GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 07, 2019

Scott Schnoor
Spectrum Community Services
28303 Joy Rd.
Westland, MI 48185

RE: License #: AM110091925
Investigation #: **2019A0462016**
Eau Claire Residence

Dear Mr. Schnoor:

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,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-9037

enclosure

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

THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AM110091925
Investigation #:	2019A0462016
Complaint Receipt Date:	12/12/2018
Investigation Initiation Date:	12/12/2018
Report Due Date:	02/10/2019
Licensee Name:	Spectrum Community Services
Licensee Address:	28303 Joy Rd. Westland, MI 48185
Licensee Telephone #:	(734) 458-8729
Administrator:	David Schnoor
Licensee Designee:	David Schnoor
Name of Facility:	Eau Claire Residence
Facility Address:	2860 M-140 Eau Claire, MI 49111
Facility Telephone #:	(269) 944-1927
Original Issuance Date:	05/19/2000
License Status:	REGULAR
Effective Date:	06/12/2017
Expiration Date:	06/11/2019
Capacity:	12
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 12/09/2018, while smoking a cigarette outside unsupervised, Resident A fell and broke his hip.	No
Direct care workers bring illegal drugs into the facility.	No
Direct care workers are rude to residents.	No
Direct care workers sleep during their shifts.	No
Additional finding.	Yes

III. METHODOLOGY

12/12/2018	Special Investigation Intake 2019A0462016
12/17/2018	Inspection Completed On-site. Interview with licensee designee David Schnoor, home manager Patsy Briggs, DCWs John Romhilt, Angela Holmes, Diana Ramirez and Melanie Sutton. Interviews with Residents B and C. Documents requested and reviewed.
12/18/2018	Contact - Telephone interviews with Berrien County Recipient Rights Officer Basil Scott and APS Specialist Leslie Steinberger.
01/31/2018	Contact- Telephone interviews with DCWs Cassandra Flewellen and Annie Atkins.
02/04/2019	Exit conference with licensee designee David Schnoor.

ALLEGATION:

On 12/09/2018, while smoking a cigarette outside unsupervised, Resident A fell and broke his hip.

INVESTIGATION:

On 12/12/2018, Berrien County Adult Protective Services (APS) forwarded this complaint to the Bureau of Community and Health Systems (BCHS) through the BCHS' on-line complaint system. The written complaint indicated that a facility staff member was to accompany Resident A, who was unable to verbally communicate, had a diagnosis of schizophrenia and was at risk for falls, whenever Resident A went outside. According to the written complaint, on 12/09, Resident A was outside with four or five other residents when he fell and broke his hip. The written complaint

indicated that at the time of Resident A's fall, no facility staff members were outside with him. According to the written complaint, Resident A was currently hospitalized at Lakeland hospital in St. Joseph.

On 12/17, while conducting an inspection at a different facility also operated by Spectrum Community Services, I interviewed licensee designee Scott Schnoor regarding this allegation. Mr. Schnoor stated that he was aware of the allegation and informed me that both Berrien County APS Specialist Leslie Steinberger and Recipient Rights Officer (RRO) Basil Scott were also conducting investigations. Mr. Schnoor confirmed that due to being at risk for falls, Resident A required continuous supervision by direct care workers (DCW) while at the facility. Mr. Schnoor also confirmed that on 12/09, Resident A fell at the facility while smoking a cigarette outside. Mr. Schnoor stated that following the incident, he and home manager Patsy Briggs, conducted an internal investigation and established that DCW John Romhilt was outside supervising Resident A at the time of Resident A's fall. According to Mr. Schnoor, Resident A was discharged from the hospital following surgery and was currently participating in rehabilitation at a long-term care facility.

I conducted an unannounced investigation at the facility and interviewed home manager Patsy Briggs, DCWs John Romhilt, Angela Holmes, Diana Ramirez, Joyce Vierck, and Melanie Sutton, as well as Residents B and C.

