GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 8, 2019

Sharon Blain
Spectrum Community Services
28303 Joy Rd.
Westland, MI 48185

RE: License #: AS410338054
Investigation #: 2019A0355064
Skyway Home

Dear Mrs. Blain:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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) 356-0100.

Sincerely,

Grant Sutton, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4437

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410338054
Investigation #:	2019A0355064
Complaint Receipt Date:	09/30/2019
Investigation Initiation Date:	09/30/2019
Report Due Date:	11/29/2019
Licensee Name:	Spectrum Community Services
Licensee Address:	28303 Joy Rd., Westland, MI 48185
Licensee Telephone #:	(616) 447-9380
Administrator:	Sharon Blain
Licensee Designee:	Sharon Blain
Name of Facility:	Skyway Home
Facility Address:	5626 Skyway Dr., Comstock Park, MI 49321
Facility Telephone #:	(616) 551-2093
Original Issuance Date:	02/27/2013
License **Status:**	REGULAR
Effective Date:	08/27/2019
Expiration Date:	08/26/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff utilize a wheelchair harness as a restraint.	Yes
Staff threatened Resident A with losing privileges.	No

III. METHODOLOGY

09/30/2019	Special Investigation Intake 2019A0355064
09/30/2019	APS Referral
09/30/2019	Special Investigation Initiated - Telephone network 180, Office of Recipient Rights
10/03/2019	Inspection Completed On-site Interviewed staff & Resident A; reviewed facility file
10/08/2019	Exit Conference Licensee designee

ALLEGATION: Staff utilize a wheelchair harness as a restraint.

INVESTIGATION: On 09/30/2019, I received a complaint from the Adult Protective Services Centralized Intake Unit (APS) in which it is alleged that staff were observed to utilize a harness as a restraint with Resident A's wheelchair. This was observed while staff had Resident A at a doctor's appt. APS declined to investigate this allegation. Ms. Reamon has been suspended from the facility pending the outcome of the investigation.

On 10/03/2019, I conducted an on-site investigation and interviewed program manager Heather Reamon, staff Laura Dunning, and Resident A. Recipient rights staff, Bob Patterson, participated in the interviews. Corporate rights staff for the licensee, Dereka Seigel, sat in on the interviews and quality assurance manager, Sue Howell assisted with Resident A's interview. While on-site, I reviewed Resident A's facility file.

Ms. Reamon stated that Resident A's doctor expressed concern that because Resident A suffered a broken neck from a fall at a previous placement, staff should utilize a wheelchair with Resident A to reduce the chance for falls. Ms. Reamon stated that a prescription has been sent to Mary Free Bed for a wheelchair for Resident A with appropriate assistive devices, as Medicaid will cover them. Ms. Reamon stated that in the meantime, staff utilize a wheelchair from a previous

resident with Resident A. Since there is concern about Resident A falling and she tends to lean forward in the wheelchair as if to fall, Ms. Reamon stated that staff utilize the 'harness' that is attached to the wheelchair being used. Ms. Reamon denied that staff utilizes it as a restraint and indicated that it is not used all of the time.

Ms. Dunning described the use of the harness similarly to Ms. Reamon and denied that the harness is used as a restraint.

Mrs. Howell stated that she worked the first shift at the facility today. When she arrived for work, she observed that Resident A was wearing the harness. Mrs. Howell stated that she pointed out to staff that the harness is not to be utilized and removed it immediately.

When we interviewed Resident A, she was not wearing the harness but I did observe that Resident A frequently leaned forward as if to tumble out of the wheelchair and Mrs. Howell had to prompt Resident A to sit back repeatedly.

Present in Resident A's file is an order for the use of a wheelchair, but not for the use of a 'harness.'

On 10/08/2019, I conducted by telephone an exit conference with the licensee designee, Sharon Blain. Mrs. Blain accepted the findings of my investigation.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(1) An assistive device shall only be used to promote the enhanced mobility, physical comfort, and well-being of a resident.
ANALYSIS:	Program manager Heather Reamon and staff Laura Dunning acknowledged that the harness is utilized with Resident A periodically but denied using it as a restraint. There is no order present in Resident A's file from Resident A's physician for the use of a harness.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff threatened Resident A with losing privileges.

INVESTIGATION: On 09/30/2019, I received a complaint from the Adult Protective Services Centralized Intake Unit (APS) in which it is alleged that program manager Heather Reamon and staff Laura Dunning threatened Resident A with losing

privileges if Resident A did not behave while at Resident A's doctor's appt. APS declined to investigate this allegation. Ms. Reamon has been suspended from the facility pending the outcome of the investigation.

On 10/03/2019, I conducted an on-site investigation and interviewed program manager Heather Reamon, staff Laura Dunning, and Resident A. Recipient Rights staff Bob Patterson participated in the interviews and corporate rights staff for the licensee, Dereka Seigel sat in on the interviews. Quality assurance manager, Sue Howell, assisted with Resident A's interview as Resident A cried and yelled without Mrs. Howell's assistance.

Ms. Reamon denied that she or Ms. Dunning threatened Resident A while at the doctor's appt. Ms. Reamon stated that Resident A was crying and screaming in the waiting room which Ms. Reamon stated was typical behavior for Resident A so she asked Resident A, "we need you to calm down or we won't be able to go to get your hair cut after the doctor." Ms. Reamon stated that neither she nor Ms. Dunning threatened to withhold anything from Resident A but reiterated that they told Resident A that she needed to calm down as the screaming increased as Resident A became more anxious that the appt. was taking too long. Ms. Reamon expressed concern with staff's ability to successfully work with Resident A due to Resident A's demanding behaviors. Ms. Reamon also speaks with a very firm tone, in general, which might be misinterpreted in the public sphere.

Ms. Dunning described the situation at the doctor's office similarly to Ms. Reamon, denying that they threatened Resident A. Ms. Dunning stated that they stated in firm voices that Resident A needed to calm down because of the disruptive screaming exhibited by Resident A.

Resident A stated that at the doctor's appt., staff asked her to "be calm". When asked if staff were mean to her at the doctor's office, Resident A responded, "no."

On 10/08/2019, I conducted by telephone an exit conference with the licensee designee, Sharon Blain. Mrs. Blain did not have any additional comments for my report.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment.**

ANALYSIS:	Resident A stated that staff asked her to “be calm” at the doctor’s appt. and indicated that the staff were not mean to her at the doctor’s office. Program manager Heather Reamon and staff Laura Dunning denied that they threatened Resident A but asked Resident A to “calm down” when Resident A screamed and cried at the doctor’s office. I do not find a preponderance of evidence to support that a rule violation has occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend that the status of the license remain unchanged.

10/08/2019

Grant Sutton — Date
Licensing Consultant

Approved By:

10/08/2019

Jerry Hendrick — Date
Area Manager