GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 6, 2022

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

RE: License #: AS410360517
Investigation #: 2022A0350024
Parkview 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. 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,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410360517
Investigation #:	2022A0350024
Complaint Receipt Date:	05/04/2022
Investigation Initiation Date:	05/04/2022
Report Due Date:	06/03/2022
Licensee Name:	Spectrum Community Services
Licensee Address:	28303 Joy Rd. Westland, MI 48185
Licensee Telephone #:	(734) 377-3260
Administrator:	Delissa Payne
Licensee Designee:	Delissa Payne
Name of Facility:	Parkview Home
Facility Address:	2165 Bayham Dr. SE Kentwood, MI 49508
Facility Telephone #:	(616) 551-3129
Original Issuance Date:	04/28/2014
License Status:	REGULAR
Effective Date:	10/28/2020
Expiration Date:	10/27/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A left the home unnoticed and went inside the neighbor's house where he ate some of the neighbor's food at their dining table.	Yes

III. METHODOLOGY

05/04/2022	Special Investigation Intake 2022A0350024
05/04/2022	Special Investigation Initiated - On Site I met with Cedric Marshall, Program Manager, obtained copies of documents, saw Resident A and other residents
05/04/2022	Contact - Face to Face I met and spoke with the Complainant
05/04/2022	Contact - Telephone call made I spoke with Clinnisia Wysinger, DCW
05/04/2022	Contact - Telephone call made I spoke with William Johnston, DCW
05/06/2022	Exit conference – Held with Delissa Payne, Licensee Designee

ALLEGATION: Resident A left the home unnoticed and went inside the neighbor's house where he ate some of the neighbor's food at their dining table.

INVESTIGATION: On 05/04/2022, I made an onsite inspection and met with Cedric Marshall, Program Manager. I informed Mr. Marshall of this allegation and asked to review each resident's Assessment Plan, Health Care Appraisal (HCA), and Individual Plan of Service (IPOS). Mr. Marshall led me to the basement where all the files are kept, and he provided me these documents. As IPOS sections that address supervision, Individual Monitoring/Support Needs were lengthy, I requested copies of them and Mr. Marshall provided them to me. I observed in each of the four resident's Assessment Plan that none of them required two-person assistance for any reason. I noted on the residents' HCAs that they each had a diagnosis of mental retardation. Mr. Marshall informed me that none of the residents are verbal. Mr. Marshall told me that Resident A has a history of going into the garage or into staff

automobiles without staff knowing. He said that he believed it would be helpful for staff to know the whereabouts of the residents if there were sound alarms on the exterior doors and said that this home used to have them (alarms). Mr. Marshall informed me that he spoke with Delissa Payne, the Licensee Designee for this home, as well as the supports coordinator from Community Mental Health about having alarms installed, but they have not yet been approved. I asked Mr. Marshall if there was a set timeframe that staff members are expected to visually check on the residents, such as every 15 minutes, etc., but he said there was not. I inquired as to what the staffing pattern is, and Mr. Marshall said that ideally there would be two staff on per shift; however, they have a “staffing shortage”, and there have shifts when only one staff was working at the home. Mr. Marshall informed me that Clinnisia Wysinger, Direct Care Worker (DCW), was working 1st shift William Johnston, DCW on 04/29/2022 when Resident A left the house unnoticed. I asked for her cell phone number and he provided it to me. I also requested for Mr. Marshall to introduce me to Resident A and he took me to his room where he was at this time.

On 05/04/2022, I introduced myself to Resident A and asked him how he was doing and some other general comments before asking if he had left the house recently and gone into a neighbor’s house, but he did not verbally respond to any of my questions, and it became obvious that to me that he could not follow my conversation.

On 05/04/2022, I went to the neighbor’s house, and the complainant answered the door. I introduced myself and inquired about this situation. The complainant reported that she was not home when this occurred, but one of the elderly women who lives there told her that Resident A came into their home and was eating one of their bananas at their dining table. The elderly woman escorted Resident A back to Parkview Home where she knew he resided. The complainant informed me that there were loaded guns in their house. The complainant stated that on two separate occasions last summer (2021), two different residents came into her garage while she was there, and she escorted them back to their home. The complainant expressed concern about the safety of these residents and the neighbors due to these residents wandering onto other people’s property and into their homes.