According to Ms. Briggs, she instructed all DCWs to provide supervision to Resident A while he was walking and when he was outside. Ms. Briggs stated that while Resident A was fully ambulatory, he was at risk for falls. Ms. Briggs confirmed that Resident A was unable to verbally communicate and had a diagnosis of schizophrenia. Ms. Briggs stated that as a result of Resident A's fall, Resident A broke his femur and not his hip, as alleged in the written complaint. Ms. Briggs confirmed that Resident A was currently participating in rehabilitation at a long-term care facility. Ms. Briggs' statements regarding the facility's internal investigation following Resident A's fall, were consistent with the statements Mr. Schnoor provided to me.

Mr. Romhilt, Ms. Holmes, Ms. Ramierez, Ms. Vierck and Ms. Sutton all confirmed that Resident A was provided supervision while walking and when outside.

According to Mr. Romhilt, on 12/09, he was outside with several residents, including Resident A, while they were smoking cigarettes. Mr. Romhilt stated that he was seated at the picnic table, with Resident A who was seated across from him. According to Mr. Romhilt, suddenly and without warning, Resident A stood up from the table, lost his balance and grabbed onto Resident B's walker to prevent himself from falling. Mr. Romhilt stated that this startled Resident B who "moved her walker away" from Resident A, and Resident A fell to the ground. According to Mr. Romhilt, the incident happened so fast that he was unable to get to Resident A quickly enough to prevent him from falling.

Ms. Holmes, Ms. Ramirez and Ms. Vierck all stated that they were working with Mr. Romhilt on 12/09. Both Ms. Holmes and Ms. Ramirez confirmed that Mr. Romhilt was outside supervising Resident A at the time of Resident A's fall. Ms. Vierck stated that she was busy assisting other residents inside the facility at the time of Resident A's fall. Therefore, she could not say for certain if Mr. Romhilt was outside with Resident A when he fell. However, Ms. Vierck stated that she had no reason to not believe Mr. Romhilt's, Ms. Holmes' and Ms. Ramirez' statements. Ms. Sutton stated that she was not working on 12/09 when Resident A fell, and also had no reason to not believe Mr. Romhilt's, Ms. Holmes' and Ms. Ramirez' statements.

I interviewed Resident B, who stated that she was nervous. Resident B asked me if she was in "trouble", to which I answered "no." Resident B confirmed that on 12/09, she witnessed Resident A fall outside. Resident B stated that no DCWs were outside with Resident A when he fell, and it was her that notified Mr. Romhilt of Resident A's fall.

I interviewed Resident C who stated that on 12/09, he witnessed Resident A fall outside. Resident C stated that Mr. Romhilt was outside with Resident A when he fell. Resident C's statements regarding the details of Resident A's fall were consistent with the statements Mr. Romhilt provided to me.

I conducted a second interview with Ms. Briggs who stated that during her internal investigation, Resident B initially reported that no DCWs were outside with Resident A when he fell on 12/09. However, according to Ms. Briggs, Resident B later changed her statement and reported that Mr. Romhilt was outside. According to Ms. Briggs, Resident B initially made the false statement because she believed she was responsible for Resident A's fall and feared that she would get in trouble.

I reviewed Resident A's *AFC Licensing- Health Care Appraisal*, which indicated that Resident A had a diagnosis of Hypertension and Schizophrenia with psychosis. Documentation on Resident A's *Health Care Appraisal* confirmed that Resident A was unable to communicate verbally. According to Resident A's *Health Care Appraisal*, Resident A was fully ambulatory.

Other than the incident that occurred on 12/09, I requested all *AFC Incident/Accident Reports* (IR) regarding any falls that Resident A had in the facility, within the past three months. I was provided with one IR, dated 09/05/2018. According to documentation on the IR, on 09/04 Resident A got up from the couch, fell and hit his head. Documentation on the IR indicated that Resident A obtained a cut above his left eye and was examined at the emergency room. No additional injuries were identified, and Resident A returned to the facility. Documentation on the IR read, "[Resident A] has been monitored and assisted around the home". Documentation on the IR indicated that DCWs were to continue accompanying Resident A while he walked and went outside.

