GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 5, 2019

Sharon Blain
Spectrum Community Services
1111 40th St. SE
Grand Rapids, MI 49508

RE: License #: AS410316524
Investigation #: 2019A0464067
Kingdom Home AFC

Dear Mrs. Blain:

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,

Megan Aukerman, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 438-3036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410316524
Investigation #:	2019A0464067
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:	1111 40th St. SE Grand Rapids, MI 49508
Licensee Telephone #:	(616) 241-6258
Administrator:	Sharon Blain
Licensee Designee:	Sharon Blain
Name of Facility:	Kingdom Home AFC
Facility Address:	2975 52nd Street SE Kentwood, MI 49512
Facility Telephone #:	(616) 554-2226
Original Issuance Date:	03/20/2012
License Status:	REGULAR
Effective Date:	09/20/2018
Expiration Date:	09/19/2020
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
When Resident A urinates on himself staff Rita Tuck refuses to assist Resident A with cleaning himself up and getting dressed.	Yes
Staff Rita Tuck is rough with the residents and treats them poorly.	Yes
The facility medication closet is often left unlocked.	Yes
A majority of the residents are supposed to be given a puree diet, but staff Rita Tuck does not follow the special diet.	Yes
The facility always smells like urine.	Yes

III. METHODOLOGY

09/30/2019	Special Investigation Intake 2019A0464067
09/30/2019	Special Investigation Initiated - Letter Melissa Gekeler, ORR
09/30/2019	APS Referral Centralized Intake, DHHS
10/03/2019	Contact-Document received Written statement, Ellen Dilly (Staff)
10/03/2019	Inspection Completed On-site Melissa Gekeler (ORR), Sara Sutton (Facility Manager), Erika Pelton (Staff), Victor Randall (Staff), Residents B, C, D, E and F
10/11/2019	Contact-Document received Resident Records
10/14/2019	Contact-Face to face Melissa Gekeler (ORR), Dereka Seigel (Spectrum Community Services) and Rita Tuck (Staff)
11/04/2019	Exit Conference Sharon Blain, Licensee Designee

ALLEGATION: When Resident A urinates on himself staff Rita Tuck refuses to assist Resident A with cleaning himself up and getting dressed.

INVESTIGATION: On 09/30/2019, I received a complaint from the Kent County Office of Recipient Rights (ORR). The complaint alleged numerous allegations involving staff person, Rita Tuck. The complaint stated Resident A often urinates on himself. Resident A is supposed to require only one-person for assistance, however Ms. Tuck refuses to assist Resident A with cleaning and dressing himself.

On 09/30/2019, I spoke with Melissa Gekeler, ORR worker to coordinate the investigation.

On 09/30/2019, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral.

On 10/03/2019, I received and reviewed a written statement provided by staff person Ellen Dilly. Ms. Dilly stated she covered a shift at the facility on 09/26/2019. Ms. Dilly worked with Ms. Tuck from 3:00 PM to 8:45 PM. Ms. Dilly stated around dinner time, Resident A had urinated on himself. Ms. Tuck gave Resident A a dry mop and told him to clean up the urine. Ms. Dilly stated later on in the evening, Ms. Tuck observed Ms. Dilly helping Resident A put on his pajamas. Ms. Tuck then reportedly yelled at Ms. Dilly and stated Resident A can get dressed by himself. Ms. Dilly signed the written statement on 09/27/2019.

On 10/03/2019, Ms. Gekeler and I completed an unannounced, onsite inspection at the facility. We interviewed facility manager, Sara Sutton. Ms. Sutton confirmed that Resident A does urinate on himself. Ms. Sutton stated she has observed Ms. Tuck try to get Resident A to clean himself up. Ms. Sutton stated Resident A struggles with this due to his diagnosis of Dementia. Ms. Sutton stated Resident A was not present in the facility at this time as he was recently admitted to the hospital for sepsis. Ms. Sutton stated Resident A does require a one-person assist from staff and is unable to walk without the gate belt.

Ms. Gekeler and I then interviewed staff, Erika Pelton and Victor Randall, separately. Both stated Ms. Tuck refuses to assist Resident A with hygiene practices and dressing. Ms. Pelton and Mr. Randall both stated Ms. Tuck tells Resident A he is able to bathe and dress himself. Both stated they assist Resident A with bathing, grooming and dressing so that he does not fall.

While at the facility on 10/03/2019, I made face-to-face contact with Residents B, C and D. All three residents were dressed in clean clothing. None of the residents were interviewed as they are nonverbal.

