GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 29, 2025

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

RE: License #: AS370011281
Investigation #: 2025A1029023
Mt Pleasant Home

Dear Ms. Seger:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality-of-care violations the Provisional License status will continue. 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 licensee designee and the 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,

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 #:	2025A1029023
Complaint Receipt Date:	03/11/2025
Investigation Initiation Date:	03/11/2025
Report Due Date:	05/10/2025
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois, Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	Kaila Morris
Licensee Designee:	Cynthia Seger
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:	1ST PROVISIONAL
Effective Date:	12/03/2024
Expiration Date:	06/02/2025
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's seizure protocol was not followed by direct care staff members on March 6-March 7, 2025 because she was not given her PRN Valium as required.	Yes

III. METHODOLOGY

03/11/2025	Special Investigation Intake 2025A1029023
03/11/2025	Special Investigation Initiated – Telephone call from Director of Residential Services Jim Boyd
03/11/2025	Contact - Document Sent to ORR Katie Hohner. Referral made to Office of Recipient Rights. Keegan Sarker will be investigating the concerns.
03/12/2025	APS Referral Made APS referral online to Centralized Intake
03/13/2025	Contact - Document Sent to Keegan Sarker ORR
03/21/2025	Contact - Face to Face with direct care staff members Mary Bartlett, Nicole Esterline, Jaden Booth, Amonie Mannan, Marie Jeffrey, Victoria Doan, Julie Meyer, Halley Lowrey, licensee designee Cynthia Seger, and Jim Boyd at Listening Ear Office with ORR Keegan Sarker.
03/21/2025	Contact - Telephone call made to former home manager, Lisa Kappler
03/21/2025	Inspection Completed On-site - Face to Face with Resident A, Kaylie Schuster, Victoria Doan at Mt. Pleasant Home
04/08/2025	Telephone call made to licensee designee Cynthia Seger
04/08/2025	Exit conference with licensee designee Cynthia Seger

ALLEGATION: Resident A's seizure protocol was not followed by direct care staff members on March 6-March 7, 2025 because she was not given her PRN Valium as required.

INVESTIGATION:

On March 11, 2025, a complaint was received alleging Resident A's seizure protocol was not followed by direct care staff members on March 6-March 7, 2025 because she was not given her PRN Valium as required. According to the allegations, there was no communication regarding her first seizure on March 6, 2025 to second shift direct care staff members so when a second seizure occurred during second shift, direct care staff members did not follow protocol and give Resident A her PRN Valium as indicated. According to the allegations, there was a third seizure on March 7, 2025 and that is when the PRN Valium was given to Resident A.

On March 11, 2025, I received a phone call from Director of Residential Services, Jim Boyd and licensee designee Cynthia Seger who both stated there was no communication between the shifts regarding Resident A's seizures therefore the protocol was not followed. Mr. Boyd stated all direct care staff members were trained on Resident A's seizure protocol so he did not know why Resident A's seizure protocol was not followed as written. Mr. Boyd stated Resident A's seizure protocol includes a 24-hour timeclock which requires direct care staff to track how many seizures Resident A has within that time period while also timing and tracking how long each seizure lasts. Mr. Boyd stated he has not interviewed any of the direct care staff members involved at this time. Mr. Boyd and Ms. Seger also sent me the following documentation: Resident A's current seizure protocol and direct care staff member training on the seizure protocol which I reviewed.

"Seizure Protocol from February 26, 2025:
This protocol is for a 24 hour duration.

- *If seizure last more than 5 minutes or seizure activity totaling 5 minutes (in a 24 hour duration). Staff will give the following medication:*
  - *Give valium 2 ml (equals 2 mg) via peg tube*
  - *Dilute with 30 ml water then*
  - *Give a 10 ml water rinse after (this helps rinse the medication from the peg tube)*
- *If seizure event with any respiratory distress, cardiac distress, or injury occurs call 911 for transport.*
- *If seizure event lasts over 7 minutes total in duration also call 911 for transport.*

Example of seizure event:
[Resident A] has a 2.5 minute seizure on the AM shift and then has another 2.5 minute seizure during the afternoon shift, she is to receive a dose of valium. During this 24 hour duration it does not matter when she has the seizure activity. Once she gets to a total of 5 minutes, she is to receive the valium liquid. Then after she receives the medication she is to be monitored and if her seizure activity gets to 7 minutes staff are to call 911 for transport."

