GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 20, 2025

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

RE: License #: AS410360517
Investigation #: 2025A0467032
Parkview Home

Dear Mrs. Payne:

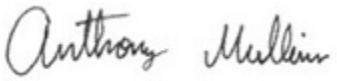
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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 #:	AS410360517
Investigation #:	2025A0467032
Complaint Receipt Date:	04/03/2025
Investigation Initiation Date:	04/03/2025
Report Due Date:	06/02/2025
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:	Parkview Home
Facility Address:	2165 Bayham Dr. SE Kentwood, MI 49508
Facility Telephone #:	(616) 551-3129
Original Issuance Date:	04/28/2014
License Status:	REGULAR
Effective Date:	10/28/2024
Expiration Date:	10/27/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 4/2/25, Resident A's blood sugar was 565 and it took approximately 1 hour before he received appropriate care.	Yes

III. METHODOLOGY

04/03/2025	Special Investigation Intake 2025A0467032
04/03/2025	Special Investigation Initiated - Letter Spoke to complainant via email
04/07/2025	Inspection Completed On-site
04/07/2025	Contact - Telephone call made AFC program manager, Olivia Rodriguez
04/07/2025	Contact - Telephone call made AFC program manager, Sam Johnson
04/10/2025	Contact - Telephone call made AFC staff member, Jessica Barajas
04/17/2025	Contact – Telephone call made to executive director Jordan Walch
05/20/2025	APS Referral
05/20/2025	Exit conference with Jordan Walch, Director on behalf of licensee designee, Delissa Payne

ALLEGATION: On 4/2/25, Resident A's blood sugar was 565 and it took approximately 1 hour before he received appropriate care.

INVESTIGATION: On 4/3/25, I received a complaint from Kent County Recipient Rights officer, Ashton Byrne via email. The complaint alleged that on 4/2/25, around lunch time, Resident A's blood sugar level was 565. As a result of this, he did not eat lunch. It was reported that the home manager, Olivia Rodriguez wanted to send Resident A to the ER due to this. However, she needed permission from her supervisor to do so. It was reported that the supervisor was contacted and staff were advised to call Resident A's primary care physician (PCP). Staff at the home did not have the phone number for the PCP readily available. Staff initially called a gerontologist for Resident A, which was incorrect due to Resident A's age. Staff were finally able to obtain contact information for the diabetes specialist to receive instructions on how to proceed. The whole process reportedly took over an hour.

During this time, Resident A appeared more lethargic, he was requesting food and became combative. Staff took Resident A on a van ride to keep him calm while his peers ate lunch at home. Staff did not feed Resident A lunch at the time to avoid putting him into a medical coma due to his blood sugar levels. The complaint alleged that “after one hour of staff attempting to seek medical care for Resident A, diabetic specialist returned calls with a course of treatment for him.”

On 4/7/25, I made an unannounced onsite investigation at the facility. Upon arrival, staff member Will (last name unknown) answered the door and allowed entry into the home. Staff member Julie Jakubiec introduced me to Resident A and informed me that his communication level is minimal and he often repeats things. Resident A acknowledged me and I attempted to speak with him briefly. However, this was unsuccessful as he repeated everything I said as anticipated. Resident A was observed to be clean and did not have any physical signs of distress.

After attempting to speak with Resident A, I then spoke to staff member, Julie Jakubiec in the staff office regarding the allegations. Ms. Jakubiec confirmed that she was working on the day in question and acknowledged that she checked Resident A’s blood sugar level, which came out to 565. Ms. Jakubiec stated that she was immediately concerned for Resident A after confirming his high blood sugar levels. Ms. Jakubiec stated that staff tried figuring out who Resident A’s PCP is and tried contacting him. The first doctor that was called was a gerontologist, which was incorrect considering Resident A’s young age. Staff were eventually able to obtain the number for Resident A’s PCP, Dr. Richard Switzer, at which point they were directed to a diabetic specialist through Corewell Health. Ms. Jakubiec shared that staff had a long talk with the diabetic specialist and they were given instructions to give Resident A 1 unit of insulin for every 50 units over 400. Ms. Jakubiec stated that a total of 12 units were given to Resident A and he was monitored closely by staff.

Ms. Jakubiec stated that Resident A’s blood sugar levels eventually stabilized. Ms. Jakubiec stated that during this time, Resident A wanted to eat. However, staff did not allow Resident A to eat until connecting with the specialist to prevent his blood sugar levels from increasing further. Ms. Jakubiec stated that staff member Jessica Barajas spoke to medical staff via phone and she reportedly made it clear to them that this was an emergency regarding Resident A. Ms. Jakubiec confirmed that Resident A appeared to be more lethargic and tired during this time. However, she added that this is also his baseline presentation. Ms. Jakubiec stated that Resident A is considered a “critical diabetic” and if he were to have other symptoms such as vomiting, fever, or being unconscious, she would have called 911 herself. Ms. Jakubiec denied any knowledge of the home manager wanting to send Resident A to the ER and needing approval from her supervisor. Ms. Jakubiec was adamant that she would have sent Resident A to the ER without supervisor’s approval if deemed necessary. Ms. Jakubiec stated that staff were stressed out during this incident and confirmed that a plan should be in place in the event of a repeat incident. Although Ms. Jakubiec initially confirmed that the incident took approximately an hour, she later stated that it lasted 30 to 45 minutes at most. Ms.

