GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 14, 2024

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

RE: License #: AS370011281
Investigation #: 2024A1033025
Mt Pleasant Home

Dear Mr. Boyd:

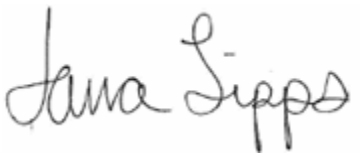
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370011281
Investigation #:	2024A1033025
Complaint Receipt Date:	01/23/2024
Investigation Initiation Date:	01/24/2024
Report Due Date:	03/23/2024
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 709-8239
Administrator:	Jenny Jacobs
Licensee Designee:	James Boyd
Name of Facility:	Mt Pleasant Home
Facility Address:	908 Sansote Mt Pleasant, MI 48858
Facility Telephone #:	(989) 772-0564
Original Issuance Date:	03/01/1988
License Status:	REGULAR
Effective Date:	07/31/2023
Expiration Date:	07/30/2025
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED

	MENTALLY ILL

ALLEGATION:

	Violation Established?
On 1/14/24 direct care staff showered Resident A, without using her shower chair, and Resident A fell in the shower.	Yes

II. METHODOLOGY

01/23/2024	Special Investigation Intake 2024A1033025
01/24/2024	Special Investigation Initiated - Letter Email correspondence with CMH, ORR representative, Katie Hohner.
02/01/2024	Inspection Completed On-site- Interview with direct care staff/home manager, Lisa Kappler, review of Resident A's resident record initiated.
02/07/2024	Contact - Telephone call made- Attempt to interview direct care staff, Kayla Major. No answer and her voicemail box was full. A text message was sent. Awaiting response.
02/14/2024	Contact - Telephone call made- Attempt to interview direct care staff, Kayla Major. No answer and voicemail box was full.
02/14/2024	Contact - Telephone call made- Attempt to interview direct care staff, Alecea Olson. No answer, voicemail message left, awaiting response.
02/14/2024	Contact – Telephone call received- Interview with direct care staff, Alecea Olson, via telephone.
02/20/2024	Exit Conference Conducted via telephone with licensee designee, Jim Boyd, voicemail message left.

ALLEGATION: On 1/14/24 direct care staff showered Resident A, without using her shower chair, and she fell in the shower.

INVESTIGATION:

On 1/23/24 I received an online complaint regarding the Mt. Pleasant Home, adult foster care facility (the facility). The complaint alleged that on 1/14/24, direct care staff, Kayla Major, performed Resident A's shower without having her shower chair accessible and Resident A fell in the shower on this date. The complaint alleges that Resident A's plan of care requires that a shower chair be immediately accessible for Resident A when she is being showered.

On 2/1/24 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/Home Manager, Lisa Kappler. Ms. Kappler reported she was made aware of Resident A's fall on 1/14/24 through a completed incident report she had received. Ms. Kappler reported there were two direct care staff members, Kayla Major, and Alecea Olson, on duty when Resident A fell in the shower. Ms. Kappler reported that the incident report documented that Resident A became weak while in the shower and fell backwards onto her buttocks. Ms. Kappler reported direct care staff have written orders from Resident A's occupational therapist to have a shower chair available when they shower her. Ms. Kappler reported that from her understanding of the incident, direct care staff did not have a shower chair immediately accessible for Resident A's use on 1/14/24 when they showered her. Ms. Kappler reported Resident A was not injured by the fall and was seen by her physician on 1/15/24. She reported that the physician added an additional order for Resident A that the direct care staff were to "always" use the shower chair when showering her.

During the on-site investigation on 1/14/24 I reviewed the following documents:

- *AFC Licensing Division Incident/Accident Report*, dated 1/14/24, for Resident A. This document was signed by Ms. Major. The report noted, "[Resident A] appeared shaky and disoriented 6 minutes into her shower. Staff started to dry her off and as she reached for the closest towel bar she fell backwards onto her behind. Staff broke her fall as much as possible trying to hold her underarm. She was stood up immediately by both staff, sat on the toilet and dried fully. Both staff assisted her to her chair and took all vitals. A shower chair will be used, not just offered. It will already be in the shower when I shower her so that she has a place to relax. Vitals completed. IR written. APD was informed on incoming shift."
- *ADL (Activities of Daily Living) Guidelines*, dated 11/2/22, for Resident A. This document was created by Katelyn Campbell, OTR/L (Occupational Therapist). Under the section, *Problem Statement*, it reads, "[Resident A] is becoming dependent on staff to complete ADL tasks (dressing, bathing, toileting, grooming/hygiene, etc) for her, and is not as willing to assist when she can. [Resident A] is able to help with parts of the task when encouraged

by staff." Under the subsection, *Bathing*, it states, "Help [Resident A] get in and out of the shower. Have the shower chair in the shower available to [Resident A] and give her the choice of sitting if she is fatigued. Encourage [Resident A] to wet and wash body parts that she can reach. Assist with washing and drying as needed."