This seizure protocol which was faxed to Mt. Pleasant Home on February 26, 2025 and was signed off by direct care staff members on February 27, 2025, which included direct care staff Ms. Schuster, Ms. Kappler, Ms. Booth, Ms. Lowrey, Ms. Esterline, Ms. Bartlett, Ms. Doan, and Ms. Meyer who all were involved in this incident.

<u>"Seizure Protocol signed off by direct care staff members on March 7, 2025:</u>
This protocol is for a 24-hour duration.
SEIZURE ACTIVITY STARTS THE 24-HOUR DURATION.

- *If seizure lasts more than 5 minutes or seizure activity totaling 5 minutes (in a 24-hour duration), staff will give the following medication:*
  - *Give valium 2 ml (equals 2 mg) via peg tube*
  - *Dilute with 30 ml water then*
  - *Give a 10 ml water rinse after (this helps rinse the medication from the peg tube)*
- *If seizure event with any respiratory distress, cardiac distress, or injury occurs call 911 for transport.*
- *If seizure event lasts over 7 minutes total in duration also call 911 for transport.*

<u>Examples of seizure event:</u>
If [Resident A] has a 3.5-minute seizure at 5 AM (this starts the 24 hours) and she has another 2.5-minute seizure at 10 AM (she is to receive her PRN Valium after 1.5 minutes of the 2nd seizure). Then she is to be monitored to see if the seizure activity reaches a total of 7 minutes. If the seizure activity reaches the 7-minute mark staff are to call 911 (if she is still actively having seizure activity).

If [Resident A] has a 5-minute seizure at 7 PM. Then anytime after 7 PM the following day if she should have any further seizure like symptoms staff are to pass the PRN Valium and monitor her. If seizure like symptoms last for 2 more minutes (which totals 7 minutes) then 911 is to be called. (This 24-hour duration would be from 7 PM – 7 PM the next day)."

This seizure protocol that was signed off on March 7, 2025. This one had a notation under "Summary of Topic Presented" which stated "Review the attached protocol - sign below. 24-hour duration starts at on-set of seizure activity. Review added information March 8, 2025." This protocol was signed off on by Ms. Dean, Ms. Meyer, Ms. Jeffrey, Ms. Lowrey, Ms. Booth, Ms. Esterline, Ms. Bartlett, Ms. Kappler (signed on March 8, 2025), Ms. Duhaime (signed on March 8, 2025), Ms. Grace (signed on March 8, 2025), Ms. Mannan, Ms. Shirey, and Ms. Schuster. This one also had a bolded statement on the top stating, "Seizure Activity starts the 24-hour duration."

I noted the seizure protocol dated March 7, 2025, was the same as the one dated February 27, 2025 however the statement added was "Seizure activity starts the 24-hour duration" instead of just "this protocol is for a 24-hour duration." There were two additional examples in this protocol including the one above which showed how to

calculate the seizure timeclock and made it clear it was not for a time period of midnight-midnight.

There is no physician order date written on this seizure protocol although direct care staff members signed off on it March 7, 2025. Ms. Kappler did not work on March 7, 2025 but according to the Specialized Residential Progress Notes written by Marie Jeffrey which I reviewed she contacted Ms. Kappler about the error and Ms. Kappler instructed Ms. Jeffrey to "put out an inservice for the protocol, post the seizure protocol around the home, add seizure activity to the consumer safety check sheets, and create a whiteboard documenting seizure activity." This *Training Inservice* for Resident A's seizure protocol was the inservice after the error was noticed.

I reviewed records for Resident A documenting she had three seizures:

1. March 6, 2025 - 5:05 PM-5:09 PM - 3 minutes 30 seconds documented by Ms. Booth – This seizure occurred at the movie theatre.
2. March 7, 2025 - 5:45 AM - 5:49 AM - 4 minutes 43 seconds documented by Ms. Bartlett.
3. March 7, 2025 - 1:43 PM - 1:45 PM - 2 minutes documented by Ms. Jeffrey.

I reviewed an *AFC Incident / Accident Report* written on March 6, 2025, by Ms. Booth with the following documentation:

"Explain what happened: While at the movies, staff looked over at [Resident A] before she turned her head to the left and begun seizing. The seizure began at 5:05 PM and ended at 5:09 PM lasting 3 minutes and 30 seconds.
Action taken by staff: Staff checked [Resident A]'s vitals every 30 minutes x 3. Staff continues to monitor Resident A for health and safety.
Corrective Measures: Continue to monitor. Proper steps and care followed and provided."

