GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 28, 2024

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

RE: License #: AS410356636
Investigation #: 2024A0467057
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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

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 #:	2024A0467057
Complaint Receipt Date:	08/29/2024
Investigation Initiation Date:	08/29/2024
Report Due Date:	10/28/2024
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?
On 8/27/24, Staff member Ahmed Jibril used excessive force while working with Resident A.	No
Additional Finding	Yes

III. METHODOLOGY

08/29/2024	Special Investigation Intake 2024A0467057
08/29/2024	Special Investigation Initiated - Letter Via email with Recipient Rights Officer, Mike Kuik
08/29/2024	Contact – telephone call received from licensee designee, Delissa Payne.
09/05/2024	Inspection Completed On-site
09/09/2024	Contact – telephone call made to Resident A's guardian.
09/11/2024	Contact – documents received from Spectrum Community Services
10/28/2024	APS Referral
10/28/24	Exit conference with licensee designee, Delissa Payne.

ALLEGATION: On 8/27/24, staff member Ahmed Jibril used excessive force while working with Resident A.

INVESTIGATION: On 8/29/24, I received a complaint from Recipient Rights Officer, Mike Kuik. The complaint alleges that AFC staff member, Ahmed Jibril used excessive force while working with Resident A on 8/27/27. As a result of the incident, Resident A reportedly sustained an injury to his right pinky finger. Mr. Kuik sent me a picture of Resident A's pinky, which appeared to be bruised and swollen.

Mr. Kuik also provided me with a copy of the incident report, which was completed by AFC staff member, Erin Ganley. I reviewed the incident report, and it indicated that Resident A's Support Coordinator, Karen Irving was in the home and reported that Resident A had been physical with Mr. Jibril and "they were going rounds." This incident started because Resident A was upset that the power was out and his fan and lights in his room were not working. Ms. Ganley stated that Ms. Irving left the home and Mr. Jibril was attempting to help Resident A settle down. Ms. Ganley reported that when AFC staff member, Kamala Petters arrived at the home,

Resident A came out of his room and Mr. Jibril was “grabbing (Resident A) by the arms and hands and trying to drag him back to his room.” Ms. Ganley stated that she and Ms. Peters both told Mr. Jibril that he needed to let Resident A go and that he couldn’t grab him that way. This reportedly caused Resident A to become upset and he “spun around to swing, punch, and hit (Mr. Jibril).” Resident A then went back to his room. Ms. Ganley then took Resident A with her to pick-up pizza and when he grabbed her hand, she noticed that “his right pinky finger was bruised and swelling.”

On 8/29/24, I spoke to licensee designee, Delissa Payne regarding the allegations. She informed me that Resident A’s Support Coordinator was present at the home and provided a different explanation as to what occurred. However, she confirmed that Resident A was sent to urgent care the following day and it was determined that he has a fracture in his right pinky finger. Mrs. Payne agreed to send me Mr. Jibril’s statement once obtained.

On 8/29/24, Recipient Rights Officer, Mr. Kuik provided me with a written statement from AFC staff member, Kamala Peters. Ms. Peters was reportedly present during the incident. The statement from Ms. Peters indicated that she arrived at the home and was informed that Resident A was concerned that the home had no power. Ms. Peters stated that Mr. Jibril came out of Resident A’s room and Resident A was following staff around while asking for his light to be turned on, in addition to his computer/laptop. Ms. Peters stated that Resident A was sweating due to the home being without power. Ms. Peters stated that Resident A “appeared towards (Mr. Jibril) very aggressively.” Mr. Jibril reportedly redirected Resident A to his room. Ms. Peters then stated that after Mr. Jibril left the home, “the staff that worked with him showed me a picture of (Resident A’s) hand. She asked me did I see what happened and I told her I didn’t see what happened.”

