GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 9, 2021

Delissa Payne, Licensee Designee
Spectrum Community Services
Suite 700
185 E. Main St
Benton Harbor, MI 49022

RE: License #:	AS410356636
Investigation #:	2021A0356024
	Terrace Park Home

Dear Ms. Payne:

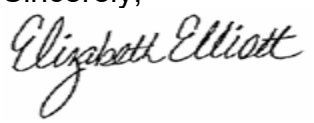
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410356636
Investigation #:	2021A0356024
Complaint Receipt Date:	03/31/2021
Investigation Initiation Date:	03/31/2021
Report Due Date:	05/30/2021
Licensee Name:	Spectrum Community Services
Licensee Address:	28303 Joy Rd. Westland, MI 48185
Licensee Telephone #:	(269) 927-3472
Administrator:	Delissa Payne
Licensee Designee:	Delissa Payne
Name of Facility:	Terrace Park Home
Facility Address:	5901 Terrace Park Dr. NE Rockford, MI 49341
Facility Telephone #:	(616) 884-5788
Original Issuance Date:	03/12/2014
License Status:	REGULAR
Effective Date:	10/24/2019
Expiration Date:	10/23/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff were physically and verbally aggressive with Resident A.	Yes
The facility is understaffed.	No
Direct care staff are not properly trained.	No
Direct care staff do not regularly clean Resident A's toilet creating an unsanitary environment.	Yes

III. METHODOLOGY

03/31/2021	Special Investigation Intake 2021A0356024
03/31/2021	Special Investigation Initiated - Telephone Area Manager, J Hendrick re: complaint info.
03/31/2021	APS Referral-
04/01/2021	Contact - Telephone call received. Ed Wilson, ORR, Kent County Network 180.
04/05/2021	Inspection Completed On-site
04/05/2021	Contact - Face to Face Ed Wilson, Resident A, Relative #1 & #2.
04/12/2021	Contact - Face to Face Ed Wilson and Anne Marie Brenner, Behavior Specialist, Network 180.
04/21/2021	Contact - Face to Face Melissa Stewart, home manager, Laurie Jones, DCW, Ceciley Rodriguez, DCW, Marie Brodock, DCW.
05/13/2021	Contact-Document Sent Request for facility documents.
05/14/2021	Contact-Document Received Facility documents for review.

05/25/2021	Contact-Document Received Ed Wilson, report information.
05/25/2021	Contact-Face to Face Inspection at the facility, Melissa Stewart, home manager. Spoke to LD Delissa Payne on telephone during this inspection.
06/09/2021	Exit Conference-Licensee Designee, Delissa Payne.

ALLEGATION: Direct care staff were physically and verbally aggressive with Resident A.

INVESTIGATION: On 03/31/2021, I received a written complaint in letter form forwarded to LARA from Edward Wilson, Office of Recipient Rights Director, Kent County Network 180 (Community Mental Health). The complainant reported on March 20, 2021, an incident occurred that involved staff *'Laurie (Jones) bending (Resident A) backwards over (Resident A's) bed and holding her down. At one point, she was holding both (Resident A's) hands and she was holding her head down at another point. Part of this was witnessed by another staff, Ceciley (Rodriguez). Because of her inability to effectively interact with (Resident A) and de-escalate her (Resident A) she did not shower this day. This meant she (Resident A) went 3 days without a shower.'*

The complainant also reported, staff have a history of verbally antagonizing Resident A, that some staff talk to Resident A in an 'antagonistic and demeaning fashion.' The complainant reported in the past, staff have said things like, 'you are 27 years old, not 5, a 27-year-old should make her own PB&J sandwich, I am not your slave,' 'you are higher functioning, you should be a role model,' 'you are not going to pinch me all night,' 'do you like hurting people?' 'nothing helps you,' adults don't get put to bed,' 'poor (Resident A) she broke her glasses,' 'you are lucky you are going to your parents today as you have been assaulting staff,' and 'the other consumers have to deal with you too.' The complainant reported staff, Laurie Jones, despite numerous and repeated discussions, meetings, and individualized training, continues to fight with Resident A and escalates situations rather than being helpful and engaging in de-escalation techniques. The complainant gave specific examples of things Ms. Jones said to Resident A such as, 'I never met anybody who goes to the bathroom as much as you. You're the only one,' 'Hands are for helping, not going after people,' 'How many people's glasses have you broken?' 'What's wrong with you?' 'You better not go home and tell your parents about this and get me into trouble.'

The complainant reported Resident A was sent home by staff for a visit with stool in her underwear and Relative #2 was told by staff at the facility, 'you can come over, pick up your kid and take care of her yourself.' Also, a Zoom class leader heard staff, commanding loudly that Resident A "sit down." The leader of the class was surprised by the manner in which this was done and reported to Relative #1 & #2 what she

heard via the zoom meeting. The complainant reported staff continue to make comments to Resident A that are not constructive and consistently violates Resident A's dignity.

