GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 26, 2022

Janet Difazio
Spectrum Community Services
28303 Joy Rd.
Westland, MI 48185

RE: License #: AS630397222
Investigation #: 2022A0991021
Adams Home

Dear Ms. Difazio:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 (248) 975-5053.

Sincerely,

Kristen Donnay

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630397222
Investigation #:	2022A0991021
Complaint Receipt Date:	03/17/2022
Investigation Initiation Date:	03/17/2022
Report Due Date:	05/16/2022
Licensee Name:	Spectrum Community Services
Licensee Address:	28303 Joy Rd. Westland, MI 48185
Licensee Telephone #:	(734) 458-8729
Licensee Designee:	Janet Difazio
Name of Facility:	Adams Home
Facility Address:	4609 Butler Troy, MI 48098
Facility Telephone #:	(248) 524-1275
Original Issuance Date:	06/18/2019
License Status:	1ST PROVISIONAL
Effective Date:	12/14/2021
Expiration Date:	06/13/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident D passed away on 03/16/22 after being found unresponsive on the floor next to her bed at 5:00am. The incident report notes staff checked on her at 3:00am and 5:00am, but Resident D's plan indicates bed checks should be completed every 15 minutes.	Yes

III. METHODOLOGY

03/17/2022	Special Investigation Intake 2022A0991021
03/17/2022	Special Investigation Initiated - Telephone To licensee designee, David Powell
03/17/2022	Contact - Document Received Incident Report and bed check sheet
03/17/2022	Referral - Recipient Rights Call to Office of Recipient Rights, left message for Brittany Navetta
03/17/2022	Contact - Telephone call made To licensee designee, David Powell, re: inconsistencies with bed check forms
03/18/2022	APS Referral Adult Protective Services (APS), call made to Centralized Intake
03/18/2022	Contact - Telephone call received From Brittany Navetta- ORR worker
03/18/2022	Contact - Document Received Crisis plan and plan of service
03/22/2022	Inspection Completed On-site Unannounced onsite inspection - interviewed home manager
03/22/2022	Contact - Document Received Health care chronological, IPOS training sheet,
03/22/2022	Contact - Telephone call made Left message for Cynthia Pringle

03/28/2022	Contact - Telephone call made To Christen Collins, no voicemail
03/28/2022	Contact - Telephone call made To Cynthia Pringle, left message
03/28/2022	Contact - Telephone call received Interviewed staff, Christen Collins
03/28/2022	Contact - Telephone call received From Spectrum Chief Operating Officer (COO), Sharon Blain
03/28/2022	Contact - Telephone call made Interviewed Spectrum nurse, Brenda Curtis
03/28/2022	Contact - Telephone call made Left message for Spectrum deputy director, Carla Wicks
03/28/2022	Contact - Telephone call received Interviewed staff, Cynthia Pringle
03/28/2022	Contact - Document Received Records request sent to Troy Police from ORR
03/29/2022	Contact - Telephone call received Interviewed deputy director, Carla Wicks
03/29/2022	Contact - Document Received Received Resident D's death certificate
04/15/2022	Contact - Document Sent Records request to Troy Police Department
04/19/2022	Contact - Document Received Police report and 911 recording
04/20/2022	Exit Conference Via telephone with licensee designee, Janet DiFazio

ALLEGATION:

Resident D passed away on 03/16/22 after being found unresponsive on the floor next to her bed at 5:00am. The incident report notes staff checked on her at 3:00am and 5:00am, but Resident D's plan indicates bed checks should be completed every 15 minutes.

INVESTIGATION:

Adams Home is currently on a 1st provisional license, which was issued on 12/14/2021 following the licensing renewal inspection due to numerous quality of care deficiencies.

On 03/16/22, I received a phone call from the licensee designee, David Powell, informing me that Resident D died earlier that morning. Mr. Powell reported that staff found Resident D on her bedroom floor, next to her bed, at 5:00am. Staff called 911 and notified David Powell, but Resident B was already cold to the touch. Mr. Powell reported that staff previously checked on Resident D at 3:00am and then found her on the floor around 5:00am. Mr. Powell believed Resident D required bed checks every two hours. I requested that Mr. Powell review Resident D's plan of service to verify the required bed checks. On 03/17/22, I received an email from Mr. Powell indicating that Resident D's plan requires bed checks every 15 minutes. Based on this information, I created an intake on 03/17/22, which was assigned to me for investigation. I made a referral to the Office of Recipient Rights (ORR) and Adult Protective Services (APS).

