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## STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

December 8, 2021

Monica Salingue Spectrum Community Services Suite 700 185 E. Main St Benton Harbor, MI 49022

> RE: License #: AS690402535 Investigation #: 2022A0009007

> > Dakota

#### Dear Ms. Salingue:

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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (231) 922-5309.

Sincerely,

Adam Robarge, Licensing Consultant

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Bureau of Community and Health Systems

Suite 11

701 S. Elmwood Traverse City, MI 49684

(231) 350-0939

enclosure

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

#### I. IDENTIFYING INFORMATION

License #:	AS690402535
Investigation #:	2022A0009007
Investigation #:	2022A0009007
Complaint Receipt Date:	11/16/2021
Investigation Initiation Date:	11/16/2021
Report Due Date:	12/16/2021
Report Bue Bate.	12/10/2021
Licensee Name:	Spectrum Community Services
Licensee Address:	28303 Joy Rd.
	Westland, MI 48185
Licensee Telephone #:	(173) 445-8872
Administrator:	Monica Salingue
Licensee Designee:	Monica Salingue
Licensee Designee.	Worlica Sailingue
Name of Facility:	Dakota
Facility Address:	784 Dakota Ave
	Gaylord, MI 49735
Facility Telephone #:	(989) 448-2716
Original Issuance Date:	06/09/2020
License Status:	REGULAR
License Status.	REGOLAR
Effective Date:	12/09/2020
Expiration Date:	12/08/2022
Capacity:	5
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Program Type:	DEVELOPMENTALLY DISABLED
	MENTALLY ILL

#### II. ALLEGATION(S)

Violation	
Established?	?

A direct care worker was overheard being verbally abusive to	Yes
Resident A.	

#### III. METHODOLOGY

11/16/2021	Special Investigation Intake 2022A0009007
11/16/2021	Special Investigation Initiated - Telephone call made to licensee designee/administrator Ms. Monica Salingue
11/19/2021	Inspection Completed - On-site Interview with Resident A and direct care workers Ms. Ashley Thumma and Ms. Alexis Newton
12/07/2021	Contact – Telephone call made to direct care worker Ms. Haile Edmonds
12/07/2021	Contact – Telephone call made to former direct care worker Ms. Bethany Coultes
12/07/2021	Contact – Telephone call made to licensee designee/administrator Ms. Monica Salingue
12/07/2021	Exit conference with licensee designee/administrator Ms. Monica Salingue

### ALLEGATION: A direct care worker was overheard being verbally abusive to Resident A.

**INVESTIGATION:** I spoke with licensee designee/administrator Monica Salingue by phone on November 16, 2021. She stated that her staff had reported overhearing direct care worker Bethany Coultes being verbally abusive to Resident A on November 13, 2021. Ms. Salingue stated that she responded by immediately suspending Ms. Coultes and contacting the Community Mental Health (CMH) office of recipient rights. Ms. Salingue informed me that Ms. Coultes' boyfriend and brother typically also occasionally pick up shifts at Dakota.

I conducted an unannounced site inspection at the Dakota adult foster care (AFC) home on November 19, 2021. I wore personal protection equipment to protect myself and others. Direct care workers Ashley Thumma and Alexis Newton were

present with the residents. I spoke with Resident A initially. I interviewed her using the Forensic Interviewing protocol. After some preliminary discussion, I asked her how she liked living at Dakota. She said that she liked the staff there and recently got rid of the "main problem". I asked her what she meant. Resident A stated that Bethany Coultes threatened her. Ms. Coultes told her that if she, her brother or her boyfriend got "written-up" because of her (Resident A) she would get her kicked out of the home. Resident A stated Ms. Coultes used the "f-word" and had a raised voice. I asked Resident A why Ms. Coultes said that to her. Resident A explained that Ms. Coultes' boyfriend also sometimes works at the home. She heard Ms. Coultes and her boyfriend arguing during a shift-change. They were arguing about her wanting him to do some cleaning. Resident A stated that she told another staff person about what she overheard. Ms. Coultes found out that Resident A told another staff about it and was mad at her about telling them. Ms. Coultes used a raised voice, used the "f-word" and threatened to get Resident A kicked out of the home. Resident A went on to say that it wasn't the first time that Ms. Coultes had velled at her. She said that Ms. Coultes yelled at her "about random crap". I asked her what she meant by Ms. Coultes yelling. Resident A replied that she meant that Ms. Coultes uses a "raised voice" or a "mean voice". She denied that Ms. Coultes had called her (Resident A) derogatory names or ever called her swear words. She did say that Ms. Coultes had threatened to get her A kicked out of the home one other time.

