GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 9, 2022

Spectrum Community Services
David Powell
28303 Joy Rd.
Westland, MI 48185

RE: License #: AS630397254
Investigation #: 2022A0991011
Leidich Home

Dear Mr. Powell:

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:

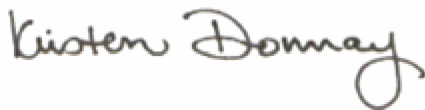
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

The issuance of a six-month provisional license was previously recommended in the renewal licensing study report dated 11/23/21, which remains in effect. You submitted documentation agreeing to the issuance of a provisional license on 12/13/21 and the 1st provisional was issued effective 12/14/2021.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days.

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 (248) 975-5053.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630397254
Investigation #:	2022A0991011
Complaint Receipt Date:	12/28/2021
Investigation Initiation Date:	12/28/2021
Report Due Date:	02/26/2022
Licensee Name:	Spectrum Community Services
Licensee Address:	28303 Joy Rd. Westland, MI 48185
Licensee Telephone #:	(734) 445-8872
Licensee Designee:	David Powell
Name of Facility:	Leidich Home
Facility Address:	1087 Leidich Lake Orion, MI 48362
Facility Telephone #:	(248) 693-4957
Original Issuance Date:	06/18/2019
License Status:	1ST PROVISIONAL
Effective Date:	12/14/2021
Expiration Date:	06/13/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 12/23/21, staff TyEshia and JoJo left Resident A in bed all day until 3:00pm or 4:00pm. Resident A asked Jojo if she could get up, and Jojo said no. Resident A was soaked in urine when the next staff came on shift.	Yes
Resident A was left with only male staff, Doug and Jojo, for an hour. She does not feel safe or comfortable with a male caregiver providing personal care. Resident A is afraid of Jojo. There are concerns that Jojo may have slapped Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

12/28/2021	Special Investigation Intake 2022A0991011
12/28/2021	Special Investigation Initiated - Telephone Call to Resident A's guardian
12/28/2021	APS Referral Received additional information from Adult Protective Service (APS) - assigned to John Cavanaugh
12/28/2021	Referral - Recipient Rights Call to Rishon Kimble
12/29/2021	Contact - Telephone call made To licensee designee, David Powell
12/29/2021	Contact - Document Sent Email to APS worker, John Cavanaugh
01/03/2022	Contact - Document Received Email from Spectrum COO, Sharon Blain- residents tested positive for COVID
01/05/2022	Contact - Telephone call made To Janet DiFazio, Spectrum area director

01/05/2022	Contact - Telephone call made To David Schnoor, Spectrum quality assurance
01/06/2022	Contact - Telephone call made To direct care worker, Tiffany Davis
01/06/2022	Contact - Telephone call made To direct care worker, Yvonne Cox- left message
01/06/2022	Contact - Telephone call made To Leidich Home- interviewed direct care worker, Tiffany Davis, and Resident A
01/06/2022	Contact - Telephone call made To quality coordinator, TyEshia Hollins
01/07/2022	Contact - Document Received Written statements from staff
01/10/2022	Contact - Telephone call made To direct care worker, Yvonne Cox
01/20/2022	Contact - Document Received Email from APS worker, John Cavanaugh
01/24/2022	Contact - Telephone call made To direct care worker, Jojo VanCamp
02/10/2022	Inspection Completed On-site Unannounced onsite inspection- interviewed staff and home manager
02/15/2022	Contact - Telephone call made To licensee designee, David Powell- requested documents
02/16/2022	Contact - Document Received Staff schedule
02/18/2022	Contact - Document Received Staff timesheets and new employee orientation
02/18/2022	Contact - Telephone call received From licensee designee
02/23/2022	Exit Conference Via telephone with licensee designee, David Powell

ALLEGATION:

On 12/23/21, staff TyEshia and JoJo left Resident A in bed all day until 3:00pm or 4:00pm. Resident A asked Jojo if she could get up, and Jojo said no. Resident A was soaked in urine when the next staff came on shift.

