GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 4, 2025

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

RE: License #: AS370011270
Investigation #: 2025A0622063
Isabella 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) 335-5985.

Sincerely,

Amanda Blasius, 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 #:** | AS370011270 |
| | |
| **Investigation #:** | 2025A0622063 |
| | |
| **Complaint Receipt Date:** | 09/16/2025 |
| | |
| **Investigation Initiation Date:** | 09/16/2025 |
| | |
| **Report Due Date:** | 11/15/2025 |
| | |
| **Licensee Name:** | Crisis Center Inc - DBA Listening Ear |
| | |
| **LicenseeAddress:** | 107 East Illinois<br>Mt Pleasant, MI 48858 |
| | |
| **Licensee Telephone #:** | (989) 773-6904 |
| | |
| **Administrator:** | James Boyd |
| | |
| **Licensee Designee:** | James Boyd |
| | |
| **Name of Facility:** | Isabella Home |
| | |
| **Facility Address:** | 2599 S Isabella Road<br>Mount Pleasant, MI 48858 |
| | |
| **Facility Telephone #:** | (989) 773-0326 |
| | |
| **Original Issuance Date:** | 10/10/1986 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 04/05/2024 |
| | |
| **Expiration Date:** | 04/04/2026 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A was found deceased at the AFC and the cause is unknown. | No |
| Direct care staff member Donna Warren was doing one handed CPR when EMS arrived. | Yes |
| Resident A did not receive the correct dose of insulin prior to her death. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 09/16/2025 | Special Investigation Intake 2025A0622063 |
| 09/16/2025 | Special Investigation Initiated – email contact with licensing consultant, Jennifer Browning. |
| 09/17/2025 | Inspection Completed On-site |
| 09/18/2025 | Contact -Voicemail left for Medical examiner, Taylor Maylee. |
| 09/22/2025 | Contact - Document Received from Licensee, James Boyd |
| 09/29/2025 | Contact - Document Sent for FOIA request |
| 10/09/2025 | Contact – Voicemail left for Medical examiner, Taylor Maylee |
| 10/15/2025 | Contact - Document Received from Recipient Rights Officer, Katie Horner. |
| 10/16/2025 | Contact - Telephone call made to direct care worker, Bill Pattersen |
| 10/22/2025 | Contact - Telephone call made to Community Mental Health Caseworker, Andrea Cottier and RN Nurse Amy |
| 10/23/2025 | Inspection Completed-BCAL Sub. Compliance |
| 11/03/2025 | Phone call to Dr. Ashwani and direct care worker, Kristy Breuchert |
| 11/04/2025 | Exit conference with licensee designee, James Boyd |

**ALLEGATION:**

- **Resident A was found deceased at the AFC and the cause is unknown.**
- **Direct care staff member Donna Warren was doing one handed CPR when EMS arrived.**
- **Resident A did not receive the correct dose of insulin prior to her death.**

**INVESTIGATION:**

On 09/16/2025, I received this intake through another licensing consultant, Jennifer Browning. Licensee designee, James Boyd called licensing consultant, Jennifer Browning to inform her that Resident A had passed away at Isabella AFC and it was an unexpected death. Licensee designee, James Boyd reported the following to licensing consultant, Jennifer Browing; "EMS noticed direct care staff member Donna Warren was doing one handed CPR when they arrived. This was not expected however she (Resident A) was medically fragile. She moved into Isabella Home three weeks ago and the Medical examiner wouldn't let anyone in the door to look at [Resident A] until the ambulance came to take her to Sparrow."

On 09/16/2025, I received an *AFC Licensing Division Incident/Accident Report* from licensing consultant, Jennifer Browning. The following was documented in the report from 9/14/25 at 1pm:

> *"[Resident A] was in bed and staff checked on her at 11am. Her blood sugar was checked and was documented at 299. Staff administered three units of insulin. [Resident A] opened her eyes and looked at staff. A staff member checked on her at 12pm and she had a large bowel movement. Staff member helped clean up [Resident A] and noticed Resident A sounded congested, therefore she suctioned her tracheostomy. [Resident A's] mucous was thick and there was little return so staff attached her misting machine and turned it on. Staff returned at 1pm and found [Resident A] to not be responsive, was not breathing and was white. One staff member started CPR and the other staff member called 911. EMT arrived within two minutes and told staff to discontinue CPR and they would take over. Staff called the program manager to inform them of the incident. The Guardian was also informed."*

On 09/17/2025, I completed an unannounced onsite investigation to Isabella Home. During the investigation, I viewed documentation and interviewed two direct care workers.

