STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

May 16, 2018

Amanda Hart
Crisis Center Inc - DBA Listening Ear
PO Box 800
Mt Pleasant, MI 48804-0800

RE: License #: AS370011270
Investigation #: **2018A0867044**
Isabella Home

Dear Ms. Hart:

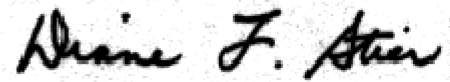
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (231) 922-5309.

Sincerely,



Diane L Stier, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0560

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370011270
Investigation #:	2018A0867044
Complaint Receipt Date:	05/04/2018
Investigation Initiation Date:	05/04/2018
Report Due Date:	07/03/2018
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	Amanda Hart
Licensee Designee:	Amanda Hart
Name of Facility:	Isabella Home
Facility Address:	2599 S Isabella Road Mount Pleasant, MI 48858
Facility Telephone #:	(989) 773-0326
Original Issuance Date:	10/10/1986
License Status:	REGULAR
Effective Date:	04/05/2018
Expiration Date:	04/04/2020
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
A staff person violated resident privacy by sending a photo of Resident A to a friend via Snap Chat.	Yes
Another staff left Resident B suspended in the Hoyer Lift over his bed while she attended to another resident.	Yes

III. METHODOLOGY

05/04/2018	Special Investigation Intake 2018A0867044
05/04/2018	Special Investigation Initiated - Telephone Complainant
05/04/2018	APS Referral
05/04/2018	Contact – Document Received Notice of APS assignment
05/09/2018	Contact - Face to Face Staff interviews at Listening Ear
05/09/2018	Inspection Completed On-site Resident Interview
05/16/2018	Exit Conference Licensee Designee Amanda Hart

ALLEGATION: A staff person violated resident privacy by sending a photo of Resident A to a friend via Snap Chat.

INVESTIGATION:

Jaclyn Dean, Human Resources Director for Listening Ear [licensee], reported that on Wednesday, 5/2/18, she got a call through the crisis line around noon reporting that Direct Care Worker (DCW) Justina Diem was posting a photo of a resident of the AFC home using the resident's full name in the posting. Ms. Dean said that the caller said she worked with Ms. Diem at another employer and knows direct care staff are not supposed to use the names of residents. Ms. Dean reported that the caller insisted on remaining anonymous because of fearing retaliation from Ms. Diem at their other job.

Ms. Dean reported that the caller made contact again on 5/4/18 and agreed to provide Ms. Diem with a copy of the video. Ms. Diem had obtained a copy of the video posting, which she showed Recipient Rights Advisor Jane Gilmore and me during the interview. The video, lasting about three seconds and originally posted on Snap Chat, showed Resident B drinking. The caption on the video said, “My favorite gal in the world.” Ms. Diem reported that in their conversation on 5/4/18, the anonymous caller said there was a second video of a different resident (Resident C) climbing into a closet, with the caption. “This is what I have to deal with every day.” Ms. Dean said that after this call, she called the Isabella Home and spoke with Stephanee Wright, Assistant Manager, and asked about the home’s phone policy. Ms. Dean said she was told that staff are to leave their cell phones in a basket at the front door when they come to work.

DCW Justina Diem was asked about the phone policy in the AFC home. Ms. Diem said, “You’re supposed to put them in the cell phone box by the front door and not have them on your person unless told differently by Andrea [Binge, Home Manager]. When asked if she had posted pictures of residents on the internet, Ms. Diem said, “Olivia [a former staff person] took pictures of (Resident D) sitting on my lap, but it’s just on my phone, not sent anywhere.” When asked if she had posted any information about residents on Snap Chat or Instant Messenger, or if she had ever used residents’ full names when talking about them outside work, Ms. Diem said she had not. When asked if she had permission to take Resident D’s picture, Ms. Diem said, “No, but Olivia had taken pictures before, so I thought it was okay.” When asked why she had her phone with her when the home’s phone policy clearly said the phones were to be left in the cell phone box at the door, Ms. Diem said, “I was ‘off’ shift, waiting for someone to count out meds. Olivia was coming on and I was going off, and we had just finished counting meds, and I was “off” by that time so I had my phone with me.” When Recipient Rights Advisor Jane Gilmore said we had seen a video posted from Ms. Diem’s phone, Ms. Diem finally acknowledged that she had made the video of Resident B and one of Resident C. Ms. Diem said she sent them on Snap Chat. Ms. Diem said, “I don’t remember who I sent them to, one or two people. Olivia and my friend Lexie.” RRA Gilmore informed Ms. Diem that this was a violation of the residents’ right to privacy.