On 8/29/24, I informed Mr. Kuik that Resident A's supports coordinator, Karen Irving was present for the reported incident and provided a different explanation as to what occurred. Mr. Kuik then provided me with a written statement from Ms. Irving, confirming that her explanation tells a different story from Ms. Ganley. Mr. Kuik noted that Ms. Irving left the home at 5:00 pm, and the incident between Resident A and Mr. Jibril reportedly occurred at 5:30 pm per the incident report.

I reviewed the statement provided by Ms. Irving, which indicates that Resident A was physically aggressive towards Mr. Jibril by “grabbing, pulling, pushing, pinching and trying to bite at (Mr. Jibril). Ms. Irving stated that this incident stemmed from the home not having power and Resident A not having access to his laptop. Despite Resident A being physically aggressive with Mr. Jibril, Ms. Irving observed Mr. Jibril using a calm voice while trying to de-escalate Resident A. She also observed Mr. Jibril stating, “nice hands” to Resident A while blocking Resident A from grabbing at him. Ms. Irving spoke highly of Mr. Jibril’s de-escalation skills.

On 9/5/24, I made an unannounced onsite investigation at the facility. Upon arrival, staff answered the door and allowed entry into the home. Acting home manager, Heather Heldt agreed to discuss the allegations in the basement office. Ms. Heldt confirmed that per Resident A's after visit summary (AVS) from Trinity Health Emergency room, he does have a fracture in his right pinky finger. I was able to verify this after reviewing Resident A's AVS dated 8/28/24. Ms. Heldt stated that AFC staff member, Ahmed Jibril was working at the home 3-4 weeks prior to the incident occurring. Ms. Heldt stated that AFC staff member, Bre Hartman had an appointment in the afternoon, and she was approved to leave by management. Per Ms. Heldt, Mr. Jibril was the only AFC staff at the home from approximately 2:00pm to 4:30 pm prior to AFC staff member, Erin Ganley arriving at the home. It should be noted that Resident A's support coordinator, Karen Irving was also at the home during this incident.

Ms. Heldt stated that when Ms. Ganley arrived, Resident A was having an outburst due to the power being out and the fan in his room not working. Ms. Heldt stated that she instructed staff to use the hotspot so Resident A could have access to the internet. Ms. Heldt was not at the home during the incident, so she is unsure if staff were able to get the hotspot working. Ms. Heldt stated that Ms. Irving left the home at 5:00 pm and informed her that Resident A was "chasing (Mr. Jibril) around" and he was given his PRN CBD oil. Ms. Heldt stated that Ms. Ganley called her around 5:20pm – 5:30pm to inform her that Mr. Jibril held Resident A's door shut and "led him down the hallway" by his hand. Ms. Ganley reportedly told Mr. Jibril that he couldn't do that. Ms. Heldt stated that AFC staff member, Kamala Peters arrived at the home minutes later and Ms. Heldt instructed Ms. Ganley to send Mr. Jibril home. Ms. Heldt denied speaking to Ms. Peters regarding the incident. Ms. Heldt stated that in her time working with Mr. Jibril, she has not had any issues with how he provides care to residents.

Ms. Heldt stated that Resident A went to urgent care the following day due to vomiting. While there, staff had them assess the bruising to his right pinky, where it was determined that he fractured it. It should be noted that Resident A does have osteoporosis, which has been verified in past investigations by his mother and medical records.

On 9/9/24, I spoke to Diane Simons, mother of Resident A via phone. Mrs. Simons stated that approximately two weeks ago, Resident A was throwing up and the manager called her and said they wanted to take him into the hospital to make sure nothing was wrong, and Mrs. Simons approved this. While in the emergency room, Mrs. Simons saw via Resident A's Mychart that an x-ray was ordered for a possible fracture of his finger. Mrs. Simon's stated that AFC staff member, Kayla Bucholz stated that she noticed the swelling on Resident A's finger on the morning that he was taken to the ER for vomiting. Mrs. Simons stated that AFC staff member Linda Schumaker was aware of Resident A's finger swelling but never relayed this information to her. Mrs. Simons stated that if Resident A wasn't vomiting, it is unknown if his finger would have ever been addressed appropriately. Resident A

now has a splint on his finger, and Mrs. Simons followed-up with his doctor, who confirmed that he doesn't need to be seen in person. Instead, his finger can be "buddy taped to the other finger."