On 09/17/2025, I interviewed direct care worker(DCW), Kristy Bruechert in person. She identified as the home manager. DCW Bruechert reported that Resident A was court ordered to be placed at Isabella AFC on 8/25/25. She stated that Resident A was in the hospital for 4-5 months prior to being placed in Isabella Home. DCW Bruechert reported that Resident A has a PEG feeding tube and a tracheostomy. She explained that on 9/4/2025, Resident A pulled her tracheostomy out and DCW Bruechert put it back in, called the doctor and then eventually took Resident A to the

hospital to assure the tracheostomy was placed properly. During the investigation, I viewed an *AFC Licensing Division Incident/Accident Report* from 9/4/25 and hospital discharge paperwork. DCW Bruechert reported that she was trained at the hospital by a nurse on how to care for Resident A and she completed all the training for the direct care workers within the home. She explained that a registered nurse from Alma hospital came into Isabella Home for a staff meeting and answered questions from direct care workers on how to care for Resident A. Documentation was reviewed from the staff meeting, confirming that RN Amy Schmidt provided information on Resident A's tracheostomy care and answered any questions direct care workers had. DCW Bruechert stated that she was not working on 9/14/25 and was unable to come into the home to meet with the police after Resident A passed away.

On 09/17/2025, I interviewed direct care worker, Donna Warren in person. She reported that she was working on 9/14/2025, when Resident A passed away. DCW Warren stated that she checked on Resident A at 7am and she was resting and feeding through her tube. DCW Warren reported that at 8am she changed Resident A's brief and around 9/9:30am DCW Warren stated that she changed Resident A's gown, repositioned her and suctioned her tracheostomy. DCW Warren reported that at 11am, DCW Bill Patterson checked Resident A's blood sugar level and gave her three units of insulin as her blood sugar was 299. At 11am, DCW Warren explained that she checked on Resident A and changed her brief as she had a bowel movement. She also reported that she suctioned Resident A's tracheostomy and put her mist machine on, as her mucous was thick and she was getting little return from the suctioning. DCW Warren stated that she also raised Resident A's head up and then went to go feed the rest of the residents. She stated that at 12pm, Resident A's eyes were open and she was moving her arms and reaching and grabbing. DCW Warren reported that she came back to check on Resident A at 1pm and found her to be white and not breathing. She explained that she yelled for DCW Bill Patterson and he found the phone to call 911. DCW Warren stated that she started CPR, but found it hard because she could not lift Resident A to the ground to have her flat. DCW Warren reported that she was trying to use a device called an Ambu Bag over her tracheostomy. DCW Warren reported that she was only using one hand to provide chest compressions. DCW Warren reported that she was not trained on how to use an Ambu Bag with a tracheostomy and was confused. She also reported that she has never provided CPR on a real person. DCW Warren stated that EMS arrived within two minutes of her providing CPR to Resident A and EMS had her discontinue CPR and leave the room. DCW Warren reported that she was trained to care for Resident A through her home manager, Kristy Bruechert, but felt that Resident A was too medically fragile and Resident A should have had one-on-one care. DCW Warren also stated that the home was short staffed.

On 9/17/2025, during the unannounced onsite investigation, I viewed documents for Resident A including Resident A's *Health Care Appraisal.* According to her *Health Care Appraisal* signed by Dr. Augsburger on 7/7/25, Dr. Augsburger documented that Resident A was diagnosed with the following: quadriplegic of cerebral palsy,

developmentally delayed, scoliosis, obstructive sleep apnea, Peripheral artery disease, Chronic Obstructive Pulmonary Disease, type 1 diabetic and has a tracheostomy with a vent assist. According to the *Health Care Appraisal*, Resident A is a tube fed only and has the following health related information or concerns; recurrent urinary tract infections, aspiration, pneumonia risk, has a port in her right chest and has a history of seizures. Dr. Augsburger also documented that Resident A uses a wheelchair.

