GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

Joyce Divis
Spectrum Community Services
Suite 700
185 E. Main St
Benton Harbor, MI 49022

June 26, 2023

RE: License #: AM110091925
Investigation #: 2023A0579037
Eau Claire Residence

Dear Joyce Divis:

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 (616) 356-0183.

Sincerely,

Cassandra Duursma

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor, 350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050
enclosure

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

THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AM110091925
Investigation #:	2023A0579037
Complaint Receipt Date:	05/25/2023
Investigation Initiation Date:	05/25/2023
Report Due Date:	07/24/2023
Licensee Name:	Spectrum Community Services
Licensee Address:	Suite 700 185 E. Main St Benton Harbor, MI 49022
Licensee Telephone #:	(269) 944-1927
Administrator:	Joyce Divis
Licensee Designee:	Joyce Divis
Name of Facility:	Eau Claire Residence
Facility Address:	2860 M-140 Eau Claire, MI 49111
Facility Telephone #:	(269) 944-1927
Original Issuance Date:	05/19/2000
License Status:	REGULAR
Effective Date:	06/12/2021
Expiration Date:	06/11/2023
Capacity:	12
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
A direct care worker has been verbally and physically aggressive with residents.	Yes
Expired Fentanyl and Norco medications were stolen from the home.	Yes

III. METHODOLOGY

05/25/2023	Special Investigation Intake 2023A0579037
05/25/2023	Special Investigation Initiated - Telephone Stacy Kingman, Direct care worker/DCW
05/25/2023	Contact - Document Sent Anne Simpson, ORR
05/31/2023	Contact- Document Received Tasha Stewart, ORR
05/31/2023	Contact- Document Received Stacy Kingman, DCW
06/12/2023	Contact- Document Sent Stacy Kingman, DCW
06/15/2023	Contact- Face to Face Resident A, Resident C, Monica Rickers (DCW), and Traniece Henry (DCW)
06/22/2023	Contact- Telephone call made Melanie Sutton, Former DCW
06/22/2023	Contact- Telephone call made Joyce Vierck, DCW
06/22/2023	Contact- Document sent Anne Simpson, ORR Tasha Stewart, ORR
06/26/2023	APS Referral
06/26/2023	Exit Conference

	Joyce Divis, Licensee Designee Stacy Kingman, DCW

ALLEGATION:

A direct care worker has been verbally and physically aggressive with residents.

INVESTIGATION:

On 5/25/23, I entered this referral into the Bureau Information Tracking System after receiving multiple *Incident/Accident Report* (I/AR) forms. The first I/AR was regarding Resident A and completed by direct care worker (DCW) Monica Rickers. It noted Resident A was assisting DCW Melanie Sutton with laundry when Ms. Sutton inquired why Resident A's laundry basket was broken. Resident A stated she does not know. Resident A then accidently dropped some clothes on the floor. Ms. Sutton yelled at Resident A calling her a "fucking idiot." Ms. Sutton then went to the office and told Ms. Rickers "Damn, I want to strangle these people sometimes."

The second I/AR was for Resident B. It was completed by Traniece Henry who reported Ms. Sutton told her that Resident B gets upset at times and likes to hit. Ms. Sutton stated Resident B once punched her in the shoulder, so Ms. Sutton hit her back and that "it was a reflex."

The third I/AR was completed by Ms. Rickers and noted Ms. Sutton reported to her that she had once gotten into an argument with Resident B and Ms. Sutton "smacked [Resident B] on the back."

On 5/25/23, I completed a telephone interview with DCW Stacy Kingman to clarify when these incidents occurred and who was involved with reporting them. Ms. Kingman confirmed these incidents were just reported all at once by the individuals listed on the I/AR and it is unknown when they occurred. Ms. Kingman reported Ms. Sutton was immediately placed on leave but she then called and voluntarily terminated her employment.

On 5/25/23, I forwarded the allegations to Anne Simpson at Riverwood Community Mental Health Office of Recipient Rights.

