GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 28, 2021

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

RE: License #: AS410281933
Investigation #: 2021A0350040
22 - Mile Home

Dear Mrs. Payne:

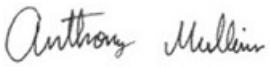
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each 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,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 204-2515

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS410281933 |
| | |
| **Investigation #:** | 2021A0350040 |
| | |
| **Complaint Receipt Date:** | 06/17/2021 |
| | |
| **Investigation Initiation Date:** | 06/17/2021 |
| | |
| **Report Due Date:** | 08/16/2021 |
| | |
| **Licensee Name:** | Spectrum Community Services |
| | |
| **Licensee Address:** | 28303 Joy Rd.<br>Westland, MI 48185 |
| | |
| **Licensee Telephone #:** | (269) 927-3472 |
| | |
| **Administrator:** | Delissa Payne |
| | |
| **Licensee Designee:** | Delissa Payne |
| | |
| **Name of Facility:** | 22 - Mile Home |
| | |
| **Facility Address:** | 2200 22 - Mile Road<br>Sand Lake, MI 49343 |
| | |
| **Facility Telephone #:** | (616) 636-8920 |
| | |
| **Original Issuance Date:** | 05/08/2006 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 11/07/2020 |
| | |
| **Expiration Date:** | 11/06/2022 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Direct Care Worker (DCW) Fredrick Brockway threatened to burn Resident A's family photo. | Yes |
| DCW Fredrick Brockway applied an inappropriate MANDT hold on Resident A on 06/11/2021. | No |

## III. METHODOLOGY

| | |
|---|---|
| 06/17/2021 | Special Investigation Intake<br>2021A0350040 |
| 06/17/2021 | Special Investigation Initiated - Telephone<br>Telephone call made to home manager, Regan Paige. |
| 06/18/2021 | Contact - Telephone call made<br>Michelle Richardson, Office of Recipient Rights. |
| 06/18/2021 | Inspection Completed On-site<br>Interviewed Resident A and staff. |
| 06/18/2021 | Contact - Telephone call made<br>Interviewed staff. |
| 06/18/2021 | Inspection Completed-BCAL Sub. Compliance |
| 06/24/2021 | Exit Conference<br>Completed with Delissa Payne |

**ALLEGATION: DCW Fredrick Brockway threatened to burn Resident A's family photo.**

**INVESTIGATION:** On 06/17/21, I received an Office of Recipient Rights complaint. The complaint alleged that Fredrick Brockway threatened to burn Resident A's family photo during an incident whe**n** Resident A was refusing to give staff a piece of plastic that he used to cut himself. The initial contact was completed by Licensing Consultant, Ian Tschirhart. The proceeding contacts were completed by AFC Licensing Consultant, Anthony Mullins.

On 06/18/21, I called Recipient Rights worker, Michelle Richardson in attempt to coordinate a plan to address the allegations together. I left a voicemail message requesting a call back.

On 06/18/21, Mr. Tschirhart and I made an unannounced onsite investigation to 22 – Mile Rd home. While onsite, we interviewed Resident A in the staff office and he was

able to recall the reported incident between he and Mr. Brockway approximately one week ago. Resident A stated that Mr. Brockway was holding him because he (Resident A) wouldn't give him a piece of plastic that he had in his mouth. During this incident, Resident A stated that Mr. Brockway was trying to fight him and asked him if he wanted to fight.

On 06/18/21, I called Krystal Vandis (DCW) and asked her to share what she observed during the incident between Resident A and Mr. Brockway. During the incident mentioned above in which Mr. Brockway was attempting to get a piece of plastic from Resident A, Ms. Vandis stated that Mr. Brockway asked Resident A "you want to fight?" Ms. Vandis stated that she told Mr. Brockway to calm down. She also added that this is consistent behavior from Mr. Brockway and he always has to get the last words with residents. DCW, John Hulbert was away from the home at this time. When Mr. Hulbert returned, Ms. Vandis stated that she stepped out of the room where Mr. Brockway and Resident A were to explain to Mr. Hulbert what was going on. After relaying the information to Mr. Hulbert, Ms. Vandis stated that she started to light a cigarette. While doing so, Mr. Brockway asked her to bring him the lighter so he could burn Resident A's family photo. Ms. Vandis stated that she told Mr. Brockway that he could not light Resident A's picture on fire and reassured Resident A that it would not happen.

On 06/18/2021, I called DCW John Hulbert. Mr. Hulbert stated that he observed what he identified as verbal abuse. Mr. Hulbert stated that Mr. Brockway picked up a photo of Resident A's family and asked who was in the picture. Resident A never responded and he Mr. Brockway told Resident A that he was going to burn the picture with the rest of his belongings. Mr. Hulbert assured Resident A that his belongings would not get burned.