Jakubiec stated that Resident A did not appear to be in distress. Ms. Jakubiec was thanked for her time as this interview concluded.

On 4/7/25, I spoke to home manager, Olivia Rodriguez via phone regarding case allegations. Ms. Rogriguez confirmed that she was working on 4/2/25 when Resident A's blood sugar levels were elevated to 565. Ms. Rodriguez confirmed that she held off on feeding Resident A to prevent him from going into a diabetic coma. Ms. Rodriguez confirmed that she wanted to send Resident A to the ER but needed approval from her supervisor to do so. Ms. Rodriguez stated that her supervisor is Tammy Franke and she was instructed to go through Resident A's emergency file to contact his doctor due to his sliding scale stopping at 400. Ms. Rodriguez stated that she spoke to Ms. Franke via text. Ms. Rogriguez confirmed that she checked Resident A's emergency file and it was determined that the number for his doctor was invalid. Ms. Rodriguez stated that Resident A's behavior specialist was in the home during this incident and she helped staff find the correct number for Resident A's doctor. When staff connected with Resident A's doctor, Ms. Rodriguez stated that they were then given another number for a diabetic nutritionist, and they were placed in a call back queue.

During this incident, other residents were having behavioral episodes in the house due to it being lunch time. Ms. Rodriguez stated that she and the behavior specialist agreed to let Resident A go on a van ride to allow the other residents to eat. Ms. Rodriguez stated that the diabetic specialist returned a call and gave directions to staff member Julie Jakubiec to provide Resident A with insulin. Ms. Rodriguez was unsure of the exact amount of insulin that was given. After Resident A received his insulin, he was monitored and his blood sugar levels decreased and then increased again. In addition to being a home manager, Ms. Rodriguez added that she is a CNA (certified nursing assistant) and in her work experience, someone in a similar situation would automatically be sent out to the hospital. However, Ms. Rodriguez stated that she was told that they (Spectrum Community Services) doesn't send residents to the hospital automatically during a situation like this. Ms. Rodriguez stated that she understands that every job is different, but she told the behavior specialist that if she was at a different job, she would have sent Resident A to the hospital to be evaluated. Ms. Rodriguez stated that a blood sugar level of "565 was ridiculous." Ms. Rodriguez stated the two staff members working first shift informed her that 3rd shift staff members informed them that Resident A's blood sugar was high. Ms. Rodriguez stated that if 3rd shift knew about this, "why didn't they try to lower it instead of leaving it for first shift staff to address?" Ms. Rodriguez stated that the behavior specialist could confirm this as well. Ms. Rodriguez confirmed that it took approximately 1 hour to connect with Resident A's medical team and provide him with insulin based on the instructions given from his medical team. Ms. Rodriguez shared that the behavior specialist in the home stated that it was "ridiculous" how long Resident A had to wait prior to receiving the care he needed. After Resident A's sugars were able to stabilize, staff were able to feed him.

After speaking to Ms. Rodriguez, I spoke to the associate director, Sam Johnson. Ms. Johnson agreed to send me Resident A's assessment plan, healthcare appraisal and his Medication Administration Record (MAR) for April 2025. She also agreed to send any documentation on orders/instructions from Resident A's doctor on how to proceed in a situation like this. Prior to sending the requested documentation, Ms. Johnson stated that she was looking through Resident A's MAR and noticed that his insulin injection states that he needs to take 3 units with a snack and 5 units with meals and complete blood sugar checks before each meal. However, in Quick MAR, which is their medication administration system, insulin injections and blood sugar checks are only documented once at 8am daily. Ms. Johnson stated that staff member, Heather Reamon is addressing this to make sure the MAR accurately reflects how often Resident A is receiving insulin and his blood sugar checks. Ms. Johnson stated that it's possible that staff have been following the MAR and only checking Resident A's blood sugar once a day as opposed to multiple times daily.

On 4/7/25, I received the requested documentation from Ms. Johnson. Resident A's assessment plan was reviewed and confirmed that Resident A is dependent on staff to administer his medications. The assessment plan also states, "if (Resident A's) blood sugar is too low or too high, he will present with uneven gait." Resident A's healthcare appraisal was reviewed and the only relevant information was that he is on a diabetic diet. I reviewed Resident A's sliding scale for his insulin, which indicated that for a blood sugar above 500, his doctor is to be called.

