GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

Joyce Divis
Spectrum Community Services
Suite 700
185 E. Main St
Benton Harbor, MI 49022

February 12, 2024

RE: License #: AS110010333
Investigation #: 2024A0579010
Echo Court Home

Dear Joyce Divis:

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 (616) 356-0183.

Sincerely,

Cassandra Duursma

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS110010333
Investigation #:	2024A0579010
Complaint Receipt Date:	12/28/2023
Investigation Initiation Date:	12/28/2023
Report Due Date:	02/26/2024
Licensee Name:	Spectrum Community Services
Licensee Address:	Suite 700 185 E. Main St Benton Harbor, MI 49022
Licensee Telephone #:	(231) 887-4130
Administrator:	Joyce Divis
Licensee Designee:	Joyce Divis
Name of Facility:	Echo Court Home
Facility Address:	4185 Echo Road Benton Harbor, MI 49022
Facility Telephone #:	(269) 944-3506
Original Issuance Date:	03/17/1993
License Status:	REGULAR
Effective Date:	05/09/2022
Expiration Date:	05/08/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

ALLEGATION(S)

	Violation Established?
A direct care worker physically assaulted Resident A.	Yes

II. METHODOLOGY

12/28/2023	Special Investigation Intake 2024A0579010
12/28/2023	APS Referral Denied
12/28/2023	Special Investigation Initiated - Letter Anne Simpson, Office of Recipient Rights (ORR)
12/28/2023	Contact- Document Received Joyce Divis, Licensee Designee
12/28/2023	APS Referral Disputed and assigned
01/24/2024	Contact- Face to Face Resident A, Tenisha Johnson (Direct Care Worker/DCW), Francis Barigye (DCW)
01/24/2024	Contact- Document Sent Joyce Divis, Licensee Designee Anne Simpson, ORR
01/31/2024	Contact- Document Received Jacob Pehur, APS
02/01/2024	Contact- Telephone Call Made Amy Weatherby, Former DCW
02/01/2024	Contact- Telephone Call Made Angel Parker, DCW
02/06/2024	Contact- Document Sent Joyce Divis, Licensee Designee
02/08/2024	Exit Conference Joyce Divis, Licensee Designee

ALLEGATION:

A direct care worker physically assaulted Resident A.

INVESTIGATION:

On 12/28/23, I entered this referral into the Bureau Information Tracking System after receiving an email from license designee Joyce Divis on 12/27/23 inquiring who to report allegations to. She described a scenario where a direct care worker (DCW) allegedly used a stun gun on a resident. I agreed to forward the allegations to Adult Protective Services (APS) and requested Ms. Divis contact local law enforcement (LE). She agreed to send me the *Incident/Accident Report* (IR) form regarding the allegations.

On 12/28/23, I received and reviewed the IR dated 12/23/23 which noted DCW Angel Parker reported concerns for how DCWs Amy Weatherby and Tenisha Johnson treat residents at Echo Court, specifically Resident A. Ms. Parker reported she was upset over an incident that occurred on 12/18/23. She stated Ms. Weatherby reported to her that she had purchased a “taser” and brought it to the home. She was showing Ms. Parker and Ms. Johnson how to use it. At that time, Resident A went to the Christmas tree in the home and attempted to pull it over. Ms. Parker reported Ms. Weatherby walked over to Resident A while pressing the taser on and off. She then touched Resident A multiple times with the taser while it was on, “tagging” him three to four times. Ms. Parker reported Resident A was on the ground and crying and she asked Ms. Weatherby what she was doing. Ms. Weatherby then took Resident A to the shower and afterward reported the marks from the taser faded slightly. Ms. Weatherby was immediately removed from the home and taken off the schedule after this was reported. Arrangements were made for Ms. Parker and Ms. Weatherby to meet with Spectrum Community Services administrative staff, David Schnoor, for interviewing. Resident A’s skin was observed on 12/27/23 by Mr. Schnoor, DCW Stacy Kingman, and Office of Recipient Rights (ORR) worker Anne Simpson. It was found he had several marks consistent with the use of a stun gun. Photographs were taken of the injuries.

