GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 15, 2023

Janet Difazio
Spectrum Community Services
Suite 700
185 E. Main St
Benton Harbor, MI 49022

RE: License #: AS630397224
Investigation #: 2023A0602011
Lake Braemar Home

Dear Mrs. Difazio:

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 feel free to 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 (248) 975-5053.

Sincerely,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630397224
Investigation #:	2023A0602011
Complaint Receipt Date:	01/12/2023
Investigation Initiation Date:	01/13/2023
Report Due Date:	03/13/2023
Licensee Name:	Spectrum Community Services
Licensee Address:	185 E. Main St, Suite 700 Benton Harbor, MI 49022
Licensee Telephone #:	(734) 458-8729
Administrator:	Janet DiFazio
Licensee Designee:	Janet DiFazio
Name of Facility:	Lake Braemar Home
Facility Address:	1255 East Davisburg Road Holly, MI 48442
Facility Telephone #:	(248) 369-8663
Original Issuance Date:	06/06/2019
License Status:	REGULAR
Effective Date:	06/14/2022
Expiration Date:	06/13/2024
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The licensee designee, Janet DiFazio, found pictures and a group text message thread on the phone of the program manager, Tyesha Hollins showing Resident A sitting with feces around him on the floor. Staff members, Terrance Knight, Ebony Smith, and Shana Briesno were involved in sending messages in which they refused to clean him up and made fun of him.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/12/2023	Special Investigation Intake 2023A0602011
01/13/2023	Special Investigation Initiated - Telephone Call made to the complainant.
01/13/2023	Contact - Document Received Received email with text messages and photos.
01/18/2023	Contact - Telephone call made Message left for the assigned Office of Recipient Rights worker (ORR) Kathleen Garcia.
01/24/2023	Contact – Telephone call made Spoke with Ms. Garcia.
02/10/2023	Inspection Completed On-site Interviewed the team lead, Bobby Hysell, observed Resident A.
02/13/2023	Contact – Telephone call made Message left for staff member, Tyeshia Hollins.
02/21/2023	Contact – Telephone call made Spoke with Resident A and Mr. Hysell.
03/08/2023	Contact – Telephone call made Interviewed staff member, Shana Briesno.

03/08/2023	Contact – Telephone call made Interviewed staff member, Ebony Smith.
03/08/2023	Contact – Telephone call made Interviewed staff member, Terrance Knight
03/08/2023	Exit Conference Held with the licensee designee, Janet DiFazio by telephone.

ALLEGATION:

The licensee designee, Janet DiFazio, found pictures and a group text message thread on the phone of the program manager, Tyesha Hollins showing Resident A sitting with feces around him on the floor. Staff members, Terrance Knight, Ebony Smith, and Shana Briesno were involved in sending messages in which they refused to clean him up and made fun of him.

INVESTIGATION:

On 1/12/2023, a complaint was received and assigned for investigation alleging that the licensee designee, Janet DiFazio, found pictures and a group text message thread on the phone of the program manager, Tyeisha Hollins showing Resident A sitting with feces around him on the floor. Staff members, Terrance Knight, Ebony Smith, and Shana Briesno were involved in sending messages in which they refused to clean him up and made fun of him.

On 1/13/2023, the licensee designee, Janet DiFazio sent licensing consultant, Kristen Donnay an email that contained pictures of Resident A and screenshots of text messages that were exchanged between staff members, Tyeisha Hollins, Shana Briesno, Terrance Knight, and Ebony Smith. On 1/13/2023 Ms. Donnay forwarded the email to me. On this same date, I received and reviewed one image of Resident A sitting on the bathroom floor on his knees holding what appears to be a soiled brief with smears of feces on the floor in front of him. Resident A was sitting on top of what appeared to be a piece of clothing.

The text messages reviewed stated as follows:

Ms. Briesno:
“And is now rubbing his turd on the bathroom floor because it fell out of the brief…someone come get him. I stg y’all.”
Ms. Briesno:
Picture of Resident A sitting on his knees with feces on the floor in front of him.
Ms. Hollins:
“Resident A if you don’t clean that crap up now”
Ms. Briesno:
“Oh, he is. He can sit in there until it’s clean.”

Ms. Smith:
“Save it and show Janet and Lisa since they just think we don’t do shit.”
Ms. Briesno:
“I will.” Now why would Resident A stand here and blatantly shit in his brief. Not diarrhea and actual hard turd like he’s a one-year-old.” “Thank you ty.”
Ms. Hollins:
“Omg” followed by a wide eyed emoji
Ms. Briesno:
“I stgggg” Just standing there watching TV pushing out poop not giving one f”
Ms. Smith:
“On yea, see nawl. I’m done.” “I would’ve dropped kicked him.”
Ms. Briesno:
“Man wtf”

On 2/10/2023, I conducted an unannounced on-site investigation at the Seven Lakes Home where Resident A has been temporarily placed. I interviewed the team lead, Bobby Hysell. Mr. Hysell stated he did not have any information regarding the incident that occurred at the Lake Braemar Home between Resident A and staff. He said he has heard staff members chatting about it, but he has no firsthand information and does not feel comfortable repeating hearsay.

On 2/10/2023, I observed Resident A laying in his bed sleeping. Mr. Hysell attempted to wake Resident A, but he refused to get out of bed. I attempted to ask Resident A questions regarding the incident but, he would not respond. Mr. Hysell stated Resident A is verbal and advised that I call the home later to interview him.

On 2/21/2023, I attempted to interviewed Resident A by telephone. Resident A said hello when he initially picked up the telephone. I was unable to obtain any information from him as he would not answer any of the questions that were asked. Resident A sat silent on the phone.