On 5/31/23, I received an e-mail from Tasha Stewart at Riverwood Community Mental Health Office of Recipient Rights confirming she had investigated the allegations, but Ms. Sutton was not responding to her telephone calls.

On 6/12/23, I exchanged emails with Ms. Kingman coordinating when best to speak to residents and DCWs involved on the I/ARs.

On 6/15/23, I completed an on-site investigation. Interviews were completed with Resident A, Resident C, Ms. Rickers, and Ms. Henry. It was reported Resident B had gone to day program and was not available for interviewing.

Resident A was observed lying in bed with her eyes closed and would irregularly respond to questioning. She stated she likes this home and there is nothing she dislikes. She stated she knows Ms. Sutton and she likes her. She denied any incident involving her and Ms. Sutton doing laundry. She denied ever hearing Ms. Sutton swear.

Resident C reported she knows Ms. Sutton and “she’s alright.” She stated her and Ms. Sutton “got into it once.” She stated she was expressing that she did not want to live in the home anymore because she does not like living around other people and Ms. Sutton began making fun of her for wanting to leave and stating that she will never leave. She stated this made her cry. She stated Ms. Sutton had a “potty mouth” and would regularly swear when speaking in front of and to residents. She stated she did not witness Ms. Sutton call anyone names or physically harm them.

Ms. Rickers stated she has worked in this home since February 2023 and during that time Ms. Sutton has always “cussed” around, yelled at, and threatened residents. She stated she has always had a poor attitude and a “bad mouth.” She stated she witnessed Ms. Sutton threaten to “smack” residents and she has witnessed Ms. Sutton withhold cigarettes from residents as punishment. She stated most residents will not admit it to me or the administrators of Spectrum Community Services, but they fear Ms. Sutton. She stated Resident B especially will not talk about the verbal and physical aggression she has received from Ms. Sutton because she is scared.

Ms. Rickers stated it was after she witnessed Ms. Sutton directly calling Resident A “a fucking idiot” to Resident A’s face and Ms. Sutton then coming into the room and saying that she wanted to “strangle these people” that she realized Ms. Sutton’s behavior was escalating and she needed to report it. She stated in the past, Ms. Sutton would only swear in front of residents and gave the example that Ms. Sutton has said, referring to Ms. Rickers, that “this idiot had a fuck up” and called her a “retard” in front of residents.

Ms. Rickers stated she has not witnessed Ms. Sutton physically abuse residents but she has seen her lift her fist up threatening to hit residents. She stated she was also present when Ms. Sutton reported that Resident B hit her on her “bad shoulder” and Ms. Sutton reported she reflexively hit Resident B back on her back. She denied knowing if Ms. Sutton struck her with an open or closed fist.

Ms. Henry stated she is transitioning to a new home and Resident B will be going there as well. She stated Ms. Sutton warned her that Resident B will hit DCWs when she is upset. She stated Ms. Sutton then told her that once Resident B hit her on her shoulder and she reflexively hit Resident B on her back. She denied knowing if Ms.

Sutton struck her with an open or closed fist. Ms. Henry stated she has heard Ms. Sutton swear in front of residents and reported she has witnessed Ms. Sutton tell residents, “Okay, we’re going to have a good day, right? We’re not going to be pissing and shitting on ourselves because no one wants to clean shit or piss.” She stated she witnessed Ms. Sutton interrupt Resident D as he was talking to tell him, “No one cares about that shit.” She stated she has witnessed Ms. Sutton yell at residents and withhold cigarettes from residents if they do not do what she requests. She stated residents, especially Resident B, are very fearful of Ms. Sutton and are too scared to discuss the mistreatment they experienced by her.

On 6/22/23, I completed a telephone interview with Ms. Sutton who stated Resident B hit her, but she did not hit Resident B back and did not tell anyone she ever hit Resident B. She stated the allegations are false and were made up by new employees who did not like her and wanted her to no longer work at the home. She denied ever swearing at or in front of residents. She stated she may have raised her voice at residents at times but every other DCW in the home has too.