I reviewed an *AFC Incident / Accident Report* written on March 7, 2025, by Ms. Bartlett with the following documentation:

"Explain what happened: While doing peri care on [Resident A] she went into a seizure which lasted 4 minutes and 43 seconds. All 3 sets of vitals were done. Staff made sure that [Resident A] did not hurt herself.
Action taken by staff: Took vitals, sat there with [Resident A] until she came out of it.
Corrective Measures: Reviewed seizure protocol with all staff. Made more clarifications."

I reviewed a third *AFC Incident / Accident Report* was completed on March 7, 2025 written by Ms. Doan after she realized the seizure protocol was not followed which included the following documentation:

"Around 9:37 AM, staff placed a call to the home manager (Lisa Kappler) as they noticed [Resident A]'s seizure protocol was not followed correctly and since 5:05 PM the night before she had about 8 minutes and 15 seconds of total seizure activity and during the seizure she had at 5:45 AM no Valium was passed, no IR was written and 911 was not called. [Resident A] did not appear to be in any distress and was ambulating fine

and smiling. The home manager directed staff to contact the doctor's office and neurologist. The neurologist office was closed for the weekend so staff left a message asking for a call back on Monday when the office was open. When staff explained to the situation to the doctors it was decided if she were to have any more seizure activity at all that the direct care staff members were to immediately pass the Valium and if it lasted two minutes or longer to call 911. Ms. Doan contacted Ms. Kappler to updated her and was directed to put out an in-service for the protocol, post the seizure protocol around the home, add seizure activity to the consumer safety check sheets, and create a white board for documenting seizure activity. All of this was done.
Later in the shift around 1:43 PM [Resident A] had another seizure that lasted for just over 2 minutes. Staff passed the Valium as she was coming out of the seizure (around 1:45 PM) and since it was 2 more minutes or seizure activity staff called 911 as well. Staff notified the home manager (the home manager notified the doctors) and staff notified the guardian. The ambulance picked [Resident A] up around 2:20 PM - 2:25 PM and took her to McLaren Hospital (a staff followed). [Resident A] arrived home at 3:55 PM with staff by the home van. The emergency room did not give any direction on what to do for another seizure, staff will contact program director and doctors."

On March 21, 2025, Office of Recipient Rights (ORR) Officer Keegan Sarker and I interviewed direct care staff member Mary Bartlett. Ms. Bartlett stated there was a "huge misunderstanding between second and third shift" about Resident A's seizure protocol. Ms. Bartlett stated direct care staff members were trained it was a 24-hour period but she did not understand the 'seizure clock' started when the first seizure occurred rather than by day/date. Ms. Bartlett stated she was with Resident A when she had a seizure which lasted approximately 4.5 minutes on March 7, 2025 around 5:45 AM while she was performing Resident A's personal care in the bathroom. Ms. Bartlett stated she timed the seizure along with direct care staff member Nicole Esterline and they took Resident A's vitals and monitored her then filled out an *AFC Incident / Accident Report*. Ms. Bartlett stated she was aware when she arrived to work that Resident A had a seizure while at the movies during second shift the previous day on March 6, 2025. Ms. Bartlett stated they continued to do bed checks for Resident A to monitor for another seizure. Ms. Bartlett stated she and all direct care staff members were trained on the seizure protocol but she believed it was from midnight – midnight rather than 24 hours duration regardless of when the seizure began. Ms. Bartlett stated if Resident A's seizure protocol had been followed, Resident A should have received her PRN medication after the seizure in the bathroom. Resident A had her first seizure on so March 6, 2025 around 5:45 pm so she thought it would restart on her shift after midnight making March 7, 2025, a new 24 hour period.

On March 21, 2025, ORR Ms. Sarker and I interviewed direct care staff member Nichole Esterline who worked third shift on March 6, 2025. Ms. Esterline stated she arrived to work and Jaden Booth notified her of Resident A's seizure earlier in the day on second shift while at the movie theater. Ms. Esterline stated Ms. Booth informed her if Resident A did not have another seizure by midnight then the time restarted and they would restart counting the 24 hours. Ms. Esterline stated she was originally told it was midnight – midnight during a training with Ms. Kappler when they were first trained on

