GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 29, 2024

Donna McBride
Spectrum Community Services
Suite 700
185 E. Main St
Benton Harbor, MI 49022

RE: License #: AS630397254
Investigation #: 2024A0465030
Leidich Home

Dear Mrs. McBride:

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,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012
Fax: 517-763-0204

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630397254
Investigation #:	2024A0465030
Complaint Receipt Date:	07/03/2024
Investigation Initiation Date:	07/09/2024
Report Due Date:	09/01/2024
Licensee Name:	Spectrum Community Services
Licensee Address:	Suite 700 - 185 E. Main St Benton Harbor, MI 49022
Licensee Telephone #:	(231) 887-4130
Administrator:	Donna McBride
Licensee Designee:	Donna McBride
Name of Facility:	Leidich Home
Facility Address:	1087 Leidich Lake Orion, MI 48362
Facility Telephone #:	(248) 693-4957
Original Issuance Date:	06/18/2019
License Status:	REGULAR
Effective Date:	06/14/2024
Expiration Date:	06/13/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 6/28/2024, direct care staff, Chelsea Henson, used an improper arm hold technique on Resident A.	Yes

III. METHODOLOGY

07/03/2024	Special Investigation Intake 2024A0465030
07/09/2024	Special Investigation Initiated - Letter I spoke to Complainant via email exchange
07/10/2024	Contact - Document Sent Email exchange with Office of Recipient Rights Officer, Rishon Kimble, via email
07/15/2024	Inspection Completed On-site I conducted an onsite investigation. I completed a walk-through of the facility, reviewed resident files, observed residents and interviewed direct care staff, Leah Plummer
07/24/2024	Contact - Document Received Facility documents received via email
07/26/2024	Contact - Document Received Facility documents received via email
08/05/2024	Contact - Telephone call made I spoke to direct care staff, Chelsea Henson, via telephone
08/13/2024	Contact - Telephone call made I spoke to direct care staff, Yvonne Cox, via telephone
08/20/2024	Contact - Telephone call made I spoke to Guardian A1 via telephone
08/22/2024	Contact – Document sent I spoke to ORR Officer, Mr. Kimble, via email exchange
08/22/2024	Exit Conference I completed an exit conference with licensee designee/administrator, Donna McBride, via telephone

08/28/2024	APS Referral I submitted an Adult Protective Services Referral

ALLEGATION:

On 6/28/2024, direct care staff, Chelsea Henson, used an improper arm hold technique on Resident A.

INVESTIGATION:

On 7/3/2024, a complaint was received, alleging that on 6/28/2024, direct care staff, Chelsea Henson, used an improper arm hold technique on Resident A.

On 7/9/2024, I spoke to Complainant via email exchange. Complainant confirmed the information contained in the complaint is accurate.

On 7/10/2024, I spoke to Office of Recipient Rights Officer, Rishon Kimble, via email. Mr. Kimble stated that his investigation is still ongoing, and a determination has not been made as to whether he will be citing a rule violation.

On 7/15/2024, I conducted an onsite investigation at the facility. I completed a walk-through of the home, reviewed resident files, observed residents and interviewed direct care staff, Leah Plummer. I observed the home to be clean and in good condition. I observed all residents to be in appropriately dressed and with adequate hygiene. At the time of my onsite investigation, there were four residents residing in the home, all of which could not be interviewed due to intellectual or cognitive/memory deficits. Resident A was not at the home due to currently being inpatient at the hospital for medical reasons.

I reviewed Resident A's file. The *Face Sheet* stated that Resident A was admitted to the facility on 3/8/2024 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Moderate Cognitive Impairment. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, is not alert to his surroundings, has a history of verbal and physical aggressive behavior towards staff and other residents, needs assistance with daily personal care tasks and does not require use of assistive devices for mobility. The *Easterseals MORC Crisis Prevention & Safeguard Plan,* dated 4/22/2022, listed the following crisis intervention plan techniques for Resident A when he becomes physically aggressive:

- Separate vulnerable people
- If Resident A hits or kicks, do not react. Remain calm. Do not talk about the behavior. Focus on the behavior you wish to see. Do not say things like, "stop hitting." Try to ignore and move out of range.
- Relax your (caregiver's) whole body.

