GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 26, 2022

Janet DiFazio
Spectrum Community Services
28303 Joy Rd.
Westland, MI 48185

RE: License #: AS630397254
Investigation #: 2022A0991024
Leidich Home

Dear Ms. DiFazio:

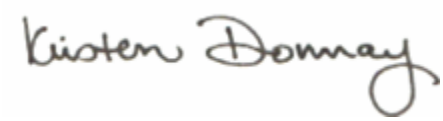
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 feel free to 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 (248) 975-5053.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., 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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS630397254
Investigation #:	2022A0991024
Complaint Receipt Date:	05/02/2022
Investigation Initiation Date:	05/02/2022
Report Due Date:	07/01/2022
Licensee Name:	Spectrum Community Services
Licensee Address:	28303 Joy Rd. Westland, MI 48185
Licensee Telephone #:	(734) 377-3260
Licensee Designee:	Janet DiFazio
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?
Direct care worker, Tiffany Davis, was verbally aggressive as she yelled and swore at Resident A and Resident B.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/02/2022	Special Investigation Intake 2022A0991024
05/02/2022	Special Investigation Initiated - Telephone To Office of Recipient Rights (ORR)
05/02/2022	Referral - Recipient Rights Referred to ORR worker, Rishon Kimble
05/02/2022	APS Referral Call to Adult Protective Services (APS) centralized intake
05/03/2022	Inspection Completed On-site Unannounced onsite inspection- interviewed staff and residents
05/03/2022	Contact - Telephone call made To direct care worker, Martina Pierce
05/03/2022	Contact - Telephone call made Left message for direct care worker, Karla Haig
05/05/2022	Contact - Telephone call received Interviewed direct care worker, Karla Haig
05/05/2022	Contact - Telephone call made Interviewed direct care worker, Tiffany Davis
05/17/2022	Contact - Telephone call received From licensee designee, Janet DiFazio
05/19/2022	Exit Conference Via telephone with licensee designee, Janet DiFazio

ALLEGATION:

Direct care worker, Tiffany Davis, was verbally aggressive as she yelled and swore at Resident A and Resident B.

INVESTIGATION:

On 05/02/22, I received and reviewed two incident reports from Leidich Home, which indicated that staff reported to the home manager on 04/27/22 that they witnessed direct care worker, Tiffany Davis, yelling and swearing at Resident A and Resident B on 04/20/22 and 04/23/22. On 05/02/22, I created a special investigation intake, which was assigned to me for investigation. I initiated my investigation on 05/02/22, by contacting the Office of Recipient Rights (ORR) and Adult Protective Services (APS).

On 05/03/22, I conducted an unannounced onsite inspection at Leidich Home. I interviewed direct care worker, Jordan McAboy. Mr. McAboy stated that he has worked at Leidich Home for seven years. Mr. McAboy indicated that he was not working in the home when the alleged incidents occurred. Spectrum is completing an internal investigation and he was contacted by a Spectrum auditor regarding the allegations. Mr. McAboy was told that direct care worker, Tiffany Davis, screamed at Resident A and Resident B. Mr. McAboy has worked shifts with Ms. Davis, and she is typically a great worker. He has never seen Ms. Davis upset with any of the residents in the home. Mr. McAboy never witnessed any staff, including Ms. Davis, yell at any resident. Mr. McAboy stated that Ms. Davis was having a conflict with another staff, Karla Haig, related to a change in staff positions/titles. Ms. Davis recently voiced that she wanted to quit. Mr. McAboy stated this could be the reason Ms. Davis “blew up.”

On 05/03/2022, I interviewed Resident A. Resident A reported that he recently moved into Leidich Home, and things are going well. Resident A stated that on an unknown date, during dinner, staff Tiffany Davis yelled at him about juice. Ms. Davis told Resident A that he could not have juice because it was diet juice. Resident A indicated that when this incident occurred Karla Haig was also present but did not do anything. Resident A could not recall exactly what Ms. Davis said. Resident A reported Ms. Davis did not get in his face, and she did not speak in a raised voice.
Resident A also reported that on an unknown date, during dinner, Ms. Davis yelled at Resident B. Ms. Davis yelled at Resident B for “stealing food.” Resident A further explained that Resident B ate someone else’s dinner on accident and Ms. Davis yelled at him. Resident A could not remember if Ms. Davis used profanity when she yelled at Resident B.

