GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 3, 2021

Donna McBride
Spectrum Community Services
Suite 700
185 E. Main St
Benton Harbor, MI 49022

RE: License #: AS810013390
Investigation #: 2021A0575026
Bateson Residence

Dear Mrs. McBride:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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
(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 #:	2021A0575026
Complaint Receipt Date:	07/27/2021
Investigation Initiation Date:	07/27/2021
Report Due Date:	08/26/2021
Licensee Name:	Spectrum Community Services
Licensee Address:	28303 Joy Rd. Westland, MI 48185
Licensee Telephone #:	(269) 927-3472
Administrator:	Donna McBride, Designee
Licensee Designee:	Donna McBride
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 fell in the bathroom, which probably was the accident that resulted in her breaking her hip.	No

III. METHODOLOGY

07/27/2021	Special Investigation Intake 2021A0575026
07/27/2021	APS Referral received
07/27/2021	Special Investigation Initiated – Telephone Contact-document received- incident reports and Fay Brown and Judith Acquah-direct care staff written statements
07/29/2021	Contact - Telephone calls made-(a) Laura Affana-direct care staff; (b) Bryanna Robinson-direct care staff; (c) Dylan Lambo- quality control; (d) Michael Hale- home manager
07/29/2021	Contact - Document Received-Resident A's PCP from Donna McBride-licensee designee
07/30/2021	Contact - Document Received-Resident A's-AFC Assessment from Donna McBride-licensee designee
07/30/2021	Exit Conference with Donna McBride-licensee designee

ALLEGATION: Resident A fell in the bathroom, which probably was the accident that resulted in her breaking her hip.

INVESTIGATION: An APS referral was received on 7/27/21. Resident A was not interviewed because she is currently hospitalized.

I interviewed staff Laura Affana (direct care staff) on 7/29/21 and she stated Resident A does not need to use a walker or wheelchair for mobility, so staff try to have her maintain her independence by limiting her use of a wheelchair. Therefore, after Resident A used the toilet on 7/21/21, she placed a wheelchair in front of her with the handles toward her so she could get off the toilet by herself. Laura Affana stated that that was when Resident A grabbed onto the wheelchair handles but fell to the floor. She stated another direct care staff, Bryanna Robinson came and assisted her with lifting Resident A into the wheelchair. This was the only fall.

I interviewed Bryanna Robinson on 7/29/21 and she stated she did not have any first -hand knowledge of Resident A's fall as she was not in the bathroom with Resident A on 7/21/21, the day she fell.

I interviewed Michael Hale on 7/29/21 and he stated he was a new manager and had not read Resident A's personal care plan, so he did not know what level of staff assistance she needed for personal care.

I interviewed quality control staff Dylan Lambo on 7/29/21 and she stated Resident A does use a gait belt, or a walker or wheelchair. She stated Resident A drags her feet when she walks.

I reviewed the written statement from direct care staff Fay Brown, and Judith Acquah dated 7/22/21. They stated Resident A was lethargic and was unable to walk. They put her in a wheelchair and called 911. Resident A was transported to UM hospital where it was determined she had a broken hip.

I reviewed Resident A's personal care plan dated 2/26/21, and her AFC assessment dated 5/21/21. Her personal care plan states she is a fall risk and she is experiencing more difficulties with walking. Her AFC assessment states she does not need assistance with walking/mobility, and she needs "24-hour staff to assist if needed" for toileting.

I conducted an exit conference with Donna McBride on 7/30/21. She agreed with the findings and conclusions.

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:	Although it is apparent that Resident A fell and broke her hip, the staff complied with the level of care as written in her AFC assessment. Therefore, the licensee provided supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend no changes to the status of the license.

Jeffrey J. Bozsik
Licensing Consultant

Date: 08/02/2021

Approved By:

Jerry Hendrick
Area Manager

Date: 08/03/2021