Resident A's *Assessment Plan for AFC Residents (assessment plan)* was viewed and states that Resident A needs full assistance from staff members in regards to self-care. The assessment plan also documented that Resident A is tube fed and cannot receive anything by mouth. According to Resident A's *Assessment Plan for AFC Residents* all her medications are to be administered through her feeding tube. The special equipment used included the following: wheelchair with seatbelt, shower chair, lift with sling, oxygen, vent, trachea tube, PEG feeding tube with suction. The plan also states that Resident A is not to lay flat.

I viewed Resident A's prescribed prescriptions and all the special equipment and assistive devices had appropriate doctor orders.

On 9/17/25 I viewed Resident A's person-centered plan and the in-service sign in sheet, which confirmed that all staff were trained on her person-centered plan.

I viewed documentation from 8/14/2025, which confirmed that nurse Julie Simon from Alma hospital trained direct care workers, Kristy Bruecher and Kaila Morris on how to properly remove Resident A from her ventilator and the proper way to remove the inner cannula from her tracheostomy tube, as well as blood sugar testing and insulin administration.

I viewed documentation from the licensee's monthly report for Resident A for September 2025. On the report it stated medication changes which included the following; Dr. Ashwini discontinued miconazole 2% as she reported that she was on too much anti-fungal medications, Resident A's insulin dosage was also changed to sliding scale. According to the monthly report, Dr. Ashwini visited Resident A on 9/2/25, which is when the new sliding scale was issued. On 9/2/25, nurse Vanessa Lapham visited the home for her weekly check-in. On 9/4/25, Resident A was taken to the doctor's office to see Dr. Chomchi as her tracheostomy came out and they wanted to have it checked. The monthly report also documented when family visited Resident A which occurred on 9/1/25, 9/3/25, 9/5/25, 9/6/25 and 9/10/25.

Resident A's medication administration record and insulin prescriptions were viewed. According to the medication administration record, on 8/25/25, Resident A was prescribed insulin Lispro 100 unit/ML solution. The order states to inject 1-5 units under the skin every six hours. A low sliding scale was viewed from 8/25/25. According to Resident A's monthly report, it was documented that Dr. Ashwini changed Resident A's insulin dosage and sliding scale on 9/2/25. A sliding scale

was provided and the units for low dosage insulin went up to 8 units, which does not match the current order for Lispro 100 unit/ML solution. No updated insulin order was found in Resident A's Medication Administration Record. I also contacted Downtown Drugs, who fills all the prescriptions for Isabella Home and no updated prescribing order was received from Dr. Ashwini regarding Insulin to increase the units to 8, if needed. Dr. Ashwini completed ancillary orders on 9/2/25 and on the form the following was documented: Insulin Lispro 100 unit/ML injection, inject 1-5 units under the skin every six hours. Use sliding scale to the correct amount of units.

I also viewed additional documentation for Resident A's care. A treatment sheet was completed and documented brushing Resident A's teeth, changing her bedding, peri care in the morning and documenting any bowel movements. Direct Care worker Donna Warren documented that she completed all these tasks for Resident A on 9/14/25.

I viewed a treatment sheet for Resident A, which documented times when Resident A's tracheostomy tube was flushed during her feedings. According to the treatment sheet, Resident A did not receive a flushing of her tube on 9/13/25 at 10am and on 9/14/25 at 6:30am and 10:00am. According to an order signed by Dr. Ashwini on 9/2/2025, Resident A should have water flushes of 150cc every four hours while feeding is running.

On 11/03/2025, I interviewed direct care worker, Kristy Bruechert via phone. She reported that she no longer works at Isabella Home AFC. She reported that she did not receive any documentation from Resident A's visit with Dr. Ashwini on 9/2/25, other than Resident A's monthly report that she filled out after the visit. DCW Bruechert reported that she attempted to call Dr. Ashwini's office many times to get a new order filled for her change in insulin dosage but was unsuccessful. DCW Bruechert stated that she mainly called but had no documentation of attempting to contact Dr. Ashwini regarding needing a change in her prescribed insulin. DCW Bruechert stated that she did not have direct care workers follow the new insulin sliding scale, as it did not match the prescribed order in the medication administration chart. DCW Bruechert stated that when meeting with Dr. Ashwini, she was unfamiliar with working with an adult foster home and did not understand that any over the counter medications needed to be approved and prescribed through a doctor.