- Try walking or leaving the area together.
- Position yourself slightly to the side, in a face-to-face position, with your shoulder an arm length away if needed for safety.
- Keep out of kicking range.
- Attempt to learn what the basis is for the frustration.
- Perform sensory activities (e.g. swing, sit in a beanbag, take a shower, chew gum, squeeze a ball, jumping jacks, etc.).
- If Resident A experiences a behavior, he should take a breather in his room. Staff can stand outside of the door and give him a moment to collect his thoughts and feelings. His room is a safe space for him. If he begins harming himself, staff should intervene. Use Gentle Teaching tactics.

I reviewed the *Incident/Accident Report*, dated 6/25/2024, completed by direct care staff, Chelsea Henson with added comments from prior Licensee Designee/Administrator, Janet DeFazio. The document stated the following:

> 6/25/2024 at 7:30am: Resident A purposely dumped his bowl of cereal out on the kitchen table. I asked him why he dumped his bowl of cereal out on the kitchen table. I asked him why he did that and if he didn't want it all he had to do was tell me and we could have got something different. I told him to clean up his mess and he told me no and tossed the spoon down. I told him if he wasn't going to clean it up then he should go to his room for a breather, he told me no again and went to throw himself over the couch but got stuck half way over, so I reached for his arm while stating, “come on Marcus let's turn our day around,” and at that time he threw himself backwards and headbutted me twice, then slapped me three times, so I used the arm hold technique we was shown to help gain control and he kicked me and ran to his room and threw himself down on the floor and started hitting on his walls and throwing things. I switched places with the other staff present (Leah Plummer) to try and deescalate the situation. Resident A went in his room and took his glasses and gave them to me to put up. Ms. Plummer went back in there and talked to him about the things, got him calm down and sat in there while he took a rest time and called the house manager and informed her of what happened. Corrective Measures Taken: Staff switched places for the shift. Resident A stayed in his room for rest time and was talked to about his actions/behaviors. ADD: Per Area Director Ensured person served is free from injury. Consulted staff and discovered CPI techniques and support aspects were not completely followed during the incident. Post-reminder in Communication Log for the whole team to utilize their CPI training skills and follow supports plans. Will schedule additional in-services as able to reiterate support plan content and processes. Please note: Reporting staff resigned effective 6-25-2024 after consultation meeting for clarification of report. Completed by Janet DiFazio

I interviewed direct care staff, Leah Plummer. Ms. Plummer stated that she has worked at the facility for seven months. Ms. Plummer stated, “I am familiar with Resident A. He has a history of physically aggressive behavior towards staff and the other residents. Recently, his behavior has been escalating. I was working the day this incident occurred. I was working with direct care staff, Chelsea Henson. It was morning time,

and we had served all the residents' breakfast. Resident A was at the table with a bowl of cereal. Suddenly, he threw his bowl of cereal all over the table and Ms. Henson asked Resident A why he did that. And he replied that he did it because he didn't want to eat it. Ms. Henson then suggested to Resident A that he take a break and breather in his room. But Resident A escalated from there and he threw himself over the couch and Ms. Henson went over to help him get up. When she did help Resident A up, he headbutted her in her head three times and then he hit her and kicked her. She then took his arm and had it underneath her arm. She was holding his arm and restraining his arm. I understand why she did it, but technically we are not supposed to do that. We are not allowed to restrain any resident and Resident A's plan does not allow for physical restraint of any kind. I eventually stepped in and was able to get Resident A to calm down and walked him to his room so he could have some alone time. Prior to this incident, I have never seen any staff ever restrain a resident before." Ms. Plummer acknowledged that this complaint is true.

