GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 8, 2024

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

RE: License #: AS400069154
Investigation #: 2024A0009021
North Birch

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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame 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 (231) 922-5309.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS400069154
Investigation #:	2024A0009021
Complaint Receipt Date:	04/17/2024
Investigation Initiation Date:	04/17/2024
Report Due Date:	05/17/2024
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	Sherry Kidd
Licensee Designee:	James Boyd
Name of Facility:	North Birch
Facility Address:	2200 N Birch Kalkaska, MI 49646
Facility Telephone #:	(231) 258-5105
Original Issuance Date:	01/25/1996
License Status:	REGULAR
Effective Date:	02/23/2024
Expiration Date:	02/22/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A fell in the shower and broke his hip. He requires assistance when bathing, but staff were not present when he fell.	Yes

III. METHODOLOGY

04/17/2024	Special Investigation Intake 2024A0009021
04/17/2024	Special Investigation Initiated – Telephone call made to Community Mental Health recipient rights officer Brandy Marvin
04/17/2024	Contact – Documents (email with attachment) received from administrator Sherry Kidd
04/19/2024	Inspection Completed On-site Interview with home manager Kelly Happel and Face to face contact with Resident A
05/02/2024	Contact – Telephone call made to direct care worker Leah Howe
05/02/2024	Contact – Telephone call made to direct care worker LaToya Parks
05/06/2024	Contact – Document (email with attachment) received from home manager Kelly Happel
05/07/2024	APS Referral
05/07/2024	Exit conference with administrator Sherry Kidd

ALLEGATION: Resident A fell in the shower and broke his hip. He requires assistance when bathing, but staff were not present when he fell.

INVESTIGATION: I spoke with Community Mental Health (CMH) recipient rights officer Brandy Marvin by telephone on April 17, 2024. She reported that the recent incident of Resident A falling in the shower was investigated by recipient rights officer Amanda Dixon. Ms. Dixon did not find that Resident A's rights were violated because the CMH care plans did not outline a "step by step" instruction for staff when showering Resident A.

I received an email from administrator Sherry Kidd on April 17, 2024. She provided CMH documentation for Resident A detailing his care needs. I reviewed the documents at that time. I noted that Resident A's CMH Health Care Plan dated February 15, 2024 reported, "*(Resident A) did suffer a serious fall in March of 2019 which broke his left hip and required a surgical intervention to repair*." The plan indicated under the Personal Care Assistance heading that Resident A requires "extensive assistance" with bathing. The plan also indicated under the Support With Personal Care heading that Resident A requires "extensive support" and that he is "*able to perform personal care tasks with extensive support of another person*". Resident A's CMH Assessment required "*Due to (Resident A's) regression in his health within the last year, his AFC staff help with his walking, showering, and other daily needs.*"

I conducted an unannounced site visit at the North Birch adult foster care home on April 19, 2024. I met with home manager Kelly Happel at that time. She said that Resident A had fallen on April 15, 2024. It happened right before she had gotten there for her own shift. Direct care workers Leah Howe and LaToya Parks had been working at the time it happened. They reported to her that he had fallen and that they believed he needed to be seen at the emergency department. Ms. Howe had been assisting Resident A in the shower at the time. Resident A uses a shower chair due to his mobility issues. He was belted into the chair but Ms. Howe did not use the foot peddles which Resident A does require. Ms. Happel stated that the foot peddles are important for him to use because he cannot sit straight by himself in the chair. He is unable to distribute his weight by himself so is unsteady in the chair without his feet in the peddles. Ms. Happel stated that she has instructed "each and every" staff to always use the foot peddle attachments when showering Resident A. She added that she knew that she had specifically told Ms. Howe that she needed to use the foot peddle attachments when showering Resident A. The foot peddles are detachable so were not attached to the chair at the time for whatever reason. Ms. Howe left Resident A in the shower at that time. Resident A undid the belt to the shower chair while she was gone and they believed he was trying to reach for something by himself. He tipped over in the chair and fell onto the floor of the shower. Ms. Howe reported that she was in the medication room at the time getting him his medication. Resident A has a fractured hip. He was treated and released from the hospital. He has an appointment with an orthopedic doctor. Ms. Happel reported that she has reiterated with Ms. Howe that she needs to use the foot peddles every time she showers Resident A. She said that they have left him in his shower chair in the shower before but only when he has his feet securely placed in the foot peddles of the shower chair. Ms. Happel stated that they now do believe it is in Resident A's best interest not to be left alone when showering.

