GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 14, 2019

Delissa Payne
Spectrum Community Services
28303 Joy Rd.
Westland, MI 48185

RE: License #: AS410316519
Investigation #: 2020A0350008
Madison Home AFC

Dear Ms. 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,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410316519
Investigation #:	2020A0350008
Complaint Receipt Date:	11/07/2019
Investigation Initiation Date:	11/08/2019
Report Due Date:	12/07/2019
Licensee Name:	Spectrum Community Services
Licensee Address:	28303 Joy Rd. Westland, MI 48185
Licensee Telephone #:	(616)-241-6258
Administrator:	Delissa Payne
Licensee Designee:	Delissa Payne
Name of Facility:	Madison Home AFC
Facility Address:	5993 Madison Avenue Kentwood, MI 49548
Facility Telephone #:	(616) 827-9060
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?
Staff member Hevelynn Hulsey called Resident A a "mother fucker.”	Yes
Staff member Hevelynn Hulsey is often physically rough with the residents.	Yes
Staff member Hevelynn Hulsey does not follow Resident B's dietary protocol.	No

III. METHODOLOGY

11/07/2019	Special Investigation Intake 2020A0350008
11/07/2019	Contact - Document Received I received a copy of the Recipient Rights Complaint
11/08/2019	Special Investigation Initiated - On Site I interviewed staff members
11/08/2019	Contact - Telephone call made I spoke with Staff 3, DCW
11/12/2019	Contact - Telephone call made I spoke with Staff 4, DCW
11/12/2019	Contact - Telephone call made I spoke with Hevelynn Hulsey
11/13/2019	Contact - Telephone call made I spoke with Robin Truitt, Program Manager
11/13/2019	Contact - Document Received Ms. Truitt sent me requested document
11/13/2019	Contact - Telephone call made I spoke with Staff 1, DCW
11/14/2019	Exit conference – Held with Delissa Payne, Licensee Designee

ALLEGATION: Staff member Hevelynn Hulsey called Resident A a “mother fucker.”

INVESTIGATION: On 11/07/2019, I received a copy of the Recipient Rights Complaint, written by Staff 1, Direct Care Worker (DCW) and dated 11/05/2019, and reviewed it. It stated, “When I arrived on shift Hevelynn yelled at (Resident A) “Hey Mother Fucker put yo head back…Repedly argues with other staff in front of consumers. Goes so far as screaming and cursing [sic].”

On 011/08/2019, I made an onsite inspection and spoke with Robin Truitt, Program Manager. I informed Ms. Truitt of the allegations and requested to speak with staff members. Ms. Truitt stated that only Staff 2, DCW, was working at this time and she set me up to speak with her. I asked Ms. Truitt to provide me with the other staff members’ phone numbers while I interviewed Staff 2.

On 11/08/2019, I spoke with Staff 2 who reported that she has worked at this home for 11 years. Staff 2 said that a couple of days ago she observed Hevelynn Hulsey, DCW, shaving Resident A and during this Ms. Hulsey used “the f-word” at him. Staff 2 informed me that two other staff members, Staff 3 and Staff 4 also witnessed this. Staff 2 told me that Ms. Hulsey “cusses at the residents a lot,” especially when she gets frustrated with them.

On 11/08/2019, I called and spoke with Staff 3, DCW. Staff 3 stated that she has worked with Ms. Hulsey a few times and that she didn’t have any concerns regarding her interactions with the residents. Staff 3 said that Ms. Hulsey uses “a stern voice” with the residents, but “is not (verbally) abusive” towards them. Staff 3 informed me that she has heard Ms. Hulsey cuss on the job but not at or in front of residents.

On 11/12/2019, I called and spoke with Staff 4 who stated that she has heard Ms. Hulsey cuss at the residents as well as at other staff members in front of the residents.

On 11/12/2019, I called and spoke with Hevelynn Hulsey. Ms. Hulsey informed me that she has been in this line of work for 33 years and that she doesn’t cuss at the residents, but she does “use a littler stern voice” to direct them. She denied calling Resident A a “mother fucker.” However, Ms. Hulsey reported that she does cussed at other staff members when they mess up on the job bad enough.

On 11/13/2019, I called and spoke with Staff 1, DCW. Staff 1 reported that Ms. Hulsey also said to Resident A during this incident, “Hey, mother fucker, sit your ass down!” and then said to Staff 1, “This mother fucker is hardheaded.” Staff 1 told me that Ms. Hulsey has treated Resident A this way many times before and other residents as well, including saying “This girl is out of her mind” about one resident.

On 11/14/2019, I called and held an exit conference with Delissa Payne, Licensee Designee. I informed Ms. Payne that I was citing a violation of this rule. Ms. Payne thanked me for informing me of this and said she would think about how to respond.

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:	Direct Care Workers, Staff 1, Staff 2, and Staff 3 all stated that they have personally heard Hevelynn Hulsey cuss at the residents. Staff 4 reported that Ms. Hulsey swears at other staff members, sometimes in front of the residents. Ms. Hulsey denied cussing at any of the home's residents, including calling Resident A a mother fucker. However, she did admit to swearing at other staff members when they make major mistakes on the job. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff member Hevelynn Hulsey is often physically rough with the residents.

INVESTIGATION: On 11/07/2019, I received a copy of the Recipient Rights Complaint, written by Staff 1, Direct Care Worker (DCW) and dated 11/05/2019, and reviewed it. It stated, "When I arrived on shift Hevelynn yelled at (Resident A) "Hey Mother Fucker put yo head back" and pulled his head against the back of his recliner."

On 11/08/2019, I spoke with Staff 2, DCW, who reported that she has worked at this home for 11 years. Staff 2 said that a couple of days ago she observed Hevelynn Hulsey, DCW, trying to shave Resident A and during this Ms. Hulsey pushed Resident A's head back with excessive force. Staff 2 informed me that two other staff members, Staff 3 and Staff 4 also witnessed this.