On 05/03/2022, I interviewed Resident B. Resident B reported that on an unknown date, during dinner, he ate a plate of food that was not his. It was his housemate’s plate. Resident B stated Ms. Davis had a cloth in her hand and threw it in the living room towards the TV. She told Resident B to “get the fuck out of my way.” Resident B stated that Ms. Davis pointed her finger at him and said, “it’s not you.” Resident B further explained that Ms. Davis was “going through something,” but he does not know what.

Resident B reported when this incident occurred all his housemates were sitting at the dinner table. Another staff person, Martina Pierce, was also present. Resident B reported that Ms. Davis has also yelled at Resident A in the past. Resident B later recanted his statement and stated that Ms. Davis is nice to Resident B and only yells at him.

On 05/03/2022, I interviewed the home manager, Constance Warren. Ms. Warren reported that she came in for a shift on 04/27/22, at which time direct care worker, Martina Pierce, reported to her that on 04/20/2022, during dinner, Resident B ate his housemate's plate of food by mistake. Ms. Davis and Resident B "exchanged words back and forth" and Ms. Davis used "the F bomb" towards Resident B. Ms. Warren stated Resident B also made her aware of the incident. Ms. Warren reported Resident B obsesses over things and he has told her several times about the incident. Ms. Warren stated Resident B told her that he tried to apologize to Ms. Davis and Ms. Davis put her hand up and said, "I'm done talking about it."

Ms. Warren further reported that on 04/27/22, Karla Haig reported to her that on 04/23/22, Ms. Davis was at the kitchen table feeding Resident A dinner while Ms. Haig was preparing drinks. Resident A indicated that he wanted to drink juice. Ms. Warren stated Resident A does not have any dietary restrictions; however, they do try to limit his artificial sugar intake as it tends to cause him to have diarrhea. The juice in the refrigerator was diet. Ms. Warren stated that Ms. Davis said Resident A could not have the juice because it was diet. Resident A responded stating, "Are you stupid? I can have what I want." Ms. Davis got up from the table, went into the garage, and paced back and forth. Then, she came back inside and said to Resident A, "Are you stupid?" Ms. Warren reported this situation caused Resident A to "shut down." He was depressed and refused to eat.

Ms. Warren stated that she has never witnessed Ms. Davis yell at any of the residents firsthand. Ms. Warren reported Ms. Davis was upset about staff title changes and "got into it" with Ms. Haig. Ms. Warren explained that Ms. Davis wanted to be the medication lead and was not given that title.

On 05/03/22, I interviewed direct care worker, Martina Pierce, via telephone. Ms. Pierce indicated that she has worked at Leidich Home since February 2022. On 04/20/2022, Ms. Pierce was working with direct care worker, Tiffany Davis. Around 5:30 or 6:00pm, Ms. Davis set the table and put out plates of food for the residents. Resident B sat down and started eating the food from Resident C's plate. Ms. Davis got upset and started screaming at Resident B. Ms. Davis yelled, "Why the fuck would you start eating (Resident C's) food?" Ms. Davis was waving a cloth clothing protector around while she was yelling at Resident B. Resident B flinched and Ms. Davis told him that she was not going to hit him with it. Ms. Pierce reported that the "F-bomb" was dropped numerous times by Ms. Davis as she was yelling at Resident B. Ms. Davis raised her voice and was being very loud. Resident B began apologizing to Ms. Davis. Ms. Davis put up her hand to stop him and told him to stop talking and that she did not want to hear it. Ms. Davis also yelled at Resident B, "Next time, you're going to have to go in and remake