On 04/05/2021, I interviewed Relative #1, Relative #2 and Resident A with Mr. Wilson at Relative #1 & #2's house. Resident A was hesitant to be interviewed so Mr. Wilson and I interviewed Relative #1 and #2 prior to Resident A joining us. Relative #1 & #2 stated they have been trying to work through all of their concerns with staff at the facility and do not want trouble for staff, but nothing has changed. Relative #1 and #2 stated they have numerous examples of staff speaking negatively to Resident A. Relative #2 stated, through personal experience, staff Ms. Rodriguez speaks to Resident A "like she probably speaks to her nine-year-old child". Relative #2 stated as reported by Resident A, Ms. Jones threw a medication cup at her (Resident A). In another instance, unknown staff at the facility praised a resident in the home for throwing his plate away and when Resident A threw her plate away, staff did not say anything. Relative #2 stated when Resident A asked why they did not tell her good job like they did to the other resident, staff replied by telling Resident A, "because you did not eat all of your food." Relative #1 stated if staff did not want an argument or a behavior from Resident A, they would not say things like that which set off negative behaviors for Resident A. Relative #1 and #2 stated the information in the complaint is true and the statements made by staff to Resident A were reported to them by Resident A. Relative #1 & #2 stated some, but not all of the negative comments were made by staff Emma Morgan and this staff person may not work at the facility any longer. However, the issue remains and there are other staff that engage in interactions with Resident A that are not conducive to her well-being.

Relative #2 confirmed that Resident A arrived at their home one day with stool in her pants. When Relative #2 asked Resident A what happened, Resident A told her that staff Ms. Morgan was working and after Resident A used the bathroom, she (Resident A) requested assistance with wiping from Ms. Morgan and Ms. Morgan told Resident A, "I am not helping you." Relative #2 stated Resident A likely became frustrated and pulled her pants up without wiping and later arrived at Relative #1 & #2's house with stool in her pants. Relative #2 also stated that staff at the facility are not regularly assisting Resident A with showers and are using her resistance as an excuse to not shower Resident A on a daily basis. Relative #2 confirmed that Resident A had a Zoom meeting with her LIFT group and the organizer of that group emailed Relative #2 after the meeting to inform her that she had overheard staff at the home yell at Resident A to "sit down" in a manner that was noticeably sharp. The Zoom organizer informed Relative #2 that Ms. Morgan was the staff person who yelled at Resident A to sit down.

Relative #1 and #2 described an incident that took place at the facility on 03/20/2021. They stated they were not present, and the information was given to them by Resident A and the staff that were present included Ms. Rodriguez and Ms. Jones. Relative #1 and #2 stated Ms. Rodriguez was getting Resident A ready to

take a shower and attempted to assist Resident A with removing a protective jacket, worn by Resident A to prevent self-injuries from biting her arms. Relative #1 & #2 stated Resident A must have resisted and Ms. Jones became involved and between Ms. Rodriguez and Ms. Jones, put Resident A's hands behind her back, above her head and bent Resident A over backwards onto her bed while Ms. Jones had her hand on Resident A's chin and forehead. Relative #2 stated at that point, Ms. Jones and Ms. Rodriguez gave up on trying to get Resident A into the shower but once Resident A got to her house on that same date, 03/20/2021, she (Relative #2) was able to shower Resident A without incident. Relative #2 stated Resident A goes days without a shower at the facility because staff do not want to bother with it, when Resident A should have one every day, however, she does not think Resident A had a specific goal in her treatment plan that required staff to assist Resident A with showering.

Resident A later participated in the interview and stated most of the staff are "good staff," they are "nice, friendly and calm" but that Ms. Jones is not "calm with me and that's all I'm going to say." Mr. Wilson and I asked Resident A to give us examples of what she means by "calm" and Resident A then stated Ms. Jones says things like "you go and tell your mom and dad everything" or "I can tell you're not happy" and then "tickles (Resident B's) chin but tips my head back (with her hand), the others (residents) don't know the difference because they are low functioning" but Resident A stated, "it hurts my neck." Resident A stated she "went after" Ms. Jones' glasses one day and Ms. Jones said, "how many glasses have you broken?" Resident A stated she wrote in her journal that she was "an amazing role model" and Ms. Jones made her change it to "I am working on being an amazing role model." Resident A stated Ms. Jones also has said "don't blank me, don't do it" and what Ms. Jones meant was "don't bite me" but Resident A stated she does not like to say the word "bite" because it is a "trigger" word for her and then it causes her to think about biting and then she might bite. Resident A stated those are examples of Ms. Jones not being "calm" with her. In addition, Resident A stated another staff, Ms. Rodriguez also says things such as "what is your problem?" and "since (staff) Michelle is not here, you're going to act up on me?" and "you'll just go tell your parents." Resident A stated she tells staff that talking to her like this does not help her and the reply she gets from staff is "it doesn't help that you do it!" Resident A stated, sometime in March 2021, at the facility, Ms. Rodriguez was behind her holding her arms down, she held her arms and then moved her arms up above her head and made her go back towards her bed. Resident A stated Ms. Jones was pushing her head back with her hands and putting her down across her bed on her back. Resident A and Relative #2 showed Mr. Wilson and I Resident A with her arms positioned by her side, then above her head, her head tilted back, laying on her back across the couch in the living room, the couch was acting as Resident A's bed at the facility. Resident A further explained that Ms. Jones pressed her hand on her (Resident A's) chin and forehead, so she was unable to move her mouth. Relative #2 stated this all occurred, most likely because Resident A was attempting to bite Ms. Jones.