INVESTIGATION:

On 12/28/21, I received a complaint alleging that staff neglected Resident A, as they left her bed all day and did not change her brief. I initiated my investigation on 12/28/21,by interviewing Resident A's guardian via telephone. Resident A's guardian indicated that she visited with Resident A at the home on 12/18/21, 12/20/21, and 12/26/21. On 12/26/21, Resident A was upset and crying. Resident A's guardian spoke with staff and found out that sometime between 12/20/21 and 12/26/21, staff TyEshia and Jojo were working shifts together in the home. TyEshia is the quality coordinator for Spectrum and does not typically work as a direct care worker. While they were working, Resident A was left in bed all day. Another direct care worker, Tiffany, came in around 3:00 or 4:00pm and found that Resident A was soaked "from head to toe" in urine. Tiffany asked TyEshia why Resident A was like that and asked her to help change Resident A. TyEshia told Tiffany that she "does not do that", indicating that she does not provide personal care to the residents. Resident A's guardian stated that at some point staff also told Resident A to be quiet and stay in bed. Resident A cannot get out of bed on her own and requires assistance from one staff person to transfer from her bed.

On 12/29/21, I interviewed the licensee designee, David Powell, via telephone. Mr. Powell indicated that staff, Tiffany Davis, reported that she came in to work a shift at 3:00pm on 12/23/21 and found Resident A in bed and soaked in urine. Staff also found Resident A and Resident B wet and soiled in bed on 12/24/21. Mr. Powell indicated that the quality coordinator, TyEshia Hollins, was covering shifts at Leidich due to staff having COVID symptoms. Ms. Hollins is fully trained as a direct care worker, but she does not typically work shifts as a caregiver. Ms. Hollins told Mr. Powell that she did check on Resident A throughout the shifts. Resident A did not want to get out of bed and there was no indication that she was soiled. Mr. Powell indicated that the home has never had issues with this in the past and they always keep the residents clean. The administrative staff from Spectrum Community Services would be conducting an internal investigation as well.

On 01/03/22, I received an email from the Chief Operating Officer of Spectrum Community Services, Sharon Blain, indicating that a resident and staff at Leidich Home tested positive for COVID-19.

On 01/05/22, I interviewed David Schnoor, who works with the quality assurance department at Spectrum Community Services. Mr. Schnoor indicated that he was conducting an internal investigation regarding the alleged incident. He stated that there was no physical evidence that Resident A had been left in bed unattended for hours.

Resident A was diagnosed with a urinary tract infection around the same time, which might have impacted the frequency and amount of urination. Staff indicated that Resident A wanted to stay in bed. Staff reported that on 12/23/21, they checked Resident A throughout the day and changed her. On 12/24/21, they were checking her throughout the day, but another resident's family member came to the home to pick him up and staff had to get his medications. They might not have physically checked on Resident A that afternoon. Staff document bed checks at night, but they do not document any checks during the day.

On 01/10/22, I interviewed direct care worker, Yvonne Cox, via telephone. Ms. Cox indicated that on 12/23/21, TyEshia and Jojo came in to work the morning shift. Ms. Cox was scheduled to work again that afternoon at 4:00pm. When she came in for her afternoon shift, Jojo was there by herself and stated that TyEshia left at 3:00pm. Ms. Cox began preparing to pass 4:00pm medications. JoJo informed her that Resident A did not want to get out of bed that day. Ms. Cox indicated that this was rare, as Resident A usually does not like to be in bed. When Ms. Cox went into Resident A's room, Resident A stated that she was cold. Ms. Cox pulled her covers back and observed that Resident A was soaked from head to toe in urine. Her two bed pads were also soaked. Ms. Cox asked Resident A why she was in bed and Resident A stated that staff would not let her get up. Ms. Cox cleaned and changed Resident A, but Resident A wanted to remain in bed. Ms. Cox stated that Resident A wears a brief. Staff are supposed to check on her every two hours. Resident A will typically let staff know if she is wet or if she has had a bowel movement. Staff usually change Resident A five times throughout the day and once or twice at night. Ms. Cox stated that when she checks Resident A, she pulls the tabs open on the brief and looks to see if she is wet. She stated that there is also a blue line that shows up on the brief. You could also feel if she was wet by touching the brief. Staff do not document when they change the residents throughout the day, only during the midnight shift. Ms. Cox indicated that it did not seem like Resident A had been changed at all that day, other than in the morning when Ms. Cox changed her at 6:30am, as she had soaked through two bed pads. Resident A told her that she was not changed.