her seizure protocol however, it was clarified the following day after this incident by Ms. Kappler that it was 24 hours from the first seizure regardless of what time the seizure started. Ms. Esterline stated while she was showering Resident B and Ms. Bartlett was providing personal care to Resident A in the bathroom, Ms. Bartlett stated Resident A had another seizure which they timed, took Resident A's vitals, and then passed on the information to first shift direct care staff on March 7, 2025. Ms. Esterline stated Ms. Bartlett completed the *AFC Incident / Accident Report* since she was there when it started. Ms. Esterline stated she left work at 7 AM and there was no further seizure activity. Ms. Esterline stated Valium was not administered to Resident A during this shift. Ms. Esterline stated if the seizure would have lasted over 5 minutes, they would have given her Valium or if it continued, had injuries, or went into respiratory distress then they were required to call EMS. Ms. Esterline stated Ms. Kappler did an in-service with direct care staff members and that is where the miscommunication started. Ms. Esterline stated in the meeting there was an example given of midnight to midnight as the 24-hour period however, after this incident it was clarified the 24-hour period started with the first seizure. Ms. Esterline stated Ms. Kappler personally talked with her about the seizure protocol but it was not a formal in service/training where all the shifts were in a meeting.

On March 21, 2025, ORR Ms. Sarker and I interviewed direct care staff member Jaden Booth. Ms. Booth stated on March 6, 2025 she was at the movies around 5 pm with Resident A when she had a seizure which lasted 3.5 minutes long. Ms. Booth stated she had Resident A's Valium with her in case she had a seizure that lasted over 5 minutes. Ms. Booth stated after they arrived back to the facility, Resident A ate dinner and had no other signs of seizure activity. Ms. Booth stated all direct care staff working on either second shift and third shift were told Resident A's seizure protocol timing started at 12AM and ended 24 hours later at 12AM. Ms. Booth stated this was her understanding of Resident A's seizure protocol. Ms. Booth stated she notified third shift about Resident A's seizure at the movie theatre at the beginning of their shift.

On March 21, 2025, ORR Ms. Sarker and I interviewed direct care staff member Amonie Mannan. Ms. Mannan stated she was working with Ms. Booth and Halley Lowrey when Resident A had a seizure toward the end of the movie. Ms. Mannan stated Ms. Booth and Ms. Lowrey timed the seizure and tended to Resident A. Ms. Mannan stated she left work at 9:30 PM which was before the midnight staff came in so she did not relay this information to anyone. Ms. Mannan stated her primary job task was to provide supervision to Resident B because she requires 1:1 supervision due to a PICA diagnosis. Ms. Mannan stated she understood Resident A's seizure protocol as a 24-hour duration and gave the example that if she has a seizure if she has a seizure at 5 PM, then the 24-hour restarts the following day at 5 PM. Ms. Mannan stated Kayhlie Schuster and Ms. Kappler trained her on the Resident A's seizure protocol during direct care staff member meetings so she, or other direct care staff, could ask questions for clarification. Ms. Mannan stated she did not recall when the training took place.

On March 21, 2025, ORR Ms. Sarker and I interviewed direct care staff member Marie Jeffrey. Ms. Jeffrey stated she worked 7 AM–3 PM on March 7, 2025 and worked with

Ms. Doan and Julie Meyer. Ms. Jeffrey stated since she works part time she makes sure to read resident progress notes and logs when she starts her shift so she is up to date on resident care. Ms. Jeffrey stated when reading the progress notes with Ms. Doan, she stated she learned Resident A had a seizure in the afternoon on March 6, 2025, and total seizure activity lasted more than five minutes and Valium was not administered to Resident A. Ms. Jeffrey stated she and Ms. Doan called Ms. Schuster to determine what actions needed to be taken since Resident A had experienced more than five minutes of total seizure activity between March 6, 2025 and March 7, 2025. Ms. Jeffrey stated there was no documentation that Resident A was administered PRN Valium per her seizure protocol as well as 911 was not called. Ms. Jeffrey stated Resident A had another seizure during day shift and she went to the hospital around 2:30 PM on March 7. Ms. Jeffrey stated all direct care staff members were trained on Resident A's seizure protocol by Ms. Kappler giving direct care staff members Resident A's seizure protocol to read and sign off that they understood. Ms. Jeffrey stated she worked with management on Monday and Tuesday each week so she felt like she understood the protocol better than most since they discussed it with her. Ms. Jeffrey stated the seizure protocol "seemed pretty self-explanatory" but it was also discussed in a direct care staff member meeting on an unknown date. Ms. Jeffrey stated none of her coworkers said anything to her about not understanding the protocol and she thought everyone knew what to do. Ms. Jeffrey stated she did not remember anyone saying that the procedure was from 12 AM–12 AM but after this incident occurred, she did hear this was the point of confusion.

