GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 23, 2023

Janet Difazio
Spectrum Community Services
Suite 700
185 E. Main St
Benton Harbor, MI 49022

RE: License #: AS410289784
Investigation #: 2023A0583021
Blythefield Home

Dear Mrs. Difazio:

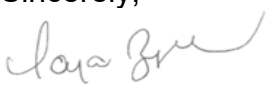
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410289784
Investigation #:	2023A0583021
Complaint Receipt Date:	02/21/2023
Investigation Initiation Date:	02/21/2023
Report Due Date:	03/23/2023
Licensee Name:	Spectrum Community Services
Licensee Address:	Suite 700 185 E. Main St Benton Harbor, MI 49022
Licensee Telephone #:	(734) 458-8729
Administrator:	Janet Difazio
Licensee Designee:	Janet Difazio
Name of Facility:	Blythefield Home
Facility Address:	3485 Rogue River Rd. NE Belmont, MI 49306
Facility Telephone #:	(616) 447-9380
Original Issuance Date:	06/25/2007
License Status:	REGULAR
Effective Date:	12/29/2021
Expiration Date:	12/28/2023
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Matthew Bigham verbally mistreated Resident A.	No
Residents' medications are unsecured.	Yes

III. METHODOLOGY

02/21/2023	Special Investigation Intake 2023A0583021
02/21/2023	Special Investigation Initiated - On Site Resident A, Resident B, Staff Inga Delooff
02/22/2023	APS Referral
02/22/2023	Contact – Email Recipient Rights Michael Kuik
02/22/2023	Contact – Telephone Resident C
02/22/2023	Contact – Telephone Staff Matthew Bingham
02/22/2023	Exit Conference Designee Monica Salingue

ALLEGATION: Staff Mathew Bigham verbally mistreated Resident A.

INVESTIGATION: On 02/21/2023 I received complaint allegations from Network 180 Recipient Rights Staff Ed Wilson via email. Mr. Wilson stated the complaint allegations are assigned to staff Michael Kuik for investigation. Mr. Wilson stated that the complaint allegations alleged that on the morning of 02/20/2023 Resident A reported that staff Matthew Bigham was "yelling" at Resident A.

On 02/21/2023 I completed an unannounced onsite investigation at the facility and privately interviewed staff Inga Delooff, Resident A and Resident B.

Staff Inga Delooff stated that on 02/20/2023 at approximately 7:00 AM, she entered the facility and observed Resident A appeared agitated and upset. Ms. Delooff stated Resident A was yelling, "I can't believe he yelled at me" and "he yelled at me". Ms. Delooff stated Resident A elaborated by stating that staff Matthew Bigham "yelled at" Resident A. Ms. Delooff stated Mr. Bigham had worked alone at the facility just prior to Ms. Delooff's shift. Ms. Delooff stated Resident A would not provide further details regarding the incident. Ms. Delooff stated she asked Resident

C why Resident A was upset, and Resident C stated Mr. Bingham “yelled at (Resident A)” however Resident C provided no further details.

I attempted to interview Resident A however Resident A stated, “you can go away now”.

I attempted to interview Resident B however Resident B lacked the ability to communicate given his developmental disabilities.

On 02/22/2023 I emailed the complaint allegations to Adult Protective Services Centralized Intake.

On 02/22/2023 I received an email from Recipient Rights staff Michael Kuik. Mr. Kuik stated he attempted to interview Resident A today however Resident A refused.

On 02/22/2023 I interviewed Resident C via telephone. Resident C stated staff Matthew Bingham “yelled at” Resident A “at dinner time” however Resident C could provide no further details given his development disability.

On 02/22/2023 I interviewed staff Matthew Bingham via telephone. Mr. Bingham stated that on 02/19/2023 he was in the kitchen preparing residents’ dinners and overheard Resident A and Resident C arguing. Mr. Bingham stated he verbally directed Resident A and Resident C to “stop fighting” but Mr. Bingham denied he raised his voice or “yelled at” either of the residents. Mr. Bingham stated he has never verbally mistreated residents.

On 02/22/2023 I completed an Exit Conference with Designee Monica Salingue via telephone. Ms. Salingue stated she agreed with the findings.

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:	Resident A refused to be interviewed. Resident C stated staff Matthew Bingham “yelled at” Resident A “at dinner time” however Resident C could provide no further details given his development disability. Staff Matthew Bingham denied he verbally mistreated Resident A.

	A preponderance of evidence was not discovered during the special investigation to substantiate a violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents' medications are unsecured.

INVESTIGATION: On 02/21/2023 I received complaint allegations from Network 180 Recipient Rights Staff Ed Wilson via email. Mr. Wilson stated complaint allegations alleged that on the morning of 02/20/2023 staff Inga Delooff arrived at the facility and observed staff Matthew Bingham was in the bathroom with the door closed. The complaint further stated that while Mr. Bingham was in the bathroom, Mr. Bigham had left the medication room and narcotics box unlocked and accessible to residents at the facility.

On 02/21/2023 I completed an unannounced onsite investigation at the facility and privately interviewed staff Inga Delooff. Ms. Delooff stated that on the morning of 02/20/2023 she entered the facility and observed that the facility's medication room was unlocked, and staff Matthew Bigham was in the bathroom. Ms. Delooff stated that the narcotics box, which is secured by a lock, was also left unlocked inside the medication room. Ms. Delooff stated residents' medications are stored in a cabinet, in plastic storage containers, and the locked narcotics box all inside the medication room. Ms. Delooff stated Mr. Bigham worked the previous shift alone and no other staff had access to the medication room. Ms. Delooff stated she did not ask Mr. Bigham if he had left the medication room unlocked.

On 02/22/2023 I interviewed staff Matthew Bingham via telephone. Mr. Bingham stated it is routine for facility staff to leave the medication room unlocked because residents are allowed to pass through the medication room in order to access the facility's basement laundry room. Mr. Bingham stated that on 02/20/2023 he did leave the medication room unlocked while he was in the bathroom but stated the narcotics box was locked. Mr. Bingham acknowledged the medication room contains all residents' medications which were unsecured on 02/20/2023.

On 02/22/2023 I completed an Exit Conference with Designee Monica Salingue via telephone. Ms. Salingue stated she agreed with the findings and would submit an acceptable Corrective Action Plan.

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 Matthew Bingham acknowledged that he left the medication room which contains residents' medications unlocked on 02/20/2023. A preponderance of evidence was discovered during the special investigation to substantiate violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

02/22/2023

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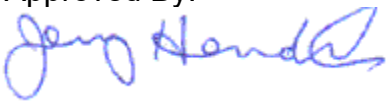
Toya Zylstra Date
Licensing Consultant

Approved By:



02/23/2023

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Jerry Hendrick Date
Area Manager