On 04/12/2021, Mr. Wilson and I conducted a face-to-face Teams meeting with Annemarie Brenner, Behavior Specialist at Network 180 (Kent County Community Mental Health). Ms. Brenner stated this facility did not have a home manager for a few months and staff did not consistently and regularly work with Resident A to get to know her and her behaviors. Ms. Brenner stated a big part of the behavior treatment plan is to not dwell on Resident A's negative behavior and not talk about it. Ms. Brenner stated a few staff tend to react to Resident A's negative behaviors rather than ignore it. Ms. Brenner stated she met with staff Marie Brodock who confirmed that some staff bring up and talk about Resident A's negative behaviors when the behaviors are not currently happening which then triggers Resident A's behaviors. Ms. Brenner stated some staff at the home view Resident A as higher functioning than the other residents and expect more from her. Ms. Brenner stated she heard about the intervention that took place at the facility on 03/20/2021. Ms. Brenner stated a hand on the forehead to stop a bite as described to her is a "MANDT hold" which is a physical intervention to release a bite rather than to prevent a bite from happening which, is what it sounded like was happening, Resident A was attempting to bite staff. Using other de-escalation techniques before resorting to a physical intervention is what they want staff to do and why there is a behavior plan in place.

On 04/21/2021, Mr. Wilson and I interviewed Melissa Stewart, home manager via telephone. Ms. Stewart stated she started as the home manager on 03/15/2021 and was the home manager but not at the home when the 03/20/2021 incident occurred. Ms. Stewart stated Resident A has a preferred staff person, Michelle Wiggins. Ms. Wiggins and Resident A have a great relationship, when Michelle left work on medical leave, Resident A's behaviors increased significantly. Ms. Stewart stated Ms. Jones does not have patience with Resident A and has said things to her like, "now you're gonna have behaviors because Michelle is gone," or "poor, poor (Resident A)." Ms. Stewart confirmed that Ms. Morgan no longer works at the facility as she walked off the job. Ms. Stewart stated Ms. Morgan had an "attitude" with Resident A. Ms. Stewart stated Ms. Morgan "could not work with" Resident A and "refused to work with" Resident A. Ms. Stewart confirmed Ms. Morgan said things to Resident A as described in the complaint. Ms. Stewart stated the incident regarding the physical intervention that occurred on 03/20/21, happened on 1st shift so she was not working at that time but the information she received is as follows. Ms. Rodriguez was downstairs with Resident A and Ms. Rodriguez was having a hard time removing the protective jacket to assist Resident A with a shower. Ms. Stewart stated Ms. Jones went to assist Ms. Rodriguez and Resident A tried to bite Ms. Jones. Ms. Stewart stated Ms. Jones and Ms. Rodriguez put Resident A's arm behind her back so she could not pinch, and Ms. Jones put her hand under Resident A's chin. Ms. Stewart stated she never heard anything about Resident A being pushed onto or over the bed on her back.

On 04/21/2021, Mr. Wilson and I interviewed Laurie Jones, staff, via telephone. Ms. Jones stated she has worked for the corporation for 10 years and 2-3 years at this facility. Ms. Jones stated Ms. Morgan used to talk "snotty" to all the residents, but

she walked off the job and is no longer working at the facility. Ms. Jones stated she does not yell at the residents, including Resident A but she tries to “redirect them and assist them in using their coping skills.” Ms. Jones explained that each resident in the facility has different coping skills, she talks to the residents calmly, gives them space, offers to color, or read with them depending on what resident she is working with. Ms. Jones stated, “I’ve never gotten to the point where I’ve hurt any of these residents” and “I may have said, we need to act like adults but never yelled.”

Ms. Jones stated on 03/20/2021, she was called downstairs at the facility to assist Ms. Rodriguez because she was going to give Resident A a shower. Ms. Jones stated Relative #1 has tried different techniques to prevent Resident A from biting herself and had a jacket specially made for Resident A to wear to protect her arms. Ms. Jones stated Ms. Rodriguez had trouble getting the jacket off to assist Resident A with taking a shower. Ms. Jones stated Resident A was “feeling high up” (which is what Resident A describes when her emotional state is elevated) while they were in Resident A’s bedroom. Ms. Jones stated Ms. Rodriguez pulled the left sleeve off of Resident A’s jacket and Resident A tried to pinch, grab, scratch, and bite Ms. Jones. Ms. Jones stated Ms. Rodriguez held Resident A’s left arm while she (Ms. Jones) held her right arm, Resident A was standing by the bed and laid back on the bed. Ms. Jones held her chin with the palm of her hand to keep Resident A’s chin up so she could not bite. Resident A’s head was on the bed and Ms. Rodriguez put Resident A’s jacket back on her. Ms. Jones stated Resident A put herself onto her bed, she went back on the bed herself while Ms. Rodriguez and she (Ms. Jones) had hold of both of Resident A’s hands. Ms. Jones stated she held Resident A’s chin until Ms. Rodriguez had Resident A’s jacket back on. Ms. Jones stated there was nothing that would have caused Resident A injury, she did not push hard on her chin and she did it so Resident A would not bite her, “like MANDT training taught us.” Ms. Jones stated Resident A got dressed, did not take a shower and she (Ms. Jones) went back upstairs and tended to other residents. Ms. Jones stated the entire incident lasted approximately 1 ½ minutes. Ms. Jones stated Resident A’s head was not on the edge of the bed. Resident A was standing next to the bed with her feet on the floor, she then laid back ½ way onto the bed with her head and back totally on the bed and her feet and butt off the bed. Ms. Jones stated no pressure was applied and Resident A was kept “stable” until Ms. Rodriguez could get the jacket back on. Ms. Jones stated physical management has been used on Resident A in the past where staff held on to Resident A’s hands, back off and redirect her. Ms. Jones stated Resident A’s arms were never held above her head, they were down by her side. Ms. Jones stated Ms. Rodriguez works well with Resident A and works with her “quite a bit.”