DCW Brenda DeFoy said she has seen other direct care staff using their cell phones while at work. Ms. DeFoy said, “No pictures, just talking.” Ms. DeFoy said, “When I confronted someone about it once, they said Andrea [Binge, Manager] was texting them. But a couple minutes before, she was talking to family members while she was standing in the kitchen.” Ms. DeFoy said that both Deandra Lewis and Candy Lucas have used their phones at work.

None of the residents of this home were able to provide information that was useful to this part of the investigation.

During an onsite inspection, I did observe a box just inside the front door labeled “Cell Phones.”

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.
ANALYSIS:	DCW Justina Diem admitted to photographing or Video-recording two residents of the home and sharing those pictures with persons who did not work in the home, all without the permission of the residents or their guardians. The residents' privacy was thus violated, and the residents were exposed to potential exploitation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Another staff left Resident B suspended in the Hoyer Lift over his bed while she attended to another resident.

INVESTIGATION:

DCW Justina Diem reported that when she came into work just before 11 PM on 5/1/18, she started by doing bedchecks on the residents. Ms. Diem reported that when she got to Resident A's room "he was hanging above his bed in his lift [sling]." Ms. Diem reported that she asked Resident A why he was hanging in the sling, and Resident A told her that he had to go to the bathroom. Ms. Diem said that Resident A was suspended 1"-2" above the bed. Ms. Diem said there were no soaker pads or blue pads under the resident on the bed. Ms. Diem said, "Normally, you put him in his toilet chair, cover him with a blanket or towel, and take him to the toilet, and his chair slides right over the toilet." Ms. Diem said that once Resident A is positioned over the toilet, Resident A likes privacy, so the door is then closed. Ms. Diem said that when she discovered Resident A, she asked him if he was ready to go to bed and he said he was. Ms. Diem said, "He was dry, the bed was dry, and the sling was dry. There were no feces anywhere. There was no indication that he had done anything." Ms. Diem said that Resident A was only wearing a t-shirt when she found him. Ms. Diem said she did find a blue pad [disposable] tucked under Resident A in the sling itself. Ms. Diem said she lowered Resident A to the bed, removed the sling, put a brief on Resident A, and got him dressed for bed. Ms. Diem said, "After I put his brief on, I went and got soakers [pads] to put under him. There was nothing on the bed except sheets until then." Ms. Diem said she then went out to the living room where the other staff were at the time. Ms. Diem said, "I told Candy [Lucas] and Brenda [DeFoy], and Brenda said that he [Resident A] told her he couldn't make it to the bathroom." Ms. Diem reported that she told Ms. DeFoy that Resident A was dry, and Ms. DeFoy said, "Well, he said he couldn't make it, so I just left him there to finish." Ms. Diem reported that Resident A did not have any marks on him and he did not appear to be in distress when she found him. Ms. Diem said that when she first arrived for her shift, Ms. DeFoy was taking care of Resident B, and Ms. Diem proceeded to begin her bedchecks. Ms. Diem said DCW Deandra Lewis was counting medications during this time.

I referred this incident to Adult Protective Services (APS) and was informed that APS Worker James Helwig was assigned to investigate.