I received and reviewed a copy of the incident report that was completed by the medication lead, Cynthia Pringle. It notes that the incident occurred at 5:15am on 03/16/22. The incident report states that staff walked into Resident D's bedroom and noticed her lying on the floor next to the bed in a fetal position with one leg straight. Staff moved items out of the way. Staff immediately called 911 and the director. There was a report of death form attached to the incident report that notes Cynthia Pringle checked on Resident D at 3:00am. The staff indicated she was fine. Staff checked Resident D again at 5:00am. She was found on the floor in a fetal position. The staff indicated she was cold to the touch. Staff contacted 911 and called the director, David Powell, to inform him of the incident. Paramedics arrived at 5:35am. Resident D was pronounced dead at 5:40am. Resident D's guardian, supports coordinator, and the state licensing consultant were informed of the incident. The report of death notes that Resident D had no significant medical changes in the last 90 days.

I received and reviewed copies of Resident D's monitoring chart that is used for bed checks. The licensee designee, David Powell, indicated that staff originally completed the incorrect form for bed checks, as it was for second shift and not the midnight shift. This monitoring chart was initialed "S" for sleeping in 15-minute increments from 3:00-5:15 on 03/15/22. It does not specify AM or PM. The monitoring sheet was not completed at all for 03/16/22. Mr. Powell indicated that he told Ms. Pringle that she was using the wrong form, so she sent him a different monitoring form that was completed for the midnight shift. This form was initialed "S" for sleeping in 15-minute increments from 9:15-5:00 on 03/15/22. It does not specify AM or PM. The form was initialed "C" for changed at 10:00, 12:00, and 3:00. Mr. Powell indicated that he did not know how staff were conducting checks. It was unclear if they were just listening at the door or going into the room and completing a visual check. He stated that if they were completing checks every 15 minutes, Resident D likely would not have been cold to the touch when they found her at 5:00am.

I received and reviewed a copy of Resident D's individual plan of service (IPOS) and crisis plan which were effective 02/01/22, as well as a copy of her AFC assessment plan dated 03/07/21. I noted the following information from the documents:

Resident D's crisis plan indicates Resident D has bed checks performed every 15 minutes, as Resident D may try to get up and out of bed on her own, posing a possible fall risk. Home staff currently keep mats/pillows on floor around the bed. An updated OT (occupational therapy) assessment will be requested to address bed safety and provide appropriate bed safeguards as needed.

Resident D's crisis plan indicates that Resident D has a floor mat, as Resident D is at risk for falling if she gets out of her bed at night, or gets up out of a chair.

Resident D's AFC assessment plan indicates that Resident D uses a floor mat alarm, as she will try to get up and fall.

Resident D's IPOS notes that caregivers are responsible to maintain equipment on a daily basis. They should contact OT (occupational therapy) or SC (supports coordinator) when there are repair or replacement needs. OT will order equipment and/or train caregivers as needed. Prescriptions are necessary for all new equipment and repairs. Resident D is unable to get up by herself, which is a safety risk. She needs assistance for ambulation as she has an unsteady gait.

On 03/22/22, I conducted an unannounced onsite inspection at Adams Home with the assigned ORR worker, Brittany Navetta. I interviewed the home manager, Thomasina Harris. Ms. Harris indicated that she has worked in the home since January 2022. Ms. Harris was not working on 03/16/22 when Resident D passed away. She stated that Cynthia Pringle and Christen Collins were on shift. Ms. Harris stated that Resident D required bed checks every 30 minutes throughout the night. Staff would check to see if Resident D needed to be changed or if she was up, as Resident D was frequently up at night. Staff are required to go into the bedroom when they are completing their bed checks. Ms. Harris did not know if staff were required to document bed checks on the midnight shift. She stated that she does not work midnights. Ms. Harris typically begins work at 7:00am. Resident D is still in bed when she begins her shift.