On 04/21/2021, Mr. Wilson and I interviewed Ms. Rodriguez via telephone. Ms. Rodriguez stated she has worked at this facility for 2½ years and currently works 1st shift. Ms. Rodriguez stated she works with Resident A “a majority” of the time and that she does not mind being with and working with Resident A but other staff do. Ms. Rodriguez stated she has heard staff tell Resident A she was old enough to make her own sandwich. Ms. Rodriguez stated lately she feels “uncomfortable” with

Resident A as she throws things, goes after staff, tries to bite, pinch, scratch, and tries to get glasses off other's faces to break them. Ms. Rodriguez stated Resident A has been more aggressive lately and there have been a lot of complaints from Resident A and Relative #2 which makes her "uncomfortable" working with Resident A after 2½ years of working with Resident A. Ms. Rodriguez stated Resident A is "very preoccupied" with Ms. Wiggins and this preoccupation with Ms. Wiggins can "completely ruin" (Resident A's) day if Ms. Wiggins is not at work, that is how much Resident A focuses on Ms. Wiggins. Ms. Rodriguez stated if any attention goes to another resident, Resident A will have a behavior, so the attention is focused back on her. Ms. Rodriguez stated Ms. Jones is "not sure how to deal with" Resident A. Staff do not want to work with her (Resident A) because they do not want to get into trouble. Ms. Rodriguez stated she tries to keep her interactions with Resident A to a minimum so she does not get into a position or situation with Resident A that would get her (Ms. Rodriguez) into trouble. Also, Ms. Rodriguez stated Resident A does tell "untruths" to try and get staff into trouble such as reporting that she (Ms. Rodriguez) was texting and driving and when Resident A asked Ms. Jones if she (Ms. Jones) thought she (Resident A) slept too much. Ms. Rodriguez stated Ms. Jones told Resident A maybe she should get up and do some activities and Resident A reported that Ms. Jones said she could not nap on 2nd shift any more. Ms. Rodriguez stated all of this is untrue.

Ms. Rodriguez stated on 03/20/021, she began the process of getting Resident A ready for a shower, Resident A was "high up" trying to bite, scratch and pinch so she (Ms. Rodriguez) asked Ms. Jones to come and help her. Ms. Rodriguez stated she was trying to get a jacket off Resident A that is made specific to prevent Resident A from biting herself. Ms. Rodriguez stated the jacket has a zip tie that has to be cut off, so Ms. Jones was holding onto Resident A's hands while standing in front of her and holding her hands, not hard, not hurtful while she cut the zip tie from the jacket. Ms. Rodriguez stated then she and Ms. Jones stood on each side of Resident A and she (Ms. Rodriguez) held Resident A's arm. Ms. Jones held her other arm trying to keep Resident A safe, while Resident A was trying to scratch Ms. Jones. Ms. Rodriguez stated Ms. Jones told Resident A, "we aren't doing a shower today," so Ms. Rodriguez left the room to go to the office and get a new zip tie and at that point, Ms. Jones held both of Resident A's hands. Ms. Rodriguez stated she put a new zip tie on Resident A's jacket and that was it, she and Ms. Jones backed away from Resident A and Ms. Jones went back upstairs. Ms. Rodriguez stated she assisted Resident A in getting dressed and went on with their day. Ms. Rodriguez stated nothing else happened. Resident A's hands were not held up above her head and her hands/arms were not put behind her back. Ms. Jones stood in front of Resident A and held her hands while she (Ms. Rodriguez) went to get the zip tie, that was it. Mr. Wilson and I asked Ms. Rodriguez about Ms. Jones holding Resident A's chin, Ms. Rodriguez stated that Ms. Jones told her she held Resident A's chin, but Ms. Rodriguez stated she did not see it, that Ms. Jones must have done it while she was out of the room. Ms. Rodriguez stated this occurred in Resident A's bedroom while they were standing next to Resident A's bed. Resident A had her back to her bed while she and Ms. Jones were on either side of Resident A. Resident A was not

laying on her bed as Resident A's bed is high and even leaning on the bed, it is midway up Resident A's back so she could not have laid on the bed on her back without jumping up onto the mattress. Ms. Rodriguez stated her hip or leg had been touching the bed to "stabilize us" but at no time did Resident A fall or be put down on the bed. Ms. Rodriguez stated no one was trying to hurt Resident A. Ms. Rodriguez stated Resident A's complaint of back and shoulder pain "makes no sense to me at all," there was no pulling of Resident A's arms, she was not put down on the bed nor was Resident A standing in any way that would cause her pain. Ms. Rodriguez stated this incident occurred during the day and when Resident A came home from a family visit, Relative #1 said Resident A had told him that Ms. Jones held her face and put her down on the bed. Ms. Rodriguez stated she responded by telling Relative #1 that she did not see that, and she did not see Ms. Jones do anything inappropriate to Resident A. Ms. Rodriguez stated Resident A did not mention any pain or anything at all but after several days went by, she said her back still hurt because of what Ms. Jones had done to her.

