GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 10, 2024

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

RE: License #: AS410356636
Investigation #: 2024A0467038
Terrace Park Home

Dear Mrs. Payne:

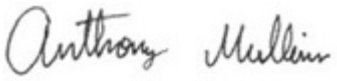
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0183.

Sincerely,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410356636
Investigation #:	2024A0467038
Complaint Receipt Date:	05/21/2024
Investigation Initiation Date:	05/21/2024
Report Due Date:	07/20/2024
Licensee Name:	Spectrum Community Services
Licensee Address:	Suite 700 185 E. Main St Benton Harbor, MI 49022
Licensee Telephone #:	(734) 458-8729
Administrator:	Delissa Payne
Licensee Designee:	Delissa Payne
Name of Facility:	Terrace Park Home
Facility Address:	5901 Terrace Park Dr. NE Rockford, MI 49341
Facility Telephone #:	(616) 884-5788
Original Issuance Date:	03/12/2014
License Status:	REGULAR
Effective Date:	10/24/2023
Expiration Date:	10/23/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's broken left pinky finger is not consistent with the explanation given by staff.	No
Resident A was not showered between 5/3/24-5/724.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/21/2024	Special Investigation Intake 2024A0467038
05/21/2024	Special Investigation Initiated - Telephone
05/22/2024	Inspection complete – onsite
06/03/2024	Contact – telephone call made Jayden Cunningham
07/10/2024	APS Referral
07/10/2024	Exit conference with licensee designee, Delissa Payne and associate director, Jordan Walch.

ALLEGATION: Resident A's broken left pinky finger is not consistent with the explanation given by staff.

INVESTIGATION: On 5/21/24, I received a complaint via phone informing me that Resident A had a seizure on 5/7/24, resulting in him falling to the ground and breaking his left pinky finger. The complainant stated that she was told that Resident A fell on his right side after the seizure, so she is unsure how he would have broken his left pinky finger. The staff members working during the fall were Jayden Cunningham and Dickinson Ixanord. The complainant stated that AFC staff member, Kayla Bucholtz observed the bruise to Resident A's left pinky finger on the morning of 5/8 and took pictures of the injury. In addition to the broken pinky finger, Resident A also had bruises to his chest/left peck area. The complainant is concerned that the explanation provided by staff as to what caused the broken pinky is not consistent with the injury. The complainant shared that Resident A does have osteoporosis.

On 5/22/24, I made an unannounced onsite investigation at the facility. Upon arrival, AFC staff member Heather Reamon allowed entry into the home and agreed to discuss case allegations. Also present with Ms. Reamon was the new manager of the home, Cassandra Hodges. Ms. Reamon confirmed that Resident A had a seizure on 5/7/24 and broke his left pinky as a result of it. Ms. Reamon also confirmed that Resident A had bruises to the left side of his chest. On the day in

question, Ms. Reamon confirmed that AFC staff members, Jayden Cunningham and Dickinson Ixanord were working 2nd shift. The following morning (5/8), AFC staff member Kayla Bucholtz observed the injuries to Resident A and sent pictures in the work group chat inquiring what occurred. Ms. Reamon stated that AFC staff member, Brianna Hartman was also working the morning of 5/8 when the injuries were observed on Resident A.

Ms. Reamon stated that Ms. Bucholtz took Resident A to urgent care, where he was diagnosed with a broken left pinky. Ms. Reamon provided me with a copy of Resident A's discharge summary from urgent care, which indicated that he had a "closed displaced fracture of middle phalanx of finger of left hand" and an "outpatient referral to hand surgery" was made. In the discharge summary, there was no indication that the injury was the result of any form of abuse or negligence from Resident A's caregivers in the AFC home. Ms. Reamon shared that Resident A does have osteoporosis, which can contribute to broken bones.