DCW Candy Lucas said that when she arrived at work on the night of 5/1/18, she started counting medications with DCW Deandra Lewis and sent DCW Justina Diem to check on the residents. Ms. Lucas said, "Justina came and said she found (Resident A) left in his Hoyer [lift] hanging over his bed." Ms. Lucas said she asked if the resident was not in bed, and that Ms. Diem told her that she had put Resident A in bed. Ms. Lucas said, "Brenda [DeFoy] was putting (Resident B) in bed at the time, and when she came out, I yelled at her." According to Ms. Lucas, Ms. DeFoy said, "(Resident A) said he had to go to the bathroom but wouldn't make it to the bathroom, so I left him in the Hoyer over the tope of his bed." Ms. Lucas said she did not see anything herself, because Ms. Diem was the one who found him and put him to bed. Ms. Lucas said, "(Resident A) never said anything to me about the incident." Ms. Lucas said that Resident A is usually continent of bowels, but that he does wear a brief all the time. Ms. Lucas said that Resident A does not generally ask to use the toilet during the night, but that if he did she would transfer him to the toilet chair and then wheel the toilet chair to the bathroom and position it over the toilet. Ms. Lucas said she asked Ms. DeFoy, "Why in the world did you leave (Resident A) in the sling?" Ms. Lucas said that Ms. DeFoy told her that Resident A said he could not get to the bathroom." Ms. Lucas reported, "I told her there were so many other options, and that it was a safety issue and a dignity issue!" Ms. Lucas said she told Ms. DeFoy that she could have lowered Resident A to the bed, and Ms. DeFoy responded to her, "Why, so he could poop on himself?" Ms. Lucas said, "I told her, 'Then you would just clean it up! But don't leave him and walk away to take care of someone else!'" Ms. Lucas said that Resident A is capable of "hollering" to let someone know he needs help, and that he did not do so. Ms. Lucas said, "It just pissed me off to no end. You just don't do that!" Ms. Lucas said she had been in the AFC home at least 5-10 minutes before Ms. Diem found Resident A, and she did not know how long he had been in the sling before that. Ms. Lucas said that DCW Deandra Lewis had told her she did not know that Ms. DeFoy had left Resident A in the sling.

DCW Deandra Lewis reported that she worked the 2nd shift on 5/1/18 (from 3-11 PM) and was counting out medications at the end of her shift. Ms. Lewis said, "A little before that, Brenda [DeFoy] went to put (Resident A) to bed. He's usually last because he doesn't like to go to bed. We usually get (Resident B) to bed around 8 or 9. We'll ask (Resident A) but he normally wants to stay up and watch TV." Ms. Lewis said she did not remember what time Resident B went to bed that night. Ms. Lewis said she thought Ms. DeFoy went to put Resident A to bed around 10:40 PM. Ms. Lewis said she was in the medication room waiting for DCW Candy Lucas [the staff assigned to medications for the next shift] to come in. Ms. Lewis said, "We counted meds, and then I don't remember what time Brenda came out. I leave after counting meds." Ms. Lewis said, "Justina [Diem] normally goes around and makes sure bedrails are up and everyone [the residents] are dry." Ms. Lewis said that she did not know that Resident A had been left in the Hoyer until Ms. Lucas told her about it on Tuesday night (5/8). Ms. Lewis said, "That was the first I heard about it." Ms. Lewis said that Resident A will tell staff

when he needs to use the bathroom. Ms. Lewis said, “He will tell you #1 or #2. He has said, ‘I’m not going to make it!’ before, but I still take him to the toilet. He will go on the way maybe, but then I just clean it up!” Ms. Lewis said that she removes Resident A’s lower clothing before putting him in the lift, then covers his lower half with a blanket and takes him to the bathroom. Ms. Lewis said that in general she has concerns with Ms. DeFoy’s “decision-making.” Ms. DeFoy said that when she [Ms. Lewis] was in the med room, she thought Ms. DeFoy was with Resident A and had already put Resident B to bed. Ms. Lewis said, “Frequently what Brenda [DeFoy] says she’s done, she hasn’t really done yet.”