On 04/21/2021, Mr. Wilson and I interviewed Marie Brodock, staff, via telephone. Ms. Brodock stated she has worked at this facility for 3 years and has worked with Resident A often. Ms. Brodock stated she began the month prior to Resident A being placed in this facility so she has worked with Resident A for as long as she has lived at the facility. Ms. Brodock stated Resident A will "target" staff for a period of time and Ms. Jones is one of those staff that she targeted. Ms. Brodock stated Ms. Jones has said that Resident A "does things to get us in trouble" and "all you're doing is trying to get all us staff in trouble." Ms. Brodock stated Ms. Jones is "rude" to Resident A when she talks to her for example, when Resident A asks a question, Ms. Jones may answer by saying, "you know the answer, why do we have to keep doing this with you, you should know better." Ms. Brodock stated Ms. Jones and Ms. Rodriguez have problems with Resident A and do not realize she is "here for a reason, our job is to care for her." Ms. Brodock stated that she has heard Resident A lie to her parents to get staff in trouble but also, she (Ms. Brodock) stated, Resident A "doesn't always get treated right" by staff. Ms. Brodock stated she noticed Resident A was "eyeing a DVD player" and knew Resident A was going to throw it so staff took it away from Resident A to keep everyone safe. Ms. Brodock stated Resident A called Relative #1 and reported that staff would not let her watch a movie on the DVD player. Ms. Brodock stated I talked to her calmly and Resident A admitted she was going to throw the DVD player at me. Ms. Rodriguez does not give Resident A the attention Resident A wants when she is downstairs with Resident A because she spends most of that time on her phone and ignores Resident A which increases Resident A's behaviors. Ms. Brodock stated Resident A told her that Ms. Jones "pinned her hands above her head stretching her shoulders out."

On 05/14/2021, I received and reviewed an IR (Incident Report) dated 03/20/2021, written by Ms. Jones. I also reviewed progress notes and the Network 180 Intrusive, Restrictive & Physical Management Incident Report dated 03/20/2021 written by Ms. Jones. The IR, the progress notes and the Physical Management Report all document the same information reported to Mr. Wilson and me by Ms. Jones during

our interview. Ms. Jones documented that both she and Ms. Rodriguez held Resident A's arms and Resident A laid back on her bed. Ms. Rodriguez documented that she placed the palm of her hand on Resident A's chin 'for about 30 seconds to prevent (Resident A) from biting' her.

On 05/14/2021, I received and reviewed an Individual Plan of Service (IPOS) dated 12/10/2020, and an addendum to the IPOS on 03/03/2021 written by Crystal Burnet, Network 180 supports coordinator. The IPOS did not have any goals or directives for assistance with personal care such as showering. The plan directed facility staff to 'prompt (Resident A) as needed to communicate in socially acceptable ways. (Resident A) will be praised when she initiates appropriate communication with others." The IPOS does not explain or describe further what communication is considered appropriate.'

On 05/14/2021, I received and reviewed a Behavior Support Plan (BSP) dated 10/12/2020 and revised on 11/18/2020 and written by Ms. Brenner. The BSP documented that staff are to *'identify and encourage (Resident A) to utilize her coping skills and strategies as appropriate." The plan also directs staff to use "enthusiastic, behavior-specific praise when (Resident A) does something you have asked her to do." In response to self-injurious behavior, staff are instructed to "limit conversations with (Resident A)" and "not react emotionally, dramatically, or in any way that shows shock or disgust for the act or injury.'*

On 05/14/2021, I received and reviewed Resident A's Assessment plan for AFC Residents dated 05/13/2021 and signed by Licensee Designee, Delissa Payne and Relative #1. The assessment plan documents that Resident A requires assistance from staff with bathing and explains that *'(Resident A) can do most things independently but due to self-injurious behaviors need monitoring.' The plan documents that Resident A does exhibit self-injurious behavior and that staff are to 'follow the behavior plan that is in place.'* The plan documents that Resident A does not control aggressive behaviors and that staff are to *'follow the behavior plan in place to assist with multiple areas.'*

On 05/19/2021, Mr. Wilson consulted with Network 180 (Community Mental Health) Mandt (physical intervention) trainers Melissa Gekeler and Marcy Rosen. Mr. Wilson documented the following information, '*Ms. Rosen provided a biting release protocol taught in the Mandt curriculum. Ms. Rosen and the document both indicated that the process for releasing a bite is to place one hand on the individual's forehead and place another on the chin bone. Staff are to place "firm downward pressure on the person's chin." Note, however, that both trainers indicated that the written protocol was designed to be in response to after the individual had already bitten and would not release the staff from the bite and is not to be used to prevent a bite from occurring. Ms. Rosen stated the process to prevent a bite would involve "de-escalation techniques, talking with someone, re-directing someone, moving someone to a less distracting environment, identifying the stimulus.'*

On 06/09/2021, I conducted an Exit Conference with Licensee Designee, Delissa Payne via telephone. Ms. Payne stated she will submit an acceptable corrective action plan.

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:	Based on investigative findings, there is a preponderance of evidence to show that while the techniques used on Resident A during the incident on 03/20/2021 involving Ms. Jones were consistent with MANDT training techniques for releasing a bite, Resident A had not actually bitten her. While Ms. Jones and Ms. Rodriguez reported not enough pressure was applied to Resident A during the incident to harm her in any way, Resident A complained of pain. According to Ms. Rosen, staff should have used other methods of de-escalation prior to resorting to a MANDT technique. Due to these investigative findings, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Based on investigative findings, there is a preponderance of evidence to show that some staff at the facility, both past and present, did not follow Resident A's treatment plan. The plan documented staff are not to react emotionally in response to Resident A's behaviors and interviews with staff Ms. Stewart,

	Ms. Jones, Ms. Brodock and Ms. Rodriguez indicated that some staff, both past and present do react in a negative manner verbally towards Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility is understaffed.