Ms. Cox then went into Resident B's room. Jojo told Ms. Cox that the nurse came out to change Resident B's catheter that day. When Ms. Cox pulled back Resident B's covers, Resident B was completely exposed. The nurse had pulled down the front part of Resident B's brief to change the catheter and nobody put the brief back on. Resident B was lying on top of the brief and had a bowel movement. The bowel movement was still mushy and was not caked on or dried. Ms. Cox stated that Resident B likes to stay in bed and watch movies, so it was not as unusual for her to be in bed. Ms. Cox indicated that on Friday morning, TyEshia came in and made a comment that she is not trained to do personal care. Ms. Cox stated that she has never worked a shift with TyEshia, as she is the quality coordinator and does not typically work direct care shifts. Ms. Cox reported Resident A and Resident B's condition to the assistant home manager. Spectrum sent someone to the home to take statements. I reviewed Ms. Cox's written statement, which notes that when she came in on 12/23/21 at 4:00pm, she asked Jojo and Ty how the shift went. They both said it went ok. This contradicts Ms. Cox's verbal

interview, as she stated that TyEshia left before she arrived at the home. Ms. Cox indicated that she made a mistake in her written statement and TyEshia was not in the home when she arrived on 12/23/21. The rest of the written statement is consistent with the information provided during Ms. Cox's interview.

On 01/06/22, I interviewed direct care worker, Tiffany Davis, via telephone. Ms. Davis indicated that on Friday, 12/24/21, she came in around 2:00pm. She had been exposed to COVID-19, so she was bringing her negative test results in to show that she could return to work that day. She gave the COVID information to TyEshia, the quality coordinator, who was covering shifts due to staff COVID exposures. Ms. Davis then went to check on Resident A. She found that Resident A was still in bed. Her brief, pajamas, and sheets were soaked with urine. TyEshia came in to say goodbye and when Ms. Davis asked her why Resident A was wet, she stated that she is not trained for personal care. Ms. Davis indicated that TyEshia was working on shift with Jojo, who is a transgender individual. Jojo is not supposed to provide personal care to the female residents in the home, so TyEshia was assigned to the female residents while she was on shift. Ms. Davis indicated that it did not seem as though Resident A had been changed at all that day, as her bed pads were soaked. Staff are supposed to check Resident A every two hours or more often if necessary. They do not document when they change Resident A throughout the day. This is only documented during the midnight shift. Resident A does not typically stay in bed during the day. Resident A was later diagnosed with a urinary tract infection on 12/29/21. Ms. Davis indicated that Resident B was also still in bed when she went to check on her. Resident B had a bowel movement and there was a brown stain on the bed pad. The bowel movement had started to dry, and Ms. Davis had to scrub Resident B's bottom. Ms. Davis indicated that Resident B likes to stay in bed and watch movies, so it was not as unusual for her to be in bed as it was for Resident A.

On 01/06/22, I interviewed Resident A via telephone. Resident A stated that she remembered being left in bed all day. She stated that a man was working when this happened, and it was Jojo. Resident A stated that Jojo told her to go back to sleep. When asked if anyone changed her that day, Resident A stated, "hell no." She then stated that Tiffany changed her that day and was the only person who changed her. Nobody checked on her during the day. Resident A stated this happened another time, but she could not recall what happened that day or who was working.

On 01/06/22, I interviewed the quality coordinator, TyEshia Hollins. Ms. Hollins indicated that she does not typically work as a direct care worker, but she is fully trained and was covering shifts at Leidich due to a staff shortage from staff being exposed to COVID-19. On Thursday, 12/23/21, Ms. Hollins came in at 6:30am. Yvonne Cox briefed her about the previous shift. Ms. Hollins indicated that Resident A did not want to get out of bed that day. She checked on Resident A at 8:45am and Resident A was not wet. At 11:00am, Resident A was damp. Ms. Hollins changed her and gave Resident A her medications. Ms. Hollins stated that she had to wipe down Resident A because she had some pudding on her after taking her medications. Resident A's window was open, so she closed it and put on Christmas music for her to listen to. Ms. Hollins checked on

