GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 7, 2021

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

RE: License #: AS410338053
Investigation #: 2021A0467001
Lake Gerald Home

Dear Mrs. Payne:

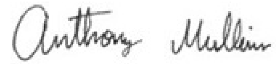
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each 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) 356-0183.

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 #:	AS410338053
Investigation #:	2021A0467001
Complaint Receipt Date:	06/28/2021
Investigation Initiation Date:	06/28/2021
Report Due Date:	08/27/2021
Licensee Name:	Spectrum Community Services
Licensee Address:	28303 Joy Rd. Westland, MI 48185
Licensee Telephone #:	(269) 927-3472
Administrator:	Delissa Payne
Licensee Designee:	Delissa Payne
Name of Facility:	Lake Gerald Home
Facility Address:	9410 Lake Gerald Sparta, MI 49345
Facility Telephone #:	(616) 205-5557
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?
The facility is not staffed with an adequate number of direct care workers to meet the residents' needs. Management has been made aware but has not addressed the problem.	No
Additional Findings	Yes

III. METHODOLOGY

06/28/2021	Special Investigation Intake 2021A0467001
06/28/2021	APS Referral.
06/28/2021	Contact - Document Sent Ed Wilson, ORR.
06/28/2021	Special Investigation Initiated - Telephone Telephone call made to the Complainant.
06/30/2021	Inspection Completed On-site Interviewed staff and residents regarding the complaint.
06/30/2021	Inspection Completed-BCAL Sub. Compliance.
07/07/2021	Exit Conference Completed with Delissa Payne.

ALLEGATION: The facility is not staffed with an adequate number of direct care workers to meet the residents' needs. Management has been made aware but has not addressed the problem.

INVESTIGATION: On 06/28/21, I received a BCAL online complaint. On the same day, I made the initial contact in this case by speaking with the complainant. The complainant wished to remain anonymous as they made it clear that they did not want to get anyone in trouble. The complainant stated that the home is "severely understaffed" and as a result, the staff are working 8-12 hours shifts alone. Per the complainant, there is supposed to be two staff members working at all times as the home is "mostly total care." The complainant stated that management has been aware of this issue for more than a year and nothing has been done to address it. The complainant acknowledged that it has been difficult to get people back to work, likely due to the Covid-19 pandemic. The complainant stated that the home is supposed to have 12 staff members total but there are only 7 and will soon be 6. The complainant stated that staff at the home need more support as there are at

least two residents who require two-person assist, which is the complainant's concern for their only being one staff member working.

On 06/28/21, I made a referral to Kent County Adult Protective Services (APS). I also sent an email to Ed Wilson, Recipient Rights Director at Kent County Community Mental Health, Network 180 (N-180) due to the home having a special certification. I asked Mr. Wilson to notify me if the allegations were pertaining to one of their residents and if the case would be assigned to one of his staff.

On 06/30/21, I made an unannounced onsite special investigation at Lake Gerald AFC home. Upon arrival, introductions were made with staff members, Jessica Vandenbrook and Patricia Misner, as well as the Program Manager, Cassandra Erickson. After meeting the staff, I was able to speak with Resident A on the front porch. Resident A stated that she has lived in the home since 10/30/20. Resident A stated that things are going "okay" in the home and she is the only resident that is able to verbally speak. Regarding staffing, Resident A confirmed that Ms. Misner was working by herself "all last week." Resident A also stated that Ms. Vandenbrook was also working alone in the home recently although she could not recall when. After speaking to Resident A, I attempted to speak with Resident B in his room. Resident B declined to speak with me.

On 06/30/21, I spoke to Ms. Vandenbrook. Ms. Vandenbrook stated that she has been employed at Lake Gerald home for two years. Although things have historically been "pretty good," Ms. Vandenbrook stated that the home has had "staffing issues" for the last couple of weeks. Ms. Vandenbrook stated that for majority of her time at Lake Gerald home, there have always been two staff members working each shift. As of late, Ms. Vandenbrook and other staff members (Ms. Misner) have worked 8-12 hour shifts alone and she stated that it is too much. Her last time working a 12 hour shift alone was this past weekend. Ms. Vandenbrook stated that the home is supposed to have two staff members working at all times. Ms. Vandenbrook stated that she has expressed her concern to the program manager, Ms. Erickson, and she reportedly told Ms. Vandenbrook that they do not need two staff during the day but they do need more at night. As a result of the staffing issue, Ms. Vandenbrook stated that she resigned and her last day at Lake Gerald home will be 07/13/21. Ms. Vandenbrook stated that working at Lake Gerald home is an easy job but it is hard when she has to work by herself. Ms. Vandenbrook stated that she feels rushed to address the residents needs while working alone. She stated that she does not believe that any of the residents in the home require a two-person transfer. Ms. Vandenbrook stated that Resident C used to require this until he received a hoyer lift approximately one year ago.

