GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 25, 2023

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

RE: License #: AS410356636
Investigation #: 2023A0467046
Terrace Park Home

Dear Mrs. Payne:

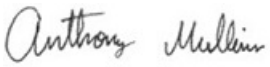
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



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 #:	AS410356636
Investigation #:	2023A0467046
Complaint Receipt Date:	05/25/2023
Investigation Initiation Date:	05/25/2023
Report Due Date:	07/24/2023
Licensee Name:	Spectrum Community Services
Licensee Address:	Suite 700 185 E. Main St Benton Harbor, MI 49022
Licensee Telephone #:	(734) 458-8729
Administrator:	Delissa Payne
Licensee Designee:	Delissa Payne
Name of Facility:	Terrace Park Home
Facility Address:	5901 Terrace Park Dr. NE Rockford, MI 49341
Facility Telephone #:	(616) 884-5788
Original Issuance Date:	03/12/2014
License Status:	REGULAR
Effective Date:	10/24/2021
Expiration Date:	10/23/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has sustained three different fractures in a short period of time. It is unknown how these injuries occurred.	No
Resident A is not receiving his medications as ordered.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/25/2023	Special Investigation Intake 2023A0467046
05/25/2023	APS referral – Kent County APS worker, Marques McLemore investigated the allegations and denied the complaint.
05/25/2023	Special Investigation Initiated - On Site
05/17/2023	Kent County APS worker, Marques McLemore investigated the allegations and denied his complaint.
07/13/2023	Inspection completed – On Site
07/17/2023	Contact – document received from Program Administrator, Jordan Walch.
07/24/2023	Exit conference completed with licensee designee, Delissa Payne.

ALLEGATION: Resident A has sustained three different fractures in a short period of time. It is unknown how these injuries occurred.

INVESTIGATION: On 5/25/23, I received a complaint stating that Resident A received three different fractures in a short period of time and it is unknown how these injuries occurred.

On 5/25/23, I made an unannounced onsite investigation at the facility. Upon arrival, staff member Zach Clelland answered the door and allowed entry into the home. Mr. Clelland stated that Resident A is currently at St. Mary's hospital (Trinity Health). AFC staff member Brianna Hartman was also present during this onsite investigation. Staff were asked about Resident A's ability to communicate. Staff stated that Resident A needs prompting to speak and his communication is limited. Resident A can reportedly say yes or no when asked if he needs his medications or if he's happy or not. Ms. Hartman assisted me in trying to obtain Resident A's assessment plan. After looking through different file folders, this information was

unable to be located. Staff provided me with contact information for the home manager, Melissa Stewart to obtain these documents.

On 5/25/23, I spoke to Ms. Stewart via phone regarding the allegations. Ms. Stewart was asked to provide a timeline of Resident A's injuries. Ms. Stewart stated that on 4/14/23, Resident A sustained his first injury, which was a broken left foot. Resident A was walking out of his room and had a "drop seizure", causing him to fall and break his foot. Ms. Stewart stated that she received a call from staff and she was five minutes away and told staff to keep him where he was until she arrived. When Ms. Stewart arrived at the AFC, she realized that Resident A's foot was swollen and bruised. After noticing this, Ms. Stewart stated that she called Resident A's mom and informed her, as well as an ambulance to transport Resident A to the hospital. At the hospital, it was confirmed that Resident A broke his 4th and 5th metatarsal, which are bones in his foot. This led to Resident A being in the hospital for 3+ weeks. During Resident A's time in the hospital, there was reportedly a lot of back and forth with AFC staff and his mom because she wanted him to return to the AFC. Ms. Stewart stated that Resident A's mom refused physical therapy and said it was too much for him to go to sub-acute rehab (SAR) at that time. Resident A was initially non-weightbearing. Prior to Resident A returning to the AFC facility, he needed to be weightbearing and capable of using a walker. Ms. Stewart was adamant that she and AFC staff never once told Resident A or his mother that he could not return to the AFC.

Resident A returned to the AFC on 5/5/23 after 3+ weeks in the hospital. Resident A reportedly needed durable medical equipment (DME) to return home, including a walker, gait belt, bed alarm, and shower chair. All equipment was obtained prior to his return. Resident A then broke his right foot on 5/15/23. He was mobilizing with his walker and fell while trying to get a drink in the kitchen. Resident A also tried to reach for staff during this fall. Resident A was then taken to the hospital to address this injury. Resident A was reportedly discharged from the hospital on 5/16/23 due to being weightbearing on both feet. Ms. Stewart stated that Resident A required a walking boot on his left foot and a cam boot on the right foot with the use of walker. Resident A returned home and had an appointment with the orthopedic surgeon on 5/18/23. At that time, his cam boot was taken off.