Mrs. Simons confirmed that Resident A's supports coordinator, Karen Irving called her last week when the home lost power and informed her that Resident A was being aggressive to Mr. Jibril. Mrs. Simons stated that she also spoke to associate director, Jordan Walch regarding this incident. Regarding Mr. Jibril, Mrs. Simons stated that he was the first male staff person who "bonded well" with Resident A. Mrs. Simons stated that Resident A loved Mr. Jibril as well and he did a great job of caring for him. Mrs. Simons stated that Ms. Irving was there for the entire incident, and she helped managed the situation. Mrs. Simon stated that so many things could have been avoided with this if Resident A had gotten his CBD oil a little sooner when the power was out. Mrs. Simon stated that Ms. Irving was texting her during the incident, which she was appreciative of. Despite not being in the home to witness the incident, Mrs. Simon denied any concerns regarding Mr. Jibril and spoke highly of his interactions with Resident A. In fact, Mrs. Simons stated that she was sad when she found out that Mr. Jibril would no longer be working at the home. Mrs. Simons stated that she doesn't think that anyone would purposefully hurt Resident A and acknowledged that it is possible that he sustained the broken pinky finger by hurting himself when he was attacking Mr. Jibril.

It should be noted that Mr. Jibril's statement was received from associate director, Jordan Walch. Mr. Jibril did not disclose using any form of physical force against Resident A.

On 10/28/24, 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:	AFC staff member Ms. Granley reported that she observed Mr. Jibril grab Resident A by his hands and attempt to drag him down the hall. AFC staff member Ms. Harris and Resident A's Support Coordinator, Ms. Irving wrote statements regarding what they observed, and neither of them observed Mr. Jibril using excessive force against Resident A. Therefore, there is not a preponderance of evidence to support this applicable rule.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: While investigation the allegation above, it was brought to my attention that Resident A did not receive his PRN (as needed) CBD oil when requested. On 10/9/24, I spoke to Resident A's mother, Mrs. Simon via phone. Mrs. Simon stated that this past weekend (9/8/24), Resident A requested his CBD oil from staff member Kerline Francois and she told him he could not have it since it was only for the morning and nighttime, despite it being a PRN. Mrs. Simons stated that this is a big deal for Resident A to ask for this, considering his limited language. Mrs. Simons stated that the CBD oil helps prevent some of the negative behaviors he can have. Ms. Simons stated that she spoke to Ms. Francois via phone and she confirmed that she did not give him the medication. After the phone call, the medication was not given to Resident A since he was reportedly sleeping.

On 9/9/24, I spoke to AFC staff member, Kerline Francois via phone. Ms. Francois confirmed that she worked at the AFC home yesterday (9/8/24). I informed Ms. Francois that I received an allegation that Resident A requested his CBD oil yesterday and he did not receive it due to her not knowing it was available as a PRN. Ms. Francois confirmed that Resident A requested his CBD oil yesterday. She also confirmed that she did not give him his CBD oil because she believed that his medication was already given to him in the morning. Ms. Francois confirmed that she had no knowledge that Resident A could receive the medication on an as needed basis. Ms. Francois stated that two hours after Resident A requested the medication, his mother called her and informed her that he could receive the medication when requested. Ms. Francois stated that he never received his CBD oil during her shift because he was asleep when his mother called to inform her.

