GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 4, 2023

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

RE: License #: AS340285830
Investigation #: 2023A0783017
Prairie Creek

Dear Ms. Jacobs:

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 (517) 284-9730.

Sincerely,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS340285830
Investigation #:	2023A0783017
Complaint Receipt Date:	06/08/2023
Investigation Initiation Date:	06/08/2023
Report Due Date:	08/07/2023
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	Jenny Jacobs
Licensee Designee:	Jenny Jacobs
Name of Facility:	Prairie Creek
Facility Address:	1017 Prairie Creek Rd. Ionia, MI 48846
Facility Telephone #:	(616) 522-0513
Original Issuance Date:	04/23/2007
License Status:	REGULAR
Effective Date:	10/22/2021
Expiration Date:	10/21/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's prescribed PRN (as – needed) Diastat (Diazepam) gel was not administered as prescribed on June 3, 2023.	Yes

III. METHODOLOGY

06/08/2023	Special Investigation Intake- 2023A0783017
06/08/2023	Special Investigation Initiated – Letter - Email from assigned licensing consultant Jennifer Browning
06/08/2023	Contact - Document Received - Two *AFC Licensing Division Incident/Accident Reports* for Resident A
06/08/2023	Contact - Document Received - Written physician's order for Resident A's prescribed Diastat (also known as Diazepam)
06/22/2023	Contact - Telephone call made to facility administrator Jenny Jacobs
06/22/2023	Contact - Telephone call made to direct care staff members Jessica Marek and Ashlyn Sanborn
06/26/2023	Inspection Completed On-site - Observed Resident A who is nonverbal
06/26/2023	Contact - Face to Face interviews with direct care staff members Wendy Cooke and Tarah Sargeant
06/26/2023	Contact – Document Received – Resident A's resident record
07/26/2023	Exit Conference with Jenny Jacobs

ALLEGATION:

Resident A's prescribed PRN (as – needed) Diastat (Diazepam) gel was not administered as prescribed on June 3, 2023.

INVESTIGATION:

On June 8, 2023 I received a complaint that stated, "Resident [A] had several seizures in the morning on third shift starting around 6:40 am and [direct care staff members] Jessica Marek / Ashlyn Sanborn did not administer his Diastat [also known as Diazepam] as required according to his seizure protocol. 1st shift came into work (Wendy Cooke) and administered this to him. When she asked the 3rd shift staff if he received it, they both said "yes" but Wendy noticed it was not touched in the medication cabinet, so she went back and asked them and they said, "I thought you meant the morning med" and they both stated they were not trained on the seizure protocol."

On June 8, 2023 I received a written email message from assigned Adult Foster Care licensing consultant Jennifer Browning which stated in part that Ms. Browning contacted Miranda Sowles who is the home manager, who stated she was not there at the time of the incident, and the two staff members on shift were not specific about when the seizures started. Ms. Browning's email message documented Ms. Sowles stated Resident A's seizures started around 6:30-6:40 am and he received his prescribed Diazepam after first shift staff members arrived at 6:55 am. Ms. Browning's email message documented Ms. Sowles said it was not normal for Resident A to have seizures for that long unless he is over stimulated throughout the day. Ms. Browning's email message documented Ms. Sowles stated there have been incidents since she has worked at the facility when Resident A had multiple seizures but typically after Resident A has two seizures, direct care staff members administer his Diazepam as prescribed, and the seizures stopped. Ms. Browning's email message documented Ms. Sowles said direct care staff member Wendy Cooke administered the Diazepam to Resident A at approximately 7:00 am on June 3, 2023. Ms. Browning's email message documented Ms. Sowles stated one of the staff members working told her Resident A had ten seizures before his prescribed Diazepam was administered and Resident A's seizure protocol and written medication order state if he has two seizures within 12 hours then he needs the Diazepam 10 mg and if he doesn't go to baseline within an hour he needs to go to the hospital. Ms. Browning's email message documented Ms. Sowles said Resident A's seizure protocol is reviewed as part of the facility training process. Ms. Browning's email message documented Ms. Sowles said facility policy is to count the medications each day and Diazepam is in the cabinet and one of the medications staff members Jessica Marek and Ashlyn Sandborn were supposed to be counting. Ms. Browning's email message documented Ms. Sowles said the medication comes as a rectal gel and there is two to a pack with a syringe and this is one of the medications on the sheets which staff members are supposed to count. Ms. Browning's email message documented Ms. Sowles talked about doing a