Resident A a couple hours later, around 1:00pm. Resident A was not wet, so she did not change her. Ms. Hollins asked Resident A if she wanted to get up, and Resident A said no. Ms. Hollins stated that she touched Resident A's backside to see if the diaper felt wet. Ms. Hollins stated that Resident B also wanted to stay in bed that day. The nurse came in and changed Resident B's catheter during the afternoon on Thursday. Ms. Hollins stated that they checked on Resident B every two hours and she did not have a bowel movement. Resident B has a catheter and only needs to be changed if she has a bowel movement. Ms. Hollins stated that Resident B had a bed pad underneath her. She was wearing a long gown and did not have on a brief while Ms. Hollins was there. Ms. Hollins stated that she did not know if Resident B was supposed to wear a brief. Ms. Hollins indicated that this was the first time she had worked hands on with the residents. She previously covered night shifts and did not need to provide personal care. She stated that she was kind of thrown in and felt like she was "winging it". She did not shadow anyone in the home prior to working the shift.

On Friday, 12/24/21, Ms. Hollins came in at 6:30am. Yvonne briefed her about the previous shift and stated that Resident A did not want to get up. She told Ms. Hollins to check on her periodically. Ms. Hollins did her first check around 8:45am. Resident A did not want to get up and was not wet. Ms. Hollins checked on Resident A and passed her medications at 11:00am. She had to wipe down her arm and face, as she got pudding on her from her medications. Resident A was not wet and did not want to get out of bed. She wanted music, so Ms. Hollins tucked her in and put on music. An hour later, Jojo came in and did rounds, checking on all of the residents. Ms. Hollins stated that she did rounds again at 1:00pm and checked on the female residents. Resident C got up and took a shower. Resident B wanted to stay in bed and watch a movie. Resident A still wanted to remain in bed. Around 2:00pm, Tiffany Davis came in and stated that she was negative for COVID and wanted to work. Ms. Hollins told Ms. Davis that she needed to provide documentation of a negative test result. She told Ms. Davis that they already had staff to cover the shift, but Ms. Davis could work for a few hours after she received the proof of a negative COVID test. Around 2:30-3:00pm, Resident D's mother came to pick him up. Ms. Hollins was talking to her and gave her Christmas presents for Resident D as well as his medications for the weekend. During this time, Ms. Davis went to check on Resident A. When Ms. Hollins went to say goodbye to Ms. Davis, Ms. Davis told her that Resident A "could stand to be changed." Ms. Hollins stated that she told Ms. Davis that she had been checking Resident A. Ms. Hollins indicated that she checked on Resident A throughout the shift, but she had not changed her that day as she did not appear to be wet. Ms. Hollins stated that she never told Ms. Davis or anyone else that it was not her job to provide personal care or change the residents. She stated that she was willing to do whatever needed to be done and she did not have a problem stepping in to help. Ms. Hollins stated that nobody showed her how to change the residents or how to provide personal care to the residents at Leidich.

On 01/24/22, I interviewed direct care worker, Jojo VanCamp. Ms. VanCamp indicated that the week of 12/20/21 was chaotic. Tiffany Davis called in because she was exposed to COVID-19, so the quality coordinator, TyEshia Hollins, was covering shifts at Leidich. Ms. VanCamp reported that Ms. Hollins does not typically provide personal

care to the residents in her role as the quality coordinator, but she stepped in to help at the home. Ms. Hollins was very attentive while she was working in the home, and she did not neglect anybody. Ms. VanCamp stated that they completed checks every two hours. They do not document when they check or change the residents throughout the day. Ms. VanCamp stated that they do not change the residents if they are not wet or soiled. Resident B has a catheter, so she only needs to be changed if she has a bowel movement. On 12/23/21 and 12/24/21, they never observed Resident B to have a bowel movement. Ms. VanCamp indicated that they checked on Resident B before the nurse came out to change her catheter. She could not recall if they checked on her after the nurse left. Ms. VanCamp indicated that Resident B wears a brief in case she has a bowel movement. Ms. VanCamp stated that she cannot provide personal care to Resident A, as Ms. VanCamp is transgender and Resident A's guardian did not agree to Resident A receiving personal care from a male staff. Resident A was refusing to get out of bed on 12/23/21 and 12/24/21. Ms. VanCamp and Ms. Hollins never told Resident A that she had to stay in bed and continued to check on her throughout the shift. Ms. VanCamp stated that there was a separate occurrence during the midnight shift when Resident A wanted to get up in the middle of the night. Ms. VanCamp told her to stay in bed and asked her if she wanted to listen to music. Resident A said yes, so Ms. VanCamp turned on Christmas music and Resident A went to sleep.