On 11/03/2025, I interviewed Dr. Ashwini via phone. She reported that she saw Resident A in her office on 9/2/25 and issued a new sliding scale for her insulin dosage. Dr. Ashwini confirmed that she did not issue a new prescription for Insulin and the only order in the system was from 8/25/25. Dr. Ashwini stated that she provided a new sliding scale for Resident A as her blood sugar was reaching almost 400 during her feeding times. Dr. Ashwini reported that she could not provide any documentation to me as it would need to be approved through the guardian to release any records.

Based upon the sliding scale provided to Isabella Home on 9/2/25 from Dr. Ashwini and Resident A's medication administration record, Resident A did not receive the appropriate dose of insulin as of 9/3/25-9/14/25, when she passed away. On 9/14/25, at 11am Resident A was given 3 units of insulin, but according to the sliding scale provided from Dr. Ashwini on 9/2/25, she should have been provided 4 units of insulin.

On 10/09/2025, I interviewed direct care worker, Kaila Morris via phone. She reported that she is the residential manager at Isabella Home and she received a call on 9/14/25, that Resident A had passed away. DCW Morris reported that she arrived at the home around 1:30pm and the state police were there. DCW Morris reported that she talked with DCWs as they seemed shook up, then was interviewed by the police and called the licensee designee James Boyd. DCW Morris reported that the police asked her if staff members Donna Warren and Willam Patterson were trained in CPR and she reported "yes." DCW Morris stated that the police informed her that when EMT arrived Donna Warren was providing CPR with one hand. DCW Morris reported that she talked with DCW Donna Warren and she admitted to providing one handed CPR, and stated that "[Resident A] was clearly already gone, and she was afraid to hurt her." DCW Morris reported that DCW Donna Warren was remorseful during their conversation. DCW Morris stated that she talked with DCW Willam Patterson and he reported that he did not observe DCW Warren giving CPR as he was on the phone with 911.

On 10/22/2025, I interviewed the RN nurse from Alma Hospital, Amy Schmidt via phone. She reported that she helped care for Resident A at the hospital and went to Isabella home the day after Resident A arrived for a staff meeting. Ms. Schmidt reported that staff members had some questions on the finger prick needed to test her blood sugar, but otherwise most of the questions were general. Ms. Schmidt stated that all staff members reported being comfortable caring for Resident A. Ms. Schmidt observed Resident A during her visit and she appeared well. Ms. Schmidt stated that Resident A needed to be propped up during feeding time at a 30 degree angle from 6pm-10pm. Ms. Schmidt stated that she assisted with setting up a visiting nurse weekly from Michigan Home Care.

On 10/22/2025, I interviewed the visiting nurse from Michigan Home Care, Vanessa Lapham, via phone. She reported that she visited Resident A on 9/2/25 and 9/9/25 in the home. Ms. Lapham stated that she had a direct care worker demonstrate tracheostomy care and she observed no concerns. Ms. Lapham stated that on 9/9/25, Resident A had some drainage from her PEG tube, which was clear. She explained that her skin was just wet and was still intact, therefore she was not concerned. Ms. Lapham reported that the AFC staff members reported to her that they were concerned that family members visiting were giving her Mountain Dew into her PEG tube when they were visiting. Ms. Lapham reported that she called Resident A's family members to discuss this allegation, but they denied it. Ms. Lapham reported that she did not have concerns about how direct care workers were caring for Resident A. Ms. Lapham reported that Resident A was a high-needs

resident, as she was in the hospital since January 2025. She also stated the AFC home was in the process of getting a Dexcom G7 Retriever to check her inulin without having to poke her.

On 10/22/2025, I interviewed Resident A's community mental health case worker, Andrea Cotter via phone. She reported that she was new to Resident A's care as of 8/25/25. Ms. Cotter reported that she had no concerns regarding the care Resident A was receiving at Isabella Home. Ms. Cotter reported that she was informed of Resident A's new insulin sliding scale but was unaware that the sliding scale did not match the prescribed order, nor that a new insulin order was needed.

