STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

September 30, 2018

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

RE: License #: AS370011270
Investigation #: **2018A0867059**
Isabella Home

Dear Ms. Hart:

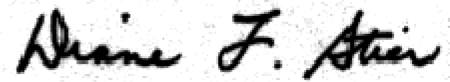
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2018A0867059
Complaint Receipt Date:	07/26/2018
Investigation Initiation Date:	07/27/2018
Report Due Date:	09/24/2018
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	Ellen Powell
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 left Resident A on his toilet chair for around 2 hours.	Yes

III. METHODOLOGY

07/26/2018	Special Investigation Intake 2018A0867059
07/27/2018	Special Investigation Initiated - Face to Face Interviews at Listening Ear
07/31/2018	APS Referral
08/16/2018	Exit Conference Licensee Designee Amanda Hart
09/28/2018	Contact – Telephone call made Recipient Rights Advisor Jane Gilmore
09/28/2018	Contact – Document Received Recipient Rights Investigation Report

ALLEGATION: A staff person left Resident A on his toilet chair for around 2 hours.

INVESTIGATION:

Recipient Rights Advisor Jane Gilmore, from CMH for Central Michigan, reported to me on 7/26/18 that she had received information from Direct Care Worker (DCW) Candy Lucas that on 7/25/18 DCW Brenda DeFoy left Resident A on his toileting chair in his bedroom for "at least 1.5 hours." According to the information provided, Ms. Lucas became aware of this when she arrived at work on the evening of 7/25/18, and the other staff person working with Ms. DeFoy was DCW Stefanee Wright.

On 7/31/2018, I made a referral to Adult Protective Services.

On 7/27/18, DCW Candy Lucas reported that she arrived at the AFC home on the evening of 7/25/18 at 9 PM. Ms. Lucas reported that she was replacing DCW Stefanee Wright. Ms. Lucas said that she and Ms. Wright counted medications together, and then Ms. Wright left. Ms. Lucas said, "After Stefanee left, I went down the hall and [DCW] Brenda [DeFoy] was putting (Resident B) to bed. No one else was up, the bedroom doors were closed, and the bathroom was empty." Ms. Lucas said that she then prepared lunches for the next day, prepared a grocery list, and restocked a closet.

Ms. Lucas said, “I sat down at the table with the menu and grocery list, and Brenda [DeFoy] sat down at the table with me, helping go through the menu. I looked at the clock on the wall across from me when Brenda [DeFoy] got up from the table, and it was 10:30 [PM].” Ms. Lucas said, “I thought I heard yelling, so I turned the radio down and heard that it was (Resident A). I don’t know what he was saying, just a yell. I asked Brenda [DeFoy] where (Resident A) was, if he was in bed. She [DCW Brenda DeFoy] said, ‘Oh no! I forgot! He’s on the toilet.’” Ms. Lucas said she asked Ms. DeFoy how long Resident A had been on the toilet and Ms. DeFoy responded, “Quite a while.” Ms. Lucas said Resident A had to have been on the toilet chair in his bedroom, because she had seen for herself that both bathrooms were empty earlier. Ms. Lucas said, “I assumed, since the last time, that (Resident A) was in (Resident B’s) toileting chair, because we agreed to use (Resident B’s) chair if (Resident A) couldn’t make it to the bathroom because (Resident B’s) chair has a bucket under it.” Ms. Lucas said that she did not go down to Resident A’s bedroom at this time. Ms. Lucas said, “Minimally, (Resident A) was on the toilet chair from at least 9 PM [when Ms. Lucas arrived for work] and 10:30 PM.” Ms. Lucas was asked if she knew what Ms. DeFoy was doing during the period of time between her arrival at 9 PM and 10:30 PM when Resident A called out. Ms. Lucas said, "Brenda never went to the bedrooms; she was following me around talking. She went to the garage twice to check the freezer and for recycling. She was in the kitchen looking through the cupboards talking about the grocery list. Brenda just wrote in the chart that (Resident A) went to bed at 10:30 PM." Ms. Lucas said Resident A has been known to say he needs additional time in the restroom but even then, it is "only a few minutes longer not another hour." Ms. Lucas said she works midnight shifts and has never gotten Resident A up to go to the bathroom during the midnight shift.