I spoke with direct care worker Leah Howe by telephone on May 2, 2024. She confirmed that she was the one who showered Resident A on April 15, 2024. She said that she belted him into his chair and noticed that she hadn't brought in the lotion he needs. She went to the medication room to retrieve the lotion. Ms. Howe went on to say that she heard a "thump" and heard Resident A say "Oww". When

she went back to the bathroom she found Resident A on the floor of the shower. She assumed that Resident A had taken off his belt and believes he was reaching for the shower head. Ms. Howe admitted that the foot peddles had not been attached to the shower chair at the time. I asked her if Ms. Happel had spoken with her about the foot peddles being attached to the shower chair when Resident A used it. Ms. Howe acknowledged that Ms. Happel had told her that she wanted the foot peddle attachments on the chair when Resident A showered. Before this incident, they had not always supervised him completely in the shower. Although they had known him to take off the belt in his wheelchair, they had not known him to take off the belt in the shower chair before. Ms. Howe said that she does feel that Resident A needs "complete supervision" in the shower now.

I then spoke with direct care worker LaToya Parks by telephone on May 2, 2024. I asked her about the incident of Resident A falling on April 15, 2024. She said that she had been at the dining room table doing paperwork at the time it happened. She saw Ms. Howe go by on her way to the medication room. She knew that Ms. Howe was in the middle of showering Resident A. Ms. Parks said that she heard what sounded like the shower head falling on the floor. She then heard Resident A say "Oww". As soon as she heard him say that she got up to help him and found him on the floor of the shower. I asked Ms. Parks how long Ms. Howe had been absent from the bathroom. Ms. Parks replied, "not even five minutes." She said that they had not felt that he needed complete supervision in the shower as long as he was belted into his shower chair with his feet in the foot peddles. I asked Ms. Parks how she knew that he always needed to have his feet in the foot peddles when showering. She replied that she was trained to always use the foot peddle attachments when Resident A showers and to ensure his feet are in the peddles at all times.

I received Resident A's Assessment Plan for AFC Residents (BCAL-3265) dated February 5, 2024 from home manager Kelly Happel on May 6, 2024. The written assessment indicated that Resident A did require assistance with bathing. In the comments section it read, "*Staff uses a 'Sit-to-Stand' to transfer him safely to the shower chair. Staff need to make sure he is sitting up straight in shower chair and buckled in.*"

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:	On March 15, 2024, Resident A was left in a shower chair in the shower by himself. He tipped over in the chair, fracturing his hip from the fall. It was documented in Resident A's CMH Health

	Care Plan that he needs extensive assistance and extensive support when bathing and with personal care. Resident A's written assessment indicated that staff need to make sure that Resident A is sitting up straight in his shower chair and buckled in. Resident A had not necessarily been known to unbuckle the belt on his shower chair before but had been known to unbuckle the belt for his wheelchair. Direct care worker Leah Howe did not use the foot peddles for Resident A which she had previously been instructed to do. She then left Resident A unattended for up to several minutes while she reportedly went to get something for him. The other direct care worker was sitting at the dining room table and saw her walk by knowing Resident A was showering. In consideration of the above information, it is determined that the licensee did not provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with administrator Sherry Kidd by telephone on May 7, 2024. I told her of the findings of my investigation and gave her the opportunity to ask questions.

IV. RECOMMENDATION

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

Adam Robarge 5/7/2024

Adam Robarge Date
Licensing Consultant

Approved By:

Jerry Hendrick 5/8/2024

Jerry Hendrick Date
Area Manager