GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

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

October 13, 2023

RE: License #: AM110091925
Investigation #: 2023A0579045
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

I. IDENTIFYING INFORMATION

License #:	AM110091925
Investigation #:	2023A0579045
Complaint Receipt Date:	08/29/2023
Investigation Initiation Date:	08/29/2023
Report Due Date:	10/28/2023
Licensee Name:	Spectrum Community Services
Licensee Address:	Suite 700, 185 E. Main St, Benton Harbor, MI 49022
Licensee Telephone #:	(734) 458-8729
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:	06/12/2023
Expiration Date:	06/11/2025
Capacity:	12
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The home was excessively hot.	Yes
Additional Finding	Yes

III. METHODOLOGY

08/29/2023	Special Investigation Intake 2023A0579045
08/29/2023	Special Investigation Initiated - Face to Face Resident A, Resident B, Resident C, Resident D, Direct Care Worker (DCW) A, DCW B, DCW C
08/29/2023	Contact - Document Sent Complainant
08/29/2023	Contact - Document Sent Tasha Stewart, ORR
10/04/2023	Contact- Document Received Tasha Stewart, ORR
10/13/2023	Contact- Document Sent Joyce Divis, Licensee Designee Stacy Kingman, DCW
10/18/2023	Contact- Telephone Call Received Joyce Divis, Licensee Designee Stacy Kingman, DCW
10/18/2023	Contact- Document Sent Joyce Divis, Licensee Designee
10/20/2023	Contact- Telephone Call Received Joyce Divis, Licensee Designee Stacy Kingman, DCW
10/20/2023	Exit Conference Joyce Divis, Licensee Designee

ALLEGATION:

The home was excessively hot.

INVESTIGATION:

On 8/29/23, I received this referral through the Bureau of Community Health Systems' on-line complaint system. The referral alleged Riverwood Office of Recipient Rights (ORR) received a call from someone in the home stating the home was incredibly hot and residents were complaining of heat related health symptoms. ORR worker, Tasha Stewart, went to the home and found residents sweating. Resident A stated, "I'm dying in here. I'm feeling so sick." The thermostat near resident bedrooms by the medication room was reading between 83-85 degrees Fahrenheit while Ms. Stewart was in the home. An ambulance was called to the home for two residents. Direct care workers (DCW) reported the air conditioner in the home has not been working properly for months and administration has not addressed this, even though it was reported to Ms. Divis and Ms. Kingman.

On 8/29/23, I completed an unannounced on-site investigation. Interviews were completed with Resident A, DCW A, DCW B, and DCW C. Direct care workers reported they did not want to speak to me unless their names were coded in this report because they feared retaliation.

I observed the thermostats in the home to be 72, for the side of the home that is through the kitchen to the dining area, and 76 for the side of the home that is near the medication room. I witnessed maintenance staff working on the air conditioner. The home did not feel uncomfortably warm. Residents were wearing jackets and sweatshirts and appeared comfortable.

Resident A stated she felt terrible, could not breathe, was dizzy, and felt sick to her stomach when the air conditioning was not working recently. She stated she was treated at the hospital for high blood pressure. She stated she wished they would fix the air conditioner in the home because this summer the home has been hot because the air conditioner does not work correctly sometimes. She stated the air conditioning did work near the dining room on the day the home was hot, but she did not want to be on that side of the home because she could not watch television. She stated when she returned from the hospital that day, there were fans in the home which made it cooler.

DCW A stated the temperature in the home when residents were taken to the hospital was 72-73 degrees Fahrenheit on the dining room side of the home and 83-84 degrees Fahrenheit on the side of the home near the medication room. She stated two residents were taken to and treated at the hospital because of the temperature. She stated staff encouraged all residents to remain on the side of the home that was cooler, but the working television is on the other side of the home, so they refused. She stated the air conditioning in the home has not been working

correctly for some time now. She stated she and other DCWs have completed maintenance request forms that were part of a corrective action plan I previously received from Ms. Divis, but Ms. Divis and Ms. Kingman claim none of the forms were received and therefore they do not believe there were sent. She stated she feels this is intentional because then DCWs get blamed for maintenance issues instead of Ms. Divis and Ms. Kingman arranging to have them fixed. She stated when Ms. Kingman came to the home and found that copies of the maintenance requests were being saved in the home to prove DCWs were sending them, she took them and told DCWs they were not allowed to copy the requests. She stated DCWs have been saving them in a hidden location, but she is not certain where it is. She stated on the day the home was hot, efforts were made to contact Ms. Divis and Ms. Kingman but they did not respond. She stated after residents were hospitalized, permission was granted to purchase several fans for the home and maintenance has been working to repair the air conditioning unit yesterday and today.