On 05/04/2022, I called and spoke with Ms. Wysinger, who confirmed that she worked from 7:00 a.m. to 3:00 p.m. on 04/29, and that Resident A had gotten out of the house unnoticed during that shift. Ms. Wysinger stated that she had been keeping a close eye on another resident who eats paper and cardboard and was cleaning dishes when Resident A left the home. Ms. Wysinger informed me that Resident A often tries to leave the home. She told me that she was working with William Johnston, DCW, but she was not sure what he was doing at the time

Resident A left the house. Ms. Wysinger said that Resident A left between 12:00 and 1:00 p.m., and that the neighbor brought him back to the home.

On 05/04/2022, I called and spoke with William Johnston, DCW, who stated that he worked from 8:00 a.m. to 4:00 p.m. on 04/29. Mr. Johnston informed me that Resident A got out of the house unnoticed by Ms. Wysinger and him. He said that while he was folding laundry just after lunch, a woman brought Resident A back to the home. Mr. Johnston stated that usually the residents are all nearby staff, and if one goes into his room, staff will know. However, Mr. Johnston added that "it can be difficult" supervising the residents while doing chores. He, too, expressed his opinion that it would be a good idea to have sound alarms on the exterior doors so staff would know if a resident opens a door to leave the home.

On 05/05/2022, I reviewed the Individual Monitoring/Support Needs section of each resident's IPOS. In Resident A's report, it states, "(Resident A) has a history of wandering away from his AFC staff if not adequately supervised. (Resident A) does not possess any independent pedestrian safety skills and relies on staff to help him safely cross the street." It also states, "(Resident A) should be monitored to prevent elopement. (Resident A) has no safety skills and has run from the home into the street, and staff had to pull (Resident A) back from being hit by an oncoming car." There was no protocol mentioned in Resident A's IPOS regarding measures to help prevent him from wandering from the home. No elopement risks or special supervision requirements were mentioned in Resident B's IPOS other than he needs to be monitored when he is in the kitchen. In Resident C's IPOS, there is also no mention of elopement risks or special supervision requirements except while he is in the kitchen. Although Resident D's IPOS does not state that he has elopement tendencies, it does indicate that he "has no pedestrian safety skills" and that while in the community, "(Resident D) requires arm's length supervision so that staff can intervene if he tries to cross the street or go near a moving vehicle."

On 05/06/2022, I called and held an exit conference with Delissa Payne, Licensee Designee. I informed Ms. Payne that I was citing violation of this rule. I advised Ms. Payne to have Resident A's Assessment Plan and Individualized Plan of Service amended to reflect his need for protection regarding his elopement risk. Ms. Payne added that the process "can be kind of slow" in getting IPOS's re-written, but she would work on this. Ms. Payne apologized a couple of times about this situation and said she would work on the corrective action plan right away.

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:	Resident A left the home unnoticed and went inside a neighbor's house without being invited during the afternoon of 04/29/2022, while Clinnisia Wysinger and William Johnston were working.

	He took some of their food and was found eating it at the dining table by an elderly woman who lives there. Both staff stated they did not see or hear Resident A leave the house, and Mr. Johnston said that it was difficult to do chores and supervise the residents at the same time. There are no door alarms at this home. Resident A's Assessment Plan and Individualized Plan of Service identifies him as an elopement risk. Resident A has a history of elopement and has almost been hit by a car on one of those occasions. In addition, there are no specified supervision requirements for any of the home's residents, except that Resident B and Resident C need to be closely monitored while in the kitchen. Resident A's protection and safety was not assured when he left the home unbeknownst to staff. He was not adequately supervised by either of the two staff members who worked 1st shift on 04/29, and Resident A ended up in a potentially dangerous situation. My findings support that this rule was violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

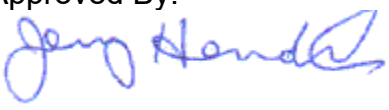
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

May 6, 2022

Ian Tschirhart — Date
Licensing Consultant

Approved By:



May 6, 2022

Jerry Hendrick — Date
Area Manager