GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 15, 2024

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

RE: License #: AS410316524
Investigation #: 2024A0467021
Kingdom Home AFC

Dear Mrs. Payne:

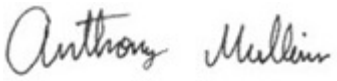
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS410316524
Investigation #:	2024A0467021
Complaint Receipt Date:	02/21/2024
Investigation Initiation Date:	02/22/2024
Report Due Date:	04/21/2024
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:	Kingdom Home AFC
Facility Address:	2975 52nd Street SE Kentwood, MI 49512
Facility Telephone #:	(616) 554-2226
Original Issuance Date:	03/20/2012
License Status:	REGULAR
Effective Date:	07/27/2022
Expiration Date:	07/26/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A had a bruise on her back and her feeding tube (j-tube) was pulled out. It is unknown how both incidents occurred.	No
Additional Findings	Yes

III. METHODOLOGY

02/21/2024	Special Investigation Intake 2024A0467021
02/21/2024	APS Referral Complaint received from Kent County APS
02/22/2024	Special Investigation Initiated - Telephone
02/26/2024	Inspection Completed On-site
04/15/2024	Exit conference completed with licensee designee, Delissa Payne

ALLEGATION: Resident A had bruises on her back and her feeding tube (j-tube) was pulled out. It is unknown how both incidents occurred.

INVESTIGATION: On 2/21/24, I received a BCAL online complaint from Kent County Adult Protective Services (APS). The complaint alleged that on 2/13/24, Resident A had a bruise on her back that resembled a “rug burn.” The injury was reportedly in an area that Resident A would be unable to inflict upon herself during behavioral episodes, which she is known to have. The complaint also alleged that Resident A’s feeding tube (j-tube) was pulled out on 2/17/24 and it is unknown how this occurred. The complaint alleged that a week prior, Resident A had “scrape on her face” and it is unknown how this occurred.

On 2/22/24, I spoke to Emily Graves, assigned Kent County APS worker. Mrs. Graves stated that she forwarded the complaint to law enforcement. It is unknown if the case will be assigned to a detective. Mrs. Graves stated that she went to the facility this past Saturday to see Resident A. Mrs. Graves was informed that Resident A was at Butterworth Hospital due to behavioral concerns, and she discharged home. Shortly after discharging from the hospital, Resident A returned to Butterworth hospital for additional care because of her increased behavioral concerns. While at the hospital, Mrs. Graves stated that Resident A was hitting herself in the face, leading to her being sedated by the medical team. Mrs. Graves stated that she observed Resident A in soft restraints while at the hospital. Mrs. Graves stated that the previous house manager, Charlena Garrison has a picture of the bruise to Resident A’s back and she will send me a copy of it. Mrs. Graves stated that Resident A had marks on her face as well as near her eye, where she reportedly holds a portable speaker on her face/cheek bone while listening to music.

It should be noted that Resident A is unable to be interviewed due to being non-verbal.

Based on Mrs. Graves conversation with the former house manager, Ms. Garrison, it is believed that 3rd shift staff member, Heaven Amandou, may have caused the injury to Resident A. Mrs. Graves stated that it was relayed to her that Ms. Amandou "gets easily frustrated with (Resident A) and verbally combative when (Resident A) frustrates her." Mrs. Graves shared that Resident A is restricted as her hands are typically clinched. Mrs. Graves stated that Ms. Garrison shared that she does not believe that Resident A has the strength to cause the injuries to herself. Mrs. Graves shared that the facility has incident reports associated with both incidents on 2/13/24 and 2/17/24. Mrs. Graves sent me the picture of Resident A's back/right side rib area, which appeared to have a rug burn mark on it as she indicated. Mrs. Graves and I agreed to meet at the home on 2/26/24 to complete a joint investigation.