DCW Brenda DeFoy said she had no idea what the investigation might be about. Ms. DeFoy was told that we were concerned that at shift change around 11 PM on 5/1/18, staff had found Resident A in his Hoyer lift sling suspended over his bed. Ms. DeFoy said, “I was taking care of three people on my shift. I suspended (Resident A) over his bed because he didn’t think he could make it to the bathroom without pooping all over the floor.” When asked what time she started helping Resident A get ready for bed, Ms. DeFoy said, “About 9:30 [PM] I took him into his room. Then I put them pad things on his bed, and a blue thing [disposable pad] over top.” Ms. DeFoy said, “(Resident A) said he didn’t think he’d make it to the bathroom. I thought I’d leave him over the bed so he wouldn’t make a mess on the floor.” Ms. DeFoy said there was a soaker and blue pad on the bed. Ms. DeFoy said, “I put a blue pad over him down there [indicating the genital area], too, in case he peed so it wouldn’t go everywhere.” Ms. DeFoy said she was sure there were blue soakers on Resident A’s bed underneath him. Ms. DeFoy said that once Resident A was suspended over his bed, she went to Resident B, who was on the toilet in her room. Ms. DeFoy said, “(Resident B) was done so I put her in bed. I came out – it takes me a while with the girls [female residents] – changing her into her pajamas, a brief, then putting on her CPAP [breathing assistance]. It was probably about 10:30 [PM] when I finished with (Resident B).” When asked if that meant Resident A was suspended over his bed from around 9:30 PM until 10:30 PM, Ms. DeFoy said, “No, I went and checked on him after I finished with (Resident B) but he hadn’t done anything. He said to give him another 10 minutes. Then I went to (Resident E), because she was in the hallway.” Ms. DeFoy said that the workers for the next [midnight] shift arrived around 10:45 PM. Ms. DeFoy then explained that another reason she did not put Resident A into his toilet chair was that it takes two people to transfer Resident A. When asked why she did not ask for a second person to help that night, Ms. DeFoy said, “I don’t remember what Deandra [Lewis] was doing. We can’t leave anyone in the front room without someone being there. Maybe I just thought she was too busy with (Resident C) to help me.” Recipient Rights Advisor (RRA) Jane Gilmore asked if we should assume that Resident A was in his lift sling, suspended over his bed, from around 9:30 PM until Ms. Diem found him around 10:45 PM, Ms. DeFoy said that was probably about right. RRA Gilmore said, “Does that seem like a long time?” and Ms. DeFoy replied, “Too long.” When asked what she would do differently if she could, Ms. DeFoy said, “I wouldn’t string him up anymore. I’d make staff come and help me.” Ms. DeFoy acknowledged, however, that she had not asked any other staff to help her.

Resident A was not able to remember a specific instance of being left in the lift sling suspended above his bed but said he has been left hanging in the lift before. Resident A said that staff sometimes cannot get him on the commode fast enough and "they have to clean a mess." Resident A said all the staff in the home were good. Resident A said he thought it would be good if his commode had a bucket under it in case they couldn't get it to the bathroom in time. Resident A was not able to provide any more information useful to this investigation.

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:	While Resident A did not incur any injuries as a result, Resident A was not treated with dignity, and his needs for protection and safety were not attended when DCW Brenda DeFoy left him in the sling of his Hoyer lift, suspended over his bed, for a period of time that may have been as long as 75 minutes.
CONCLUSION:	**VIOLATION ESTABLISHED**

In our exit conference, Licensee Designee Amanda Hart reported that she will submit a written corrective action plan addressing the violations established in this investigation.

IV. RECOMMENDATION

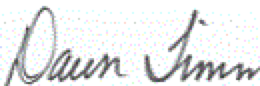
Pending receipt of an acceptable written corrective action plan, I recommend continuation of the current status of the license of this AFC adult small group home.

May 16, 2018

Diane L Stier
Licensing Consultant

Date

Approved By:



05/21/2018

Dawn N. Timm
Area Manager

Date