On March 21, 2025, ORR Ms. Sarker and I interviewed direct care staff member Victoria Doan. Ms. Doan stated she arrived to work at 7:30 AM on March 7, 2025 and Ms. Jeffrey and Ms. Meyer informed her Resident A had a seizure that morning. Ms. Doan stated when she was going through the paperwork from the previous shift, they noticed there was a seizure the day prior and that Resident A's seizure protocol was not followed. Ms. Doan stated when they realized the error, she contacted Ms. Kappler and Resident A's neurologist to find out what to do because Resident A had over 8 minutes of seizure activity in less than 24 hours. Ms. Doan stated she spoke with Ms. Kappler about Resident A's seizure protocol but she did not consider this to be a formal training. Ms. Doan stated there was an in-service which was a "read and sign" which she signed off confirming she understood because the protocol seemed straight forward. Ms. Doan stated she did not know her coworkers were confused about how to interpret the 24 hour seizure timeclock until after the incident.

On March 21, 2025, ORR Ms. Sarker and I interviewed direct care staff member Julie Meyer. Ms. Meyer stated she was trained on the seizure protocol by Ms. Kappler handing her a sheet of paper and telling her to sign it if she understood and if she did not understand she should ask questions. Ms. Meyer stated she stated she did not have questions because "it was quite simple" to understand. Ms. Meyer stated Resident A went to the hospital on her shift after she had a seizure on March 7, 2025 but she didn't recall what time because she was administering medications to other residents when Resident A experienced the seizure. Ms. Meyer stated there is a requirement to read the daily log when starting her shift and she always does this after administering

medications which is how she discovered Resident A had a previous seizure on March 6, 2025.

On March 21, 2025, ORR Ms. Sarker and I interviewed direct care staff member Halley Lowrey. Ms. Lowrey stated she read through the seizure protocol on March 6, 2025 and made sure she was able to understand the procedure. Ms. Lowrey stated she was able to understand it because an example was given her if Resident A had a seizure at 12 AM then it would be up at 12 AM the following day because this was a 24-hour period. Ms. Lowrey stated since this was used as an example, this stuck in her mind and she thought it was by each day and not 24 hours from the time the seizure activity starts. Ms. Lowrey stated shift change is busy and "a little chaotic" but she talked to Ms. Kappler and told her she understood the procedures as it was written that after 5 minutes total she would receive Valium and after 7 minutes she would go to the emergency room. However, Ms. Lowrey reiterated that initially she understood the seizure timeclock to be from 12 AM – 12 AM. Ms. Lowrey stated this was corrected after this incident, so she now understands Resident A's seizure timeclock starts with the first seizure, regardless of what time that occurs, and ends 24 hours later.

On March 21, 2025, ORR Ms. Sarker and I interviewed Director of Residential Services, Jim Boyd. Mr. Boyd stated the incident was not reported until March 12, 2025 when it should have been reported on March 8, 2025 directly after the incident. Mr. Boyd stated Ms. Kappler stated she did not have a reason why she waited four days to report the incident and did not report the concerns to Office of Recipient Rights (ORR). Mr. Boyd stated Ms. Kappler trained direct care staff that the seizure protocol timeclock was 12 AM-12 AM before she had the written protocol in hand, so this was the understanding for direct care staff members from February 27, 2025-March 6, 2025. Mr. Boyd stated although the new protocol was received from the neurologists office on February 27, 2025, Ms. Kappler continued to train direct care staff to use a 12AM to 12AM as the seizure timeclock instead of the prescribed way of tracking 24 hours from the first seizure.

On March 21, 2025, ORR Ms. Sarker and I interviewed former direct care staff member whose role was home manager Ms. Kappler. Ms. Kappler stated direct care staff members were trained twice on Resident A's seizure protocol. Ms. Kappler stated direct care staff members were trained on February 27, 2025 because she took Resident A to the neurologist on February 26, 2025. Ms. Kappler stated direct care staff members were trained again after this incident on March 7, 2025. Ms. Kappler stated the in-service was done visually and verbally each time with each shift separately and not all at the same time. Ms. Kappler stated there was an example used for the 24-hour duration and what that would look like by saying if a seizure started at midnight then it would go to midnight the next night and if it started at 3 PM it would start again 3 PM the following day. Ms. Kappler stated the *AFC Incident / Accident Reports* were not signed until March 8, 2025 by her and she did not know why there was a delay in reporting the incidents to Office of Recipient Rights. Ms. Kappler stated when Resident A's seizures occurred, she was not working however when she was notified about them she had the direct care staff members working read the "seizure board" and reviewed the seizure

