW, Grand Rapids, MI 49548
Licensee Telephone #:	(616) 466-5242
Administrator:	Darcy Bourdo-Grider
Licensee Designee:	Michelle Jannenga
Name of Facility:	Roth Group Home
Facility Address:	99 Roth Street, SE, Grand Rapids, MI 49548-7728
Facility Telephone #:	(616) 459-1205
Original Issuance Date:	06/13/2001
License Status:	REGULAR
Effective Date:	12/17/2025
Expiration Date:	12/16/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A wandered from the home without supervision.	Yes

III. METHODOLOGY

04/02/2026	Special Investigation Intake 2026A0579029
04/03/2026	Special Investigation Initiated - Letter Complainant
04/03/2026	APS Referral Leondra Fair, APS Worker
04/23/2026	Contact - Face to Face Resident A April Williams, Direct Care Worker
04/24/2026	Contact - Document Sent Michelle Jannenga, Licensee Designee
04/27/2026	Contact- Telephone Call Made Elijah Kitur, Direct Care Worker
04/27/2026	Contact- Telephone Call Made Gaspard Rutamu, Direct Care Worker
04/27/2026	Contact - Document Sent Michelle Jannenga, Licensee Designee
04/28/2026	Contact- Telephone Call Made Elijah Kitur, Direct Care Worker
04/29/2026	Contact- Telephone Call Received Elijah Kitur, Direct Care Worker
05/04/2026	Exit Conference Michelle Jannenga, Licensee Designee

ALLEGATION: Resident A wandered from the home without supervision.

INVESTIGATION: On 4/2/26, I received this referral which alleged that Resident A is not being adequately supervised. He wandered away from this home in 30-degree

Fahrenheit weather wearing shorts and a shirt. He was located by an ambulance crew who transported him to the hospital.

On 4/3/26, I contacted the complainant who confirmed Adult Protective Services worker Leondra Fair was also investigating the allegation.

On 4/3/26, I contacted Ms. Fair who reported that since Resident A wandered, there have since been alarms installed in the home and increased staffing for Resident A.

On 4/23/26, I completed an unannounced on-site investigation at the home. An interview was completed with direct care worker (DCW) April Williams. Resident A was spoken to and smiled but could not engage in interviewing due to being nonverbal.

Ms. Williams reported she was not working when this incident occurred and does not have direct knowledge of what occurred. She stated Resident A did attempt to wander and exit the home often when he first moved into the home in January or February 2026. She stated she believed he was confused and trying to leave due to being new to this home. She stated she does not believe Resident A has exited and wandered from the home recently and he has never exited and wandered from the home while she was working.

I reviewed Resident A's assessment plan which noted he cannot move independently in the community and requires staff supervision while out of the home.

On 4/24/26, I contacted licensee designee, Michelle Jannenga, to request the incident report regarding this incident and the contact information for the DCWs who were working at the time it occurred. She reported the incident occurred in February 2026. She provided an incident report and contact information for the DCWs involved.

The incident report completed by DCW Elijah Kitur noted Resident A was agitated at 2:10 a.m. on 2/22/26 and given an as needed "PRN" medication to help but it was unsuccessful in calming his agitation. At 6:40 p.m., Resident A went to the restroom and after taking a while, DCWs went to check on him and found an exit door open and Resident A's whereabouts were unknown. 911 was contacted. Resident A was located at a local hospital and returned to the home upon his discharge.

On 4/27/26, I attempted a telephone interview with Mr. Kitur. The call was not answered. A voicemail message was left requesting a return phone call.

On 4/27/26, I attempted a telephone interview with DCW Gaspard Rutamu. The call was not answered. A voicemail message was left requesting a return phone call.

On 4/27/26, I exchanged emails with Ms. Jannenga, discussing staff availability. It was agreed that since Mr. Kitur completed the incident report and Mr. Rutamu works

overnight, it would be best to interview Mr. Kitur.

On 4/28/26, I attempted a telephone interview with Mr. Kitur. The call was not answered. A text message was sent requesting a return phone call.

On 4/29/26, I completed a telephone interview with Mr. Kitur. He reported Resident A attempted to leave the home often when he was first admitted around February 2026. He stated Resident A could have benefitted from 1:1 staffing but it was not authorized for him prior to his elopement. He stated Resident A was agitated on the night he eloped from the home and one of Resident A's prescribed PRNs was given to help calm him earlier in the night but it did not work. He stated shortly before medication pass, Resident A left the living room and appeared to be going to the bathroom but DCWs did not follow him. He stated when Resident A did not return to the living room after a reasonable period, he and Mr. Rutamu went to check on him and found a side door to the home open. He stated Mr. Rutamu searched the area but could not locate Resident A. He stated the home supervisor and law enforcement were contacted. He stated Resident A was later found to have been brought to the hospital by someone and was discharged back to this home. He stated Resident A's wandering and elopement behaviors have decreased since this incident.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Resident A's assessment plan noted Resident A does not move independently and requires supervision within the community. An incident reported completed by direct care worker Elijah Kitur noted Resident A left the living room and after a period of time it was realized Resident A had exited the home. 911 was contacted and Resident A was later located at a local hospital. Mr. Kitur confirmed via telephone interview as well. Based on the interview completed and documentation reviewed, there is sufficient evidence that Resident A did not receive the supervision, protection, and personal care specified in his assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/4/26, I completed an exit conference with Ms. Jannenga who reported Resident A was placed in the home following hospitalization after living in his family home. She reported Resident A was new to this home and it was not known that he would elope until he did. She reported his assessment plan documents that he only needs supervision within the community.

I explained that the DCWs interviewed expressed concern that Resident A had frequent exit seeking and/or elopement attempts upon arriving at the home. I also advised it was reported Resident A was agitated prior to successfully eloping and allowed to go out of sight of DCWs for a period of time. Therefore, sufficient measures were not taken to ensure that Resident A did not leave the home or if he left the home, that he was provided with the supervision specified in his assessment plan.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remains the same.

Cassandra Duursma 05/04/2026

Cassandra Duursma Date
Licensing Consultant

Approved By:

Jerry Hendrick 05/04/2026

Jerry Hendrick Date
Area Manager