Ms. Reamon stated that Resident A's mother was at the home on 5/8 and asked Mr. Cunningham what happened. Ms. Reamon stated that Mr. Cunningham told Resident A's mother that he was throwing something away in the trash. While doing so, Resident A dropped to the floor. Ms. Reamon was adamant that Mr. Cunningham told Resident A's guardian that he fell on his left side as she was present during the conversation. Ms. Hodges stated that Mr. Cunningham shared that Resident A's pinky was under the fridge when he fell, which he believed could have caused the pinky finger to break.

While onsite, Ms. Reamon provided me with a copy of Resident A's Individualized Plan of Service (IPOS) from Network 180, which indicates that he has a history of seizures, including injuries resulting from his seizures.

After speaking to Ms. Reamon and Ms. Hodges, staff assisted me to Resident A's room, where I observed him lying in bed watching his tablet. Resident A acknowledged me and allowed me to observe his left pinky finger and his chest. His pinky had some bruising on it, but there were no marks or bruises to his chest area. Resident A was not interviewed due to his limited communication skills. Resident A was thanked for his time as this brief meeting concluded.

On 6/3/24, I spoke to AFC staff member, Jayden Cunningham via phone. Mr. Cunningham confirmed he was a witness to Resident A falling, which occurred sometime last month on 2nd shift between 5:00 and 6:00 pm. On the day in question, Mr. Cunningham stated that Resident A was throwing his chicken nuggets away. After doing so, "he dropped and had a seizure right in front of the fridge." Mr. Cunningham initially stated that Resident A fell on his left side. He then stated that Resident A fell on his right side as he recalls his left hand being under the refrigerator and his head being near the refrigerator. Mr. Cunningham denied telling anyone that Resident A fell on his opposite side. Mr. Cunningham stated that he was unaware of Resident A having any bruising or a broken finger until the following day

when his colleagues, Ms. Bucholtz and Ms. Hartman informed him, and the bruises settled in.

After Resident A had his seizure, Mr. Cunningham stated that he and his colleague turned Resident A over and he was able to get up within a minute. Mr. Cunningham shared that Resident A presented as his normal self after getting up from the seizure and he went back into his room. Mr. Cunningham stated that he checked for injuries after the fall, and he did not observe any.

Mr. Cunningham confirmed that his colleagues observed the injuries the following day, which is what led to them taking Resident A to the hospital or urgent care to be assessed, which is when they were informed of the injuries. Mr. Cunningham stated that his colleague, Mr. Ixanord heard the fall since he was in the house, but he did not witness it.

On 07/10/24, I conducted an exit conference with licensee designee, Delissa Payne and associate director, Jordan Walch. They were informed of the investigative findings and denied having any questions.

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 sustained a broken left pinky finger due to falling after having a seizure. Resident A has been diagnosed with osteoporosis, which can contribute to bruising and breaking bones. Resident A has a known history of falling and being injured due to his seizures. There were some discrepancies as to which side of Resident A's body hit the floor when he fell. However, there is no evidence that Resident A's broken pinky is the result of abuse or neglect by staff. Therefore, there is not a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A was not showered between 5/3/24 – 5/7/24.

INVESTIGATION: On 5/21/24, I received a complaint via phone stating that Resident A's hygiene is not being addressed appropriately. The complainant stated that Resident A was not showered between 5/3/24-5/7/24. There are also concerns that Resident A is not brushing his teeth.

On 5/22/24, I made an unannounced onsite investigation at the home. AFC staff member Heather Reamon and Cassandra Hodges were interviewed. Ms. Reamon stated Resident A is currently getting at least 4 showers per week. By the end of the day, Resident A's hair is greasy, and it can sometimes look as if he's not being bathed. Ms. Reamon shared that Resident A can be extremely aggressive with staff while they are trying to shower him. Sometimes, a second staff member will assist to distract him and prevent him from hitting and scratching staff. Ms. Reamon did add that Resident A wasn't being showered as often as he should have in October when she arrived at the home. She also added that there are a lot of times that Resident A refuses to shower.

