GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 19, 2024

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

RE: License #: AS630397254
Investigation #: 2024A0993013
Leidich Home

Dear Mrs. Difazio:

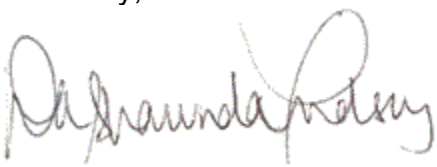
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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 (248) 975-5053.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630397254
Investigation #:	2024A0993013
Complaint Receipt Date:	03/01/2024
Investigation Initiation Date:	03/01/2024
Report Due Date:	04/30/2024
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:	Leidich Home
Facility Address:	1087 Leidich Lake Orion, MI 48362
Facility Telephone #:	(248) 693-4957
Original Issuance Date:	06/18/2019
License Status:	REGULAR
Effective Date:	06/14/2022
Expiration Date:	06/13/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED

II. ALLEGATION(S)

	Violation Established?
The facility is refusing to accept Resident A back from the hospital.	Yes

III. METHODOLOGY

03/01/2024	Special Investigation Intake 2024A0993013
03/01/2024	Special Investigation Initiated - Telephone Telephone call made to Trinity Health Emergency Social Worker. Left a message.
03/01/2024	Contact - Document Received Received an incident report (IR) and discharge notice
03/05/2024	Contact - Telephone call made Telephone call made to Trinity Health Emergency Social Worker Allison Gittleman. Left a message.
03/05/2024	Referral - Recipient Rights Forwarded allegations to recipient rights advocate Rishon Kimble
03/06/2024	Inspection Completed On-site I conducted an unannounced onsite investigation
03/06/2024	Contact - Telephone call made Telephone call made to recipient rights advocate Rishon Kimble. Left a message.
03/06/2024	Contact - Telephone call made Telephone call made to Trinity Health Emergency Social Worker Allison Gittleman. Left a message.
03/06/2024	Contact - Face to Face Interviews at Trinity Health Emergency Department
03/21/2024	Contact - Telephone call made Telephone call made to Trinity Health Emergency Social Worker Beata Jedrzejczyk

03/21/2024	APS Referral Forwarded allegations to adult protective services (APS)
03/21/2024	Contact - Telephone call made Telephone call made to Resident A's guardian's paralegal
03/21/2024	Contact - Telephone call made Telephone call made to Resident A's case manager
03/21/2024	Contact - Telephone call made Telephone call made to licensee designee Janet Difazio
03/21/2024	Exit Conference Held with licensee designee Janet Difazio

ALLEGATION:

The facility is refusing to accept Resident A back from the hospital.

INVESTIGATION:

On 03/01/2024, I received the allegations from Bureau of Child and Adult Licensing (BCAL) Online Complaints.

03/01/2024, I received an emergency discharge notice dated 02/29/2024. Resident A was discharged due to self-destructive behavior, serious physical assault, destruction of property, and for the safety of others in the home and the community.

On 03/06/2024, I conducted an unannounced onsite investigation. I interviewed staff Leah Plummer. Ms. Plummer verified Resident A was sent to the hospital from the facility. Ms. Plummer did not know Resident A's whereabouts, but she confirmed Resident A was no longer a resident in the facility.

On 03/06/2024, I interviewed Resident A at Trinity Health Emergency Department. Resident A stated she was only in the facility for one day prior to being sent to the hospital. Per Resident A, when she arrived at the facility, she felt she was being crowded by another resident. The resident was following her and she did not like it. She told the resident to stop. Staff told the resident to stop. Resident A stated the resident liked her, but she did not like him. Resident A stated she went outside because she wanted to vape. Resident A did not have a vape in the facility. She became upset and ran away twice. Resident A also stated she tried to attack staff with a knife because

staff made her angry prior to going to the hospital. Resident A could not recall the name of that staff. Staff called the police and she was transported to the hospital. Resident A stated she has been in the hospital since that incident. She could not recall the date of the incident. The facility is refusing to pick her up.

While at the emergency room, I interviewed Trinity Health Emergency Social Worker Allison Gittleman. She stated Resident A was transported to the hospital by police, on or around 02/29/2024, after allegedly trying to hit someone in the home and grabbing a knife. Resident A was also threatening to cut herself. Resident A is medically cleared to discharge, but the facility is refusing to pick up Resident A. Resident A's guardian and case manager are aware of the situation. They are actively looking for another placement for Resident A.

On 03/21/2024, I conducted a telephone interview with Trinity Health Emergency Social Worker Beata Jedrzejczyk. She stated Resident A was still at the emergency department waiting for placement.

On 03/21/2024, I conducted a telephone interview with Resident A's guardian's paralegal. She stated she was aware the facility was refusing to pick up Resident A. Resident A was only at the facility for a couple of hours before being transported to the hospital. An emergency discharge notice was issued after Resident A was already at the emergency department. Per Resident A's guardian's paralegal, Resident A would have been allowed to return to the facility if the facility had not refused to pick her up.

On 03/21/2024, I conducted a telephone interview with Resident A's case manager. She stated she was aware the facility was refusing to pick up Resident A. She was also notified of the discharge notice. She has not made progress with finding a suitable placement for Resident A.

On 03/21/2024, I conducted a telephone interview with licensee designee Janet Difazio. She confirmed Resident A cannot return to the facility. An emergency discharge notice was issued. She conducted an exit meeting with Macomb County Mental Health, TTI and others and it was decided it was not safe for Resident A to return to the facility. Ms. Difazio denied abandoning Resident A at the hospital. Ms. Difazio stated she was never informed of Resident A's behaviors. She did not receive an Individual Plan of Service (IPOS) for Resident A. Resident A needs 1:1 staffing. Ms. Difazio stated Resident A could not return without 1:1 staffing. Macomb County was supposed to seek a more suitable placement for Resident A.

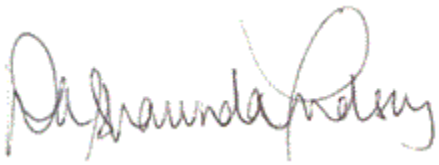
On 03/21/2024, I conducted an exit conference with licensee designee Janet Difazio. I informed her of the findings. She agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(4) A licensee may discharge a resident before the 30-day notice when the licensee has determined and documented that any of the following exists: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home.** **(b) Substantial risk, or an occurrence, of self-destructive behavior.** **(c) Substantial risk, or an occurrence, of serious physical assault.** **(d) Substantial risk, or an occurrence, of the destruction of property.**
ANALYSIS:	An emergency discharge notice was issued to Resident A on 02/29/2024 due to self-destructive behavior, serious physical assault, destruction of property, and for the safety of others in the home and the community.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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 was sent to the hospital on or around 02/29/2024. She was medically cleared, but the facility refused to pick her up.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

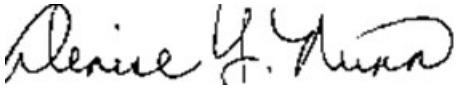
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



04/11/2024

DaShawnda Lindsey Date
Licensing Consultant

Approved By:



04/19/2024

Denise Y. Nunn Date
Area Manager