On 12/28/23, I forwarded the allegations to APS. The referral was denied for investigation.

On 12/28/23, I exchanged emails with Ms. Simpson. She confirmed she saw Resident A and saw bruising consistent with the use of a stun gun which she photographed. She stated when Ms. Kingman asked Resident A if he “was shot”, he said, “No, pop, pop, pop, pop” and made noises consistent with a stun gun. She explained Ms. Parker referred to the weapon as a taser but it was a stun gun, which is an electric shock device with prongs that are held on the person’s skin to

administer painful electric current. She stated there are marks on his arm, side, and buttocks that are consistent with different levels of stun gun injuries.

Ms. Simpson wrote Ms. Johnson denied witnessing the incident and it was suggested Ms. Parker and Resident A were having delusions about the incident occurring. Ms. Simpson denied this, writing it was obvious Resident A was hurt. She also wrote Ms. Parker is certain Ms. Johnson directly witnessed the incident, so she has reached out to Ms. Johnson to give her another chance to speak privately. She stated she also advised Ms. Divis to contact LE and she believed interviews were being conducted by LE on 12/28/23.

On 12/28/23, Ms. Simpson reported she was able to speak to Ms. Johnson on the telephone and Ms. Johnson admitted she was aware Ms. Weatherby had a stun gun in the home. She stated Ms. Johnson claims she was in a different area in the home and when she returned, Resident A was on the ground crying and Ms. Weatherby was standing by him smiling. She admitted she previously was not honest when interviewed, and she believes Ms. Weatherby used the stun gun on Resident A, although she denies witnessing it directly.

On 12/28/23, I resubmitted the referral to APS. I was notified the referral was reconsidered and assigned to worker Jacob Pehur for investigation.

On 1/24/24, I completed an unannounced on-site investigation at the home. Interviews were completed with DCWs Tenisha Johnson and Francis Barigye. I attempted to interview Resident A, but he led me to his bedroom, got in his bed, and told me to go. While I was in the home, he engaged with me by attempting to grab my hair and firmly grabbing my hands and thumbs and refusing to let go. He would not respond to questioning. He did, eventually, respond to verbal redirecting when requested he release my hands because I had to leave.

Ms. Johnson appeared annoyed with my questioning and short with her responses. She reported she already told “everyone else” what happened. Ms. Johnson stated she did not witness anything, even though someone said she did, but she knew Ms. Weatherby had a stun gun in the home although she did not see her use it. She stated at the time of the incident, she was in a bedroom in the home and did not hear anything. She stated when she came out of the room, Resident A was on the ground crying and Ms. Weatherby was standing over him smiling. She stated she did not know what happened, but she believes Ms. Weatherby likely used the stun gun on Resident A. She denied knowing why it was reported she witnessed the incident because she did not. She denied seeing marks or bruises on or witnessing abuse to Resident A prior to this incident.

Mr. Barigye reported Resident A does not need physical management. He reported due to Resident A’s diagnosis of Down syndrome, Resident A is not very strong and although he will grab hair or hands or arms, he can easily be redirected without using force and usually just by talking to him. He denied witnessing any marks or

bruises on Resident A or any concerns for Resident A being abused. He reported if he saw injuries or suspected abuse, he would complete an IR and notify management.

On 1/24/24, I exchanged emails with Ms. Divis and Ms. Simpson who reported there has been no additional information from LE and their report was not received due to their investigation not being completed. It was also reported that Ms. Weatherby was no longer providing direct care but was listed as an employee so she could be held accountable for interviewing should she not voluntarily cooperate.

On 1/31/24, I received photographs from Mr. Pehur at APS. The photographs were taken by Ms. Simpson on 12/27/23. The photographs show circular marks the size and shape of pencil tip erasers approximately one inch apart in approximately 10 locations on Resident A's body. The marks looked to be in various stages of healing with some being bright red, some being dull red, and others appearing as circular bruising. Mr. Pehur denied having additional medical information regarding Resident A.