On 10/11/2019, I received and reviewed Resident A's Individual/Family Plan of Services (IPOS). The IPOS was completed and signed on 03/26/2019 by Megan Staat with Spectrum Community Services. Under the Activities of Daily Living Section of the IPOS it states, "(Resident A) struggles with incontinence. (Resident A) requires some hands-on assistance with daily living activities, such as changing his brief, laundry, housekeeping and personal care". Under the

Toileting/Supervision in the bathroom section of the IPOS it states, “staff should assist (Resident A) in changing his brief or cleaning up when necessary. (Resident A) should be woken up every two hours to try to use the toilet”.
On 10/14/2019, Dereka Seigel, Spectrum Community Services Rights Coordinator, Ms. Gekeler and I interviewed Ms. Tuck at Spectrum Community Services office. Ms. Tuck stated she received a phone call last week and was informed she was suspended, pending an investigation. Ms. Tuck stated she had no idea what the investigation was about. Ms. Tuck denied she has provided care for Resident A in over one month due to her back issues. Ms. Tuck stated she typically works with another staff person and her coworker will be the one who cares for Resident A. Ms. Tuck stated Resident A frequently urinates on himself, however he wears an adult diaper. If Resident A leaks through the diaper, she would assist him with showering. Ms. Tuck stated Resident A can dress himself. Ms. Tuck stated she has no intention of returning to work after the investigation. Ms. Tuck signed a letter of resignation for Ms. Seigel.

On 11/05/2019, I completed an exit conference with licensee designee, Sharon Blain. She was informed of the investigation findings and recommendations. Ms. Blain confirmed Ms. Tuck is no longer employed by the agency.

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:	Facility staff, Sara Sutton, Erika Pelton and Victor Randall all reported Resident A struggles with incontinence and will urinate on himself. All three stated Resident A requires staff assistance with getting cleaned up and changed. Ms. Sutton, Ms. Pelton and Mr. Randall stated staff person, Rita Tuck will not assist Resident A with getting cleaned or changed. Resident A was not interviewed as he had been admitted to the hospital for sepsis. Ms. Tuck stated she has not care for Resident A in over a month due to issues with her back. Prior to her back issues, Ms. Tuck stated she would assist Resident A with showering. Ms. Tuck stated Resident A is able to dress himself. Residents B, C, and D were unable to be interviewed as they are nonverbal.

	Resident A's Individual/Family Plan of Services (IPOS) states Resident A struggles with incontinence and needs staff assistance with activities of daily living, such as changing his brief. Based on the investigative findings, there is sufficient evidence to support a rule violation that Ms. Tuck did not provide assistance to Resident A when needed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff Rita Tuck is rough with the residents and treats them poorly.

INVESTIGATION: On 09/30/2019, I received an ORR complaint that alleged Ms. Tuck treats the residents poorly. On 09/26/2019, Ms. Tuck was reportedly observed grabbing Resident B by the arms and pushing him down in the chair. Later that day, while Ms. Tuck was bathing Resident C, she was observed moving Resident C's face forcefully, while shaving him. Ms. Tuck also forcefully held down Resident D's legs while attempting to change his adult diaper.

On 10/03/2019, Ms. Gekeler and I completed an unannounced, onsite inspection at the facility. We interviewed Ms. Sutton, Ms. Pelton and Mr. Randall all individually. Ms. Sutton denied she has witnessed Ms. Tuck treat the residents poorly or yell at them. Ms. Sutton stated she was informed of the concerns by Ms. Dilly. Both Ms. Pelton and Mr. Randall stated they have witnessed Ms. Tuck yell and swear at the residents. Ms. Pelton sated Residents A and F will often yell and call Ms. Tuck derogatory names. Ms. Pelton stated Ms. Tuck then swears and yells back at them. Ms. Pelton stated she has seen Ms. Tuck sit on Resident C's legs while she is changing his brief, so that Resident C does not become combative. Mr. Randall stated he has heard Ms. Tuck say to the residents, "shut the fuck up and sit your asses down". Mr. Randall denied he has observed Ms. Tuck become physically aggressive towards any of the residents.

Face-to-face contact was made with Residents B, C and D. All three residents were observed to have no obvious marks or bruises. Resident A was not present as he was hospitalized for sepsis.

On 10/11/2019, I received and reviewed a written statement provided by staff person Ellen Dilly. Ms. Dilly stated she worked a shift with Ms. Tuck on 09/26/2019. During the shift, Ms. Dilly reportedly observed Ms. Tuck yell and scream at the residents. Ms. Dilly also reportedly observed Ms. Tuck pull on Resident B's arm and push him down into the dining room chair. Ms. Dilly observed Ms. Tuck aggressively push and pull Resident C's face, while shaving him in the bathtub. Ms. Dilly also witnessed

Ms. Tuck kneel on Resident D's legs, with all of her weight, while she was changing Resident D's brief. The written statement was signed by Ms. Dilly on 09/27/2019.