On 8/5/2024, I spoke to direct care staff, Chelsea Henson, via telephone. Ms. Henson stated that she worked at the facility for six months, with her last being the date of this incident, 6/28/2024. Ms. Henson stated, "I had a good relationship with Resident A prior to this incident happening. I was really surprised when it did happen. Resident A has a history of verbal and physical aggression, but I had not personally been targeted or hit by him before. On that day, Resident A was at the table, eating cereal and out of nowhere, he threw it across the table and became very upset. I did ask him why he did it and I also asked him to clean it up. He refused and became more upset. He then threw his body over the couch and was sort of stuck between the couch and the wall. I went over to help him up. While helping him up, I slid my hand though or over his hand and we were interlocked. And I was redirecting him and walking him to his room. He then began to hit me in the head and kick me. I had my hand over his hand, and I don't want to say I was restraining him. I was doing more of an interlock hand technique to stop him from hitting me. I then maneuvered his arm under my arm to try and protect myself and so that I could get away. Resident A then ran to his room and Ms. Plummer took over with redirecting and interacting with Resident A at that time. I do not feel that I restrained Resident A or hurt him. I remember learning how to use an interlock technique from CPI training, but I do not recall if this type of technique is allowed per Resident A's crisis plan."

On 8/13/2024, I spoke to direct care staff, Yvonne Cox, via telephone. Ms. Cox stated that she has worked at the facility for six years. Ms. Cox stated, "I am familiar with Resident A and his behaviors. He will hit, push and kick staff and residents when he is upset. We do have a behavioral plan for him that gives us direction on how to interact with him and how to de-escalate him when he becomes aggressive. We are not allowed to use any form of restraint for Resident A. We did all complete CPI training, and we were taught different ways to interact and de-escalate behaviors, but we were not taught to use restraint techniques and Resident A's plan does not allow for any form of physical management. We can only follow what is in Resident A's crisis plan. I have never used any sort of physical restraint or hand interlock with any resident, including Resident A."

On 8/20/2024, I spoke to Guardian A1 via telephone. Guardian A1 stated, “Resident A has a long history of aggressive behavior and needs to be in a facility for supervision and structure. He has lots of behaviors, both physical and verbal. He can have a good day and then his behavior can suddenly get very bad. I understand why physical restraint cannot be used on him, but I also feel he requires restraint sometimes to keep himself and others safe. I feel the staff are doing the best they can, but I think he requires more support. I am considering a new, more structured setting for him in the future.”

On 8/22/2024, I completed an exit conference with licensee designee/administrator, Donna McBride, via telephone. Ms. McBride is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	According to the *Easterseals MORC Crisis Prevention & Safeguard Plan,* when Resident A becomes physically aggressive, staff are to use Gentle Teaching Techniques, including verbal redirection and utilization of physical space separation. The crisis plan does not include use of any form of physical restraint or arm interlock hold. According to the *Incident/Accident Report* and Ms. Plummer, Ms. Plummer observed Ms. Henson use a physical restraint/hold of Resident A’s arm on 6/28/2024. According to Ms. Plummer and Ms. Cox, Resident A’s crisis intervention plan does not allow for use of physical force or restraint of any kind. According to Ms. Henson, on 6/28/2024, she utilized a physical interlock arm technique on Resident A. Ms. Henson was unable

	to recall if this technique is referenced in Resident A's crisis plan. Based on the information above, there is sufficient information to confirm that on 6/28/2024, Ms. Henson did not appropriately implement and adhere to Resident A's crisis plan when she utilized a physical interlock arm restraint on Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

8/28/2024

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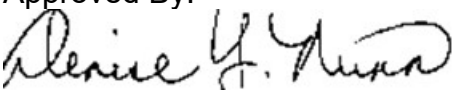
Stephanie Gonzalez Date
Licensing Consultant

Approved By:



08/29/2024

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Denise Y. Nunn Date
Area Manager