Ms. Harris stated that she was not aware of Resident D having a history of falling out of bed. Resident D did not have bed rails or a mat on the floor. She did not have any assistive devices on her bed or in her bedroom. Ms. Harris never observed anything on the floor by Resident D's bed. There were no pillows on the floor, and she never saw Resident D's wheelchair by her bed. Ms. Harris indicated that she last worked a shift in the home on 03/15/22. She stated that Resident D was fine that day. Resident D got up and had breakfast. Resident D had an appointment with her primary care physician that day to review her medications and get a new wheelchair, but she was not having any medical concerns. Ms. Harris could not locate an appointment information record in Resident D's file from that appointment. Ms. Harris indicated that she had a missed call

from Cynthia Pringle around 5:00am on 03/16/22, but she did not hear her phone ringing. She did not find out that Resident D had passed away until later that afternoon when she spoke with the licensee designee, David Powell. Ms. Harris stated that she received training regarding Resident D's plan of service. She stated that Cynthia Pringle is the medication lead and trains new staff. Ms. Pringle sat down with her and went through Resident D's plan with her. Ms. Harris provided a copy of an IPOS training record form for Resident D. Staff signed the form acknowledging that they were trained regarding the goals and objectives in Resident D's IPOS and crisis plan. The form notes that the trainer was the home manager, Thomasina Harris, and that training was completed on 03/09/22.

During the onsite inspection, I observed Resident D's bedroom. There was a bedside table next to Resident D's bed. Resident D had a thick mattress on her bed, which was high off the ground, as the bed frame also had built in dresser drawers underneath it. I did not observe any floor mats in the bedroom or closet.

During the onsite inspection, I reviewed a copy of Resident D's health care chronological (HCC). Cynthia Pringle made an entry on the HCC dated 03/16 at 5:30am. It indicates: "(Resident D) bed check done upon staff notice her on floor/next to bed lying in a position of a fetal with one leg straight. Staff moved items out of the way, moved wheelchair. Immediately staff called 911 and director."

On 03/28/22, I interviewed direct care worker, Christen Collins, via telephone. Ms. Collins indicated that she has worked at Adams Home since February 2022. She was working the midnight shift from 10:00pm until 6:00am on 03/16/22 with Cynthia Pringle. Resident D was already in bed when Ms. Collins arrived for her shift. There were no notes to indicate that Resident D had any issues during the day. Ms. Collins stated that they complete bed checks every 15 minutes for Resident D. She stated that she personally did not check on Resident D every 15 minutes, but she rotated throughout the shift with Ms. Pringle. One staff person would go back to do checks and then the other staff would do checks. They do not have set times when they are responsible for doing the bed checks. They work as a team and communicate with one another, rotating throughout the night. Ms. Collins stated that when they are completing bed checks, they go all the way into the bedrooms and visually check on the residents to see if they are sleeping or need to be changed. They do not touch the residents or wake them up.

Ms. Collins stated that on 03/16/22, she personally last checked on Resident D at 2:30am. Resident D appeared to be sleeping at that time. There were no pads or pillows on the floor by Resident D's bed. Ms. Collins stated that Resident D did not have bed rails. Some staff would put the wheelchair next to Resident D's bed "to try to help because she did not have bed rails." Ms. Collins stated that on the night Resident D passed away, her wheelchair was near her bed. Ms. Collins stated that Resident D was at risk for falling. She stated that Adams Home did not have a bed check sheet for staff to initial when they completed bed checks, and she never initialed any forms. Ms. Pringle is the med lead for the home, so it is possible that she filled out a form, but Ms.

Collins was not aware of a bed check sheet. Ms. Collins stated that she was in with another resident when Ms. Pringle found Resident D on the ground around 4:45-5:00am. Ms. Pringle was in a panic and called 911. She also called the licensee designee, David Powell. Ms. Collins stated that Ms. Pringle followed the protocols when she found Resident D. Ms. Collins observed Resident D lying on the floor next to her bed, but she did not go all the way into the bedroom. She stated that the paramedics, police, and the funeral home staff came out to the home. Ms. Collins indicated that she was trained regarding Resident D's plan of service. She was aware that Resident D was a fall risk. She never saw any floor mats in Resident D's bedroom.