On 2/26/24, Mrs. Graves and I made an unannounced onsite investigation at the facility. Upon arrival, AFC staff members Shalonda Edmonds and Tabitha Hollis allowed entry into the home. Ms. Edmonds agreed to be interviewed first regarding the allegations. Mrs. Graves and I interviewed Ms. Edmonds privately on the back patio. Regarding Resident A's feeding tube being pulled out, Ms. Edmonds stated that when she arrived to work on 2/17/24, staff informed her that Resident A's feeding tube came out. Resident A was taken to the hospital to have the feeding tube put back in place. Ms. Edmonds stated that Resident A has been at the home since November 2023 and to her knowledge, Resident A has never pulled out her feeding tube.

Regarding the reported injury to Resident A's back, Ms. Edmonds stated that she believed it occurred prior to Resident A's feeding tube being pulled out. However, she did not have a specific date. Ms. Edmonds stated that when she observed the injury to Resident A's back. It appeared to be a carpet burn as if someone "dragged" her on the rug. Ms. Edmonds stated that the day prior to Resident A having a rug burn to her back, she changed her and didn't notice any marks or bruises. Ms. Edmonds stated that Resident A is mobile and able to get up and move about on her own. However, she has never witnessed Resident A fall. Ms. Edmonds stated that she is unsure as to who observed the injury to Resident A's back first, but AFC staff member Heaven Amandou told her to check Resident A's back, which is when she observed the bruise.

Ms. Edmonds discussed known behavioral concerns with Resident A and stated, "she has her days. Sometimes she's emotional and other days she's cracking up," referring to her laughing. Ms. Edmonds confirmed that Resident A has a history of punching/hitting herself in the face, as well as others. Ms. Edmonds also confirmed that Resident A had a mark on her face near her left eye from her Bluetooth speaker rubbing against her face. Ms. Edmonds stated that this is a typical behavior of Resident A. It should be noted that I observed Resident A lying on the couch with the Bluetooth speaker pressed against her face while listening to loud music. Ms.

Edmonds stated that Resident A's behaviors are on and off, depending on the day. Ms. Edmonds showed me communication logs that are completed for Resident A where staff indicate if toileting and showering is occurring for Resident A. On 2/13/24, staff indicated that "she has bruises on her face and right side hips." On 2/17/24, the communication log states, "tube feeding came out." The logs do not indicate the staff members' names. However, Ms. Edmonds stated that the writing appeared to be Ms. Amandou's handwriting.

Mrs. Graves and I then interviewed AFC staff member, Tabitha Hollis privately in the staff's office. Ms. Hollis stated that she was not working when Resident A's feeding tube came out and she has no knowledge as to how it occurred. However, staff informed her that Resident A was sent to the hospital to fix the feeding tube. Ms. Hollis stated that according to Resident A's behavioral plan and Individualized plan of service (IPOS), she is known to pull out her feeding tube. Resident A's behavioral plan was observed and confirmed that she has a history of "mouthing" her feeding tube, which is likely to cause damage to the tube.

Regarding the rug burn on Resident A's back, Ms. Hollis stated that she didn't notice any marks or bruises on Resident A. If Ms. Hollis were to notice any, she was adamant that she would have reported it. It should be noted that Ms. Hollis was unable to provide an exact date, but she believed it to be the weekend prior to this past Sunday when Resident A was free of any marks or bruises. Sometime after the mark occurred, Ms. Hollis stated that Ms. Amandou informed her and another colleague that Resident A had a mark on her back. Ms. Hollis stated that Ms. Amandou worked the night prior to showing the bruise on Resident A's back. Ms. Hollis is unsure if Resident A is capable of causing the bruise on her back by herself. Ms. Hollis stated that Resident A does crawl, but she has never witnessed her fall. Ms. Hollis stated that Resident A is mostly steady when moving throughout the home.

There was also a mark or bruise by Resident A's eye/check that was red/pink in color. Ms. Hollis stated that Ms. Amandou also informed her of the bruise to Resident A's eye area. Ms. Hollis added that Resident A does use a Bluetooth speaker that she presses against both sides of her face (mostly left side) while listening to music. Ms. Hollis stated that Resident A does this often and this is the first time that it has left a mark.

