GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 13, 2024

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

RE: License #: AS370011281
Investigation #: 2024A1029067
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370011281
Investigation #:	2024A1029067
Complaint Receipt Date:	09/17/2024
Investigation Initiation Date:	09/17/2024
Report Due Date:	11/16/2024
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois, Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	James Boyd
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

II. ALLEGATION(S)

	Violation Established?
Resident A has PICA and was found with a used tampon applicator in her mouth because she was not properly supervised in the bathroom.	Yes

III. METHODOLOGY

09/17/2024	Special Investigation Intake 2024A1029067
09/17/2024	Special Investigation Initiated – Telephone call to Katie Hohner Office of Recipient Rights
10/02/2024	Inspection Completed On-site – Face to face with Ms. Kappler, Resident A, Demia Owensby, and Ms. Schuster at Mt. Pleasant Home
10/02/2024	Contact - Telephone call made to Jenny Jacobs
10/08/2024	Contact - Telephone call made to direct care staff member Victoria Doan
10/17/2024	Contact - Telephone call made to licensee designee Jim Boyd
10/24/2024	APS Referral made to Centralized Intake
10/24/2024	Contact - Telephone call made to Isabella County MDHHS APS specialist, Alison Witucki, she will be investigating concerns.
10/30/2024	Contact – Telephone call to Ms. Hohner. Left message. Email to Lisa Kappler, Jenny Jacobs and Jim Boyd.
11/04/2024	Contact – Face to face with administrator Jenny Jacobs at another licensed facility, telephone call to Jim Boyd.
11/04/2024	Exit conference with licensee designee Jim Boyd

ALLEGATION: Resident A has PICA and was found with a used tampon applicator in her mouth because she was not properly supervised in the bathroom.

INVESTIGATION:

On September 17, 2024 a complaint was entered after review of an *AFC Incident / Accident Report* received by Complainant indicating Resident A was not supervised properly in the bathroom and was able to obtain a used tampon applicator and put it in her mouth. Complainant stated Resident A did not ingest it because she spit it out when the direct care staff members asked her to give it to them. However, Complainant stated Resident A should have been supervised while in the bathroom as required by her plans of care. Complainant stated a Recipient Rights investigation regarding these concerns would be opened.

I reviewed the AFC Incident / Accident Report from the September 15, 2024 incident written by Ms. Schuster which included the following information:

"Explain what happened: As staff walked past the restroom, they noticed that [Resident A] had a used tampon applicator in her mouth, staff held out their hand and asked if they could have it, she took it out of her mouth and gave it to staff.
Action taken by staff: Reminded staff of [Resident A's] diagnosis and asked them to please make sure everything is out of reach and not just the toilet paper to prevent incidences.
Corrective measures: Staff removed all trash cans from within her reach and will continue to monitor."

On October 2, 2024, Office of Recipient Rights Officer (ORR) Katie Hohner and I completed an onsite investigation at Mt. Pleasant Home and interviewed direct care staff member Demia Owensby. Ms. Owensby stated she did not see Resident A put the tampon applicator in her mouth however direct care staff member Ms. Schuster came out of the bathroom and notified her and direct care staff member Ms. Doan about this incident. Ms. Owensby stated Ms. Doan was assigned to provide 1:1 staffing coverage that morning to Resident A but Ms. Owensby stated she was also checking on Resident A. Ms. Owensby stated she left the bathroom while Resident A was in there and sat down to look at some paperwork at the table so she did not have Resident A in her line of sight while she was sitting at the table. Ms. Owensby stated there was a meeting earlier (on October 2, 2024) and she was informed they are supposed to monitor her every 15 seconds after removing the items in the bathroom. Ms. Owensby stated the second time direct care staff check with her; Resident A is given something to fidget with while finishing in the bathroom. Ms. Owensby stated in these circumstances, direct care staff are directed to stay close if Resident A is displaying signs of PICA. Ms. Owensby stated this behavior was new because she does not recall Resident A reaching into the trash can before. Ms. Owensby stated she did not clean the trash cans out or remove them from the bathroom prior to Resident A using the bathroom.