medication training again in the facility and identifying what each medication is used for because staff members should have known what the medication was and how to use it.

On June 8, 2023 I received a written *AFC Licensing Division – Incident/Accident Report* for Resident A dated June 2, 2023 at 6:45 am and signed by direct care staff member Jessica Marek. The written report stated, “staff went into [Resident A’s] bedroom [to] monitor health and safety checks. Staff noticed that [Resident A] appeared uncomfortable. Staff gave [Resident A] water. [Resident A] 5 minutes later went into a seizure.” In the “action taken by staff” section of the written report it stated, “staff used VNS magnet to VNS site. Multiple seizures. Staff every one minute swiped VNS site. No response from VNS [Resident A] had multiple seizures. Staff used Diazepam gel 10 mg rectally [Resident A] was still going into a seizure. Staff notified 911. Staff called APD. APD was onsite.”

On June 8, 2023 I received a second written *AFC Licensing Division – Incident/Accident Report* for Resident A dated June 7, 2023 and signed by direct care staff member Wendy Cooke. The written report stated, “I walked in for my shift the other staff coming on [Tarah Sargeant] stated that previous shift [Jessica Marek and Ashlyn Sanborn] had called 911 for [Resident A] for having numerous seizures. I went down to his bedroom where both staff were and asked, ‘did anybody administer his diastatin?’ At that time staff member said “yes” so I told them to stay with him. I came down to med room and looked in my medicine cupboard and seen that [Resident A] still had 2 diastatin at that time and the staff member who told me “yes” walked into the med room and I took the diastatin and asked her, ‘is this what you gave him?’ She said, ‘No, I thought you were talking about his morning meds!’ I grabbed diastatin ran down to [Resident A’s] room and administered diastatin. Both staff said they had never been trained on seizure protocol and had no idea about diastatin. At that time police and ambulance showed up and took [Resident A] to the emergency room.”

On June 8, 2023 I received a written physician’s order for Resident A’s prescribed Diastat that stated, “Insert 10 mg if patient has more than 2 seizures in a 12 – hour period. Go to the ER if the patient does not return to baseline within one hour of administration.”

On June 22, 2023 I spoke to facility administrator Jenny Jacobs who stated Resident A has a seizure disorder which requires use of a VNS magnet and a rectal gel (Diastat) to be used if Resident A has more than two seizures in 12 hours. Ms. Jacobs stated every direct care staff member is trained in Resident A’s seizure protocol but during the early morning hours (third shift) on June 3, 2023 Resident A had multiple seizures and the direct care staff members who were working stated they did not know how to administer Resident A’s prescribed medication and Resident A had as many as ten seizures before first shift staff members arrived and administered Resident A’s prescribed Diastat. Ms. Jacobs stated all staff members would be retrained at the next facility staff meeting.

On June 22, 2023 I spoke to direct care staff member Jessica Marek who stated she was working and responsible for medication administration on June 3, 2023 at approximately 6:45 am when Resident A began having multiple seizures in his bedroom. Ms. Marek stated she is now aware that Resident A has a PRN (as – needed) written physician's order for Diastat which is a rectal gel to be administered if Resident A has more than two seizures in a 12-hour period. Ms. Marek stated she was not familiar with the medication on June 3, 2023 and did not administer the medication even though Resident A had three seizures before staff member Wendy Cooke who arrived at 7:00 am administered the medication. Ms. Marek stated she telephoned 911 to seek medical attention for Resident A.