On 06/18/21, I called DCW Fredrick Brockway. Mr. Brockway stated that he was attempting to get a piece of plastic away from Resident A. Mr. Brockway acknowledged that he did ask for a lighter because "I might have said I was going to burn his (Resident A) picture but I wasn't going to actually burn it." Mr. Brockway stated that if he told Resident A he wanted to fight or that he wanted to burn his picture, it was due to his "adrenaline pumping."

On 06/21/21, I spoke to Michelle Richardson from the Office of Recipient Rights. Michelle stated that she went out to address the allegations this past Thursday (06/17/21). Michelle stated that she is substantiating for a violation of the Mental Health Code for dignity and respect due to Fredrick threatening to burn Resident A's family photo.

On 06/24/21, I completed an exit conference with licensee Designee, Delissa Payne. She was informed of the investigation findings and recommendations. Mrs. Payne was accepting of the rule violation and stated that she will complete a Corrective Action Plan as soon as possible. Now that the investigation is completed, Mrs. Payne plans to proceed with disciplinary action of Mr. Brockway.

| 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 the investigative findings, there is a preponderance of evidence to show that on 06/11/21, Fredrick Brockway threatened to burn Resident A's family photo. Not only did Fredrick acknowledge this, Ms. Vandis and Mr. Hulbert also acknowledged that they heard Mr. Brockway threatening to burn Resident A's photo. Therefore, a violation of this applicable rule is established. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION: DCW Fredrick Brockway applied an inappropriate MANDT hold on Resident A on 06/11/2021.**

**INVESTIGATION:** On 06/17/2021, Adult Foster Care (AFC) Licensing Consultant, Ian Tschirhart, made the initial contact in this case by speaking with Regan Paige, Program Manager for this home. Mr. Tschirhart asked Ms. Paige about the maneuver DCW Mr. Brockway used on Resident A who was biting him on 06/11/21. Ms. Paige stated that Mr. Brockway used his arm to apply pressure to Resident A's chest but did not choke him. Ms. Paige informed Mr. Tschirhart that although this was not an approved MANDT maneuver, Resident A was not harmed in the process. MANDT is a program that uses evidence-based techniques for conflict resolution and de-escalation to help prevent violence in the workplace. Ms. Paige reported that "Bite Release" maneuvers were no longer part of MANDT training, and that Mr. Brockway was supposed to hold Resident A (she did not explain how) and to continuously tell Resident A to stop biting until he stopped.

On 06/18/21, Consultant Ian Tschirhart and I made an unannounced onsite investigation to 22 – Mile Rd home. While onsite, we interviewed Resident A in the staff office and he was able to recall the reported incident between he and Mr. Brockway approximately one week ago. Resident A stated that Mr. Brockway was holding him due to not giving him a piece of plastic that he had in his mouth. When Mr. Brockway attempted to take the plastic away from Resident A, Resident A stated that he bit Mr. Brockway's hand. After doing so, Mr. Brockway reportedly pushed down on Resident A's chest to stop him from biting him. Resident A demonstrated this motion by putting his forearm against his chest area. Resident A stated that DCW Mr. Hulbert witnessed this incident as well. Resident A showed both

consultants a superficial linear scratch on his chest that he stated was caused by Mr. Brockway. Resident A also stated that Mr. Brockway held him by the sides of his neck and demonstrated this by squeezing his hands on the sides of his neck. Resident A stated that he could barely breathe when this occurred. It should be noted that there were no visible marks or bruises observed on Resident A's neck. Prior to leaving the home, Resident A told Mr. Tschirhart that Mr. Brockway also pinched his nose and no other staff or residents witnessed the incident. There were no visible marks or bruises on Resident A's nose. There were, however, cuts on the inside and outside of Resident A's hands. Resident A admitted to harming himself out of frustration. Mr. Tschirhart and I spoke with Program Manager, Ms. Paige after she arrived. She provided me with phone numbers for all three staff members that were reportedly involved in the incident, which were Krystal Vandis, John Hulbert, and Fredrick Brockway. Ms. Paige also provided me with a copy of Mr. Brockway's MANDT training certificate and Resident A's health care appraisal. Resident A's health care appraisal did not provide any pertinent details related to this investigation. Mr. Brockway's training certificate confirms he has been provided with appropriate de-escalation techniques to address difficult and defiant residents.