On October 2, 2024 Ms. Hohner and I interviewed direct care staff member, whose role is home manager, Lisa Kappler. Ms. Kappler stated she was not there on September 15, 2024, however direct care staff members Ms. Schuster, Ms. Owensby, and Ms. Doan were working during this shift. Ms. Kappler stated Ms. Doan was the direct care staff member assigned to provide 1:1 staffing coverage to Resident A however Ms. Owensby was the direct care staff member who assisted Resident A in the bathroom.

I asked Ms. Kappler for the most updated supervision guidelines the direct care staff members were supposed to follow for Resident A and she handed me a packet which include several different training sign offs, Resident A's *Person-Centered Plan*, and the *Assessment Plan for AFC Residents*. Due to the various updates of the supervision plan for Resident A, I did not find a single document highlighting Resident A's current supervision guidelines.

Ms. Kappler stated while Resident A is in the bathroom, direct care staff members walk around and see what they can do around the house. Ms. Kappler stated it was her understanding they were supposed to give Resident A privacy and check on her every 15 seconds so they could walk away and then come back. Ms. Hohner and I reviewed the supervision plan with Ms. Kappler and informed her the most current plan stated direct care staff members need to maintain Resident A within their **peripheral** vision while she is in the bathroom and if walking away, direct care staff members will likely not be able to keep Resident A in their peripheral vision due to the layout of the facility. Ms. Hohner and I informed Ms. Kappler the direct care staff members needed to be retrained on this directive and sign they understood this information to always keep Resident A in peripheral vision while she was in the bathroom. Ms. Kappler stated she has in-serviced the supervision guidelines with the direct care staff members at least 3-4 times and also addressed this at each staff meeting especially since the last PICA incident in May 2024 occurred. Ms. Kappler stated there is a trash can in the bathroom which they could enclose in a cabinet but it was out and available to her when this incident occurred. Ms. Kappler stated Resident A does not always use the same bathroom because there is another resident who monopolizes the bathroom throughout the day so she has to be able to use both bathrooms.

I was able to observe the residents in the home however all residents are non-verbal and were unable to complete an interview.

During the onsite investigation, I reviewed the following documentation for Resident A regarding this specific incident:

1. Toileting / brief check documentation log for September 2024 showed direct care staff member Ms. Doan was responsible for toileting Resident A and completed this task at 7:45, 9:30, 11:30, and 1 PM on September 15, 2024.

2. Training In-services documented Resident A's Updated *AFC Assessment Plan for AFC Residents* was reviewed by direct care staff members.

3. Documentation explaining the 1:1 staffing ratio between the hours of 7:30 AM – 9:30 PM for Resident A which stated, "*make sure consumer is within line of sight at all times this does not mean you only focus or sit right next to that consumer unless their activities require that type of monitoring. Normal duties can still be followed but you must have one to one consumer within your site at all times."* This document was signed by Ms. Kappler, Ms. Owensby, Ms. Doan, and Ms. Schuster indicating their understanding of these guidelines.

4. A document titled *[Resident A's] 1:1 Line of Sight* which outlined the requirements of monitoring while she is in the bathroom which includes the following guidelines that were put in place on July 11, 2024:

"[Resident A] requires staff supervision and support while toileting

Before [Resident A] enters the bathroom, her staff should scan the room for any potential items she could grab and ingest while toileting.

a. *Upon entering the bathroom and preparing to toilet, staff should remove her brief (e.g., discard in trash can outside of her reach)*
b. *Staff should remove any toilet paper, paper towels, and hygiene products out of her eyesight and away from her reach.*

[Resident A] prefers to have the bathroom door open while she toilets. Staff should stand just outside the bathroom door without directly facing [Resident A]. They should monitor her with their ***peripheral*** *vision to provide her with as much privacy as possible, unless she is actively engaging in PICA. Should [Resident A] engage in Pica, staff should increase their monitoring of her:*

1. *The first time she attempts to place something in her mouth, staff should provide a verbal redirection and offer her a fidget or other item to hold in her hands. They should then monitor discreetly for 15 seconds to see if PICA behaviors continue.*
2. *If she engages in PICA behaviors a second time, staff should provide additional redirection and offer different items for her to hold. They should then monitor her for an additional 15 seconds to see if PICA behaviors continue*
3. *The third time she attempts to place something in her mouth, staff should then enter the bathroom. Staff should offer to hold her hands or engage her hands in alternative tasks to prevent her from placing items in her mouth. If at any time she attempts to drop an item or pull her hands away from staff, this should be respected and staff should let go. Her hands should not be held if she has shown clear indications that she does not want staff to hold them (e.g., pulling away, attempting to release grasp)*