On 12/18, I conducted telephone interviews with Berrien County RRO Basil Scott and APS Specialist Leslie Steinberger, who both stated that they did not have enough evidence to substantiate this allegation. Ms. Steinberger stated she interviewed Resident D who also reported witnessing Resident A's fall on 12/09, and that Mr. Romhilt was present when Resident A fell. According to Ms. Steinberger, Resident D's statements regarding the details of Resident A's fall were consistent with the statements Mr. Romhilt and Resident C provided to me.

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:	It has been established that due to being at risk for falls, Resident A required supervision by DCWs while walking and when outside. It was also established that on 12/09, Resident A fell while smoking outside and broke his femur. Based upon my investigation, which included interviews with licensee designee David Schnoor, home manager Patsy Briggs, DCWs John Romhilt, Angela Holmes, Diana Ramirez, Joyce Vierck, and Melanie Sutton, Residents B and C, RRO Basil Scott and APS Specialist Leslie Steinberger, as well as a review of documentation relevant to the allegation, there is not enough evidence to substantiate the allegation that Resident A was outside unsupervised on 12/09 when he fell and broke his femur.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Direct care workers bring illegal drugs into the facility.**
- **Direct care workers are rude to residents.**

INVESTIGATION:

These allegations were also included in the written complaint. However, no specific incidents were identified. The written complaint indicated that Ms. Briggs "covered up" several unidentified incidents that occurred in the facility.

During my unannounced investigation on 12/17, I did not observe and/or smell any evidence of and/or the presence of illegal drugs or illegal drug use in the facility.

During my interview with Mr. Schnoor on 12/17, Mr. Schnoor stated that he and Ms. Briggs also addressed these allegations while conducting their internal investigation.

Mr. Schnoor stated that Ms. Vierck reported possibly smelling marijuana on one DCW's clothing. However, according to Mr. Schnoor, Ms. Vierck also reported that this DCW did not appear to be under the influence of drugs while working. According to Mr. Schnoor, he and Ms. Briggs were unable to obtain any information regarding DCWs being rude to residents.

During my interview with Ms. Briggs on 12/17, Ms. Briggs stated that due to some employees' performance concerns, in November of 2018, she made some "personnel changes" that upset some employees. According to Ms. Briggs, she believed that these allegations stemmed from a few disgruntled current and former facility employees. Ms. Briggs stated that she never brought illegal drugs into the facility and/or participated in illegal drug use while at the facility. According to Ms. Briggs, she never observed illegal drugs and/or witnessed illegal drug use by others in the facility. Ms. Briggs stated that she had not received any reports from other employees and/or residents regarding the presence of illegal drugs and/or illegal drug use in the facility. Ms. Briggs stated that while some DCWs required additional training on how to better communicate with the mentally ill and developmentally disabled population, as well as additional coaching on how to better communicate with their fellow co-workers, she was not aware of any incidents when DCWs were intentionally rude to residents. Ms. Briggs identified DCW Shirley Edwards as one employee who could benefit from additional training and/or coaching. Ms. Briggs denied ever "covering up" any incidents in the facility.

Both Residents B and C stated that they had never observed illegal drugs and/or witnessed illegal drug use in the facility, during my interviews with them on 12/17.

Resident B stated that on an unknown date, DCW Annie Atkins had once told her to "shut the fuck up." Resident B stated she never reported this incident to Ms. Briggs, even though she felt comfortable reporting issues and/or concerns to her.

Resident C stated that he had never been treated rudely by DCWs in the facility. According to Resident C, he never witnessed DCWs be rude to other residents in the facility.

During my interview with Mr. Romhilt, Ms. Holmes, Ms. Ramirez, Ms. Vierck and Ms. Sutton on 12/17, they all denied bringing illegal drugs into the facility and/or participating in illegal drug use while at the facility. According to Mr. Romhilt, Ms. Holmes, Ms. Ramierez, Ms. Vierck and Ms. Sutton, they never observed illegal drugs and/or witnessed illegal drug use by others in the facility.

Mr. Romhilt, Ms. Holmes, Ms. Ramirez, Ms. Vierck and Ms. Sutton stated that they had never been rude to residents. According to Ms. Holmes, Ms. Ramirez and Ms. Sutton, they had never witnessed this behavior from other DCWs at the facility. Ms. Holmes confirmed that some DCWs could benefit from additional training/coaching on how to better work with the mentally ill and/or developmentally disabled

population. However, behavior from these DCWs was never intentionally rude and/or abusive.