DCW B and DCW C confirmed they were aware that temperatures reached 72 degrees Fahrenheit on the dining room side of the home and 83 degrees Fahrenheit near the medication room. They also stated there have been ongoing issues with the air conditioning that were reported to Ms. Divis and Ms. Kingman and not addressed. They each reported they have sent the maintenance forms, that were part of a previous plan of corrective action, to Ms. Kingman and Ms. Divis and it was claimed they were not sent or received. They confirmed DCWs began keeping a file with copies of the forms to prove they were appropriately sending maintenance requests, but Ms. Kingman found it, reported they were not to keep copies, and then the file went missing. They reported they continue to keep copies, but they could not be found during this on-site.

On 8/29/23, I sent an email to the complainant reporting I was assigned this investigation and had completed an on-site at the home.

On 8/29/23, I exchanged emails with Ms. Stewart confirming I was at the home and maintenance was working on the air conditioning while I was present. She confirmed she witnessed the allegations as reported.

On 10/4/23, Ms. Stewart reported she was recently at the home, and it was much cooler. She stated Home Manager, Penny Kirby, told her that both air conditioning units have since been replaced.

On 10/13/23, I sent an email discussing my findings with Ms. Divis and Ms. Kingman. Ms. Divis responded she is concerned by what DCWs are reporting and requested to discuss the allegations via telephone. She stated there was one working air conditioning unit in the home on the day the second unit failed. She stated DCWs did not take appropriate measures to contact her or Ms. Kingman for assistance, to ensure residents remained on the side of the home that was cooler, to encourage residents to wear lighter clothing, or to take residents out of the home. She stated there has been ongoing maintenance on the HVAC system including the

home's contractor servicing the air conditioning unit on 8/22/23, which is two days prior to one system failing. She stated she did not receive a maintenance request from DCWs regarding the air conditioning unit until 8/25/23, which is the day after the unit failed. She stated she has received numerous maintenance requests, most arriving on or after 8/25/23, and responds to them quickly, keeping the fax transmittal ensuring her response was received. She stated DCWs have been trained to keep their original maintenance request, their transmittal confirming it was sent, and Ms. Divis' response. She stated it is untrue that Ms. Kingman told them not to keep copies or took their records. She expressed concern that there is "some kind of hidden agenda" with the DCWs involved because they could have contacted her or Ms. Kingman at any time during the day on 8/24/23 to report the home was warm and they would have sent maintenance out immediately, but instead they waited until the evening and contacted ORR. She stated she asked why they did not contact her, and they each responded, "I don't know." She stated there is a pattern over the last year of DCWs contacting licensing, other administrators at Spectrum Community Services, and now ORR instead of following the chain of command and appropriately contacting her or Ms. Kingman to resolve concerns properly.

On 10/18/23, I completed a telephone interview with Ms. Divis and Ms. Kingman. It was discussed that there have been 22 maintenance requests received by Ms. Divis and Ms. Kingman for this home since the beginning of 2023, most of them arriving on or after 8/25/23, the day after this incident occurred. Ms. Divis stated it makes no sense why she would claim she had not received these orders, as not fixing concerns in the home only "falls back on" her. She stated she feels DCWs were not appropriately sending maintenance requests over and they realized this after this incident on 8/24/23 and now they have been sending them over regarding even minute things. She denied disregarding any maintenance requests that were received and reported she always promptly responds. We discussed several of the maintenance requests and each time a prompt response was noted by her or Ms. Kingman, with either she and/or Ms. Kingman coming to the home to observe the concern and/or maintenance being called. She stated there would have been no problem with immediately having the contractor come to the home on 8/24/23, especially since he had just been there working on the unit on 8/22/23, had DCWs called her and/or Ms. Kingman. She stated there was no reason to wait until 4:00 p.m./4:30 p.m. and to instead call ORR. She stated it is known that the HVAC system in the home could benefit from being upgraded and was scheduled to be upgraded in Spring 2023 but was delayed. She stated maintenance serviced the HVAC on 6/2/23 and 8/22/23 but was also in the home four times in July 2023 where workers could have addressed any concerns for maintenance, as they have done in the past.

Ms. Kingman stated there is no truth to allegations that she advised DCWs they could not keep copies of their maintenance requests. She stated the opposite is true and she even worked with Ms. Kirby to create a folder where the original maintenance request, the fax transmittal confirming the request went through, and Ms. Divis' response should be kept. She stated when she went to the home to

address the concerns regarding the maintenance requests, they initially could not be found in the home's office. She stated DCW Monica Rickers returned from another room with "a stack" of requests but denied having the associated fax transmittals to ensure they were received. She stated she advised the DCWs in the room that those requests should be put in the folder she made, and when she left the home the stack of requests was in the office, she did not take them from the home.