On 03/28/22, I interviewed the medication lead, Cynthia Pringle, via telephone. Ms. Pringle indicated that she has worked at Adams Home since 2019. Ms. Pringle indicated that she worked the midnight shift from 11:00pm until 7:00am on 03/16/22 with direct care worker, Christen Collins. Ms. Pringle stated that she did rounds at 12:00am and Resident D was in bed sleeping. She woke her up to do a brief change. At 2:00am, she did another check and Resident D was sleeping. Ms. Pringle indicated that she changed Resident D again at 3:00am. She stated that they complete bed checks every 15 minutes. She was rotating checks with the other staff on shift, Christen Collins. They just switch on and off and do a rotation to complete the bed checks. They look at the clock or a watch to determine when checks need to be completed. During the midnight shift, Ms. Collins is usually on her phone or computer, and Ms. Pringle watches TV. Ms. Pringle stated that they go into the room and check to see if the residents need to be changed and if they are sleeping. They do not have a formal schedule in place regarding who is responsible for completing the bed checks. They just rotate and it is "an unspoken thing." Ms. Pringle stated that there would never be a time when Ms. Collins stopped doing bed checks after a certain time. They rotated throughout the entire shift. They have a bed check sheet where they record bed checks. Staff do not initial who completed the bed check, but they will put "S" for sleeping or "C" for changed. Staff do not always fill out the bed check form as they are completing bed checks. They complete it before the end of the shift. Ms. Pringle stated that she completed the bed check sheet on 03/16/22 and Ms. Collins did not fill it out at all.

Ms. Pringle stated that around 4:45-5:00am, Ms. Collins was getting another resident up to give her a shower. Ms. Collins went into Resident D's bedroom to get towels and washcloths from a linen closet that is in the bathroom attached to Resident D's bedroom. Ms. Pringle stated that she went into Resident D's bedroom right after Ms. Collins left the room. She saw Resident D on the floor and asked Ms. Collins what happened. Ms. Collins stated that she did not know and that she did not see Resident D on the floor. Ms. Pringle stated that Ms. Collins would have walked past Resident D's bed to get to the linen closet, but the room was dark. Ms. Pringle stated that Resident D was on the floor wrapped in her blanket, as if she rolled off the bed while the blanket was around her. Resident D was lying near the end of the bed, in a fetal position, but one leg was stretched out. Ms. Pringle stated that Resident D's leg was cold to the touch. Resident D was not saying anything or moving. Ms. Pringle could tell that Resident D was not breathing. She did not see any injuries. Ms. Pringle called 911. They sent out the paramedics and police. Ms. Pringle stated that she did not know if

they tried to resuscitate Resident D. Ms. Pringle stated that the 911 dispatcher did not give her any instructions over the phone. She stated that she told them to send an ambulance because there was an emergency. She did not recall giving any details to the dispatcher about the nature of the emergency. Ms. Pringle stated that she was in shock at the time.

On 03/28/22, I interviewed Sharon Blain, the chief operating officer (COO) of Spectrum Community Services, via telephone. Ms. Blain indicated that Spectrum's deputy director and agency nurse went to Adams Home immediately following the incident. They were scheduled to go to the home for a monthly monitoring visit that day. Ms. Blain indicated that staff reported they were completing checks every 15 minutes. Cynthia Pringle mentioned last checking on Resident D at 3:00am, because that was when she personally last completed a check, but the staff were alternating their bed checks. On 03/28/22, I interviewed the agency nurse, Brenda Curtis, via telephone. On 03/29/22, I interviewed the deputy director, Carla Wicks, via telephone. Ms. Curtis and Ms. Wicks both indicated that they were scheduled to conduct a monitoring visit at Adams Home on 03/16/22 when they found out Resident D passed away earlier that morning. They decided to visit the home anyway. They arrived around 9:30am and Resident D had already been taken to the funeral home. Christen Collins was no longer at the home when they arrived, but Cynthia Pringle was still on shift. Ms. Wicks stated that Ms. Pringle originally said she checked on Resident D at 3:00am and then when she went back in at 5:00am, she found Resident D on the floor in a fetal position next to her bed. Resident D felt cold, so Ms. Pringle called 911 right away. Ms. Pringle did not report that she checked for a pulse or started CPR. Ms. Wicks stated that throughout the day they asked Ms. Pringle if they did other bed checks. Ms. Pringle later stated that they were checking every 15 minutes, but Christen Collins was doing a lot of the 15-minute bed checks. The agency nurse, Ms. Curtis, did not recall staff stating a specific time that they last completed a bed check. She stated that there was a lot of back and forth and she was not present for all of the conversations that Ms. Pringle was having with David Powell and Carla Wicks. Ms. Wicks and Ms. Curtis both stated that they did not observe any mats or pillows on the floor near Resident D's bed that day. They did not yet know the cause of death.