On 9/10/24, I spoke to associate director, Jordan Walch via phone. Mrs. Walch stated that Ms. Francois informed her that she spoke to me regarding Resident A's CBD oil. Mrs. Walch stated that program, administrator, Linda Schumaker asked Ms. Francois about the CBD oil, and Ms. Francois stated that Resident A can only have it "so often". Ms. Schumaker confirmed this to be true, and Ms. Francois told her that Resident A's mother keeps telling her that he can have the PRN CBD oil whenever he requests it, which Mrs. Schumaker stated is not true. Mrs. Walch believe Resident A can have the CBD oil every 4 hours per his prescription. Mrs. Walch agreed to have Ms. Schumaker send me Resident A's MAR for the month of September. Mrs. Walch stated that Resident A receives his CBD oil as scheduled and PRN. Despite this, there is a limit on the amount he can receive.
On 9/11/24, I received a copy of Resident A's MAR for the month of September from program administrator, Linda Schumaker. The MAR indicated that Resident A is scheduled to receive Epidiolex Sol 100MG/ML (CBD oil) twice a day (8am and 8pm). The MAR also indicates that Resident A has CBD Oil 60MG PRN (as needed) every 4 hours, not to exceed 6 doses in a 24-hour period. The MAR confirmed that

Resident A has not receive his PRN CBD from 9/1/24 to 9/11/24, despite Ms. Francois confirming that Resident A requested the medication on 9/8/24.

On 10/28/24, 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 400.14312	**Resident medications**
	(2) Medication shall be given, taken, or applied pursuant to the label instructions.
ANALYSIS:	Ms. Francois confirmed that Resident A requested his PRN CBD oil on 9/8/24 and she did not administer it due to not being aware that he could receive the medication on an as needed basis, so long as it doesn't exceed his daily maximum amount. Due to this, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegations listed above, I reviewed Resident A's MAR and noted that Resident A's MAR was not initialed on 9/1/24 for the following medications: Calcum 600/400, Epidiolex Sol 100MG/ML, Fluoxetine Tab 20MG, Hydroxyz HCL Tab 50MG, Lamotrigine 25MG, 100MG & 200MG, Loratadine 10MG Tabs, Memantine Tab HCL 10MG, Multi Vitamin Tab, Omeprazole Cap 20MG, Probiotic Cap Formula, and Zonisamide 100MG Caps.

On 10/28/24, I conducted an exit conference with licensee designee, Delissa Payne. She was informed of the investigative findings and informed that a Corrective Action Plan is due within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14312	**Resident medications**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication** **(ii) The dosage**

	(iii) Label instructions for use **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Resident A's MAR was not initialed on 9/1/24 for multiple medications listed above. Therefore, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegation listed above, I reviewed an incident report from AFC staff member, Erin Ganley on 8/27/24. Ms. Ganley stated that she observed Mr. Jibril "using all of his weight to hold (Resident A's) bedroom door closed with (Resident A) trapped inside."

On 9/18/24, Recipient Rights Officer, Mike Kuik informed me that AFC staff member, Kamala Peters was interviewed by Dereka Seigel, Quality and Rights Specialist through Spectrum Community Services. During that interview, Ms. Peters disclosed that she observed Mr. Jibril "holding (Resident A's) door closed."

On 10/23/24, I reviewed Mr. Jibril's statement regarding the 8/27/24 incident. In his statement, Mr. Jibril stated that Resident A was "still mad for the fact that his room was very warm, he was sweating heavily, so he continued to fight me as I'm blocking him to stay in his room."

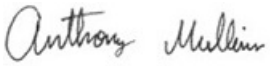
On 10/28/24, I conducted an exit conference with licensee designee, Delissa Payne. She was informed of the investigative findings and agreed to complete a corrective action plan within 15 days of receipt of this report.

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 director of the licensee, employees, or any person who lives in the home shall not do any of the following: **(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.**

ANALYSIS:	Ms. Ganley and Ms. Peters both confirmed that they observed Mr. Jibril holding Resident A's door closed while he was inside. Mr. Jibril also disclosed this as well. Despite Mr. Jibril trying to keep Resident A and other's safe, there is a preponderance of evidence to support this applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



10/28/2024

Anthony Mullins Date
Licensing Consultant

Approved By:

10/28/2024

Jerry Hendrick Date
Area Manager