INVESTIGATION: On 03/31/2021, I received a written complaint forwarded to LARA from Edward Wilson, Office of Recipient Rights Director, Kent County Network 180 (Community Mental Health). The complainant reported the facility is chronically understaffed making it extremely difficult to adequately care for the individual needs of the four residents. The complainant reported fill-in staff are often used and they lack the specific knowledge and experience to adequately care for the residents. The complainant reported that Resident A is supposed to receive 24/7 1:1 (one-on-one) care but Spectrum Community Services reported this is not the case, causing confusion.

On 04/05/2021, I interviewed Relative #1, Relative #2 and Resident A with Mr. Wilson at Relative #1 & #2's house. Relative #1 and #2 stated there are 4 residents total in the facility, there are 2-day staff and 2-night staff, Resident A is on the lower level of the facility and the other 3 residents are on the main floor. Relative #1 & #2 stated they have been told by staff at the facility that Resident A is 1:1 supervision and that staff at the facility are providing 1:1 supervision sometimes but not 24/7. Relative #1 & #2 stated they are not aware if it documented that Resident A requires1:1 supervision or not, which is the source of confusion for them. Relative #1 & #2 stated they are concerned about the amount and level of self-injurious behavior Resident A exhibits and that it most frequently occurs when Resident A is left alone. Relative #1 & #2 stated Resident A's bedroom in downstairs. Resident A takes a nap daily and/or at night while downstairs, if she wakes up and staff are not immediately present, she becomes anxious and will use this opportunity to self-harm.

On 04/12/2021, Mr. Wilson and I conducted a face-to-face Teams meeting with Annemarie Brenner, Behavior Specialist at Network 180 (Kent County Community Mental Health). Ms. Brenner stated Resident A requires 1:1 staffing all hours of the day, but she is alone in the lower level of the home when she naps or sleeps at night which is when self-injurious behaviors occurred in the past. Mr. Wilson stated that Resident A is not authorized for 24 hour 1:1 supervision that he is aware of. Ms. Brenner stated this facility did not have a home manager for a few months and has had problems with supervision.

On 04/21/2021, Mr. Wilson and I interviewed Melissa Stewart, home manager via telephone. Ms. Stewart stated since 03/15/2021, since she became the home manager, she has tried to have 3 staff on 1st shift which is 8:00AM-4:00PM, 3 staff on 2nd shift, 4:00PM-12:00PM (daytime hours) and 2 staff on 3rd shift, 12:00AM-8:00AM so one staff can be downstairs the entire time while Resident A is on the

lower level. Ms. Stewart stated they do provide 1:1 supervision of Resident A even though she is not a documented as requiring 1:1 supervision. Ms. Stewart stated no other residents in the facility require 1:1 staffing. Ms. Stewart stated the facility is always adequately staffed but acknowledged it has been difficult to keep the facility adequately staffed due to COVID19. She stated if she has to fill in for absent staff, she comes in and works shifts so the residents are properly supervised.

On 04/21/2021, Mr. Wilson and I interviewed Laurie Jones, staff, via telephone. Ms. Jones stated if Resident A is downstairs then a staff person is downstairs with her. When Resident A is sleeping for the night, she is checked on "periodically." Ms. Jones stated there were always 3 staff on 1st and 2nd shift from 8:00AM-8:00PM but more recently, there are only 2 staff each shift because of being "short staffed".

On 04/21/2021, Mr. Wilson and I interviewed Ms. Rodriguez via telephone. Ms. Rodriguez stated there are usually 3 staff on during the daytime hours, 1st, and 2nd shifts, 2 staff on the main level and 1 staff on the lower level with Resident A, 2 staff on 3rd shift with 1 on the main level and 1 on the lower level providing supervision to all residents. Ms. Rodriguez stated she does not know if Resident A is documented as requiring 1:1 staffing. Ms. Rodriguez stated staff are not always downstairs with Resident A, if she naps, staff are not always downstairs providing 1:1 supervision, but Resident A is checked on regularly.

On 04/21/2021, Mr. Wilson and I interviewed Marie Brodock, staff, via telephone. Ms. Brodock stated Resident A is the only resident that requires 1:1 supervision at all times. Ms. Brodock stated staff supervise Resident A at all times. Ms. Brodock stated there is another resident in the home, Resident B who requires some 1:1 supervision but he does not come out of his room much, so staff just check in on him from time to time while he is in his room.

On 05/14/2021, I received and reviewed Resident A's Individual Plan of Service (IPOS) dated 12/10/2020, and an addendum to the IPOS on 03/03/2021 written by Crystal Burnet, Network 180 supports coordinator. On page 5 of the IPOS dated 12/10/2020 it is documented that Resident A requires *'staff be on the same level of the home (when at home) as (Resident A). She can be in her bedroom or the bathroom alone, but staff need to check in/monitor her when there for safety. (Resident A) needs consistent, ongoing encouragement and prompting to attend to her schedule and to use identified coping skills, and visual monitoring to maintain safety and minimize/prevent self-injurious behaviors. She needs these types of intervention many times throughout the day. (Resident A) is not left alone in the bathroom by herself. She is not comfortable being alone in the bathroom because this is where the majority of her SIB (self-injurious behavior) takes place.' On page 6 of the IPOS dated 12/10/2020 it is documented, 'due to risk of elopement and SIB's there should always be a staff on the same level of the home as (Resident A). She can be allowed the opportunity to be independent in her room or bathroom. (Resident A) requests that staff be present in the bathroom when she is in there due to her urges to SIB. She sometimes likes to take a short nap, during which time she*

may be in her room. Staff should then check on her every 15 minutes during that time and may ask (Resident A) to leave her bedroom door cracked open, as this is less disruptive for them to check on her that way. If (Resident A) is in the bathroom independently, staff should check on her after a few minutes to make sure she is safe.' On page 8 of the IPOS dated 12/10/2020 it is documented, 'self-harm and aggression are currently the most egregious behaviors of concern, with (Resident A's) support team identified that she cannot be safely left alone, and there needs to be staff that are available near her in the basement of her home where her room is.' The IPOS dated 03/03/2021 states the same information as the IPOS dated 12/20/2020 in regard to Resident A's supervision needs.