(Resident C's) fucking plate." Ms. Davis went outside to smoke and Resident B continued to apologize. Resident B told Ms. Pierce that next time he will ask if it is his plate before he starts to eat. Ms. Pierce reported that she did not know what to do or say during this incident. She stated that Ms. Davis seemed to be "out of it" that week. Ms. Davis told Ms. Pierce that she was frustrated and tired of Resident B and his apologies. Ms. Pierce stated that she reported this incident to the home manager, Constance Warren, the following week. She did not complete an incident report or tell anyone else at the time the incident occurred. Ms. Pierce stated that she has worked shifts with Ms. Davis before, and this was the first time she witnessed her being verbally aggressive or swearing at any of the residents. Ms. Pierce reported that Resident A does not really care for Ms. Davis, and it takes a lot for Resident A not to like someone. Resident A never reported anything to Ms. Pierce, but he stated that Ms. Davis is "mean and grouchy." Ms. Pierce stated that she has also witnessed Ms. Davis get into yelling matches with Resident D. She stated that Resident D can be difficult, but you do not have to yell at her to get her to do something. She never heard Ms. Davis swear at Resident D, but they will yell at one another and Ms. Davis "will go back and forth with her like with a kid."

On 05/05/22, I interviewed direct care worker, Karla Haig. Ms. Haig indicated that she has worked at Leidich Home for six years. Ms. Haig stated that on Saturday, 04/23/22, she was working with direct care worker, Tiffany Davis. Ms. Davis was feeding Resident A around 5:00-6:00pm. Ms. Haig stated that Resident A does not have dietary restrictions, but the home manager told staff that he should not have sugar free drinks or food because of the ingredients. Resident A wanted some juice, but they only had sugar free juice. Ms. Haig poured Resident A a small portion of juice, and Ms. Davis stated, "He can't have that." Resident A was telling her that he can have a little bit and then said to Ms. Davis, "Are you stupid?" Resident A immediately began apologizing after making this remark. Ms. Davis stood up and stomped out to the garage, as Resident A continued to apologize. Ms. Haig reported that Ms. Davis stomped back in from the garage, with her arms folded and "daggers in her eyes." She got down in Resident A's face with her arms folded and said, "Are you fucking stupid?" Ms. Haig said she was in shock and exclaimed, "Tiffany!" as Ms. Davis stomped back into the garage. Ms. Haig went to the garage to speak with Ms. Davis. Ms. Davis stated that Resident A should not talk to her like that. Ms. Haig stated that she did not call anyone or report the incident at that point. Ms. Davis's attitude was off for the day, but she felt she could handle it. Ms. Haig went back into the house and spoke with Resident A, telling him that Ms. Davis should not cuss at him, and it was wrong. She told Resident A that she would work with him for the rest of the night. Ms. Haig stated that Ms. Davis was "crabby" for the rest of the shift. She did not know what was going on with her, but it seemed like she needed a break. She has seen Ms. Davis get frustrated in the past, but never cuss at the residents. Ms. Davis reported that Resident B told her that he had a confrontation with Ms. Davis, but he did not go into detail. He stated that he told the home manager, Constance Warren, about it.

On 05/05/22, I interviewed direct care worker, Tiffany Davis, via telephone. Ms. Davis indicated that she has worked at Leidich Home for eight years. She stated that she has been working 80 hours in a row recently and it is beginning to affect her emotionally and physically. Ms. Davis stated that when the incidents occurred, she was working a 56-hour shift. She worked Wednesday, 04/20/22, from 3:00pm-11:00pm and then returned to work on Thursday from 2:00pm until Saturday at 10:00pm, which was seven shifts in a row. Ms. Davis stated that recently Resident B has been sitting down and eating Resident C's plate. This has happened on more than one occasion, and Resident B knows what he is doing. Resident C gets double portions, and his food is pureed/ground moist. Resident B's food is bite size pieces. Ms. Davis stated that she puts the food at the table before the residents sit down, and then she assists them to the table. On Wednesday, 04/20/22, Resident B came to the table and began eating from Resident C's plate. Ms. Davis got upset because this meant she had to remake Resident C's plate. Ms. Davis stated that she yelled at Resident B, "That's (Resident C's) food. You keep doing this." She stated that she could not recall exactly what she said, and she could not remember whether she swore, but she did raise her voice. Ms. Davis stated that she thought she would have to resign from working in the home, as it was taking a toll on her health.