The following day (5/19/23), Resident A had an appointment to address a wound on his foot. After returning home from his appointment, staff used a two-person assist to help Resident A to the bathroom. While in the bathroom, Resident A started having a seizure. Ms. Stewart was in the basement when this occurred. By the time she got upstairs, Resident A's seizure was almost done. Staff assisted Resident A to the floor by sliding him down to the ground during his seizure and he landed on his shoulder. Ms. Stewart stated that she checked Resident A over and didn't see any bruises on him.

During that same night, Resident A had another seizure that lasted approximately one minute that Ms. Stewart witnessed. Ms. Stewart stated that Resident A was very

tired and weak. AFC staff gave Resident A ibuprofen and Motrin for the pain. Ms. Stewart checked in with staff on the same night and asked how Resident A was doing. Ms. Stewart stated that staff said Resident A was doing okay but not using his arm much. Ms. Stewart informed staff that if Resident A's arm gets worse, to let her know. Ms. Stewart stated that Resident A's mom was adamant that they wait until the next day so he could be evaluated by Physical Therapy (PT). Ms. Stewart and other AFC staff were not comfortable with Resident A's mom's request, so Ms. Stewart advised staff to take Resident A to the hospital. Resident A's mom reportedly sent text messages to Ms. Stewart stating that she had no right to do that and that she preferred her son go to urgent care as opposed to the hospital.

While in the hospital, AFC staff were informed that Resident A broke his shoulder and needed a sling. Ms. Stewart stated that Resident A's mom was adamant that he discharge home. Ms. Stewart was not comfortable with Resident A discharging home at this time because he must be able to walk upstairs to get into the house, which Ms. Stewart felt was a safety issue. The hospital Social Worker requested that PT/OT assess the pt, which was completed. Per Ms. Stewart, PT stated that ideally, Resident A would need three people to assist him which the home can't accommodate. Ms. Stewart stated that PT eventually recommended Sub Acute Rehab for Resident A based on his current presentation. Ms. Stewart stated that all parties were in agreement with this except for Resident A's mom as she wanted him to return to the AFC and have Porter Hills skilled services treat him at home. Ms. Stewart stated that Resident A's mom was reportedly accusing AFC staff of abuse and neglect in the hospital.

Ms. Stewart stated that she has a meeting scheduled today with the executive director, Resident A's support coordinator and her supervisor to determine the appropriate plan of care for Resident A. Ms. Stewart stated that Resident A's first fall was not witnessed when he had a drop seizure and broke his foot but the other two falls were witnessed.

On 5/25/23, I spoke to the complainant via email and phone. The complainant shared that she could not speak for Resident A's guardian, but her concerns for Resident A's safety is heightened based on the multiple injuries in a short period of time. The complainant was also concerned that Resident A reportedly had so many "alleged unwitnessed seizures in the home but not while in the hospital for days."

On 7/13/23, I made an unannounced onsite investigation to the facility. Upon arrival, staff member Brianna Hartman answered the door and allowed entry into the home. Ms. Hartman contacted Ms. Stewart, who stated that she would be at the home in 15 minutes to assist. While awaiting Ms. Stewarts arrival, AFC staff member Lauren Russell assisted me to Resident A's room. Introductions were made with Resident A as he was observed lying in bed watching a show on his laptop/tablet. It should be noted that Resident A's communication is limited due to his development and diagnosis. However, he was able to say that he's "doing good" and denied any concerns within the house. This brief interview with Resident A concluded.

AFC home manager, Ms. Stewart arrived at the home and provided me with copies of Resident A's medical records from his recent hospitalizations. The dates of the medical records ranged from 4/14/23 through 5/20/23, confirming the injuries listed above. Medical records also confirmed that Resident A did in fact have a seizure while in the hospital. Per medical records, Dr. Marilyn Innes spoke to Resident A's mom via phone and she reported that Resident A had several recent injuries. Dr. Innes confirmed that Resident A had a recent diagnosis of Lisfranc fracture of his foot. Dr. Innes stated that Resident A's mother believes that he is being abused by staff at the AFC and APS was involved. Dr. Innes stated that Resident A's mom expressed concern that someone in the hospital was reportedly suspicious that Resident A was being abused in the AFC home. Dr. Innes reviewed Resident A's recent discharge summaries, in addition to his case management notes. Dr. Innes and the hospital social worker did not find any documentation noting this concern. Dr. Innes specifically stated, "I am not concerned about the story that I have heard about his fall yesterday, and I examined his foot, which has a chronic wound that looks clean and dry and not acutely infected." All medical records were reviewed and Resident A's injuries appear to be consistent with the explanations provided by the AFC staff. Medical records also confirmed that the hospital recommended sub-acute rehab (SAR) placement for Resident A, which was declined by his mom.