On 02/10/22, I conducted an unannounced onsite inspection at Leidich Home. I interviewed direct care worker, Jordan McAboy, and the home manager, Constance Warren. Ms. Warren indicated that she just took over as the home manager this week. She was previously working as the manager at another Spectrum adult foster care facility. Ms. Warren indicated that TyEshia Hollins is the quality coordinator and does not typically provide direct care. Ms. Hollins completed training through the Macomb Oakland Regional Center (MORC). Ms. Warren stated that she recently showed Ms. Hollins how to pass medications and change briefs. Ms. Hollins had not received any on the job training before she worked shifts at Leidich. Ms. Warren stated that staff typically shadow the manager or senior staff before they work a shift in the home; however, Ms. Hollins was filling in on an emergency basis due to a staff shortage from COVID. Ms. Warren indicated that the residents should be checked on at least every two hours. Staff can ask Resident A if she needs to be changed and she will tell you. Ms. Warren stated that Resident A does have the right to say no if she does not want to be changed, but she would expect staff to change her at least once during the time period of 6:30am-2:00pm, even if she did not appear to be wet. Ms. Warren indicated that Resident B has a catheter. She wears a brief over the catheter and should always have on a brief. Mr. McAboy indicated that he was not working during the time period of 12/23/21-12/24/21. He stated that he never came in for a shift and observed any residents who had not been changed. Mr. McAboy indicated that he does not provide personal care to the females in the home.

I reviewed a copy of Resident A's individual plan of service (IPOS) and crisis plan dated 06/01/21. It notes that staff should check on Resident A every two hours at night. The plan does not specify checks during daytime hours or how often Resident A's briefs should be changed. It notes that Resident A can use a bath chair/toilet. I reviewed a

copy of Resident B's IPOS and crisis plan dated 10/01/21. It notes that Resident B is fully dependent on caregivers for toileting. She wears adult briefs and is dependent on caregivers to check and/or change her every two hours. She is usually able to tell staff when she needs to be changed.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: (d) Personal care, supervision, and protection.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the quality coordinator, TyEshia Hollins, was not trained regarding the specific personal care needs of the residents at Leidich Home before she worked shifts in the home on 12/23/21 and 12/24/21. Ms. Hollins was filling in for staff on an emergency basis due to a staff shortage from COVID exposures. She said she was just thrown in to cover the shifts at the home and felt like she was "winging it." She did not shadow any staff at Leidich prior to her shift and was not trained in how to change briefs or provide personal care to the residents. Ms. Hollins did not know if Resident B was supposed to wear a brief over her catheter and stated that Resident B was not wearing a brief during her shifts in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based on the information gathered through my investigation, there is sufficient information to conclude that the personal needs of Resident A and Resident B were not met on 12/23/21 or 12/24/21. Staff observed that Resident A was covered in urine when they came in to work the afternoon shifts on

	12/23/21 and 12/24/21. Ms. Hollins and Ms. VanCamp indicated that they had been checking on Resident A throughout the day, but Ms. Hollins did not change Resident A's brief from the time period of 6:30am-2:30pm on 12/24/21. Resident B's brief was not replaced after the nurse came out to change her catheter on 12/23/21.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was left with only male staff, Doug and Jojo, for an hour. She does not feel safe or comfortable with a male caregiver providing personal care. Resident A is afraid of Jojo. There are concerns that Jojo may have slapped Resident A.

INVESTIGATION:

On 12/28/21, I interviewed Resident A's guardian via telephone. Resident A's guardian stated that on one occasion staff, Jordan and Jojo, transported the residents back home from workshop. Jordan then left, leaving the residents home with Jojo and the home manager, Doug. Resident A's guardian did not know the date when this happened. Resident A's guardian stated that Resident A does not want to be left alone with two male caregivers. She has been saying that she is afraid of being with men. Resident A's guardian felt that something had happened in the home, but she did not have any specific information. Resident A's guardian did not know if Resident A's resident care agreement specified that she could not receive care from a caregiver of the opposite sex.

During my investigation, I interviewed the quality coordinator, TyEshia Hollins, and direct care workers, Tiffany Davis, Yvonne Cox, and Jordan McAboy. None of the individuals who were interviewed ever witnessed Jojo VanCamp being physically aggressive or mistreating Resident A. They did not have any concerns about any staff person in the home being physically aggressive towards Resident A. They all reported that Resident A does not receive personal care from male caregivers.

