



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 18, 2023

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

RE: License #: AS410356636
Investigation #: 2024A0467009
Terrace Park Home

Dear Mrs. Payne:

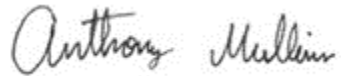
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with the 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,

A handwritten signature in cursive script that reads "Anthony Mullins".

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 #:	2024A0467009
Complaint Receipt Date:	11/21/2023
Investigation Initiation Date:	11/21/2023
Report Due Date:	01/20/2024
Licensee Name:	Spectrum Community Services
Licensee Address:	Suite 700 185 E. Main St Benton Harbor, MI 49022
Licensee Telephone #:	(231) 887-4130
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:	10/24/2023
Expiration Date:	10/23/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
AFC staff failed to take Resident A to her scheduled medical appointment.	Yes

III. METHODOLOGY

11/21/2023	Special Investigation Intake 2024A0467009
11/21/2023	Special Investigation Initiated - Telephone Spoke to the complainant via phone.
11/22/2023	Inspection Completed On-site
12/18/2023	APS Referral – sent via email.
12/18/2023	Exit conference completed with Delissa Payne, Licensee Designee.

ALLEGATION: AFC staff failed to take Resident A to her scheduled medical appointment.

INVESTIGATION: On 11/21/23, I received a BCAL online complaint stating that Resident A had a scheduled doctor’s appointment on 11/20/23. Staff at the AFC was supposed to transport Resident A to her appointment.

On 11/21/23, I spoke to the complainant via phone and she confirmed that the home manager, Heather Reamon was supposed to take Resident A to her scheduled appointment. The complainant stated Ms. Reamon never informed her of Resident A’s missed appointment. Instead, the complainant was made aware of the missed appointment due to speaking directly with Resident A.

On 11/22/23, I made an unannounced onsite investigation at the facility. Upon arrival, I spoke to AFC staff member, Heather Reamon regarding the allegation. Ms. Reamon confirmed that Resident A did in fact miss her scheduled appointment on 11/20/23 with her primary care physician (PCP). Ms. Reamon stated that Resident A’s appointment on 11/20/23, “slipped my mind”. Ms. Reamon stated that she apologized profusely to Resident A’s mother.

As a result of Ms. Reamon forgetting to transport Resident A to her appointment, Resident A’s mom told her that she would reschedule the appointment and transport Resident A herself. Ms. Reamon confirmed that she and AFC staff have transported Resident A to appointments in the past. Ms. Reamon provided me with a copy of Resident A’s Resident Care Agreement. The resident care agreement indicates that “Spectrum Community Services provides all transportation services.”

On 12/18/2023, I conducted an exit conference with licensee designee, Delissa Payne. She was informed of the investigative findings and agreed to complete a corrective action plan within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14303	Resident care; licensee responsibilities.
	(3) A licensee shall assure the availability of transportation services as provided for in the resident care agreement.
ANALYSIS:	Resident A had a scheduled appointment with her PCP on 11/20/23. AFC staff member, Heather Reamon confirmed that Resident A’s scheduled appointment “slipped her mind” due to addressing other needs/concerns within the home. Resident A’s resident care agreement was reviewed and confirmed that AFC staff are responsible for all transportation services. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Anthony Mullins

12/18/2023

Anthony Mullins
Licensing Consultant

Date

Approved By:

Jerry Hendrick

12/18/2023

Jerry Hendrick
Area Manager

Date