GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 9, 2025
Joyce Divis
Spectrum Community Services
Suite 700 185 E. Main St
Benton Harbor, MI 49022

RE: License #: AS110067868
Investigation #: 2025A1030016
Lykins

Dear Mrs. 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.

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,

Nile Khabeiry, LMSW

Nile Khabeiry, 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 #:	AS110067868
Investigation #:	2025A1030016
Complaint Receipt Date:	12/20/2024
Investigation Initiation Date:	12/20/2024
Report Due Date:	02/18/2025
Licensee Name:	Spectrum Community Services
Licensee Address:	Suite 700 185 E. Main St Benton Harbor, MI 49022
Licensee Telephone #:	(734) 458-8729
Administrator:	Donna McBride
Licensee Designee:	Joyce Divis
Name of Facility:	Lykins
Facility Address:	1249 Lykins Lane Niles, MI 49120
Facility Telephone #:	(269) 684-2058
Original Issuance Date:	10/01/1995
License Status:	REGULAR
Effective Date:	05/24/2024
Expiration Date:	05/23/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff did not seek medical care for Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

12/20/2024	Special Investigation Intake 2025A1030016
12/20/2024	Special Investigation Initiated - Telephone Interview with the referral source
12/23/2024	Contact - Face to Face Interview with Resident A
12/23/2024	Contact - Face to Face Interview with Marie Rutebuka
12/23/2024	Contact - Document Received Reviewed Resident A's Assessment Plan
12/30/2024	Contact - Telephone call made Interview with Resident A's legal guardian
12/30/2024	Contact - Telephone call made Interview with Licensee Designee
01/02/2025	Contact - Document Received Received and reviewed Incident Report
01/07/2025	Contact - Telephone call made Interview with Christine Craig
01/07/2025	Contact - Telephone call made Interview with Emily Minor
01/08/2025	Exit Conference Exit conference by phone

ALLEGATION:

Staff did seek not medical care for Resident A.

INVESTIGATION:

On 12/20/24, I interviewed the referral source (RS) by phone. The RS reported it was reported to her that Resident A fell on the pavement and hit his head on 12/14/24. The RS reported Resident A seems to be less mobile since the fall and does not believe he was ever taken to see a doctor about the fall. The RS reported two staff members witnessed the fall and did not complete an Incident Report. The RS reported she did not actually witness the incident but believes the facility did not act appropriately.

On 12/23/24, I attempted to interviewed Resident A however he suffers from Dementia and was unable to fully understand my questions. Resident A was in a wheelchair and neat, clean and dressed appropriately.

On 12/23/24, I interviewed direct care staff member (DSCM) Marie Rutebuka. Ms. Rutebuka reported that Resident A stumbled getting out the facility van as he was being helped but did not fall to the ground. Ms. Rutebuka reported DCSM Christine Craig was also assisting Resident A. Ms. Rutebuka reported that Resident A kind of fell to the side of his wheelchair. Ms. Rutebuka denied Resident A was injured or needed any medical care. Ms. Rutebuka reported they went into the agency holiday party and Resident A had a good time.

On 12/23/24, I reviewed Resident A's Assessment Plan for AFC Residents (AP) dated 12/20/23. I noted the AP documented Resident A has a legal guardian but did not sign the AP. I also noted the AP was signed by Emily Miner who is not the administrator or the licensee designee and there was white out used in several locations on the AP that indicated the type of personal care needed by Resident A. The AP indicated Resident A uses a walker and a wheelchair but will also receive assistance if needed for mobility.

On 12/30/24 I interviewed Resident A's legal guardian (Tammy Dykstra) by phone. Guardian A1 reported she was not informed of any incident involving Resident A at the agency holiday party. Guardian A1 reported the facility does not do a good job of keeping her informed of what's going on with Resident A. Guardian A1 reported she does not know why Resident A's AP was not signed by her. Guardian A1 checked her email and noted she signed previous AP and the current AP and emailed the document back to the facility.

On 12/30/24, I interviewed licensee Joyce Divis by phone. Ms. Divis reported she was unaware of the investigation but was present at the agency holiday party that was held for the residents. Ms. Divis reported Resident A was also at the party and did not appear to be in any distress or physical pain. Ms. Divis reported she will speak with the DCSM at the facility and will send me the incident report if one was completed. Ms.

Divis denied knowing why Resident A's AP was not signed by the legal guardian or was overdue.

On 1/2/25, I received an IR from Ms. Divis regarding the incident with Resident A dated 12/13/24. The IR indicated Resident A was being assisted exiting the van and stumbled and landed on the right arm of his wheelchair but did not fall to the ground.

On 1/7/25, I interviewed DCSM Christine Craig by phone. Ms. Craig reported she was working on 12/13/24 and was inside the van while DCSM Marie Rutebuka was outside of the van standing next to Resident A's wheelchair. Ms. Craig reported Resident A stumbled a little bit but did not fall to the ground. Ms. Craig reported Resident A sat down on the arm of the wheelchair and then "slide" onto the seat of the wheelchair. Ms. Craig reported that she slipped on the ice and fell on the ground, but Resident A was never injured.

On 1/7/25, I interviewed Emily Miner by phone. Ms. Miner reported she was working on 12/13/24 but did not directly witness what happened with Resident A. Ms. Miner reported she was informed that Resident A stumbled but did not actually fall to the ground or injury himself. Ms. Miner reported she called Resident A's legal guardian and left her a message about the situation with Resident A but did not receive a return call. Ms. Miner was unable to explain why Resident A's AP was overdue other than she was on vacation and would have the updated AP in his file by the end of the week. Ms. Miner was unaware that she was not supposed to sign the AP and denied whiteout was used and was unable to explain why several areas of the AP looked as though white out was used to alter the document. Ms. Miner acknowledged the AP was not signed by the legal guardian and indicated Resident A's guardian did not sign and return it to the facility but denied that whiteout had been used. Ms. Miner was informed Resident A's guardian reported she signed the last one and the most recent one however neither one was in the resident file during the on-site investigation. Ms. Miner indicated that I could contact Resident A's guardian and ask her to send me the signed documents.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	It was alleged staff did not seek medical care for Resident A after a fall. Based on interviews and review of documentation this violation will not be established. Although the referral source reported Resident A fell, hit his head and was in need of medical attention the staff members who were involved in the incident denied that he fell to the ground or was injured. An incident report was completed which indicated Resident A

	stumbled while being assisted exiting the van but did not fall on the pavement therefore was not in need of medical attention.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 12/23/24, I reviewed Resident A Assessment Plan for AFC Residents (AP) and discovered the AP was overdue, not signed by Resident A's legal guardian or the administrator of the facility and that white out was used in several locations on the AP that indicated the type of personal care needed by Resident A.

APPLICABLE RULE	
R 400.14301	**Resident assessment plan;**
	(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:	During an on-site investigation on 12/23/24 I reviewed Resident A's *Assessment Plan for AFC Residents* which was dated 12/20/23 and was the most current version. The document had not been updated annually as required and was not properly signed by the administrator or Resident A's designated representative.
CONCLUSION:	**VIOLATION ESTABLISHED**

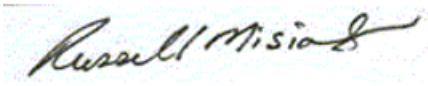
On 1/8/24, I shared the findings of my investigation with licensee designee Joyce Divis. Ms. Divis acknowledged and agreed to submit a corrective action plan.

IV. RECOMMENDATION

1/9/24

Nile Khabeiry Date
Licensing Consultant

Approved By:



1/9/24

Russell B. Misiak Date
Area Manager