On 06/30/21, I spoke to Ms. Misner. Ms. Misner stated that December will be five years that she has worked for Lake Gerald home. For the majority of her time at the home, there have always been two staff members working each shift. However, she stated, "we've been short staffed for a while now." Ms. Misner stated that they have been short staffed for at least a year and the staff members have a lot of

responsibilities. Ms. Misner stated that none of the residents can go to the bathroom by themselves. Ms. Misner stated that Resident B is supposed to require two staff for transfers based on how it is written in the Medication Administration Record (MAR). She also stated that Resident B uses a hoyer lift and only requires one staff to assist with transfers. I reviewed Resident B's assessment plan and confirmed that he does in fact use a hoyer lift. Although Resident B requires staff assistance for most, if not all needs, his assessment plan does not state that he requires a two-person transfer. Ms. Misner stated that she worked alone this past Tuesday (06/29/21) for 7 hours and this past Saturday and Sunday she worked 12 hour shifts alone. Ms. Misner stated that it is not safe for the residents to only have one staff member working due to their needs, especially if there were to be an emergency. Although staffing has been an issue for approximately a year, Ms. Misner stated that she and Ms. Vandenbrook have worked alone for approximately 3 weeks. Ms. Misner stated that Ms. Erickson helps when she can.

On 06/30/21, I spoke to the program manager, Ms. Erickson. She stated that the home currently has five residents. Ms. Erickson stated that she has been the program manager since 04/2021 and the home has had issues with staffing since 2019. Once Covid-19 became prevalent, Ms. Erickson stated that staffing issues became worse. Ms. Erickson stated that she has been employed at Lake Gerald home since 2016 and the home has only been fully staffed for approximately one month. Ms. Erickson acknowledged that the home typically has two staff members on each shift. Due to Covid-19, she stated that staffing is a company-wide issue. She stated that her boss is aware of the staffing issue and is working to assist staff. Ms. Erickson stated that she is working in Lake Gerald home to assist the staff too.

Ms. Erickson stated that for the last couple of weeks (less than a month), staff members have been working alone. She stated that staff have recently quit and/or switched to "ER" staff, meaning they are available on an emergent basis only. Since becoming the program manager in 04/2021, Ms. Erickson stated that during first shift, it is usually one staff member and herself. Ms. Erickson denied that any of the residents require a 2-person transfer. Ms. Erickson stated that Resident C previously required two staff for transfers. However, this has since changed when his guardian signed-off for him to use a hoyer lift. Ms. Erickson stated that corporate is aware of the staffing issue and a manager's meeting was held last Thursday (06/24/21) to address this issue by working on an agency contract to obtain staff. Prior to concluding the onsite investigation, Ms. Erickson provided me with copies of the fire drills and staff schedule due to their being concerns for the lack of staffing. The home was in compliance with their fire drills and the staff schedule confirmed that Lake Gerald home has had at least one staff member working each shift for the past couple of weeks.

On 06/30/21, I reviewed the assessment plans for all five Residents in the home. I noted that Resident C's assessment plan indicated that he requires two-person assist with bathing and two-person transfer. However, Ms. Erickson provided me

with a prescription from Resident C's doctor via email indicating that he utilizes a hoyer lift. Therefore, he does not require a two-person assist or transfer.

On 07/07/21, I completed an exit conference with Licensee Designee, Delissa Payne. Mrs. Payne was informed of the investigation and the findings.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Evidence was not discovered through this investigation that would support the allegation that the home is or has been sufficiently staffed to provide care and services to the residents. All of the resident's assessment plans were reviewed. Although the residents require staff assistance with most, if not all tasks, none of the residents require a two-person transfer.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: On 06/30/21, I reviewed the resident's assessment plans. Resident C's assessment plan was signed on 11/19/20, indicating that he requires two-person assist with bathing and two-person transfer. However, while speaking to Ms. Erickson, she stated that Resident C uses a hoyer lift and no longer requires a two-person transfer or assist. I called Ms. Erickson on 06/30/21 to discuss the discrepancy in what she told me versus Resident C's assessment plan. Ms. Erickson provided me with a prescription from Resident C's doctor via email indicating that he utilizes a hoyer lift. Despite this, the assessment plan does not match the care that is being provided to Resident C. I explained to Ms. Erickson that the assessment plan will need to be updated to accurately reflect the care that Resident C is receiving. She stated that she will work on updating the assessment plan.

On 07/07/21, I completed an exit conference with Licensee Designee, Delissa Payne. Mrs. Payne was informed of the investigation findings and recommendations. Mrs. Payne was accepting of the rule violation and understanding that the resident's assessment plans need to align with their treatment. Mrs. Payne plans to complete a Corrective Action Plan (CAP) as soon as possible.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(2) All work that is performed by a resident shall be in accordance with the written assessment plan.
ANALYSIS:	Based on the investigative findings, there is a preponderance of evidence to support Resident C's documentation not being updated to accurately reflect the care that he is receiving from the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/07/2021

Anthony Mullins — Date
Licensing Consultant

Approved By:

07/07/2021

Jerry Hendrick — Date
Area Manager