4. *Health and Safety Supports* document from July 11, 2024 stated:

"[Resident A's] designated staff should be able to see her at all times and be able to intervene quickly as needed. Line of sight means direct, unobstructed vision. Staff may complete other tasks but should be able to notice and reach her within seconds if she displays PICA behaviors. Staff should just stand outside the bathroom door without directly facing Resident A they should monitor her with

*their **peripheral** vision to provide her with as much privacy as possible unless she is actively engaging in PICA."*

I reviewed the following *AFC Incident / Accident Reports* which documented eight additional PICA incidents regarding Resident that occurred since June 2024. These described in part the following information of the incident:

- August 7, 2024: Resident A got a piece of paper and put it in her mouth. Staff removed the paper with a toothette. Continue to monitor and provide direction.

- July 2, 2024: During the afternoon shift Resident A was observed with 2 PICA incidents, 3 incidents of aggression, and 1 incident of self-gagging. Staff provided her with handheld objects to keep her redirected.

- July 10, 2024: Resident A was sitting in the living room and staff checked her and saw her picking at the incontinence soaker (tag). When staff approached her to redirect from picking at tag Resident A appeared to be sucking on something and staff checked her mouth and noticed part of the tag in her mouth. She allowed staff to remove it. Staff removed tags from the rest of the soakers and continued to monitor her.

- June 21, 2024: Staff was assisting a consumer and observed a piece of string hanging from Resident A's mouth which came from her blanket. Staff were able to remove with toothette.

- June 19, 2024: Resident A had aggression 1 time, anxiety 5 times, PICA 2 times, and gagged herself 2 times. Will continue to redirect.

- June 8, 2024: Resident A was noticed with the left side of her night shirt pulled down with her left arm and hand outside of her nightshirt. Staff noticed her making a sucking motion with her mouth. Staff retrieved with a toothette a piece of her brief. Upon inspection of her brief, it was the only piece missing.

- June 7, 2024: Resident A reached down in her pants and grabbed a piece of brief and swallowed it. Staff grabbed a toothette to use and Resident A refused to open her mouth and shook her head from side to side. Staff will work with her on sensory activities to keep her hands preoccupied with activities.

- June 4, 2024: While Resident A was sitting on the toilet, she pulled a string from her dress and put it in her mouth. Staff retrieved the string with a toothette and continued to monitor her in the bathroom.

On October 2, 2024, ORR Ms. Hohner and I interviewed administrator, Jenny Jacobs who stated there was a misunderstanding in the supervision guidelines. Ms. Jacobs stated although it says peripheral vision it was her and direct care staff understanding that Resident A only had to be checked every 15 seconds and when they were near the

door they had peripheral vision. Ms. Jacobs stated she will need to clarify with the direct care staff members they need to remain in peripheral vision while Resident A is in the bathroom. Ms. Jacobs stated additional training regarding Resident A's supervision level requirements will be provided to all direct care staff members.

Ms. Hohner and I observed the bathroom which had a large utility cabinet near the wall where a trash can could easily be stored in. This cabinet has doors that are difficult to open and it is unlikely Resident A could access the trash can inside this cabinet. I discussed with Ms. Kappler about putting the trash can into this cabinet if it cannot be removed completely from the bathroom.