On 05/14/2021, I received and reviewed a Behavior Support Plan (BSP) dated 10/12/2020 and revised on 11/18/2020 and written by Ms. Brenner. The BSP documented on page 5 *'staff are recommended to provide line of sight supervision to (Resident A) at all times, which is defined as staff remaining within 3-5 feet of (Resident A). As much as possible, it is recommended that (Resident A) receives one on one staffing throughout all 24 hours of the day each day. During nighttime/early morning hours, it is recommended in order to decrease (Resident A's) likelihood of engaging in self-injurious behaviors due to less interaction/supervision from staff: staff provide visual checks every 15-30 minutes, and (Resident A) is provided with a walkie talkie that she can utilize throughout these hours to contact staff at any time.'*

On 05/14/2021, I received and reviewed Resident A's Assessment plan for AFC Residents dated 05/13/2021 and signed by Licensee Designee, Delissa Payne and Relative #1. The assessment plan does not document that Resident A requires 1:1 supervision. I received and reviewed Resident A's Resident Care Agreement (RCA) dated 05/13/2021 and signed by Ms. Payne and Relative #1. The RCA does not document that Resident A requires 1:1 supervision.

On 05/14/2021, I received and reviewed the staff schedule from February 2021 through April 2021. The staff schedules show two staff, every shift for first and second shifts in February 2021. Beginning in March 2021 the schedules document three staff are scheduled more often on first shift (but not always) and two staff on second shift. The staff schedules show two staff on third shifts throughout February, March, and April 2021.

On 05/25/2021, I conducted an inspection at the facility and met with Ms. Stewart. I reviewed Resident's B, C, & D's assessment plans for AFC residents and none of the residents require 1:1 supervision. I reviewed Resident's B, C & D's Resident Care Agreements, and none of the RCA's document that Resident's B, C or D require increased supervision or 1:1 supervision.

On 06/09/2021, I conducted an Exit Conference with Licensee Designee, Delissa Payne via telephone. Ms. Payne stated she agrees with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on investigative findings, there is not a preponderance of evidence to show that Resident A or any of the residents in this facility are not being adequately supervised according to their documented plans or that the facility is understaffed and cannot meet the supervision needs of the residents. The care plans for Resident A provide conflicting information regarding the amount of 1:1 supervision Resident A requires but staff are following the most detailed information regarding the supervision of Resident A from the IPOS plan. Therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Direct care staff are not properly trained.

INVESTIGATION: On 03/31/2021, I received a written complaint forwarded to LARA from Edward Wilson, Office of Recipient Rights Director, Kent County Network 180 (Community Mental Health). The complainant reported staff at the facility lack the training and skills to effectively interact and provide adequate care for Resident A.

On 04/05/2021, I interviewed Relative #1, Relative #2 and Resident A with Mr. Wilson at Relative #1 & #2's house. Relative #1 and #2 stated Resident A will fixate on a thought or idea if staff present it to her such as saying, "do not bite," then that will be what Resident A will fixate on, biting. Relative #1 stated by addressing the behavior they are trying to prevent, often will cause Resident A to fixate on that behavior. Relative #1 & #2 stated staff at the facility clearly do not understand Resident A's behavior treatment plan or how to follow the proactive measures in that plan while working with Resident A.

On 04/12/2021, Mr. Wilson and I conducted a face-to-face Teams meeting with Annemarie Brenner, Behavior Specialist at Network 180 (Kent County Community Mental Health). Ms. Brenner stated she meets with staff individually weekly for the first few months of a behavior treatment plan to review Resident A's BSP and coach staff. Ms. Brenner stated however, due to COVID-19, she has not been to the facility to train staff face-to-face but uses virtual methods to train. Ms. Brenner stated staff "in general do not have good behavioral knowledge" and that some staff at the home

treat (Resident A) different than other residents because (Resident A) is higher functioning so they “expect more from her.”

On 04/21/2021, Mr. Wilson and I interviewed Melissa Stewart, home manager via telephone. Ms. Stewart stated the IPOS was completed without staff input. Ms. Stewart stated it is important to have staff input because they work with Resident A daily because the staff are implementing the IPOS every day. Ms. Stewart stated staff at the facility are properly trained in all aspects of resident care including Resident A’s IPOS and BSPs.

On 04/21/2021, Mr. Wilson and I interviewed Laurie Jones, staff, via telephone. Ms. Jones stated staff have talked to a behavior specialist on video about Resident A and about how to handle her behaviors, but Ms. Jones does not recall reading an IPOS document for Resident A. Ms. Jones stated staff try to implement coping skills with Resident A and often talk to Resident A about making better choices. Ms. Jones stated staff at the facility are trained.

On 04/21/2021, Mr. Wilson and I interviewed Ms. Rodriguez and Ms. Brodock via telephone. Ms. Rodriguez and Ms. Brodock stated staff are trained in all aspects of resident care including Resident A’s IPOS and BSP plans.