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:	Ms. Stewart, DCW A, DCW B, and DCW C confirmed one air conditioning unit in the home was not working on 8/24/23, which led to the temperature in the home becoming a safety concern for residents. They confirmed the temperature in the home had gone up to 83-84 degrees Fahrenheit on one side of the home, which led to residents having to go to the hospital for treatment. Resident A stated she was unwell and went to the hospital when the temperature in the home was very high one day, although she confirmed one side of the home was cooler, but she did not want to be on that side of the home. Although DCW A, DCW B, and DCW C reported Ms. Divis and Ms. Kingman were aware the air conditioning unit did not work correctly, Ms. Divis and Ms. Kingman reported maintenance had worked on the unit on 6/2/23 and 8/22/23 but they were not appropriately notified on 8/24/23 that the unit was not working that day. Both stated DCWs, instead of calling them for immediate assistance, waited until the evening to contact the Office of Receipt Rights to notify ORR instead. Ms. Divis and Ms. Kingman said DCWs did not attempt to call them, did not remove residents from the home, did not have residents remain on the cooler side of the home, did not put residents into cooler clothing, and failed to appropriately respond so that efforts to cool residents and/or fix the air conditioning unit could be made immediately during the day. I confirmed the air conditioning unit was serviced on 6/2/23, 8/22/23, and maintenance was in the home four times in July 2023 where DCWs could have addressed maintenance concerns. Furthermore, no maintenance requests for the air conditioning were received prior to 8/25/23, which is the day after the incident.

	Based on the interviews completed and observations made, there is sufficient evidence to support allegations that residents' personal needs, including protection and safety, were not attended to all times and that the staff did not act appropriately and timely to address resident concerns for the high temperature in the home that led to two resident hospitalizations.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

On 8/29/23, DCW A, DCW B, and DCW C expressed concern that there is a gap between the tiled floor in the resident bathroom and the wood floor in the hallway that is a trip hazard and that a resident has fallen in the bathroom due to the lip created by the tile. They said they were advised by Ms. Kingman and Ms. Divis to duct tape the gap to make it safer, but they felt that was not an appropriate solution and maintenance needed to install a proper transition piece for resident safety.

DCW A, DCW B, and DCW C also expressed concern that proper PPE is not maintained in the home to keep residents safe. They each reported they are assisting residents with toileting, poking their fingers for blood sugar monitoring, and applying topical medications without gloves because gloves are not regularly maintained in the home. They each expressed concern that at times the home has run out of hand soap as well. They denied having gloves available to use in the home today.

I observed the transition piece between the two floors to be missing at the entrance of the resident bathroom creating a gap and a lip that could be a potential trip hazard for residents with ambulatory challenges.

On 10/13/23, Ms. Divis responded she has not observed the missing transition piece, but Ms. Kingman has after it was reported on 8/25/23 along with numerous other maintenance concerns that were previously unreported. She stated maintenance has been at the home in May 2023, 6/2/23, four times in July 2023, and 8/22/23. She stated DCWs usually approach the maintenance person with all their concerns when he is in the home, so she is unsure why DCWs did not report the gap to the contractor one of the several times he has been at the home or prior to 8/25/23, if they are claiming residents have fallen and it was a safety hazard. She stated if residents had fallen, a maintenance request should have come with an incident report but no incident reports regarding the gap or residents tripping over it have been completed.

On 10/18/23, Ms. Divis and Ms. Kingman confirmed there is one resident who has fallen in the bathroom, but it occurred while standing in the bathroom and not at the doorway according to the incident report completed by DCWs. Ms. Divis stated Ms. Kingman observed the transition piece after a maintenance report was filed on 8/25/23 and denied concerns that residents in the home would trip over it.

On 10/18/23, Ms. Divis stated she is not certain why DCWs would say there is not appropriate PPE in the home. She stated there is a regular order for gloves and she has viewed receipts for use of petty cash showing that DCWs regularly purchase more gloves. She stated in addition there are receipts for hand sanitizer being purchased too. She stated extra supplies are also available at the main office if they were to request more. She agreed to look into this prior to continuing our discussion on 10/20/23.

On 10/20/23, Ms. Kingman reported she went to the home this week and observed appropriate PPE including boxes and bags of gloves, gowns, and masks and denied that PPE is not appropriately kept in the home.