On 7/13/23, I spoke to Resident A's mom/guardian via phone. Resident A's mom was asked if she has concerns that the AFC staff members are abusing her son, leading to his injuries. Resident A's mom denied having concerns that her son is being physically abused "in the traditional since of abuse." Resident A's mom stated, "it's not an abusive situation, it's just not a nurturing situation" as she does not feel that staff go above and beyond to attend to her son's needs. Resident A's mom stated that her son's long hospitalization has taught her that her son can tolerate a lot more when staff take the time to explain things to him. Resident A's mom stated she feels that because he isn't the "squeaky wheel," he doesn't get the attention he deserves.

On 07/24/23, I conducted an exit conference with licensee designee, Delissa Payne. She was informed of the investigative findings and denied having any questions.

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 sustained three fractures between April and May 2023. Resident A fractured his right foot, left foot, and his shoulder. All three injuries occurred after a fall, two of which were witnessed per Ms. Stewart.

	Dr. Innes and the hospital social worker did not report any concerns related to abuse of Resident A. Resident A's mom also denied any concerns that Resident A had been physically abused by staff. Therefore, there is not a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A is not receiving his medications as ordered.

INVESTIGATION: On 5/25/23, I spoke to the complainant via phone and email. The complainant expressed concerns that, "maybe (Resident A's) meds aren't being administered as ordered, that supervision could be lacking, overall neglect." It should be noted that this concern was relayed to me after my initial onsite investigation at the home earlier today.

On 5/25/23, I spoke to house manager Ms. Stewart. Ms. Stewart stated that Resident A has lived in the home for approximately four to five years. Ms. Stewart stated that Resident A receives his medication as prescribed daily. Ms. Stewart was unsure if Resident A has any medical diagnosis that would cause him to have broken bones easier than the average person.

On 7/13/23, I made a second unannounced onsite investigation to the facility. Upon arrival, AFC staff member Brianna Hartman answered the door and allowed entry into the home. I requested Resident A's medication administration record (MARs) from May 2023 through July 2023. Ms. Hartman attempted to help with my request but this was unsuccessful. Ms. Hartman contacted Ms. Stewart, who stated that she would be at the home in 15 minutes to assist. Ms. Stewart arrived at the home and provided copies of Resident A's Mars from May through June as requested.

Resident A's May 2023 MAR was reviewed and the table below shows inaccuracies based on scheduled doses and times that the medications should have been given:

Medication:	**Scheduled time of dose:**	**Date(s) of missed dose:**	**Explanation given on MAR for missed dose:**
Calcum 600/400	8:00 am	5/11/23, 5/12/23	Out of Facility – although other 8:00 am meds were given.
Hydroxyz HCL Tab 50MG	8:00 am	5/11/23 – 5/14/23	Out of facility – although other 8:00 am meds were given
Melatonin Tab 5MG & 10MG	8:00 pm	5/20/23, 5/22/23, 5/25/23	N/A

Lamotrigine Tab 25MG	8:00 pm	5/20/23	N/A
Memantine Tab HCL 10MG	8:00 pm	5/20/23	N/A
Montelukast Tab 10MG	8:00 pm	5/20/23, 5/22/23, 5/25/23	N/A
Omeprazole Cap 20MG	8:00 pm	5/20/23	N/A
Zonisamide Cap 100MG	8:00 pm	5/20/23, 5/22/23, 5/25/23	N/A
Epidiolex Sol 100MG/ML	8:00 pm	5/20/23	N/A

Resident A's June 2023 MAR was reviewed and the table below shows inaccuracies based on scheduled doses and times that the medications should have been given:

Medication:	**Scheduled time of dose:**	**Date(s) of missed dose:**	**Explanation given on MAR for missed dose:**
Acetaminophen 325MG Tabs	2:00 am	6/3/23, 6/4/23, 6/23, 6/26, 6/28	N/A
Acetaminophen 325 Tabs	2:00 pm	6/23/23, 6/25/23	N/A
Acetaminophen 325 Tabs	8:00 pm	6/8/23, 6/12/23, 6/29/23	N/A
Epidiolex Sol 100MG/ML	8:00 pm	6/8/23	N/A
Hydroxyz HCL Tab 50MG	8:00 pm	6/8/23, 6/29/23	N/A
Lamotrigine Tab 200MG:	8:00 pm	6/8/23, 6/29/23	N/A
Melatonin Tab 5MG & 10MG	8:00 pm	6/8/23, 6/29/23	N/A
Memantine Tab HCL 10MG	8:00 pm	6/8/23, 6/29/23	N/A
Montelukast Tab 10MG:	8:00 pm	6/8/23, 6/29/23	N/A
Omeprazole Cap 20MG	8:00 pm	6/8/23, 6/11/23, 6/13/23, 6/29/23.	N/A

Resident A's July 2023 MAR was reviewed and the table below shows inaccuracies based on scheduled doses and times that the medication should have been given:

Medication:	Scheduled time of dose:	Date(s) of missed dose:	Explanation given on MAR for missed dose:
Fluoxetine Tab 20MG	8:00 am	7/11/23	Out of facility – although other 8:00 am meds were given.