protocol again. Ms. Kappler was asked about the note that was added on March 8, 2025 which stated on the protocol "review added information March 8, 2025" but she was not sure what the added information was except they verbally reviewed the protocol was again with direct care staff members. Ms. Kappler stated she contacted Resident A's physician for clarification and the only change was providing a few more examples and that she wrote on the top of the paper "24 hours starts at the beginning of the seizure activity." Ms. Kappler stated she never understood it as midnight to midnight rather than the 24 hour timeclock started after the first seizure and ended 24 hours later. Ms. Kappler stated she thought she sent the *AFC Incident / Accident Reports* on March 10, 2025 in the morning but she sent them again because they did not go through. Ms. Kappler stated she did not notify Recipient Rights by phone or email. Ms. Kappler stated Mr. Boyd asked for the *AFC Incident / Accident Report* and Ms. Jacobs also had them as well so she "used that as a backup."

On March 21, 2025 I completed an unannounced on-site investigation at Mt. Pleasant Home and interviewed Ms. Doan and Ms. Schuster. Ms. Schuster stated Resident A has a neurologist however she is not able to get another appointment until August 27, 2025. Ms. Schuster stated Resident A is on the wait list for any earlier appointments. Ms. Schuster stated she trained direct care staff members on February 27, 2025 and it was always her understanding the 24-hour timeframe started at the first seizure. Ms. Schuster stated Resident A had eight seizures in January 2025, five seizures in February 2025, and six seizures in March 2025. I reviewed Resident A's resident record and the seizure logs which verified Ms. Schuster's statement. I also observed a large white board outside the medication room to track Resident A's seizures and Resident A's seizure protocol is now posted throughout the home. According to Resident A's *Assessment Plan for AFC Residents* under special equipment used, "Due to seizure activity and needing close monitoring staff will utilize an audio monitor only when sleeping (VNS has been removed)."

I also observed Resident A at Mt. Pleasant Home however Resident A is non-verbal and unable to complete an interview regarding the allegations.

On April 8, 2025, I interviewed licensee designee Cindy Seger. Ms. Seger stated there have been some changes in the administration at Mt. Pleasant Home since Ms. Kappler is no longer a Listening Ear employee or home manager at Mt. Pleasant Home. Ms. Seger stated Kaila Morris is also the new administrator at Mt. Pleasant Home. Ms. Seger stated she believes the root cause of this incident was direct care staff members not following the processes that were put in place. Ms. Seger stated it's not enough to just verbally tell people, they need to sit down and talk through and give people the opportunity to ask questions which was not done if direct care staff members were told to just "sign off" on her seizure protocol. Ms. Seger stated there was some confusion on the protocol and after clarification was provided, Ms. Kappler only had direct care staff members read the information instead of discussing it with them. Ms. Seger stated Ms. Kappler had been there a long time and she thought Ms. Kappler would have followed the procedures they have set in place at Listening Ear for training direct care staff members. Ms. Seger stated she should have gone through the protocol in a facet-to-

face manner. Ms. Seger stated moving forward the homes with higher medical needs, such as Mt. Pleasant Home, are going to require higher medical training for direct care staff members. Ms. Seger stated there may be a shift premium for the home in order to attract more candidates for higher medical training such as possibly recruiting direct care staff members who hold a Certified Nursing Assistant (CNA).

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	The seizure protocol for Resident A was not followed after she had her first seizure on March 6, 2025 at 5:05 PM and then had two more seizures on March 7, 2025 at 5:45 AM and again at 1:43 PM. After the second seizure (March 7, 2025 at 5:45 AM), Resident A should have been given PRN Valium as required by the seizure protocol because the seizures were within 24 hours and over five minutes total however, this was not administered to her. Direct care staff members Ms. Bartlett, Ms. Esterline, and Ms. Booth who were working during the first seizure did not understand the protocol correctly and thought the 24 hour seizure timeclock would “reset” at midnight and any additional seizures would be counted separately and seizures before midnight would not count toward the 24 hour seizure timeclock. Due to this misunderstanding, Resident A was not administered the Valium as required in her seizure protocol.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Based upon an approved Corrective Action Plan, I recommend continuation of the 1st Provisional License.

_ _____04/23/2025_____

Jennifer Browning — Date
Licensing Consultant

Approved By:

04/28/2025

_____

Dawn N. Timm — Date
Area Manager