On 1/31/24, I completed a Google search for "stun gun marks." The image results showed photographs of injuries identical to the marks found on Resident A's body.

On 2/1/24, I completed a telephone interview with Ms. Weatherby. She stated on the day of the alleged incident, it was a "typical day." She stated a typical day is when Resident A will have behaviors for hitting and pushing other residents in the home. She stated although Resident A will hit and push, he does not need physical management. She stated he can be verbally redirected, and no one needs to use force to manage his behaviors. She stated, "nothing happened that day" and she was glad to be speaking to me because she is hopeful to "get back to work." I advised these allegations were very serious and very specific to have been fabricated. In addition, there being marks consistent with a stun gun injury found on Resident A. She stated she showered Resident A that day and did not witness any marks on him, so she has "no idea" where those marks came from or if he even had marks because she had never seen them. She stated she believes this was reported because someone was jealous of her. She denied having any additional information.

On 2/1/24, I interviewed Ms. Parker by telephone. She stated the day of the incident was a "regular day" and Resident A was having routine behaviors including knocking things off the walls and attempting to knock over the Christmas tree in the home. Ms. Parker stated she was preparing lunch in the kitchen, while Ms. Johnson was standing at the kitchen counter which overlooks the dining room. She stated Ms. Weatherby was in a separate room but later came out into the dining room. She stated when Ms. Weatherby came out, she showed her and Ms. Johnson that she had a "taser" which she had purchased "half off at the hair store" and advised Ms. Johnson and Ms. Parker they should get them as well since they were on sale. She stated Ms. Weatherby then turned the taser on and began pressing the buttons.

Ms. Parker stated Resident A then attempted to push the Christmas tree over again and Ms. Weatherby walked over to him with the taser on and in her hand. She stated Ms. Weatherby stated, “I’m about to tase him,” and began pressing the taser, “tagging” him, multiple times. She stated Resident A dropped to the ground and Ms. Weatherby stood over him. She stated she looked at Ms. Johnson who was still standing at the counter and Ms. Johnson looked back at her in shock. She stated she ran over to Resident A and said to Ms. Weatherby, “Look what you did! You left bruises on his body.” She stated Ms. Weatherby seemed shocked that she had left marks on Resident A and stated she was going to give Resident A a shower.

Ms. Parker stated she was extremely upset by what she witnessed and had to step outside. She stated when she came back inside, Ms. Weatherby had finished quickly showering Resident A and she observed there were still red circular marks, the size of the pencil tip eraser, approximately one inch apart on Resident A’s arms. Ms. Parker stated she had not noticed marks like these on Resident A before. She stated Resident A regularly had bruising, but it was because when he becomes upset, he will “death drop” which is dropping all his weight to the floor. She stated she did notice that Resident A seemed to be fearful of when she got up or moved quickly more recently but she did not understand why until this incident.

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: **(i) Any electrical shock device.**
ANALYSIS:	Interview with Ms. Parker and review of the IR regarding this incident revealed Ms. Weatherby had a stun gun in the home on the day of the incident and seemingly used it on Resident A multiple times. Ms. Johnson acknowledged she knew Ms. Weatherby had a stun gun in the home and believed she used it on Resident A, although she denied witnessing it. Marks on Resident A’s body, in various stages of healing, consistent with marks left by a stun gun were photographed by ORR and reviewed by me.

	Based on the interviews completed and photographs observed, there is sufficient evidence that Ms. Weatherby used an electrical shock device on Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/8/24, I exchanged emails with Ms. Divis discussing the findings of my investigation and the rule cited.

III. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

Cassandra Duursma 2/12/24

Cassandra Duursma Date
Licensing Consultant

Approved By:

Russell Misiak 2/12/24

Russell B. Misiak Date
Area Manager