Per Ms. Hodges, Resident A is being bathed almost daily. Ms. Hodges stated that Resident A has gotten better with showers, as he tends to respond better with certain staff members. Ms. Hodges and Ms. Reamon provided me with a copy of Resident A's assessment plan, which indicates that he needs verbal prompts and can't be left alone. I reviewed Resident A's Individualized Plan of Service (IPOS) from Network 180, which indicates that staff are to prompt and assist Resident A with showering daily. I also reviewed Resident A's Shower and oral hygiene log. The log confirmed that Resident A was not showered from 5/3/24 through 5/7/24. The log also confirmed that Resident A did not brush his teeth from 5/4/24 through 5/7/24.

On 6/3/24, I spoke to AFC staff member, Jayden Cunningham via phone. I asked Mr. Cunningham how often Resident A is supposed to be showered. Mr. Cunningham stated that Resident A is supposed to be showered/bathed daily on second shift. I asked Mr. Cunningham if he is aware of Resident A going 4-5 days without being showered. Mr. Cunninghan stated that he has heard of Resident A not being showered for several days. This was not brought to his attention until Resident A's mother mentioned it and he noticed Resident A wearing the same clothes sometime in early May. Mr. Cunningham was adamant that he showers Resident A on all his shifts.

On 07/10/24, I conducted an exit conference with licensee designee, Delissa Payne and associate director, Jordan Walch. They were informed of the investigative findings and agreed to complete a CAP within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14314	**Resident Hygiene**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Resident A's IPOS confirmed that he is supposed to be prompted and assisted with showering/bathing daily. Resident A's hygiene log confirmed that he was not showered or bathed

	between 5/3/24 and 5/7/24. The log also confirmed that staff did not assist Resident A with bruising his teeth between 5/4/24 and 5/7/24. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegations listed above, it was determined that AFC staff member, Jayden Cunningham did not follow the seizure protocol for Resident A on 5/7/24. Per Resident A's assessment plan, "(Resident A) has a seizure protocol to follow." Ms. Reamon confirmed that Resident A's seizures are supposed to be timed, documented, and after 3 minutes, he is supposed to be given his nasal spray. Resident A also gets a second dose of nasal spray if the seizure hasn't resolved in 10 minutes. Ms. Reamon confirmed that Mr. Cunningham told Resident A's mother that he did not time the seizure because he reportedly did not need the nasal spray. Mr. Cunningham reportedly stated that he was not trained on seizure protocol.

I reviewed the documentation log for Resident A's 5/7 seizure, and Mr. Cunningham noted that the seizure last from 6:00 pm to 6:05 pm, although he put the duration of the seizure as 1 minute. This indicates that the seizure was not timed per protocol, or documentation was falsified.

I later asked Mr. Cunningham via phone about Resident A's seizure protocol. He stated that it consists of timing his seizure, providing him with Nayzilam spray if it last more than 5 minutes, documenting what occurred, including any injuries, and calling to inform his mother. Mr. Cunningham acknowledged that he did not inform Resident A's mother like he should have because "I wasn't 100% sure what to do." The following morning, Mr. Cunningham was informed by his peers to inform Resident A's mother after his next seizure. Mr. Cunningham was adamant that he did time the seizure.

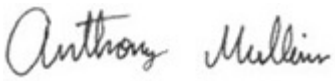
On 07/10/24, I conducted an exit conference with licensee designee, Delissa Payne and associate director, Jordan Walch. They were informed of the investigative findings and agreed to complete a CAP within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Resident A's assessment plan states that he has a seizure protocol to follow, which includes timing his seizures. Ms. Reamon heard Mr. Cunningham tell Resident A's mother that he did not time the seizure. Despite this, he still documented that he did in fact time the seizure. He also confirmed that he did not inform Resident A's mother of the seizure. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



07/10/2024

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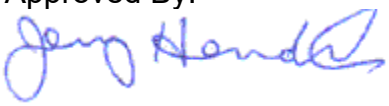
Anthony Mullins Date
Licensing Consultant

Approved By:



07/10/2024

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Jerry Hendrick Date
Area Manager