Both Mr. Romhilt and Ms. Vierck stated that Ms. Edwards lacked patience when working with the residents. Ms. Vierck stated that Ms. Edwards was “loud and bossy”. According to Ms. Vierck, she reported these concerns to Ms. Briggs and stated, “[Ms. Briggs] will take care of it.”

Mr. Romhilt, Ms. Holmes, Ms. Ramirez, Ms. Vierck and Ms. Sutton denied the allegation that Ms. Briggs “covered up” incidents that occurred in the facility. Mr. Romhilt stated, “[Ms. Briggs] is the best boss I’ve ever had.” According to Ms. Holmes, Ms. Briggs was a “good manager”. Ms. Ramirez stated, “staff are good, especially [Ms. Briggs]”. According to Ms. Vierck, she believed that a few DCWs, who were recently disciplined for poor attendance and work performance, reported these false allegations when they “didn’t get their way”.

Both Mr. Scott and Ms. Steinburg stated that they did not have enough evidence to substantiate these allegations during my interviews with them on 12/18.

On 01/31, I conducted telephone interviews with DCWs Cassandra Flewellen and Annie Atkins. Regarding illegal drugs being brought into the facility, Ms. Atkins stated, “I heard talk of it”. However, Ms. Atkins was either unwilling or unable to provide further information regarding this allegation. Both Ms. Flewellen and Ms. Atkins denied bringing illegal drugs into the facility and/or participating in illegal drug use while at the facility. According to Ms. Flewellen and Ms. Atkins, they never observed illegal drugs and/or witnessed illegal drug use by others in the facility.

Ms. Flewellen stated that she had never been rude to residents. According Ms. Flewellen, she had never witnessed this behavior from other DCWs at the facility. Ms. Atkins denied ever telling Resident B to “shut the fuck up” and stated that she had never been rude to other residents in the facility. Ms. Atkins stated that she had never witnessed this behavior from other DCWs in the facility. According to Ms. Atkins, she had a positive relationship with Resident B and believed Resident B was displaying “attention seeking behavior” when she made the allegation.

Ms. Flewellen stated that she believed these false allegations stemmed from “employee drama.” However, the facility’s work environment had improved. Ms. Atkins stated, “most of the staff are comfortable with [Ms. Briggs] and “I have a good relationship with [Ms. Briggs].”

APPLICABLE RULE	
R 400. 14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**

ANALYSIS:	Based upon my investigation, which included interviews with licensee designee David Schnoor, home manager Patsy Briggs, DCWs John Romhilt, Angela Holmes, Diana Ramirez, Joyce Vierck, Melanie Sutton, Cassandra Flewellen, and Annie Atkins, Residents B and C, RRO Basil Scott and APS Specialist Leslie Steinberger, there is not enough evidence to substantiate the allegation that DCWs bring illegal drugs into the facility or use illegal drugs in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	It has been established that some DCWs required additional training on how to better communicate with the mentally ill and developmentally disabled population, as well as additional coaching on how to better communicate with their fellow co-workers. Based upon my investigation, which included interviews with licensee designee David Schnoor, home manager Patsy Briggs, DCWs John Romhilt, Angela Holmes, Diana Ramirez, Joyce Vierck, Melanie Sutton, Cassandra Flewellen, and Annie Atkins, Residents B and C, RRO Basil Scott and APS Specialist Leslie Steinberger, there is not enough evidence to substantiate the allegation that DCWs intentionally mistreated residents by being rude to them.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Direct care workers sleep during their shifts.

INVESTIGATION:

This allegation was included in the written complaint.