On 6/22/23, I exchanged emails with Ms. Stewart from ORR. She stated she interviewed Resident B who confirmed Resident B and Ms. Sutton argued and Ms. Sutton hit Resident B “only one time.”

On 6/26/23, I forwarded the allegations to APS.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	Ms. Rickers and Ms. Henry reported Ms. Sutton would swear in front of, yell at, and threaten residents. Ms. Rickers reported witnessing Ms. Sutton call Resident A a vulgar name and reported Ms. Sutton called Ms. Rickers vulgar names in front of residents. Ms. Rickers and Ms. Henry reported Ms. Sutton told them that she once hit Resident B after Resident B hit her. Ms. Stewart confirmed Resident B stated Ms. Sutton did hit her one time during an argument.

	Resident C reported Ms. Sutton made fun of her about not leaving the home and made her cry. Resident A denied concerns. Ms. Rickers and Ms. Henry reported residents, especially Resident B, are fearful of Ms. Sutton and will not disclose their experiences with her. Ms. Sutton denied the allegations and reported new DCWs who did not want her working at the home made false allegations to get her to leave. Based on the interviews completed and documentation observed, there is sufficient evidence to support that residents were not treated with dignity, consideration, and respect due to Ms. Sutton's behavior.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Expired Fentanyl and Norco medications were stolen from the home.

INVESTIGATION:

On 5/31/23, Ms. Stewart reported during her investigation, allegations of misuse of expired medications were brought up as well.

On 5/31/23, I received two I/AR forms from Ms. Kingman. One was completed by Ms. Rickers and stated on 5/30/23, Ms. Rickers contacted DCW/Lead Medication Worker Joyce Vierck asking for the keys to a locked medication cabinet which holds extra resident medication. Ms. Vierck reported she cannot give DCWs the key and inquired why Ms. Rickers would need to go into that cabinet. Ms. Rickers advised she saw Ms. Sutton going through the cabinet and knew there was body wash in there and the body wash was currently out. Ms. Vierck reported she would be at the home immediately. Ms. Vierck and Ms. Rickers went through the medications in the cabinet and saw that medications were missing. They attempted to locate the medications but could not find them.

A second I/AR was completed by Ms. Vierck and stated on 5/30/23, she was contacted by Ms. Rickers requesting her key for a locked medication cabinet. She stated she advised Ms. Rickers only she and Ms. Kingman can have access to that cabinet and no one else should be in there. Ms. Rickers reported she witnessed Ms. Sutton in the cabinet. Ms. Vierck came to the home and provided Ms. Rickers with

the body wash she was requesting out of the cabinet. At that time, Ms. Vierck noticed some medications were missing. She and Ms. Rickers attempted to locate the medications. The medications were for Resident E who expired in 2021, were in a brown paper bag, and had not been disposed of. One 25 MG Fentanyl patch out of a new box was missing and one bottle of liquid Norco was missing. This was confirmed by the disposal sheet which was left in the cabinet. Ms. Vierck reported this to Ms. Kingman who contacted law enforcement. An officer came to the home and provided advice about places that will accept and destroy controlled substances so the medications can be disposed of on a more regular basis moving forward.

On 6/15/23, Ms. Rickers said she had concern that Ms. Sutton would leave the home during her shift to purchase Fentanyl for a relative who is addicted to substances. She stated it disturbed her how Ms. Sutton enabled this and openly discussed this behavior like she was proud of herself and her relative. She stated Ms. Sutton did speak about purchasing substances in front of residents but would leave by herself, on her shift, to purchase the substances. She stated on 5/30/23, she text messaged Ms. Vierck, who is the Lead Medication Worker, asking to access the locked overflow medication cabinet. She stated she had seen Ms. Sutton in there before so she believed that staff were allowed to be in the cabinet. She stated Ms. Vierck responded very sternly that only her and Ms. Kingman can be in that cabinet. She stated she explained that she recently saw Ms. Sutton going through the cabinet, that is how she knew there was body wash in the cabinet, and she needed more body wash. She stated Ms. Vierck immediately came to the home and she requested assistance counting the medications to make sure everything was there. She stated they could not locate Fentanyl patches and a bottle of liquid Norco. She stated she is not certain when Ms. Sutton was in the cabinet and whether Ms. Vierck was in the home. She stated Ms. Vierck always keeps that cabinet's key on her person so she does not know how Ms. Sutton would have obtained the key. She denied directly witnessing Ms. Sutton take anything from the cabinet and reported she did not realize Ms. Sutton was not supposed to be in the cabinet. She stated Ms. Vierck told her that no facility would take the medications to dispose of them because they were controlled and commonly misused substances, but Ms. Vierck has since learned of places that will appropriately destroy these substances so this situation will not happen again.