On 7/27/18, DCW Stefanee Wright reported that she worked from 9 AM to 9 PM on 7/25/18. Ms. Wright said that when she and Ms. DeFoy started to get residents ready for bed, Ms. Lucas took care of Residents C, D, and E while Ms. DeFoy took care of Residents A, B, and E. Ms. Wright said, “Brenda [DeFoy] put (Resident A) on the toilet chair in the bathroom at 8:05 PM. I saw him there. We always ask him how long he wants to sit, and he said, “15.” Ms. Wright said she asked Ms. DeFoy to leave Resident A in his shower chair when he was finished so Ms. Wright could give Resident A his medications. Ms. Wright said, “At 8:33 [PM] he was in his bedroom on his shower chair. It was *his* chair. His is the tallest one [shower chair], has a padded seat, and doesn’t have anything [e.g., a bucket] underneath.” Ms. Wright said she gave Resident A his medications and then saw that he had a pad under him. Ms. Wright said she asked Resident A, “What are you doing?” and that Resident A replied, “I feel like I might still have to go.” Ms. Wright said she left Resident A on his toilet chair in his room. Ms. Wright said that when she left her shift at 9 PM, she assumed Ms. DeFoy had already put Resident A to bed. Ms. Wright said, “(Resident A) is verbal. He’ll tell you how long he wants to sit. He will call when he’s finished.” Ms. Wright said that she usually works from 7 AM to 3 PM but worked longer shifts during this week. Ms. Wright said she does not usually work with Ms. DeFoy. Ms. Wright said, “I think Brenda [DeFoy] forgot he was still in the chair. When I finished meds, I reminded Brenda [DeFoy] he was still in the chair. She was checking my meds. When I left, I assumed she had taken care of (Resident A) but I didn’t peek in to see.”

On 7/27/18, DCW Brenda DeFoy reported that Resident A had been in the bathroom on his toilet chair over the toilet, and that Resident A said he was finished around 8:30 PM. Ms. DeFoy said she took Resident A to his bedroom in his toilet chair. Ms. DeFoy said, "Before I could get him out of his chair, he said he thought he still had a little bit to go. So I put a blue pad underneath him on the floor and left." Ms. DeFoy said, "He actually sat by himself in the room about 15 minutes." Ms. DeFoy said, "Candy [Lucas] came in and asked where (Resident A) was, and I said in his room. I went in and put the sling on and put him in his bed." Ms. DeFoy said that it was around 9:10 PM when she got him off the toilet chair. Ms. DeFoy said she took Resident A off the toilet chair within 10 or 15 minutes of when DCWs Stefanee Wright and Candy Lucas counted medications at 9 PM. Ms. DeFoy denied telling Ms. Lucas that Resident A had been on the chair a long time. Ms. DeFoy denied that Ms. Lucas asked her how long Resident A had been on the toilet chair. When asked if she was sure that she hadn't been sitting with Ms. Lucas at the table when Resident A called out around 10 PM, Ms. DeFoy said, "It wasn't 10 PM. He [Resident A] did call out, though." Ms. DeFoy acknowledged having had previous problems with leaving Mr. Brewer in his sling or on the toileting chair for a prolonged period of time. Ms. DeFoy was asked a second time about the time frame of the events on the night in question and said, "I did not say 'long time' and it was 40 minutes total." Ms. DeFoy was asked if she had been given feedback about placing a soaker pad beneath Mr. Brewer and having him "just finish going" while in his bedroom with his roommate. Ms. DeFoy said she recalled being told not to leave him suspended in the lift over his bed to do that (urinate/defecate) but felt leaving him in the chair was acceptable.

I consulted the licensing file and noted that in Special Investigation Report 2018A0867044, it was substantiated that DCW Brenda DeFoy left Resident A in his sling over his bed for an extended period of time. In that investigation, Ms. DeFoy again stated that she thought Resident A was still in the process of having a bowel movement and left him in the sling until he had finished. A violation of R 400.14305(3) was cited in that report.

Resident A stated that he did not recall the incident in question and did not wish to discuss specific staff. Resident A stated that he often calls out to staff when he is finished in the restroom and likes to "give myself some time to do what I need to do."

I noted that Resident A shares a bedroom with Resident F. Resident A, sitting on his toileting chair, would have been completely visible to Resident F.

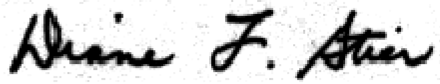
In an exit conference on 8/16/18, Licensee Designee Amanda Hart reported that DCW Brenda DeFoy's employment had been terminated on 7/30/18. Ms. Hart noted that Resident A's plan would be reviewed with staff.

On 9/28/18, Recipient Rights Advisor Jane Gilmore reported that CMH Nurse Judy Riley confirmed that, due to the risk of skin breakdown and other issues related to circulation, Resident A should not be left in one position on a hard surface for a period of time "longer than 15-30 minutes at most."

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:	DCW Candy Lucas reported that Resident A was not moved off the toilet seat until after 10:30 when she had looked at the clock. DCW Brenda DeFoy first stated that she had gotten Resident A off the toilet seat by 9:15 PM and later stated the resident was on the toilet seat for 40 minutes. While the length of time Resident A was left on the toilet seat may not be completely determined (between 40-90 minutes), he should not have been left that long, according to the CMH Nurse. Additionally, Resident A was not treated with dignity when he was left on his toilet seat in his bedroom shared with another resident.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED-[SEE SIR 2018A0867044 AND CAP DATED 5/22/18.]**

IV. RECOMMENDATION

I recommend continuation of the current status of the license of this AFC adult small group home (capacity 1-6).

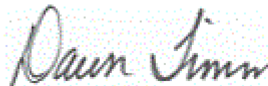


September 28, 2018

Diane L Stier
Licensing Consultant

Date

Approved By:



09/30/2018

Dawn N. Timm
Area Manager

Date