On 4/10/25, I spoke to staff member, Jessica Barajas via phone regarding the allegations. Ms. Barajas confirmed that she was working at the home on 4/2/25 when Resident A's blood sugar level exceeded 500. Ms. Barajas stated that when she arrived at work at 7am, Resident A's sugars were already high. Ms. Barajas stated that Resident A wears a Dexcom monitor that stated "high" for his blood sugar levels. Ms. Barajas stated that this happens at times, depending on what Resident A has for breakfast. However, this typically decreases throughout the day. Ms. Barajas stated that on the day in question, Resident A's blood sugar levels were consistently high throughout the morning. Around lunch time, staff member Julie Jakubiec checked Resident A's levels and this is when it was determined his levels exceeded 500. Ms. Barajas stated that Ms. Rodriguez and the behavior specialist were both at the home during this incident. Ms. Rodriguez stated that Resident A's blood sugar levels had never been that high. This led to staff looking at Resident A's chart, which indicated that if his levels are above 500, they need to call his doctor.

Ms. Barajas stated that staff initially could not find the face sheet/paperwork with Resident A's doctor's information on it. Once the contact information for the doctor was found, it was determined that the number was incorrect. Ms. Barajas stated that she ended up finding the doctor's information via Google and was able to get ahold of a medical provider for Resident A "after waiting forever." Ms. Barajas stated that the medical provider informed her that Resident A goes through a diabetic service and provided her with a direct number. Ms. Barajas called the diabetic service line

and staff were reportedly asking her questions about Resident A's current condition. After answering their questions, the medical team stated that they would call her back. Ms. Barajas stated that she also told the medical team that they didn't feed him yet to prevent his blood sugar levels from increasing further. Ms. Barajas stated that while waiting for a call back, the behavior specialist encouraged staff to take Resident A out on a van ride to allow the other residents to eat. Ms. Barajas stated that Ms. Rodriguez did not want to do this as she was concerned for Resident A potentially falling asleep and not waking up. Ms. Barajas stated that the behavior specialist told staff that they must pick their battles as Resident A becomes aggressive with others and tries to fight them for their food. Ms. Barajas stated that she took Resident A on a van ride and they were away from the home for approximately 20 minutes. While she was driving around with Resident A, his medical team returned a call and informed staff to provide him with a specific amount of insulin. Ms. Barajas stated that his blood sugar levels started to slowly decrease after receiving insulin. Ms. Barajas confirmed that from the time Resident A's blood sugar levels were around 565 until the time they connected with his medical team and provided him with insulin, this process took approximately 1 hour. Ms. Barajas stated that nothing like this has ever happened. Ms. Barajas confirmed that the home manager, Oliva Rodriguez, recommended sending Resident A to the ER due to waiting on a response from his medical team. However, this never occurred as he was taken on a van ride and eventually heard back from his medical team with instructions on how to proceed. Ms. Barajas stated that Ms. Rodriguez messaged her supervisor, Tammy Franke but she is unsure of the exact communication between the two. Since this incident occurred, Ms. Barajas confirmed that Resident A's emergency file has been updated to be prepared if a similar incident was to occur. Ms. Barajas confirmed that Resident A was looking tired/lethargic. However, this is his known baseline. Ms. Barajas denied Resident A looking as if he was in distress or appearing as if he was going to pass out. Ms. Barajas was thanked for her time.

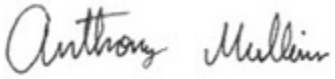
On 4/17/25, I spoke to Spectrum Community Services executive director, Jordan Walch regarding the allegation. I explained that Resident A's blood sugar was high (565) and it took approximately 1 hour to get answers on how to proceed for Resident A. I informed Mrs. Walch that I am aware that staff attempted to contact Resident A's doctor. However, they initially had the wrong number on file, which ultimately delayed communication with his medical team. During this hour period, Resident A was left in limbo, which put him at risk of a diabetic coma. Mrs. Walch stated that Cedric Marshall was the previous manager of the home and 3 days prior to the incident, he indicated that he had all the correct documentation was readily available for Resident A, including doctor's name, phone numbers, and instructions on how to proceed in a situation like this. However, when this incident occurred, the correct information was not readily available for the new manager, Olivia Rodriguez. Mrs. Walch stated that Tammy Franke was instructing home manager, Ms. Rodriguez as to where the documentation should be. However, the documentation wasn't where it was supposed to be.

On 5/20/25, I conducted an exit conference with executive director Jordan Walch on behalf of 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 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.** **(b) Special diets.** **(c) Susceptibility to hyperthermia and hypothermia and related limitations for physical activity, as appropriate.** **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Resident A's blood sugar level was 565 on 4/2/25. During this incident, it took staff approximately an hour to connect with his medical team due to not having contact information readily available in the home. Resident A's sliding scale states that if his blood sugar level exceeds 500, staff are to contact his doctor to receive instructions on how to proceed. Resident A's MAR also does not accurately reflect that he receives insulin and blood sugar cheeks more than once a day. Based on the information obtained, 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 changes to the current license status.



05/20/2025

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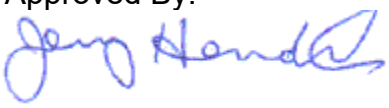
Anthony Mullins Date
Licensing Consultant

Approved By:



05/20/2025

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Jerry Hendrick Date
Area Manager