I noted there were also guidelines for Resident A's supervision posted on the wall in the bathroom. These guidelines read as follows:

> *"While [Resident A] is in the restroom staff should be standing by the door, glance at her every 15 seconds to make sure she isn't picking at strings or showing signs of PICA, if you observe her picking at anything you are to redirect her with the bucket of sensory objects above the toilet, then stand back out and check on her every 15 seconds. If she does it a second time, give her a different sensory object, if she attempts a third time staff are to sit in the restroom until she is done. You can talk to her, hand her objects, hold her hands, etc. While she is in the restroom she is not to have a brief on, nor should there be any paper towel or toilet paper within her sight.*
>
> **She is now opening cupboards looking for items. Cupboard above toilet is to be cleared of all items except for sensory items!*
>
> *Additional information was added after this incident on September 17, 2024: When she is in the bathroom staff are to complete the monitoring protocol, remove items as listed but will also need to remove all trash cans or any items that may cause her harm."*

On October 2, 2024, ORR Ms. Hohner and I interviewed direct care staff member whose role is assistant home manager Ms. Schuster. Ms. Schuster stated after setting up Resident A's medications Ms. Owensby was double checking the medications and she walked by the bathroom and saw Resident A with a tampon applicator in her mouth. Ms. Schuster stated she went into the bathroom, asked Resident A to give it to her and Resident A took it out of her mouth. Ms. Schuster stated Ms. Owensby took Resident A to the bathroom while Ms. Doan was acting as the 'second checker' for Resident A's medications. Ms. Schuster stated Ms. Owensby should have been monitoring Resident A while she was in the bathroom. Ms. Schuster stated her understanding of the supervision requirements while Resident A was in the bathroom was line of sight and every 15 seconds if she is showing signs of PICA. Ms. Schuster stated if Resident A is displaying signs of PICA, Resident A can be given an activity to do such as her blocks or pop-its. Ms. Schuster stated if Resident A is not displaying signs of this, then direct care staff can leave the bathroom while keeping Resident A within line of sight. Ms.

Schuster stated direct care staff need to remain standing outside the bathroom so they can get to Resident A quickly. Ms. Schuster stated when she is supervising Resident A, she does not leave the bathroom door while Resident A is toileting. Ms. Schuster stated she generally stands outside in the hallway while continuing to peek in on Resident A every 15 seconds. Ms. Schuster stated Ms. Owensby used to sit in the bathroom the entire time and then she was told they are not supposed to sit in there the whole time unless Resident A was observed to display PICA signs three times.

On October 8, 2024, Ms. Hohner and I interviewed direct care staff member Victoria Doan. Ms. Doan stated she has worked there for 1.5 years. Ms. Doan stated she was working the day Resident A ended up putting the tampon applicator in her mouth but did not observe this. Ms. Doan stated she did not toilet Resident A during that shift. ORR Ms. Hohner informed Mts. Doan she signed the data sheet confirming she assisted Resident A in the bathroom when this incident occurred. Ms. Doan replied she may have signed it despite not completing the task. Ms. Doan was advised by Ms. Hohner not to initial a log sheet in the future if she did not perform the task. Ms. Doan stated direct care staff are supposed to take Resident A into the bathroom, make sure everything is out of reach, and monitor her “every couple second or minutes” to see if she is picking at anything. Ms. Doan stated she was ‘second checker’ for medications at that time so she did walk away from the bathroom because her assistant supervisor Ms. Schuster had asked her to check medications. Ms. Doan stated Ms. Schuster checked on Resident A while she was checking medications and saw she had the tampon applicator. Ms. Doan stated she believes they were able to walk away from the door as long as they were checking on her regularly. Ms. Doan stated she now understands direct care staff are required to stand right in the doorway. Ms. Doan stated the tampon applicator came from the trash can. Ms. Doan stated if she did put her in the bathroom at that time, she may not have removed the trash can. Ms. Doan stated any time there is an update to a resident’s care needs/protocols, facility administration conducts an in-service / staff meeting. Ms. Doan stated at the most recent staff meeting Resident A’s supervision guidelines were discussed.

On October 17, 2024, I interviewed licensee designee Jim Boyd. Mr. Boyd stated he is completing a root cause analysis for the situation because he is trying to determine why this keeps occurring. Mr. Boyd stated Ms. Kappler is an experienced home manager and is typically great at documentation however he also had to look closely at a protocol and an addendum to see there were differences between Resident A’s addendum and the protocol. Mr. Boyd also recognized there were several updates and addendums making it unclear what the current supervision guidelines were. Mr. Boyd stated the steps not followed in this incident included: checking for items in the bathroom, not standing with the door open and keeping Resident A in their peripheral vision. Mr. Boyd stated direct care staff members were all trained on Resident A’s behavioral treatment plan on May 24, July 11, and September 17, 2024. Mr. Boyd stated Ms. Doan was the direct care staff member responsible for Resident A’s 1:1 staffing coverage at the time of this PICA incident. Mr. Boyd stated Ms. Owensby assisted Resident A to the bathroom and walked away to double check the medications per Ms. Schuster’s direction. Mr. Boyd stated Ms. Doan completed documentation on the Bathroom Log but