On 2/26/24, I spoke to Sam Johnson, Program Administrator for the facility. Ms. Johnson stated that she has Incident Reports for the allegations listed above and she will send them to me. Ms. Johnson stated that the mark on Resident A's face and on her back appear to be rug burn texture. However, it was never officially determined how the mark on Resident A's back occurred. Ms. Johnson stated that the mark on Resident A's face was caused by a Bluetooth speaker that she holds against her face often while listening to music. Ms. Johnson stated that the previous manager, Ms. Garrison was concerned that staff didn't document appropriately regarding the marks on Resident A's body, so everyone would know exactly where

they're coming from. Due to this, disciplinary action was taken with staff. A staff meeting was held and all expectations and requirements for Chassidy were reviewed.

Regarding Resident A's feeding tube, Ms. Johnson stated that Resident A has a long history of her feeding tube coming out and needing to be replaced. Per Ms. Johnson, there did not appear to be a preceding event that led to the feeding tube coming out. Ms. Johnson confirmed that Resident A was taken to the hospital to have the issue addressed.

I reviewed the Incident Reports for Resident A on 2/17/24 and 2/12/24. On 2/17/24, AFC staff member, Heather Amandou completed an Incident Report stating that Resident A's feeding tube was "almost out" during her scheduled feeding at 6:00 am. The feeding tube eventually came out and she covered it with a gauze sponge and notified her supervisors. Staff were educated on what to do if the feeding tube comes out. Resident A was transported to the hospital to place the j-tube back in place. She was then taken to the emergency department due to self-injury behaviors.

On 2/17/24, Ms. Garrison also completed an incident report stating that she transported Resident A to the hospital to have her feeding tube (j-tube) replaced. The feeding tube was replaced without incident. However, prior to discharging, Resident A "began to hit her face with a closed fist aggressively" while in her wheelchair. Resident A "then punched herself with her right wrist and her lower lip began to bleed." Ms. Garrison assisted Resident A to the emergency department where she continued hitting herself, leading the hospital staff to place her in soft restraints and giving her PRN Ativan. Resident A was admitted to the hospital on this night due to her heart rate being low due to the medication.

On 2/12/24, Ms. Amandou completed an Incident Report stating that she went to change Resident A in her bedroom and noticed that she had a "big bruise" on her right side under her hips and notified the supervisor. Ms. Garrison reached out to staff on the previous shift and they confirmed that Resident A did not have any behaviors that may have caused a bruise. Ms. Garrison came to the home the following morning and noted that the bruise was not on Resident A's side. Instead, it was an abrasion that "appeared to look and feel like a rug burn because it was sensitive to touch" for Resident A. The abrasion was also red and scabbing. Ms. Garrison cleaned the abrasion and put antibiotic ointment on it and a gauze to cover it. She also reminded Ms. Amandou to complete all documentation regarding the abrasion/bruise.

On 3/11/24, Kent County APS worker Mrs. Graves informed me that she spoke to AFC staff member, Ms. Amandou regarding the allegations and she denied knowing how Resident A sustained the mark/bruise on her back. Ms. Amandou told Mrs. Graves that Resident A's feeding tube falls out "all the time" and due to this, it has to be replaced quarterly. Mrs. Graves stated that program administrator, Ms. Johnson

supported Ms. Amandou's statement that the injuries that Resident A sustained were more than likely self-inflicted. Mrs. Graves did not substantiate for physical abuse as there was no direct evidence to indicate that a specific staff member caused the injury to Resident A.