During my interview with Ms. Briggs on 12/17, Ms. Briggs stated that due to the care needs required by the residents who lived in the facility, every DCW was required to stay awake during all shifts. According to Ms. Briggs, she did not personally catch any DCWs sleeping during their shifts. However, DCW Teqila Smith, who was not present at the time of my on-site investigation, provided Ms. Briggs with a picture of DCW Cassandra Flewellen allegedly sleeping while working the facility's second-shift on 11/01/2018. Ms. Briggs showed me a picture, which was of a woman she identified as Ms. Flewellen. Upon reviewing the picture, I observed the back of a woman's heads. It was unclear whether this individual was awake or sleeping. Ms. Briggs stated that she questioned Ms. Flewellen who confirmed that the picture was of her while at the facility. However, Ms. Flewellen denied the allegation that she was sleeping in the picture. According to Ms. Briggs, Ms. Flewellen denied ever sleeping during any of her work shifts at the facility. Ms. Briggs stated that Ms. Smith and Ms. Flewellen had previous "personal issues" with one another. However, they had since made up and were now friendly. According to Ms. Briggs, she had received no other reports of DCWs sleeping during their shifts.

During my interview with Mr. Romhilt on 12/17, Mr. Romhilt denied ever sleeping during any of his shifts at the facility. Mr. Romhilt stated that he was not aware of any other DCWs sleeping during their shifts at the facility. According to Mr. Romhilt, he often worked with Ms. Flewellen on the facility's second-shift and never observed Ms. Flewellen sleeping.

Ms. Holmes, Ms. Ramirez and Ms. Sutton all denied sleeping during any of their shifts at the facility during my interviews with them on 12/17. Ms. Holmes, Ms. Ramirez and Ms. Sutton all stated that they were not aware of any other DCWs sleeping.

During my interview with Ms. Vierck on 12/17, Ms. Vierck denied ever sleeping during any of her shifts at the facility. Ms. Vierck stated that "sometime around 11/01/2018, she worked during the facility's second shift. While working, Ms. Vierck stated that she observed Ms. Flewellen sleeping during their shift.

During my interviews with Residents B and C on 12/17, Resident B stated that on one recent occasion, she observed Ms. Flewellen sleeping in a chair during her shift. According to Resident B, another DCW woke Ms. Flewellen up. Resident C stated that he had never observed any DCWs sleeping during their shifts.

During my telephone interviews with Ms. Flewellen and Ms. Atkins on 01/31, Ms. Flewellen denied the allegation that she slept during her shifts at the facility. Ms. Flewellen stated that she had never witnessed other DCWs sleeping during their shifts. Ms. Atkins also denied sleeping during any of her shifts at the facility. According to Ms. Atkins, she had never personally observed any DCWs sleeping during their shifts. However, although she had not personally observed them, she had heard that DCWs had taken several pictures of Ms. Flewellen sleeping during various shifts at the facility.

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:	Upon reviewing a picture of a woman alleged to be DCW Cassandra Flewellen sleeping during her shift, it was unclear whether this individual was awake or sleeping. While both Resident B and DCW Joyce Vierck reported observing Ms. Flewellen asleep during her shift, there is no evidence that during this time, the care needs of the residents were not met by the other DCWs working. Based upon my investigation, which included interviews with home manager Patsy Briggs, DCWs John Ramirez, Angela Holmes, Diana Ramirez, Joyce Vierck, Melanie Sutton, Cassandra Flewellen and Annie Atkins, and Residents B and C, there is not enough evidence to substantiate the allegation that DCWs failed to provide residents with supervision, protection and personal care when Ms. Flewellen allegedly fell asleep during her shifts at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

I reviewed Resident A's *Assessment Plan for AFC Residents* (assessment plan), dated 03/27/2018. Documentation on Resident A's assessment plan indicated that Resident A required no assistance with walking and/or mobility. However, Resident A did require assistance from DCWs with climbing stairs. There was no documentation in Resident A's assessment plan indicating that Resident A was at risk for falls and/or that DCWs were to provide Resident A with continuous supervision while walking and when outside.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall

	maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	While there is enough evidence to establish that DCWs provided Resident A with continuous supervision while he walked and when outside, Resident A's assessment plan did not accurately reflect Resident A's current status and required care needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/04, I conducted an exit conference with licensee designee David Schnoor via email and shared with him the findings of this investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

Michele Streeter 02/04/2019

Michele Streeter Date
Licensing Consultant

Approved By:

Dawn Timm 02/07/2019

Dawn N. Timm Date
Area Manager