On 11/12/2019, I called and spoke with Staff 4 who stated that she observed Ms. Hulsey "forcibly" push Resident A in his chair to get him to sit back. Staff 1 reported that she has often witnessed Ms. Hulsey being "a little rough" with the residents and has heard her cuss at them as well as at other staff members in front of the residents.

On 11/12/2019, I called and spoke with Hevelynn Hulsey. Ms. Hulsey informed me that she has been in this line of work for 33 years and has never hurt anyone and

never had a complaint against her. Ms. Hulsey said that she did not hurt Resident A when she shaved him last, but she did have to use some strength to lift his head up to shave his neck because he “gets a little strong on you.”

On 11/13/2019, I called and spoke with Staff 1, DCW. Staff 1 stated that when she most recently observed Ms. Hulsey shave Resident A with an electric razor, she believed she did so in an “unnecessarily rough” way, shoving his head back against the chair. Staff 1 told me that Ms. Hulsey has treated Resident A this way many times before and other residents as well but did not provide details of other incidents.

On 11/14/2019, I called and held an exit conference with Delissa Payne, Licensee Designee. I informed Ms. Payne that I was citing violation of this rule. Ms. Payne thanked me for informing me of this and said she would think about how to respond.

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:	Three Direct Care Workers, Staff 1, Staff 2, and Staff 4, all stated that they have personally observed Hevelynn Hulsey forcibly push Resident A’s head back in his chair while shaving him recently. Ms. Hulsey denied using excessive force or hurting Resident A while shaving him. She stated that it requires some strength to shave him. My findings support that this rule had been violated as three DCWs witnessed Ms. Hulsey shaving Resident A and believed she was too rough with him.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff member Hevelynn Hulsey does not follow Resident B's dietary protocol.

INVESTIGATION: On 11/07/2019, I received a copy of the Recipient Rights Complaint, dated 11/05/2019, and reviewed it. It stated, “…Hevelynn also will refuse to give (Resident B) protocol (Carnation Instant Bkfst) if he does not eat his dinner or refuses dinner.”

On 011/08/2019, I made an onsite inspection and spoke with Robin Truitt, Program Manager. I informed Ms. Truitt of the allegations and requested to speak with staff members. Ms. Truitt stated that only Staff 2, Direct Care Worker (DCW), was working at this time and she set me up to speak with her. I asked Ms. Truitt to provide me with a copy of Resident B's special dietary protocol and she got these things together while I interviewed Staff 2.

On 11/08/2019, I spoke with Staff 2 who stated that she hasn't witnessed Ms. Hulsey withholding Carnation Instant Milk from Resident B when he hadn't finished his meal.

On 11/08/2019, Ms. Truitt provided me with a copy of Resident B's special diet protocol, which states, "(Resident B's) prescribed diet is general, soft foods. (Resident B) needs to be offered carnation instant breakfast daily, as needed, if he eats 50% or less of a meal."

On 11/12/2019, I called and spoke with Staff 4 who stated that Ms. Hulsey mostly works 3rd shift and that she doesn't pay too much attention to whether Ms. Hulsey gives Resident B Carnation Instant Milk if he doesn't eat much or anything at all. However, she did say that she thought Ms. Hulsey "does a pretty good job" of feeding Resident B.

On 11/12/2019, I called and spoke with Hevelynn Hulsey who stated that if Resident B doesn't finish his meal or doesn't eat any of it, she will offer him a peanut butter and jelly sandwich or a glass of Carnation Instant Mild every time. However, she said, he sometimes won't eat or drink anything, including the sandwich or milk. Ms. Hulsey informed me that the percentage (100%, 50%, 25%, etc.) of each meal Resident B eats is logged in his Activities of Daily Living (ADL) book.

On 11/13/2019, I called Ms. Truitt and requested that she send me a week's worth of notes showing the percentage of the meal Resident B ate for each me and she said she would.

On 11/13/2019, I received the log that I requested, and it showed that Resident B ate 100% of most of the 48 meals, including snacks, that were provided from November 1st to November 13th. He only refused to eat four of the meals, two of which were snacks. This document does not state whether Carnation Instant Breakfast or peanut butter and jelly sandwiches were given to Resident B after he refused to eat what was served.

On 11/13/2019, I called and spoke with Staff 1, DCW, who reported that she has observed Ms. Hulsey more than once refusing to give Resident B Carnation Instant Milk or a peanut butter sandwich when he doesn't eat the meal that's being served, which is supposed to happen according to Resident B's dietary protocol.

On 11/14/2019, I called and held an exit conference with Delissa Payne, Licensee Designee. I informed Ms. Payne that I was not citing violation of this rule. Ms. Payne thanked me for informing her of this and had no further comment.

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:	Only one staff member, Staff 1, reported that she observed Hevelynn Hulsey fail to give Resident B Carnation Instant Breakfast or a peanut butter and jelly sandwich after he refused to eat what was served. Ms. Husley denied refusing to offer Carnation Instant Breakfast or a peanut butter and jelly sandwich after Resident B refused to eat what was served; however, she added that he sometimes won't eat these alternatives either. Staff 4 stated that she has not observed Ms. Hulsey refusing to offer alternative foods to Resident B, and believes she "…does a pretty good job" of feeding Resident B. My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

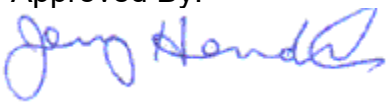
Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

November 14, 2019

_____

Ian Tschirhart Date
Licensing Consultant

Approved By:



November 14, 2019

_____

Jerry Hendrick Date
Area Manager