Ms. Henry reported she does not know what is in the locked cabinet in the medication room. She denied seeing anyone go into that cabinet. She stated she believes only Ms. Vierck has access to that cabinet and does not know why any staff person would need to go into that cabinet.

On 6/22/23, I attempted a telephone interview with Ms. Vierck. A voicemail message was left requesting a return phone. Ms. Kingman previously reported Ms. Vierck is out on extended medical leave and not currently working at the home.

On 6/22/23, Ms. Sutton denied ever being in the locked medication cabinet and stated those allegations are also false. She reported she was unaware those

controlled substances were in the cabinet and she assumed they had been destroyed when other medications were destroyed because they have been there for years. She stated Ms. Vierck and Ms. Kingman are the only individuals with keys and both always keep the keys with them. She stated there was also no damage to the cabinet, so it is impossible that she ever went into the cabinet without keys or damaging the cabinet. She stated she does not use substances or know anyone who uses substances. She denied ever speaking about or ever purchasing substances for a relative. She stated she valued her job and would not have risked it by leaving to purchase substances or taking controlled substances from the home.

On 6/22/23, I exchanged emails with Ms. Simpson who stated she completed an interview with Ms. Vierck on 5/31/23 and Ms. Vierck reported only she and Ms. Kingman have a key to the cabinet. She stated she is not certain how Ms. Sutton or anyone would have been able to get into the cabinet and denied ever being without the key. Ms. Vierck stated there was no damage to the cabinet either. Ms. Simpson stated while at the home she observed there was a documented full bottle of Hydroco/Apap missing that was signed by Ms. Vierck and additionally signed in different ink by Ms. Sutton. Ms. Simpson also observed three missing Fentanyl patches. She stated Ms. Vierck reported since 2021, facilities would not dispose of liquid medications due to COVID-19 but reported law enforcement did advise of a drug disposal occurring soon where the remaining medications would be accepted. She stated Ms. Vierck reported she last counted the expired medication with Ms. Rickers on 5/4/23 but did not document what was present. She stated Ms. Vierck reported Ms. Sutton has told her that her relative uses substances so she believes it is possible Ms. Sutton took some of the medication and left some because she only took what her relative needed at that time.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	Ms. Simpson stated full bottle of Resident E's Hydroco/Apap and three Fentanyl patches were known to be in the cabinet despite Resident E passing in 2021. Ms. Rickers and Ms. Simpson reported Ms. Vierck stated the medications were left in the home because no one would take the controlled substances for disposal during the pandemic. Based on the interviews completed, there is sufficient evidence that controlled substances utilized by Resident E, who died in 2021, were not properly disposed of as this rule requires.

CONCLUSION:	VIOLATION ESTABLISHED

On 6/26/23, I completed an exit conference with Licensee Designee, Ms. Divis and Ms. Kingman due to her involvement in the investigation. They did not dispute my findings or recommendations.

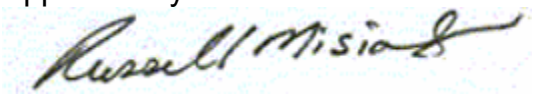
IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

6/22/23

Cassandra Duursma — Date
Licensing Consultant

Approved By:



6/23/23

Russell B. Misiak — Date
Area Manager