On 01/06/22, I interviewed Resident A. Resident A stated that nobody ever hit her or hurt her.

On 01/24/22, I interviewed direct care worker, Jojo VanCamp. Ms. VanCamp denied ever being physically aggressive towards Resident A. She stated that she felt Resident A was being coached to say things. Ms. VanCamp felt that she was being targeted due to being a transgender individual. Ms. VanCamp indicated that she has years of experience as a direct care worker and has never mistreated anyone. Ms. VanCamp stated that Resident A's guardian was not comfortable with Ms. VanCamp providing personal care to Resident A due to Ms. VanCamp being transgender. Ms. VanCamp

stated that she has never provided personal care to the female residents in the home. She always works with a female staff person.

I reviewed a copy of Resident A's resident care agreement dated 02/17/21. The resident care agreement does not specify that Resident A cannot receive assistance with bathing, dressing, or personal hygiene by a staff member of the opposite sex. The licensee designee, David Powell, indicated that they were in the process of obtaining a new resident care agreement from Resident A's guardian. Mr. Powell indicated that there was an occasion when Doug and Jojo were on shift for 30 minutes to an hour while they were waiting for a female staff to come in, but they never worked an entire shift together. Mr. Powell was not aware of Doug or Jojo providing personal care to female residents during this time.

On 01/21/22, I received an email from the assigned APS worker, John Cavanaugh. Mr. Cavanaugh indicated that he was planning on substantiating for neglect, but he did not have any information to support the allegations of physical abuse.

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: (b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that direct care worker, Jojo VanCamp, was physically aggressive towards Resident A. Resident A's guardian felt something happened, but she did not have any specific information. Resident A denied that anyone ever hit her or hurt her. None of the staff who were interviewed observed Ms. VanCamp being physically aggressive towards Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(6) A licensee shall afford a resident the opportunity to receive assistance in bathing, dressing, or personal hygiene from a member of the same sex, unless otherwise stated in the home's admission policy or written resident care agreement.

ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that Resident A was not afforded the opportunity to receive personal care from a member of the same sex. Resident A's resident care agreement does not specify that she cannot receive personal care from a member of the opposite sex. All of the staff interviewed indicated that the male staff and transgender staff in the home do not provide personal care to Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During the investigation, I reviewed a copy of the staff schedule for Leidich Home from 12/19/21-12/25/21. The staff schedule was not updated to reflect the actual hours or shifts worked by staff and the scheduling changes that were made after staff called in sick. The schedule did not include shifts that were covered by the quality coordinator, TyEshia Hollins, or staff from other Spectrum homes. I also reviewed copies of the staff time sheets, which did not match the schedule that was provided.

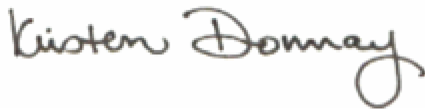
On 02/23/22, I conducted an exit conference via telephone with the licensee designee, David Powell, and reviewed my findings. Mr. Powell indicated that he would submit a corrective action plan to address the issues identified during the investigation. Mr. Powell indicated that he would create a plan for the quality coordinator to be trained regarding the personal care needs of the residents in each home in case she needs to cover shifts in the future. He stated that a process would also be put in place for staff to be briefed regarding each resident's personal care needs and to review the plans for each resident before they begin working a shift if they are covering shifts at another home. Mr. Powell indicated that he would be discussing the importance of updating the staff schedule to accurately reflect who worked each shift at the next scheduled manager's meeting.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: (a) Names of all staff on duty and those volunteers who are under the direction of the licensee. (b) Job titles. (c) Hours or shifts worked. (d) Date of schedule.

	(e) Any scheduling changes.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the staff schedule was not updated to reflect scheduling changes and the actual hours or shifts worked by staff at Leidich Home for the time period of 12/19/21-12/25/21.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommended the issuance of a 1st provisional license in the renewal licensing study report dated 11/23/21. Contingent upon the receipt of a corrective action plan, the recommendation for a provisional license remains in effect.



02/23/2022

Kristen Donnay — Date
Licensing Consultant

Approved By:

03/09/2022

Denise Y. Nunn — Date
Area Manager