I observed photographs that Ms. Kingman took in the home showing bags and boxes of PPE in the home.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	DCW A, DCW B, and DCW C reported there is a transition piece that is missing between the hallway floor and bathroom floor that creates a trip hazard for residents. I observed the transition piece between the hallway floor and bathroom floor to be missing creating a lip that could be a trip hazard for residents. DCW A, DCW B, and DCW C each reported at times the home is without necessary PPE such as gloves and hand soap to ensure the health and safety of residents of the home. Ms. Divis reported gloves are regularly provided, in addition to DCWs using petty cash to purchase more gloves, and PPE is available at the main office if needed too. She stated DCWs use petty cash for hand sanitizer as well. I observed photographs of boxes and bags of PPE in the home. There was insufficient evidence to support this allegation. Based on the interviews completed and observations made, there is sufficient evidence to support allegations that the home is not maintained to adequately provide for the health, safety, and wellbeing of residents due to the missing transition piece between the hallway floor and tiled bathroom floor creating a lip that could be a trip hazard.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** ~~SIR~~ Special investigation report # 2022A0579011 dated 12/1/21, licensing study report dated 12/20/21, and CAP dated 1/3/22

During the investigation, DCW A, DCW B, and DCW C expressed significant concern regarding food in the home. The concerns were primarily that DCWs cannot eat with residents which causes residents to become upset when they bring their own food. They expressed concern that there is no bottled water or snacks that residents like if they refuse a meal and that no “junk food” is purchased even if it is on the menu. They expressed concern that, for example, nine chicken breasts or only eight porkchops may be purchased for 11 residents. I did not feel these allegations related to rule violations; however, I did address these concerns.

I reviewed the menu, which DCWs reported was followed, and found it to be nutritionally balanced. I observed sufficient food in the home including fresh, frozen, canned, and boxed proteins, grains, vegetables, fruits, and grains. I reviewed residents’ weights and did not observe significant weight loss.

Resident A reported overall she likes the food in the home and gets enough to eat even though she does not always like each meal. She denied concerns relating to food in the home.

Resident B stated he really likes the food in the home and only sometimes he does not like certain meals they serve. He reported he gets enough food to eat.

Resident C stated sometimes residents are served too much starch but recently the menu has improved, it is “pretty good”, and she gets enough to eat.

Resident D stated he does not like when pork is served because of his false teeth but he is sometimes given choices of what to eat and the food has gotten better. He stated he is not always full from dinner and he does not get second servings but he does get Boost meal supplement after dinner.

I shared these concerns with Ms. Stewart at ORR. She reported Anne Simpson from ORR is working with DCWs to address their concerns regarding food in the home. I discussed these concerns with Ms. Divis and Ms. Kingman as well and provided consultation on educating staff as to why items are being purchased (such as that nine large chicken breasts may create enough servings for 11 residents depending on the portion size specified by the menu) to see if that lessen DCW concerns regarding the food in the home.

I spoke with Ms. Divis and Ms. Kingman who stated DCWs have regularly expressed concerns about the menu, and it has been an ongoing discussion. Ms. Divis explained the Home Manager uses the menu to send a list to Ms. Kingman for weekly purchases. Ms. Kingman then orders from Walmart, picks up the order, and then delivers the order to the home. She stated DCWs are responsible for getting Ms. Kingman the list of groceries so if items are not being ordered correctly, it is because DCWs are not giving Ms. Kingman the correct list.

Ms. Kingman stated on 10/17/23, a training was done with DCWs regarding completing a substitution log or finding alternatives should there not be correct food in the home or if a resident requests something else. She stated weekly house meetings are done with residents, so they have input on the menu and arrangements can be made for holidays or other special meals. She stated it is known Resident D does not like pork, so he will always have a substitute protein and it will be logged appropriately. She stated last week, she reminded the Home Manager that she needed the grocery list by Wednesday at the latest because she would not be available on Friday, as she typically is, to deliver groceries. She stated she never received the grocery list and received phone calls on Saturday, requesting that she order food because they needed groceries. She stated not having correct groceries and having to use substitutions is the fault of the DCWs in this home, because she relies on them reporting what items she needs to purchase.

I emailed Ms. Simpson regarding appropriate use of resident mealtimes so compliance is maintained for licensing.

On 10/20/23, I completed an exit conference with Ms. Divis and Ms. Kingman who did not dispute my findings or recommendations. Acceptable corrective actions were discussed.

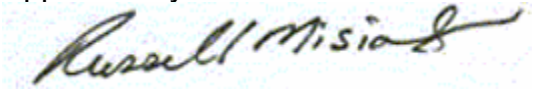
IV. RECOMMENDATION

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

10/20/23

Cassandra Duursma — Date
Licensing Consultant

Approved By:



10/24/23

Russell B. Misiak — Date
Area Manager