On 10/14/2019, Ms. Gekeler, Ms. Seigel and I interviewed Ms. Tuck at Spectrum Community Services. Ms. Tuck stated she has worked at the facility for over three years. Ms. Tuck denied she has ever yelled or swore at any of the residents. Ms. Tuck also denied becoming physical with any of the residents or has ever sat on Resident D. Ms. Tuck stated Resident D does become combative when he gets his brief changed, but Ms. Tuck stated she just rests her hands on his legs while she is changing him. Ms. Tuck stated all of the residents are like her family and she cares about each individual.

On 11/05/2019, I completed an exit conference with Mrs. Blain. She was informed of the investigation findings and recommendations. Ms. Blain confirmed Ms. Tuck is no longer employed by the agency.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	Staff, Ellen Dilly, Erika Pelton and Victor Randall all stated they have witnessed Ms. Tuck yell at the residents. Mr. Randall has also reportedly witnessed Ms. Tuck swear at the residents. Both Ms. Dilly and Ms. Pelton stated they have witnessed Ms. Tuck forcefully sit on Resident A's legs while she is changing his brief. Ms. Dilly also reportedly witnessed Ms. Tuck forcefully move Resident B's face while shaving him. Staff person, Rita Tuck denied she has ever yelled or swore at any of the residents. Ms. Tuck also denied she has ever become physically aggressive towards any residents. Ms. Tuck ended her employment with the facility on 10/14/2019. Based on the investigative findings, there is sufficient evidence to support a rule violation that Ms. Tuckhas mistreated the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility medication closet is often left unlocked.

INVESTIGATION: On 09/30/2019, I received an ORR complaint that alleged Ms. Tuck often leaves the medication closet unlocked, giving residents direct access to medications.

On 10/03/2019, Ms. Gekeler and I completed an unannounced, onsite inspection at the facility. We interviewed Ms. Sutton, Ms. Pelton and Mr. Randall. Ms. Sutton and Mr. Randall denied witnessing Ms. Tuck leave the medication closet unlocked during any time. Ms. Sutton stated she has however, had to remind Ms. Tuck of her tasks to be completed as Ms. Tuck struggles with follow through. Ms. Pelton stated she has witnessed Ms. Tuck leave the medication closet unlocked on more than one occasion.

During the inspection, I completed a tour of the facility. The medication closet was observed to be locked and only staff had access to the medication closet keys.

On 10/11/2019, I reviewed the written statement provided by Ms. Dilly. Ms. Dilly stated on 09/26/2019, she personally witnessed Ms. Tuck leave the medication closet unlocked.

On 10/14/2019, Ms. Gekeler, Ms. Seigel and I interviewed Ms. Tuck at Spectrum Community Services. Ms. Tuck admitted she has left the medication closet unlocked, with the keys in the door. Ms. Tuck stated she has also witnessed other staff leave the keys in the medication closet door.

On 11/05/2019, I completed an exit conference with Mrs. Blain. She was informed of the investigation findings and recommendations. Ms. Blain confirmed Ms. Tuck is no longer employed by the agency.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Staff Erika Pelton and Ellen Dilly stated they have witnessed staff Rita Tuck leave the medication closet unlocked, giving residents access, on more than one occasions. Ms. Tuck admitted she has left the medication closet unlocked, with the keys in the door. Ms. Tuck provided the facility a resignation letter on 10/14/2019. Based on the investigative findings, there is sufficient evidence to support the allegations that resident medications were not properly locked, to prevent resident access.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: A majority of the residents are supposed to be given a puree diet, but staff Rita Tuck does not follow the special diet.

INVESTIGATION: On 09/30/2019, I received an ORR complaint that alleged Ms. Tuck will not puree the residents' food who are on a special diet and that her failure to do so is causing a choking risk to the residents.

On 10/03/2019, Ms. Gekeler and I completed an unannounced, onsite inspection at the facility. We interviewed Ms. Sutton, Ms. Pelton and Mr. Randall all separately. All three staff reported Residents B, C and D are all on puree diets. They stated their food has to be blended otherwise the residents would be at risk of choking. Ms. Sutton and Ms. Pelton stated they have witnessed Ms. Tuck fail to puree the residents' food and have instructed her to do so. Mr. Randall stated when he works

a shift with Ms. Tuck, he will typically do the cooking and puree the food, therefore he has not witnessed Ms. Tuck fail to follow the residents' diets.