On 05/14/2021, I received and reviewed staff training documents including MANDT training, IPOS, Behavior Plan training in-service form with staff signatures ranging in dates from 01/18/2021 through 03/22/2021. In addition, an IPOS in-service document dated 02/02/2021 signed by all staff and instructor Crystal Burnett, was reviewed.

On 06/09/2021, I conducted an Exit Conference with Licensee Designee, Delissa Payne via telephone. Ms. Payne stated she agrees with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(3) A licensee and direct care staff who are responsible for implementing the resident’s written assessment plan shall be trained in the applicable behavior intervention techniques.
ANALYSIS:	Based on investigative findings, there is a preponderance of evidence to show through a review of staff trainings and in-service records for Resident A’s IPOS and BSP plans, that staff have been trained in applicable behavior intervention techniques.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Direct care staff do not regularly clean Resident A's toilet creating an unsanitary environment.

INVESTIGATION: On 03/31/2021, I received a written complaint forwarded to LARA from Edward Wilson, Office of Recipient Rights Director, Kent County Network 180 (Community Mental Health). The complainant reported the water to Resident A's toilet is turned off and staff do not regularly flush or clean out the toilet leaving it dirty and soiled.

On 04/05/2021, I interviewed Relative #1, Relative #2 and Resident A with Mr. Wilson at Relative #1 & #2's house. Relative #1 stated over the years, Resident A has flushed in excess of $10,000.00 worth of glasses, lenses to her glasses, expensive diabetic equipment, and numerous other items down the toilet. Relative #1 stated due to this, Resident A's toilet is turned off and on by staff to prevent Resident A from flushing things down the toilet. This is part of Resident A's approved behavior plan, staff are responsible for turning the water on, flushing the toilet, and then turning the water back off. Relative #1 stated recently, he went into Resident A's bathroom and found the toilet full of toilet paper, urine, and stool. There was so much that Relative #1 put on a glove and physically removed all of this out of the toilet as it was well beyond what could be flushed. On 03/20/2021, Relative #1 took Resident A back to the facility after being gone for 5.5 hours and found the toilet, again, filled with urine and stool, the bathroom smelled. Relative #1 stated staff took care of it this time.

On 04/12/2021, Mr. Wilson and I conducted a face-to-face Teams meeting with Annemarie Brenner, Behavior Specialist at Network 180 (Kent County Community Mental Health). Ms. Brenner stated there are no written protocols for staff to turn Resident A's toilet off to prevent her from flushing items down the toilet. Ms. Brenner stated staff should be present when Resident A uses the bathroom anyway and it is not unreasonable to expect that the toilet be flushed and cleaned out.

On 04/21/2021, Mr. Wilson and I interviewed Laurie Jones, staff, via telephone. Ms. Jones stated Resident A's toilet water is turned off because she was flushing items down the toilet. Ms. Jones stated the toilet water is turned back on each time Resident A has a bowel movement in the toilet, at least one time per shift the water is turned back on and the toilet is flushed. Ms. Jones states she "rarely" saw the toilet not flushed and stated that sometimes staff may get sidetracked and forget to flush the toilet, but every time Resident A had a BM, the toilet is flushed by staff.

On 04/21/2021, Mr. Wilson and I interviewed Ms. Rodriguez via telephone. Ms. Rodriguez stated that staff flush Resident A's toilet periodically throughout the day but stated she has observed times when the toilet was not flushed and full of waste as the complaint details.

On 04/21/2021, Mr. Wilson and I interviewed Ms. Brodock via telephone. Ms. Brodock stated Resident A's toilet is supposed to be flushed and staff are not doing

it on a consistent basis. Ms. Brodock stated she has found the toilet full of waste and disgusting. Ms. Brodock stated she has “gotten after” staff about this.

On 05/14/2021, I received and reviewed an Individual Plan of Service (IPOS) dated 12/10/2020, and an addendum to the IPOS on 03/03/2021 written by Ms. Burnet, and a Behavior Support Plan (BSP) dated 10/12/2020 and revised on 11/18/2020 and written by Ms. Brenner. Neither plan documents that Resident A’s toilet water should be shut off.

On 05/14/2021, I received and reviewed Resident A’s Assessment plan for AFC Residents and the assessment plan does not document any instructions that Resident A’s toilet water should be shut off to prevent Resident A from flushing items down the toilet. The assessment plan documents that Resident A does not need assistance with toileting, she is independent with toileting (but needs help with monitoring behaviors while in the bathroom).

On 05/25/2021, I conducted an inspection at the facility, inspected Resident A’s bathroom and interviewed Ms. Stewart. Ms. Stewart showed me a cleaning log that staff keep which documents when Resident A’s toilet was flushed and cleaned. I inspected Resident A’s bathroom and the bathroom was clean, the toilet water was off, and the bowel was clean. Ms. Stewart showed me how staff turn the water back on and that the toilet is in good working order by flushing it. The rest of the bathroom was clean and did not smell.

On 06/09/2021, I conducted an Exit Conference with Licensee Designee, Delissa Payne via telephone. Ms. Payne stated she will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Resident A’s assessment plan, IPOS or BSP plan do not document any directions to turn the toilet water on and off to prevent Resident A from flushing items down the toilet. Based on my investigative findings, there is evidence to show that on more than one occasion staff and Relative #1 have found Resident A’s toilet was full of waste and not clean. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

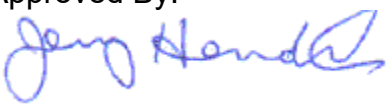
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

06/09/2021

Elizabeth Elliott — Date
Licensing Consultant

Approved By:



06/09/2021

Jerry Hendrick — Date
Area Manager