GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 15, 2020

Kimberly O'Neal
Spectrum Community Services
332 First St
Manistee, MI 49660

RE: License #: AS810013390
Investigation #: 2020A0575026
Bateson Residence

Dear Mrs. O'Neal:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On July 14, 2020, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9720.

Sincerely,

Jeffrey J. Bozsik, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 417-4277

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

I. IDENTIFYING INFORMATION

License #:	AS810013390
Investigation #:	2020A0575026
Complaint Receipt Date:	07/10/2020
Investigation Initiation Date:	07/10/2020
Report Due Date:	08/09/2020
Licensee Name:	Spectrum Community Services
Licensee Address:	28303 Joy Rd. Westland, MI 48185
Licensee Telephone #:	(734) 458-8729
Administrator:	Kimberly O'Neal
Licensee Designee:	Kimberly O'Neal
Name of Facility:	Bateson Residence
Facility Address:	2832 Bateson Court Ann Arbor, MI 48105
Facility Telephone #:	(734) 332-4148
Original Issuance Date:	09/01/1994
License **Status:**	REGULAR
Effective Date:	04/25/2020
Expiration Date:	04/24/2022
Capacity:	6
Program Type:	PH; DD

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided satisfactory personal care by home staff.	Yes

III. METHODOLOGY

07/10/2020	Special Investigation Intake 2020A0575026
07/10/2020	Special Investigation Initiated - Telephone
07/14/2020	Contact - Telephone calls made-(a) Olajide Olufola- area manager; (b) Gemma Tarsi- R.N. case manager; (c) unknown direct care staff
07/14/2020	Corrective Action Plan Requested and Due on 07/21/2020
07/14/2020	Corrective Action Plan Received
07/14/2020	Corrective Action Plan Approved
07/14/2020	Exit Conference with the licensee designee, Kim O'Neal

ALLEGATION:

Resident A was not provided satisfactory personal care by home staff.

INVESTIGATION:

I did not interview Resident A due to her cognitive impairment.

I interviewed Gemma Tarsi on 7/14/2020 and she stated that this doctor's office provides medical care to all the six residents residing in the Bateson facility. She stated the residents appeared to receive good personal care from the former manager, but since he has been out on medical leave for testing positive for the coronavirus in March 2020, the quality of care has been poor. She stated some of the residents had poor skin care as evidenced by irritated skin from briefs that were changed infrequently. She also stated that it seemed like no one person was in charge of the facility, the staff (she didn't remember which ones specifically) couldn't

provide medical information for 3 residents, and that Resident A was supposed to have a follow-up medical appointment 14 days after her discharge from rehab in early June and they just saw her on July 9th.

I interviewed Olajide Olufola on 7/14/20 and he stated the staff who transported Resident A to her medical appointment took a copy of her medication sheet. He stated the doctor's office did not request her discharge orders from her rehab stay of April-June 2020 due to an infection with the coronavirus. He stated she has been back in the facility since early June 2020. Finally, he stated there are 2 staff on every shift to provide for the resident's care.

When I contacted the facility on 7/14/2020, I spoke with a female staff person who refused to give her name and referred me to Olajide Olufalo, area manager.

I conducted an exit conference with the licensee designee, Kim O'Neal.

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 preponderance of credible evidence is that although this facility may be adequately staffed, the staff have not been providing for the residents' personal needs, including protection and safety, probably since the former manager went on medical leave months ago.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable plan of correction was received; therefore, I recommend no changes in the status of the license.

Jeffrey J. Bozsik
Licensing Consultant

Date: 7/14/20

Approved By:

Ardra Hunter, Area Manager

Date: 7/15/2020