On 10/11/2019, I reviewed the written statement provided by Ms. Dilly. Ms. Dilly stated on 09/26/2019, as Ms. Tuck was preparing dinner for the residents, and she witnessed Ms. Tuck give the residents cut up food instead of pureeing their food, as they are instructed to do.

On 10/11/2019, I received and reviewed the Individual/Family Plan of Service (IPOS) for Residents B, C and D. The IPOS was completed and signed for Resident B on 11/26/2018 by Andrea Paulin. Under the Special Diet section of the IPOS it states, "(Resident B) must be given a general low fat, low cholesterol, pureed diet with all foods. (Resident B) needs to be monitored by staff for all meals so that he does not choke".

The IPOS for Resident C was completed and signed on 02/21/2019 by Megan Staat. Under the Special Diet section of the IPOS it states, "(Resident C) is on a pureed diet with double portions of nectar lick liquid due to his trouble with swallowing".

The IPOS for Resident D was completed and signed on 02/25/2019 by Megan Staat. Under the Special Diet section of the IPOS it states, "(Resident D) is not on any special diets".

On 10/14/2019, Ms. Gekeler, Ms. Seigel and I interviewed Ms. Tuck at Spectrum Community Services. Ms. Tuck stated there was only one incident where she did not puree Residents B, C and D's food. She stated it was over the summer and they were out on an outing with the residents during lunch. They did not have anything to puree the food, therefore they just cut the soft food into tiny pieces.

On 11/05/2019, I completed an exit conference with Mrs. Blain. She was informed of the investigation findings and recommendations. Ms. Blain confirmed Ms. Tuck is no longer employed by the agency.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.

ANALYSIS:	Staff, Sara Sutton, Erika Pelton, Ellen Dilly and Victor Randall all stated Residents B, C and D are on special, puree diets. Ms. Sutton, Ms. Pelton and Ms. Dilly have all reportedly witnessed staff person, Rita Tuck fail to puree Residents B, C and D's food. Ms. Tuck admitted to one occasion where she did not puree the residents' food. The Individual/Family Plan of Service (IPOS) was reviewed for Residents B, C and D. The IPOS for Residents B and C state they are on pureed food special diets. Resident D's IPOS states he is not on any special diet. Based on the investigative findings, there is sufficient evidence to support a rule violation that Ms. Tuck did not follow Resident B and C's special diet. As of 10/14/2019, Ms. Tuck no longer works at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility always smells like urine.

INVESTIGATION: On 09/30/2019, I received an ORR complaint stating the facility smells strongly of urine.

On 10/03/2019, Ms. Gekeler and I completed an unannounced, onsite inspection at the facility. Upon entering the facility, there was a strong odor of urine. We interviewed Ms. Sutton, Ms. Pelton and Mr. Randall. All three staff stated all but one resident wears an adult brief. The residents frequently urinate on themselves. All three staff stated they are constantly cleaning and doing laundry.

On 10/11/2019, I reviewed the written statement provided by Ms. Dilly. Ms. Dilly stated she covered a shift at the facility on 09/26/2019. She stated the facility smelled strongly of urine. Ms. Dilly opened the facility doors to try and air out the strong odor.

On 10/14/2019, Ms. Gekeler, Ms. Seigel and I interviewed Ms. Tuck at Spectrum Community Services. Ms. Tuck stated the facility does smell like urine as the residents wear briefs and urinate on themselves. Ms. Tuck stated occasionally some of the residents will pull down their pants and urinate on the floor. Ms. Tuck stated staff clean the floors when this happens. Ms. Tuck stated she is always washing bedding and resident clothing, but the facility still smells of urine.

On 11/05/2019, I completed an exit conference with Mrs. Blain. She was informed of the investigation findings and recommendations. Ms. Blain stated they were able to determine where the urine smell was coming from. They discovered one of the residents had been secretly urinating in one of the heat registers. Mrs. Blain stated they have rectified the issue.

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:	On 10/03/2019, an unannounced, onsite inspection was completed the facility and a strong odor of urine was present. Staff Sara Sutton, Ellen Dilly, Erika Pelton, Rita Tuck and Victor Randall all acknowledged the facility smells of urine and stated they are constantly cleaning. Based on the investigative findings, there is sufficient evidence to support a rule violation that the facility has a strong odor of urine.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the licensing status remain unchanged.

Megan Aukerman, MSW 11/05/2019

Megan Aukerman Date
Licensing Consultant

Approved By:

Jerry Hendrick 11/05/2019

Jerry Hendrick Date
Area Manager