- *Training Inservice For Listening Ear Crisis Center*, dated 11/17/22. Under the section, *Summary of Topic Presented*, it reads, "Reviewed Functional Mobility Guidelines – ADL Guidelines." This document was available in Resident A's resident record. It contained a list of direct care staff signatures for who had completed this Inservice. Ms. Major signed this training log on 9/2/23 and Ms. Olson signed this training log on 10/5/23.
- *Assessment Plan for AFC Residents form*, dated 12/6/23, for Resident A. On page 2, under section, *II. Self Care Skill Assessment*, subsection, *C. Bathing*, it reads, "Requires full staff assistance, does not have the ability to perform personal care needs. Does have the ability to follow simple requests when washing herself. Staff are to follow guidelines created by Katelyn Campbell, OTR/L on 11/2/2022 (re-inserviced on 1/25/23) which states that staff help [Resident A] to get into the shower, 2) have shower chair in the shower or available to [Resident A] and give her a choice of sitting if she is fatigued, 3) Encourage [Resident A] to wet and wash body parts that she can reach, 4) assist with washing and drying as needed. She will also be encouraged to hold onto the shower head and help rinse herself off."
- *Training Inservice For Listening Ear Crisis Center*, dated 12/6/23, for Resident A. The Topic of this training was titled, *[Resident A] assessment (Home's)*. Ms. Olson's name was listed as completing this training on 12/15/23, and Ms. Major was listed as completing this training on 12/28/23.
- *Community Mental Health for Central Michigan Physician's Orders for AFC & Specialized Contract Providers*, dated 1/16/24, for Resident A. Under the section, *Medications/Treatment – Additions, Deletions, Changes (Explain below)*, is the statement, "Must use shower chair at all times in shower." The name of the physician was not legible on this form but it was signed and dated for 1/16/24.

On 2/7/24 and 2/14/24 I made attempts to interview Ms. Major, via telephone, without success. I have not received a response from Ms. Major regarding the allegation.

On 2/14/24 I interviewed Ms. Olson, via telephone. Ms. Olson reported that she had been working on 1/14/24 when Resident A had a fall in the shower. Ms. Olson reported that she was not the one who was showering Resident A and did not observe the fall. She reported that Ms. Major had been showering Resident A and called to her for assistance in getting Resident A off the floor. Ms. Olson reported that when she arrived in the bathroom, Resident A was sitting on her buttocks on the shower floor, Ms. Major was behind her, and Resident A's shower chair was in the bathroom, but it was not in the shower area. Ms. Olson reported that they were able to get Resident A back to a standing position and she did not appear to have any injury from the incident.

On 1/18/23, Special Investigation #2022A1029008 cited a rule violation of Rule R.400.14303, Resident care; licensee responsibilities, (2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan. The analysis section of this report noted, Resident A was not provided supervision according to her *Assessment Plan for AFC Residents* on October 16, 2022, and July 28, 2021, allowing Resident A to ingest a small portion of her adult brief. The corrective action plan, dated 1/24/23 and signed by Timothy Carmichael, noted, “Resident’s assessment plan and CMH PCP was reviewed with staff regarding PICA diagnosis and her requirement for line-of-sight supervision. Staff will continue with ongoing training on assessment plans, CMH PCP and consumers specific protocols.” The resident identified in this referenced investigation is the same resident identified in the current report/allegation.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based upon interviews with Ms. Kappler & Ms. Olson, as well as review of Resident A’s resident record it can be determined that on 1/14/24 Ms. Major did perform Resident A’s shower and did not have a shower chair available in the shower for Resident A’s use, as identified in her occupational therapy guidelines and her written assessment plan. According to the incident report, completed by Ms. Major, Resident A became weak in the shower and ultimately fell on her buttocks on the shower floor. There were training records which indicated Ms. Major had been educated to the occupational therapy guidelines and assessment plan for Resident A, therefore a shower chair should have been available in the shower for Resident A.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2022A1029008 AND CAP DATED 1/24/23].**

III. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

02/14/24

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Jana Lipps Date
Licensing Consultant

Approved By:

02/20/2024

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Dawn N. Timm Date
Area Manager