I then spoke with direct care worker Ashley Thumma. She said that Resident A had told her about overhearing Ms. Coultes and her boyfriend verbally fighting with each other at the home. Ms. Thumma mentioned something to Ms. Coultes about it. On the morning of November 13, 2021 she came in to work and Ms. Coultes was finishing her shift. Ms. Coultes was angry at Resident A because she knew that Resident A had told someone about Ms. Coultes fighting with her boyfriend at the home. That morning, she heard Ms. Coultes tell Resident A that she is sick of her creating a bunch of drama in the home. She told Resident A, that if anything happens with her, her boyfriend or her brother they were going to have a "fucking problem". She also told Resident A that she would get her (Resident A) "kicked out" of the home. Ms. Coultes was using a loud voice, not guite yelling but using a raised voice. When she entered the room, she saw Resident A starting to dig at her arms. Resident A self-harms and this is the first sign that she is going to do that. Resident A later told her to take a pen away from her because she was feeling as if she was going to hurt herself with it. Ms. Thumma stated that Ms. Coultes often gets mad at the residents and uses a raised voice with them. Ms. Thumma stated she did not have any other examples of Ms. Coultes mistreating any of the home's residents.

I then spoke with direct care worker Alexis Newton. She was not present when Ms. Coultes made the comments to Resident A on November 13, 2021. Ms. Newton stated that the only thing that she has ever noticed about how Ms. Coultes interacts with residents is her tone of voice. She said that the tone of voice that Ms. Coultes uses with the residents is "awful". It is not exactly what she says but how she says it. She never knew her to call the residents names or say things of a derogatory

nature. She said that was all she really knew and does not often work the same shift as Ms. Coultes. She did not know about anything else inappropriate happening at the home.

I spoke with direct care worker Haile Edmonds by telephone on December 7, 2021. She said that it was only her second day of work at the Dakota AFC home on November 13, 2021. She had just come into work and Ms. Thumma was showing her how to administer medication at the medication cart. They heard Ms. Coultes "yelling at" Resident A. Ms. Coultes told her, "Me and you are going to have a fucking problem if me or Joe gets in trouble." Ms. Coultes further told Resident A that she was going to get her (Resident A) kicked out of the home or she, herself, would transfer to another home. Ms. Coultes then said loudly, "I'm done with this" and left. Ms. Edmonds stated that Resident A was really upset and crying for about three hours following the incident. Resident A told them she was nervous about being kicked out and about Ms. Coultes returning to the home. Ms. Edmonds denied that Ms. Coultes has returned and stated that things have been good at the home since that time.

I spoke with former direct care worker Bethany Coultes by telephone on December 7, 2021. She said that her employment with Spectrum (Community Services) had been terminated. I told her that she did not need to make a statement to me but that she could if she wished. Ms. Coultes admitted that she used the "f-word" with Resident A. She said that she regretted that. She said that she just told Resident A that if she caused "an issue" for her, they would have a "fucking problem". Ms. Coultes stated that she only told Resident A that she, herself, would transfer to another home. She denied telling her that she would get Resident A kicked out of the home. Ms. Coultes stated that she knew she "messed up". She said that her employment was suspended after the incident and she was more recently terminated.

I spoke with licensee designee/administrator Ms. Monica Salingue by telephone on December 7, 2021. She confirmed that Ms. Coultes' employment with Spectrum Community Services had been terminated.

APPLICABLE RULE		
R 400.14307	Resident behavior interventions generally.	
	(1) A licensee shall ensure that methods of behavior intervention are positive and relevant to the needs of the resident.	
ANALYSIS:	It was confirmed through this investigation that the licensee did not ensure that methods of behavior intervention were positive and relevant to the needs of Resident A. This occurred on November 13, 2021, when a direct care worker told Resident A that she would have a "fucking problem" with her if she or others	

	got into trouble and that she would have Resident A kicked out of the home.
CONCLUSION:	VIOLATION ESTABLISHED

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:  (a) Use any form of punishment. (b) Use any form of physical force other than physical restraint as defined in these rules.  (c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.  (d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.  (e) Withhold food, water, clothing, rest, or toilet use.  (f) Subject a resident to any of the following:  (i) Mental or emotional cruelty.  (ii) Verbal abuse.  (iii) Derogatory remarks about the resident or members of his or her family.  (iv) Threats.  (g) Refuse the resident entrance to the home.  (h) Isolation of a resident as defined in R400.14102(1)(m).  (i) Any electrical shock device.	
ANALYSIS:	It was confirmed through this investigation that a direct care worker did subject Resident A to mental or emotional cruelty, verbal abuse and threats. This occurred on November 13, 2021, when a direct care worker told Resident A that she would have a "fucking problem" with her if she or others got into trouble and that she would have Resident A kicked out of the home.	
CONCLUSION:	VIOLATION ESTABLISHED	

I conducted an exit conference with licensee designee/administrator Ms. Monica Salingue by telephone on December 7, 2021. I told her of the findings of my investigation and gave her the opportunity to ask questions.

#### IV. RECOMMENDATION

I recommend no change in the license status.

ada Polian	12/08/2021
Adam Robarge	Date
Licensing Consultant	
Approved By:	
0 0	12/08/2021
Jerry Hendrick	Date
Area Manager	