I received and reviewed a copy of Resident D's death certificate. It indicates that Resident D was pronounced dead at 5:50am on 03/16/2022. Resident D's death manner of death was natural due to acute myocardial infarction and the interval between onset and death was immediate. An autopsy was not performed.

I received and reviewed a copy of the case report from the Troy Police Department. The report notes that officers were dispatched to the home at 5:32am on 03/16/2022 for a dispatched offense of "sick care for medical." The verified offense was listed as "sudden death- natural." The case report notes that Resident D resided at the group home for 35 years. She was non-verbal, autistic, and had hypertension and cardiac problems. Cynthia Pringle found Resident D deceased at approximately 0530 hours and last saw her alive at approximately 0315 hours. Officers arrived on scene and found Resident D

deceased beyond help. There were no signs of trauma or suspicious circumstances. The officer contacted the medical examiner's office.

I received and reviewed an audio file of the 911 call made by Cynthia Pringle. The call came in on 03/16/22 at 5:32am. Ms. Pringle requested that an ambulance be sent to 4609 Butler. When asked what the problem was, Ms. Pringle stated that a client fell out of bed and looks like she is deceased. Ms. Pringle stated that the client was not breathing. When transferred to the ambulance and fire dispatcher, Ms. Pringle provided the address of the home. When asked to describe exactly what happened, Ms. Pringle stated, "I went in to check on a client, and I noticed that she had fell, and I looked at her and she is deceased. She is quite pale." When the dispatcher asks if she thinks she is beyond help, Ms. Pringle responds, "Yes. I think she's dead. I touched her body, and she is cold." When the dispatcher asked Ms. Pringle when she last saw her, Ms. Pringle responded, "Uh one, two, like three hours ago."

On 03/23/22, I received notification from the Spectrum COO, Sharon Blain, indicating the licensee designee, David Powell, is no longer employed with Spectrum Community Services. Janet DiFazio was appointed and approved as the new licensee designee for the Spectrum homes in Oakland County.

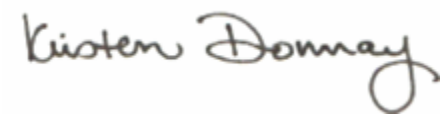
On 04/20/22, I conducted an exit conference via telephone with the licensee designee, Janet DiFazio, and reviewed my findings and recommendation. Ms. DiFazio indicated that they are continuing to make changes and improvements at Adams Home. They have implemented a new bed check form that staff must initial at the time bed checks are completed.

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:	Based on the information gathered through my investigation, there is sufficient information to conclude that the licensee did not provide supervision and protection as specified in Resident D's written assessment plan. Resident D's crisis plan indicated that bed checks were required every 15 minutes. On 03/16/22, staff found Resident D deceased on the floor next to her bed around 5:15am. The 911 call, police report, and incident report all indicate that staff last checked on Resident D several hours prior, around 3:00am. Resident D's plan also indicates that she is a fall risk and utilizes a floor mat by her bed. The staff who were interviewed indicated that Resident D did not have a mat next to her bed.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 information gathered through my investigation, there is sufficient information to conclude Resident D's protection and safety were not attended to at all times. Resident D's crisis plan indicated that bed checks were required every 15 minutes. On 03/16/22, staff found Resident D deceased on the floor next to her bed around 5:15am. The 911 call, police report, and incident report all indicate that staff last checked on Resident D several hours prior, around 3:00am. Resident D was cold to the touch by the time staff found her on the floor and was beyond help. Resident D's plan also indicates that she is a fall risk and utilizes a floor mat by her bed. The staff who were interviewed indicated that Resident D did not have a mat next to her bed. Staff, Christen Collins, indicated that staff sometimes put a wheelchair next to Resident D's bed to try to help, because she is a fall risk and does not have bed rails.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend revocation of the license.



04/20/2022

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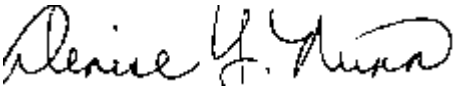
Kristen Donnay Date
Licensing Consultant

Approved By:



04/21/2022

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Denise Y. Nunn Date
Area Manager