On June 22, 2023 I spoke to direct care staff member Ashlyn Sanborn who said she worked at the facility the morning of June 3, 2023 and that she was working with direct care staff member Jessica Marek who was responsible for administering medication. Ms. Sanborn said at approximately 6:30 am she and Ms. Marek went into Resident A's bedroom to check on him and administer his scheduled morning medication and Resident A began to have multiple seizures. Ms. Sanborn said she knew that Resident A had a PRN physician's order for Diastat but she was not aware of the details of the order. Ms. Sanborn said she directed Ms. Marek to go look for the medication after Resident A had four seizures and that Resident A had six seizures in total before direct care staff member Wendy Cooke arrived at 7:00 am and administered Resident A's prescribed Diastat. Ms. Sanborn said Ms. Marek called an ambulance for Resident A and when they arrived, they took him to the hospital because he continued to seize.

On June 26, 2023 completed an unannounced onsite investigation at the facility where I observed Resident A. I attempted to interview Resident A regarding the allegation however he is expressively nonverbal and was unable to participate in an interview.

On June 26, 2023 I interviewed direct care staff member Wendy Cooke who said when she arrived to work her shift at the facility at approximately 7:00 am on June 3, 2023 direct care staff member Tarah Sargeant who was also arriving to work first shift told her that direct care staff members Jessica Marek and Ashlyn Sandborn who worked the previous overnight shift called an ambulance for Resident A because he was seizing. Ms. Cooke said Resident A has a seizure disorder and has written physician's orders to administer diastatin rectal gel if he has more than two seizures in 12 hours so she asked if the medication had been administered. Ms. Cooke said the third shift staff member told her the PRN medication was administered but when she checked the medication cupboard the medication was there, so she asked direct care staff member Jessica Marek who was responsible for administering medication that shift if she administered the Diastat rectal gel and she confirmed that she had not administered that medication. Ms. Cooke stated she immediately administered the medication. Ms. Cooke stated direct care staff member Ashlyn Sandborn told her Resident A had eight to ten seizures, but Ms.

Marek did not administer the PRN Diastat as ordered because the two stated they had no knowledge of the medication.

On June 26, 2023 I interviewed direct care staff member Tarah Sargeant who stated that when she arrived to work her shift at the facility at approximately 7:00 am on June 3, 2023 direct care staff member Jessica Marek approached her and stated she had given Resident A "his pill" but did not indicate she gave him Diastat which is a rectal gel prescribed to Resident A to be given if he has more than two seizures in twelve hours. Ms. Sargeant said Ms. Marek and Ms. Sanborn told her that Resident A had "between eight and ten" seizures while they were working with him before she arrived, and they had called an ambulance for Resident A. Ms. Sargeant said her coworker Wendy Cooke looked in the medication cabinet and told her Ms. Marek had not administered Resident A's PRN rectal gel to be administered after two seizures in a 12-hour period.

On June 26, 2023 I received and reviewed Resident A's written medication administration record (MAR) for June 2023 which indicated Diastat gel, 10 mg was administered rectally at 7:00 am by direct care staff member Wendy Cooke.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on statements from Ms. Sowles, Ms. Jacobs, Ms. Marek, Ms. Sanborn, Ms. Cooke, and Ms. Sargeant along with written documentation at the facility there is sufficient information that Resident A's prescribed Diastat (also known as Diazepam) was not administered as prescribed on June 3, 2023. The written physician's order stated Resident A's medication should be administered if Resident A has more than two seizures in a twelve-hour period and this investigation revealed that Resident A had as many as eight seizures in 30 minutes and the medication was not administered by direct care staff members who called an ambulance for Resident A instead.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in the status of the license.

07/26/23

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Leslie Herrguth Date
Licensing Consultant

Approved By:

08/04/2023

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Dawn N. Timm Date
Area Manager