On 06/18/21, I called DCW Ms. Vandis. She stated DCW Mr. Hulbert was away from the home transporting another resident. While Mr. Hulbert was away, Mr. Brockway called her to assist him in getting a piece of plastic from Resident A after he cut his hand with it and put it in his mouth. Resident A refused to give Ms. Vandis the plastic and she notified the program manager Ms. Paige via phone. Ms. Vandis and Mr. Brockway both attempted to get the plastic out of Resident A's possession. While doing so, Resident A began kicking. Ms. Vandis held Resident A's legs to prevent him from harming anyone while Mr. Brockway continued to work on obtaining the plastic from Resident A. DCW Mr. Hulbert eventually returned to the home and Ms. Vandis stated that she stepped out of the room where Mr. Brockway and Resident A were to explain to Mr. Hulbert what was going on. Shortly after leaving work on the day of the incident, Ms. Vandis stated that she missed a call from the 22-Mile Rd home. The caller did not leave a message. Ms. Vandis returned a call to the home and spoke to Fredrick. Fredrick told her "I kind of choked him (Resident A)." After Krystal explained to Mr. Brockway why his reported actions were wrong. Mr. Brockway then stated, "I didn't really choke him. I applied pressure to his neck." Ms. Vandis made it clear that she did not physically see Mr. Brockway choke Resident A and was adamant that she would have intervened if she did. Ms. Vandis stated that she is MANDT trained and the technique Mr. Brockway told her he used on Resident A is not a technique that is taught in MANDT. Ms. Vandis denied witnessing Mr. Brockway assault or harm any resident in the home. Ms. Vandis stated that Mr. Hulbert denied witnessing Mr. Brockway choke Resident A.

On 06/18/2021 I called DCW Mr. Hulbert. Mr. Hulbert stated that he left the home to pick-up another resident from work. Prior to leaving, Mr. Hulbert asked Mr. Brockway and Ms. Vandis to prompt Resident A to take his medication due to him refusing. When Mr. Hulbert returned to the home, Ms. Vandis told him that Resident A used an item to cut himself and put the item in his mouth. Mr. Hulbert went to Resident A's

room to ask him what was going on. While in the room, Mr. Hulbert noticed that Resident A did in fact have a piece of plastic in his mouth. Resident A was lying in bed and eventually spit the plastic into his hand. Mr. Hulbert prompted Resident A to take his medication and he refused. Due to Resident A continuing to have the plastic in his hand, Mr. Hulbert stated that he grabbed his wrist and handed it to Mr. Brockway. Mr. Brockway tried to get the plastic out of Resident A's hand. While doing so, Resident A bit his hand. Mr. Hulbert prompted Resident A to let go of Mr. Brockway's hand and he eventually did so. Mr. Brockway was adamant that he did not witness Mr. Brockway choke Resident A or use any form of physical abuse towards him.

On 06/18/21, I called DCW Mr. Brockway. Mr. Brockway stated that he was attempting to get a piece of plastic away from Resident A. While doing so, Resident A bit his hand. To stop Resident A from biting him, Mr. Brockway stated "my arm was underneath his neck." Mr. Brockway stated that he lifted his arm near Resident A's chest area "just enough to get him off my hand." Mr. Brockway stated that he is MANDT trained and the technique he used on Resident A is not a MANDT trained technique. Despite this, Mr. Brockway was adamant that he did not hurt Resident A. The incident report that Mr. Brockway completed also stated that he used a technique that is not taught in MANDT. Mr. Brockway stated that DCW Mr. Hulbert was present when Resident A bit him but he is unsure if Mr. Hulbert saw him put his arm near Resident A's chest/neck area. Mr. Brockway denied choking Resident A and denied telling his colleagues that he choked him.

On 06/21/21, I spoke to Michelle Richardson from the Office of Recipient Rights. Michelle stated that she went out to address the allegations this past Thursday (06/17/21). Michelle stated that she is not substantiating a violation of the Mental Health Code for physical abuse as there is no evidence to confirm this based on her investigation.

On 06/24/21, I completed an exit conference with licensee Designee, Delissa Payne. Mrs. Payne was informed of the investigation and the findings.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14308** | **Resident behavior interventions prohibitions.** |
| | (2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:<br>(b) Use any form of physical force other than physical restraint as defined in these rules. |

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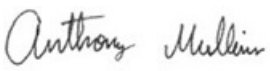
|---|---|
| **ANALYSIS:** | Based on the investigative findings, there is not a preponderance of evidence to show that on 06/11/21, Mr. Brockway used physical force other than defined in these rules to stop Resident A from biting him. Resident A stated that Mr. Brockway used his forearm to push down on his chest to stop him from biting him. He also stated that Mr. Brockway squeezed his neck on both sides. There was no physical evidence of this and no witnesses to confirm this. DCW Mr. Hulbert was in the same room when Resident A bit Mr. Brockway and denied witnessing Mr. Brockway choke him. DCW Ms. Vandis stated that Mr. Brockway told her that he "kind of" choked Resident A. Ms. Vandis acknowledged that she did not witness it herself. Therefore, a violation of this applicable rule is not established. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

## IV. RECOMMENDATION

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



06/28/2021

Anthony Mullins — Date
Licensing Consultant

Approved By:

06/28/2021

Jerry Hendrick — Date
Area Manager