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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 27, 2019

Sharon Blain
Spectrum Community Services
332 First St
Manistee, MI 49660

RE: License #: AS410338054
Investigation #: 2020A0355015
Skyway Home

Dear Mrs. Blain:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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) 356-0100.

Sincerely,

Grant Sutton, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4437

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410338054
Investigation #:	2020A0355015
Complaint Receipt Date:	11/20/2019
Investigation Initiation Date:	11/20/2019
Report Due Date:	01/19/2020
Licensee Name:	Spectrum Community Services
Licensee Address:	28303 Joy Rd., Westland, MI 48185
Licensee Telephone #:	(734) 458-8729
Administrator:	Sharon Blain
Licensee Designee:	Sharon Blain
Name of Facility:	Skyway Home
Facility Address:	5626 Skyway Dr., Comstock Park, MI 49321
Facility Telephone #:	(616) 551-2093
Original Issuance Date:	02/27/2013
License Status:	REGULAR
Effective Date:	08/27/2019
Expiration Date:	08/26/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff yelled at Resident A and treated her roughly.	Yes

III. METHODOLOGY

11/20/2019	Special Investigation Intake 2020A0355015
11/20/2019	APS Referral
11/20/2019	Special Investigation Initiated - Telephone network 180, Office of Recipient Rights
11/22/2019	Inspection Completed On-site Interviewed staff; Resident A
11/26/2019	Contact - Telephone call made Interviewed staff
11/27/2019	Exit Conference Licensee designee

ALLEGATION: Staff yelled at Resident A and treated her roughly.

INVESTIGATION: On 11/20/2019, I received a complaint filed on behalf of Resident A alleging that on 11/17/2019, staff Kathy Harrison yelled at Resident A repeatedly and treated Resident A roughly when assisting with standing and sitting.

On 11/22/2019, I conducted an on-site investigation and interviewed staff Kathy Harrison and Resident A. Recipient rights staff, Bob Patterson, and corporate rights staff for the licensee, Dereka Seigel, participated in the interviews.

Ms. Harrison stated that on the date in question, a staff who had never worked at the facility before was a substitute worker for an open shift. Ms. Harrison stated that the staff was not familiar with the 6 residents at the facility and had in fact expressed discomfort and would not assist with some of the personal care required for the residents. Ms. Harrison stated that she was frustrated during the shift because she felt she was essentially working alone and felt a great deal of pressure to complete all of the required activities related to the residents (tube feedings, suppositories, and related personal care for individuals who are total care). Ms. Harrison denied that she yelled at Resident A but acknowledged that due to the circumstances of the shift, Ms. Harrison did become “excitable” and did raise her voice to Resident A,

“probably” more than once. Ms. Harrison denied being rough with Resident A when assisting with standing and sitting.

Resident A initially stated she did not want to talk to us, then indicated she had something to say but it was only, “I want a bath” and Resident A cried constantly. Resident A would not answer the simplest of questions posed regarding staff.

On 11/26/2019, I interviewed staff Desirea Douglass by telephone. Ms. Douglass was the second staff working with Ms. Harrison on the date in question. Ms. Douglass stated that Ms. Harrison was visibly frustrated with Resident A and did repeatedly yell at Resident A. Ms. Harrison stated that she observed Ms. Harrison be rough with Resident A in one instance when assisting Resident A with standing and again when assisting Resident A with sitting. Ms. Douglass stated that she did not believe Ms. Harrisons behavior crossed into “abuse”, but expressed that Ms. Harrison did not treat Resident A with dignity and respect.

On 11/27/2019, I conducted by telephone an exit conference with the licensee designee, Sharon Blain. Mrs. Blain accepted the findings of my investigation and indicated an appropriate corrective action plan will be forthcoming upon receipt of my report.

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 Desirae Douglass stated that Ms. Harrison yelled at Resident A and was rough when assisting Resident A in standing and sitting. Resident A would not answer any questions. Staff Kathy Harrison denied yelling at Resident A and denied being rough with Resident A but acknowledged that she had become “excitable” during the shift and raised her voice to Resident A more than once. I find a preponderance of evidence to support that staff Kathy Harrison did not treat Resident A with dignity.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend that the status of the license remain unchanged.

11/27/2019

Grant Sutton — Date
Licensing Consultant

Approved By:

11/27/2019

Jerry Hendrick — Date
Area Manager