On 3/08/2023, ORR worker Kathleen Garcia and I conducted individual telephone interviews with staff members, Shana Briseno, Ebony Smith, and Terrance Knight. Ms. Briseno stated she worked for about a year at the home and on 12/17/2022 she worked alone during the day shift (between the hours of 8 am and 4 pm) and recalled having a rough day. Resident A pooped on himself while watching television in the living room. Ms. Briseno told Resident A to go into the bathroom and change his brief. When she went into the bathroom to check on him, Resident A was sitting on the floor wearing a clean brief but there was poop smeared on the floor. Resident A told Ms. Briseno that he was going to clean up the poop and she assisted him in doing so. Ms. Briseno admitted that she took a picture of Resident A sitting on the bathroom floor near the smeared poop. She said she knew they were not allowed to take pictures of the residents but Ms. DiFazio and the home manager, Tyeshia Hollins instructed staff to document everything on Resident A because his parents did not believe he was having the behaviors staff reported. During their monthly meetings, Ms. DiFazio instructed staff to take pictures of Resident A when he was having a behavior because he needed to

have 1-1 staffing. Ms. Briseno stated there was a group chat established between she and some of her coworkers. The purpose of the chat was to relieve themselves from the stress of the job and the frustration with upper management. Ms. Briseno put in her resignation the same day she was terminated.

On 3/08/2023, Ms. Smith stated she worked for almost two years at the home and usually worked the third shift (between the hours of 10 pm and 6 am or 8 pm and 8 am). On 12/17/2022 she worked the third shift and was not present at the time the incident occurred. She said the incident was discussed between she and her coworkers through group text messages. Ms. Smith said she believed a picture of Resident A was sent in the group, but she would have to check her text messages to be certain. I informed Ms. Smith that we had copies of the text messages and read her responses to her. Ms. Smith stated the text messages were used as a means of relieving stress between coworkers. Ms. Smith believes the messages were taken out of context as she would never say anything inappropriate to any resident and would never hit a resident. The statements were made from frustration only. It was not unusual for Resident A to poop on himself and smear it on the floor or mirror. Staff would encourage him to clean it up but if he refused, staff would clean it up. The picture was taken because Ms. Hollins informed staff that Ms. DiFazio instructed them to take pictures of Resident A when he was having a behavior. Ms. Smith did not receive this instruction from Ms. DiFazio and did not confirm it with her. Ms. Smith went on to apologize for the inappropriate comment she made in the group text and realizes it was very unprofessional.

On 3/08/2023, Mr. Knight stated he was Resident A's primary 1-1 staff. On 12/17/2022 he worked the day shift with Ms. Briseno. Resident A was having a behavior and did not want to get out of his bed. He threw feces out of a window and into a neighbor's yard as well as smeared feces in his bedroom and in the bathroom. Mr. Knight said there was a group chat between coworkers that was created by the direction of Ms. DiFazio to document Resident A's behaviors because his mother did not believe he was having the behaviors that were being documented. There was a picture taken of Resident A that showed him cleaning up the feces from the bathroom floor. Mr. Knight went on to state that he never responded to any of the texts in the group chat but was unable to remove himself from the group. Mr. Knight separated from the company in January 2023.

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 obtained during the investigation, there is sufficient information to determine that on 12/17/2022 Resident A was not treated with dignity. Ms. Briseno took a

	picture of Resident A sitting on the bathroom floor with smeared feces in front of him. She shared the picture in a group chat with Ms. Smith, Ms. Hollins, and Mr. Knight. Ms. Briseno and Ms. Smith made inappropriate comments (as stated above) regarding Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 3/08/2023, I spoke with the licensee designee, Janet DiFazio by telephone. I requested a copy of the staff schedule for the month of December 2022 and Ms. DiFazio stated she did not have the schedule. She said it is the responsibility of the home manager to create and maintain staff schedules. The home manager at the time of the incident, Tyeisha Hollins is no longer with the company. When asked where the staff schedules were located, Ms. Hollins stated she wrote them down and left them at the home. Ms. DiFazio was unable to locate any staff schedules at the home.

On 3/08/2023, I conducted an exit conference with the licensee designee, Janet DiFazio by telephone. I informed Ms. DiFazio of the investigative findings and recommendation documented in this report. Ms. DiFazio stated she never instructed any staff member to take pictures of Resident A at any time. She was in contact with Resident A's mother weekly and she was aware of his behaviors and never had a problem with believing what was being reported to her. Ms. DiFazio stated Ms. Hollins, Ms. Briseno, Ms. Smith, and Mr. Knight no longer work for the company. Resident A has been placed at the Seven Lakes Home until new staff can be hired. Ms. DiFazio agreed to submit a corrective action plan upon receipt of this report.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: (a)Name of all staff on duty and those volunteers who are under the direction of the licensee. (b) Job titles. (c) Hours or shifts worked. (d) Date of schedule. (e) Any scheduling changes.

ANALYSIS:	Based on the information obtained during the investigation, I determined that there was no staff schedule available for review for the month of December 2022. On 3/08/2023 I requested a copy of the staff schedule for the month of December 2022 to verify who was working on 12/17/2022 as Ms. Briseno stated she worked alone, and Mr. Knight stated they worked together. Ms. DiFazio stated it is the home manager's responsibility to create and maintain the staff schedules. She did not have a copy of the December 2022 schedule as she could not locate it after Ms. Hollins separated from the company.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

3/14/2023

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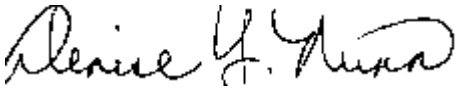
Cindy Berry Date
Licensing Consultant

Approved By:



03/15/2023

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Denise Y. Nunn Date
Area Manager