On 07/24/23, an exit conference was completed with licensee designee, Delissa Payne. She was informed of the investigative findings and agreed to complete a CAP within 15 days of receipt of this report.

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:	Resident A missed several doses of medications between May and July 2023. Some medications indicated that Resident A was "out of the facility." Despite this, Resident A received his other medications scheduled at the same time. Resident A's MARs did not provide a reasonable explanation as to why medications were not given to him. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While investigating the allegations listed above, I requested a copy of Resident A's assessment plan at the home on 5/25/23. Staff member Brianna Hartman assisted me in looking through Resident A's files for his assessment plan. The assessment plan was unable to be located. Ms. Hartman provided me with contact information for the home manager, Melissa Stewart to request the document. Ms. Stewart agreed to send me a copy of Resident A's

assessment plan by the end of the day. However, I never received a copy of the assessment plan.

On 7/13/23, I made a second unannounced onsite investigation. AFC staff member Ms. Hartman was present, along with AFC staff member Lauren Russell. Ms. Hartman called Ms. Stewart, who agreed to be at the home within 15 minutes. Ms. Stewart arrived at the home and searched through documents in the home and was unable to locate the assessment plan. Ms. Stewart planned to reach out to AFC program administrator, Jordan Walch for assistance obtaining this form. On 7/13/23, I spoke to Ms. Walch via phone and she agreed to send the requested form.

On 7/17/23, I received a copy of Resident A's assessment plan from Ms. Walch signed on 7/17/23. In the email, Ms. Walch stated that Ms. Stewart believes she may have given the assessment plan to me a couple months ago as the original instead of a copy. She also stated that Resident A's mom recalls signing the original assessment plan this past January and Ms. Stewart had her sign the assessment plan today at Resident A's doctor office. It should be noted that I never received an assessment plan for Resident A months ago. It should also be noted that the assessment plan is required to be on file in the home.

On 07/24/23, I conducted an exit conference with licensee designee, Delissa Payne. She was informed of the investigative findings and agreed to complete a CAP within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	During two onsite visits on 5/25 and 7/13, Resident A's assessment plan was not on file in the home. On 7/17/23, I received a copy of Resident A's assessment plan that was also signed on the day it was received. There was no physical proof that an assessment was completed prior to 7/17/23. Therefore, there is a preponderance of evidence to support this allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegations listed above, I requested a copy of Resident A's health care appraisal at the home on 5/25/23. Staff member Brianna Hartman assisted me in looking through Resident A's files for his health care appraisal. The health care appraisal was unable to be located. Ms. Hartman provided me with contact information for the home manager, Melissa Stewart to request the document. Ms. Stewart agreed to send me a copy of Resident A's health care appraisal by the end of the day. However, I never received a copy of it.

On 7/13/23, I made a second unannounced onsite investigation. AFC staff member Ms. Hartman was present, along with AFC staff member Lauren Russell. Ms. Hartman called Ms. Stewart, who agreed to be at the home within 15 minutes. Ms. Stewart arrived at the home and searched through documents in the home and was unable to locate the health care appraisal. Ms. Stewart planned to reach out to AFC program administrator, Jordan Walch for assistance obtaining this form. On 7/13/23, I spoke to Ms. Walch via phone and she agreed to send the requested form.

On 7/13/23, I received a copy of Resident A's authorization of personal care form from Ms. Walch signed on 7/17/23. This is a Community Mental Health (CMH) form and not a licensing form. I requested a copy of Resident A's health care appraisal and received this form instead. Health care appraisals are supposed to be completed for residents upon admission and annually. As of the completion of this investigation, I have yet to receive a copy of the requested form.

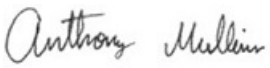
On 07/24/23, I conducted an exit conference with licensee designee, Delissa Payne. She was informed of the investigative findings and agreed to complete a CAP within 15 days of receipt of this form.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.

ANALYSIS:	During two onsite visits on 5/25 and 7/13, Resident A's health care appraisal was not on file in the home. On 7/17/23, Ms. Walch sent me an authorization of personal care for Resident A, which is not a licensing form or the form requested. The health care appraisal form is required to be completed upon a resident's admission and annually thereafter. However, I have not received a copy of the health care appraisal. Therefore, there is a preponderance of evidence to support this allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

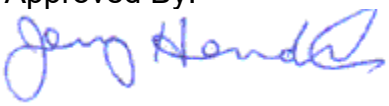
Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



07/24/2023

Anthony Mullins Date
Licensing Consultant

Approved By:



07/25/2023

Jerry Hendrick Date
Area Manager