she did not take Resident A to the bathroom. Mr. Boyd stated it is unknown what Ms. Doan was doing during this timeframe. Mr. Boyd stated direct care staff members were trained on the updated requirement to keep Resident A in their peripheral vision in July 2024.

Prior to this incident, Special Investigation # 2023A1029008 cited Rule 400.14303.2 when a similar incident occurred because Resident A was not supervised in the bathroom on October 16, 2022, and she ingested part of her brief. A corrective action plan was completed and submitted on January 24, 2023, which stated: “Residents 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 Plan, CMH PCP and consumers specific protocols.” ORR advisor Katie Hohner also went to Mount Pleasant Home with her supervisor for a staff meeting to remind direct care staff members about following safety procedures regarding PICA and [Resident A] to ensure she does not ingest any more items.”

Special investigation # 2024A1029033 written on March 4, 2024, documented Resident A ingested pieces of her brief which required surgery and while at the hospital, it was found Resident A also had a six-inch piece of tubing in her stomach. A corrective action plan was completed and submitted on April 17, 2024 which included the following statement written by administrator Jenny Jacobs. “Whenever possible, utilize reusable briefs. Data tracking will be inserviced and started immediately for inspection of brief throughout waking hours. This will be completed every time Resident is using the restroom, which is on average every hour to one and a half hours. AFC Assessment will be updated to clarify that Resident has line of sight supervision during waking hours. Home Manager and Residential Director will monitor this tracking data to ensure staff are completing these checks. Area around Resident will be checked for possible ingestible materials while alone in restroom.”

Special investigation # 2024A1029050 written on July 16, 2024, documented Resident A ingested toilet paper that was left out on the bathroom counter despite her plan stating all items should be out of reach while in the bathroom because of her PICA diagnosis. A corrective action plan was submitted on July 22, 2024 which included the following statement: “Ms. Minto was terminated from her employment with Listening Ear furthermore protocols were put in place for line of sight supervision with resident (this was done with CMH input), all staff trained and signed off on this plan residents assessment was updated and sent to licensing prior to end of investigation the home manager and residential director will continue to monitor protocols and conduct trainings on line of site with this resident.” During the exit conference for this investigation on July 11, 2024 Mr. Boyd stated the sentence about stepping outside of the door as long as they were checking on her was changed to clarify they needed to be near the door at all times because of the monitoring staffing coverage.

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:	Resident A has a diagnosis of PICA and due to direct care staff members not removing the bathroom trash can prior to Resident A entering the bathroom on September 15, 2024, Resident A was able to put a used tampon applicator taken from the trash into her mouth while she was in the bathroom. During this incident on September 15, 2024, direct care staff members Ms. Doan and Ms. Owensby did not take the items out of the bathroom before Resident A used it and they did not maintain peripheral vision of Resident A while she was in the bathroom or follow her guidelines for 1:1 line of sight staffing coverage as required per Resident A's plans. Three other Special Investigation Reports (2024A1029050, 2024A1029033, 2023A1029008) documented incidents Resident A putting items in her mouth. including one that required a surgery after she ingested part of her brief and plastic tubing. I also reviewed *AFC Incident / Accident Reports* involving Resident A from June 2024 through August 2024 and there were 8 separate incidents of PICA where Resident A put something in her mouth since June 4, 2024.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED- SEE SIR # 2024A1029050 dated July 16, 2024 and CAP dated July 22, 2024, SI# 2024A1029033 dated March 4, 2024, and CAP dated April 17, 2024, and SI# 2023A1029008 dated November 21, 2022 and CAP January 24, 2023.**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend a six-month provisional license.

_ _____11/06/2024_____

Jennifer Browning — Date
Licensing Consultant

Approved By:

11/13/2024

_____

Dawn N. Timm — Date
Area Manager