Ms. Davis stated that on Saturday, 04/23/22, she was in the kitchen with Resident A and staff, Karla Haig. Ms. Haig was getting Resident A some juice to drink, but it was diet. Ms. Davis told her that Resident A could not have that juice, because the home manager, Constance Warren, said that Resident A could not have any sugar substitutes for health reasons. When Ms. Davis stated that Resident A could not have the juice, he got really mean and nasty and said to Ms. Davis, "Are you stupid?" Ms. Davis stated that this was very hurtful. She walked away and then came back into the kitchen and repeated Resident A's statement back to him asking, "Are you stupid?" Ms. Davis indicated that she should not have done that and was very apologetic.

On 05/11/22, I interviewed the assigned Office of Recipient Rights (ORR) worker from Oakland Community Health Network (OCHN), Rishon Kimble. Ms. Kimble indicated that she was still working on her investigation, but she would likely be substantiating the allegations against Ms. Davis for dignity and respect, as well as Abuse III, due to Ms. Davis swearing and threatening that next time Resident B would have to make Resident C's plate.

On 05/17/22, I interviewed the licensee designee, Janet DiFazio, via telephone. Ms. DiFazio indicated that Tiffany Davis has been terminated and is no longer working at Leidich Home. She indicated that the facility is short staffed, as they only have five staff working in the home. Some staff have been working multiple shifts in a row, but she is actively working on hiring more staff for the home.

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: (f) Subject a resident to any of the following: (ii) Verbal abuse.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff, Tiffany Davis, was verbally abusive towards Resident A and Resident B. Ms. Davis admitted to being frustrated and yelling at Resident A and Resident B. Staff and the residents reported that Ms. Davis was verbally aggressive, as she yelled and cussed at Resident A and Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Based on the information gathered through my investigation and the incident reports provided, it was determined that staff, Martina Pierce, witnessed direct care worker, Tiffany Davis, being verbally aggressive towards Resident B during dinner on 04/20/22. Ms. Pierce did not report this information to anyone and did not complete an incident report until one week later when she told the home manager on 04/27/22.

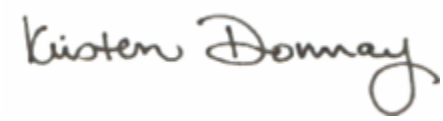
Direct care worker, Karla Haig, witnessed Tiffany Davis being verbally aggressive towards Resident A during dinner on 04/23/22. Ms. Haig did not report this information to anyone and did not complete an incident report until four days later when she told the home manager on 04/27/22. Ms. Haig stated that she did not report Ms. Davis's behavior, because she felt she could handle it. She indicated that Ms. Davis had a poor attitude for the remainder of the shift.

On 05/19/22, I conducted an exit conference via telephone with the licensee designee, Janet DiFazio. Ms. DiFazio indicated that she would complete a corrective action plan and would submit documentation showing that Ms. Davis was terminated. She indicated that she would conduct training with all staff regarding treating the residents with dignity and reporting any incidents immediately.

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: (a) Reporting requirements.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff were not competent in the area of reporting requirements. Direct care workers, Karla Haig and Martina Pierce, failed to immediately report incidents when they witnessed staff Tiffany Davis being verbally aggressive towards Resident A and Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



05/19/2022

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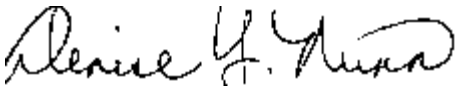
Kristen Donnay Date
Licensing Consultant

Approved By:



05/26/2022

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Denise Y. Nunn Date
Area Manager