On 04/15/24, 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:	Ms. Edmonds, Ms. Hollis, and Ms. Johnson each denied knowledge regarding how Resident A could have sustained the bruise to her back/rib area. All involved parties consistently stated that the bruise on Resident A's face was a result of her pressing a Bluetooth speaker on her face daily, which I observed in the home. APS interviewed 3rd shift staff member, Heaven Amandou and she denied any knowledge as to how Resident A sustained the injury to her back. Ms. Amandou confirmed the injury to Resident A's face is due to her pressing a Bluetooth speaker to her face. Documentation was reviewed confirming that Resident A has a history of causing issues with her feeding tube. Staff responded appropriately by taking Resident A to the hospital to have the feeding tube fixed. Based on the information provided throughout the investigation, there is not a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: While investigating the allegations listed above on 2/26/24, it was noticed that Resident A was wearing wrist weights and she was unable to use her hands due to her shirt sleeves being tied together, restricting her movement. It should be noted that Resident A was calm and did not appear to be bothered by her hands being restricted. However, this is still a restraint if a physician has not

authorized this. Ms. Edmonds stated that Resident A's hands were restricted when she arrived to work today, and this is the first time she has witnessed this. Ms. Edmonds stated that Ms. Amandou and Ms. Mugiraneza worked last night with Resident A. Ms. Hollis stated that Resident A's hands were restricted this past weekend as well. Staff were unable to confirm if this was authorized by anyone.

On 2/26/24, I spoke to Sam Johnson, Program Administrator for the facility. I informed Ms. Johnson of the weights on Resident A's wrist and her shirt sleeves being tied together, causing her hand movement to be restricted. Ms. Johnson stated that Resident A's shirt sleeves being tied together was not authorized by anyone and confirmed that it needs to be removed immediately. Ms. Johnson informed me that she called the staff at the facility and relayed this information to them as well.

Regarding the wrist weights, Ms. Johnson stated that Resident A was recently hospitalized for a few days. While at the hospital, Resident A engaged in self-injury behaviors, resulting in her being placed in soft restraints. Ms. Johnson stated that whenever the restraints were removed in the hospital, Resident A would start harming herself (hitting) again to be placed back into restraints. Ms. Johnson stated that the AFC was trying to find a less restrictive replacement to get Resident A to baseline to get her discharged from the hospital. Ms. Johnson stated that the previous home manager, Ms. Garrison had purchased the weighted bracelets as a replacement to the soft restraints in the hospital. The weighted bracelets were successful, so the AFC planned to see if they could make a case at Resident A's next doctor's appointment on 3/5/24 to have the weighted bracelets added to her order for self-soothing. Ms. Johnson stated that Resident A also has a weighted blanket that she likes to use. I informed Ms. Johnson that this practice is to stop immediately unless an order is provided by Resident A's doctor. Ms. Johnson did not know which staff member tied Resident A's shirt sleeves together, but she believes it to have occurred on 3rd shift for this particular incident. Per Ms. Johnson, AFC staff members Heaven Amandou and Gentille Mugiraneza worked 3rd shift last night.

On 04/15/24, 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 400.14308	**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: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.**

	(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident. **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.** **(e) Withhold food, water, clothing, rest, or toilet use.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.** **(g) Refuse the resident entrance to the home.** **(h) Isolation of a resident as defined in R 400.14102(1)(m).** **(i) Any electrical shock device.**
ANALYSIS:	I observed Resident A with wrist weights on, while also having her shirt sleeves tied together, restricting movement of her hands. Despite Resident A appearing to be content with this, this is considered a restraint. Program Administrator Ms. Johnson confirmed that neither practice was approved by a doctor. Therefore, there is a preponderance of evidence to support this allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegations listed above, I observed Resident A's most recent assessment plan was signed on 12/30/22 by her guardian. Per AFC licensing rules, this form is required to be completed annually.

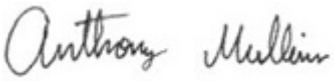
On 04/15/24, I conducted an exit conference with licensee designee, Delissa Payne. She was informed of the investigative findings and agreed to complete a CAP within 15 days of receipt of this report.

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:	Resident A's assessment plan was outdated by 4 months. Therefore, a preponderance of evidence exists 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.



04/15/2024

Anthony Mullins Date
Licensing Consultant

Approved By:

04/15/2024

Jerry Hendrick Date
Area Manager