On 10/23/2025, I interviewed direct care worker, Grace Veltkamp via phone. She stated that she worked on 9/13/25 from 11pm-7am. She stated that Resident A seemed well during her shift and she checked on her every half hour. DCW Veltkamp stated that at 5am she checked Resident A's blood sugar and gave her insulin. She explained that Resident A's vitals were well and that Resident A also has machines that beep during the night if she is breathing too heavily or not breathing enough. DCW Veltkamp stated that Resident A was on her feeding tube when she left at 7am. DCW Veltkamp stated that usually DCW Donna Warren gets Resident A up around 1pm. DCW Veltkamp stated that DCW Donna Warren was somewhat hesitant, as she did not like change. She explained that DCW Donna Warren was not always on top of everything as she was a little slower. DCW Veltkamp stated DCW Warren knew how to use Resident A's mister and how to suction her tracheostomy. DCW Veltkamp stated that she has worked with DCW William Patterson and explained that he only focuses on the male residents and would not have checked on Resident A.

On 10/23/2025, I interviewed direct care worker, Willam Patterson via phone. DCW Patterson reported that he did work on 9/14/25 when Resident A passed. He reported that he was not trained or orientated to work with Resident A and he only took care of the males in the home. DCW Patterson stated that his manager, DCW Kristy Bruechert was not in a rush to train him and another male worker on how to care for Resident A. DCW Patterson reported that a staff member from Sparrow never arrived during their staff meeting to show all the direct care workers how to use her assistive devices. He explained that the nurse that was in the home to answer questions was unaware of how to use the equipment. DCW Patterson reported that he only works on the weekends. DCW Patterson reported that he was approved to pass her medications through her feeding tube, as another direct care worker demonstrated the procedure for him and they have other residents with feeding tubes in the home. DCW Patterson stated that he passed her medications at 7am and then went back into her room at 11am to test her blood sugar. He explained that he had to prick her finger, and she opened her eyes and looked at him. DCW Patterson stated that he did not notice any concerns and she appeared fine lying in bed at 11am. DCW Patterson reported that her blood sugar was at 299, which called for three units of insulin according to the sliding scale provided. DCW Patterson stated that he injected the three units of insulin for Resident A and then

went back to caring for the other three male residents. He reported that his co-worker Donna Warren was in and out of Resident A's room, carrying the rest of the morning. DCW Patterson reported that around 1pm, he heard his co-worker Donna Warren call for him and stated that Resident A was not breathing. DCW Patterson stated that he put his hand on her chest and she was not breathing and he told DCW Warren to start CPR. DCW Patterson reported that he gave the Ambu Bag to DCW Warren and then he ran to grab the phone to call 911. DCW Patterson stated that he was also looking for the book to provide personal details regarding Resident A. DCW Patterson stated that when he was on his way back to Resident A's room, another resident was trying to get to the bathroom, so he assisted this resident with getting to the bathroom safely. DCW Patterson reported that EMT arrived within two minutes of him calling 911 and he did not have time to get back to Resident A's bedroom, therefore he did not witness DCW Donna Warren giving Resident A CPR. DCW Patterson reported that DCW Warren came out of Resident A's room after EMT arrived and told him that Resident A had passed away. DCW Patterson reported that during his shift on 9/14/25, he did not hear any equipment alarms going off and observed no medical concerns with Resident A.

I received documentation for direct care workers, Donna Warren and William Patterson's CPR certificates. Both direct care workers completed CPR through American Heart Association. William Patterson had a current certificate and completed CPR on 10/12/2024, which is valid until 10/2026. Donna Warren had a current certificate and last completed CPR on 2/28/2025, which was valid until 2/2027.

I completed a FOIA request through the Michigan State Police. According to the police report the incident status is currently open. The police report stated that they were called to Isabella Home AFC for a female who had no pulse and was not breathing. Upon arrival they found Resident A cold to the touch and lividity was present. Resident A was pronounced deceased at 1336 hours by Dr. Wilkerson of Mclaren Central Michigan. Medical Examiner Hoekwater later arrived on scene, and it was determined Resident A would be transported for an autopsy. Per the report, this incident is open pending autopsy results. According to the police report, fire fighters were first to arrive and Resident A was cold to the touch, not breathing, had no pulse, lividity was setting in, and life saving measures were not attempted. The police reported the following: "was found deceased on her bed in her bedroom. [Resident A] was lying supine and clad in a t-shirt and was wearing a diaper. [Resident A] was found by AFC employee Donna Warren around 1320 hours. [Resident A] was last seen alive by Donna around 1200 hours when Donna advised she changed [Resident A's] diaper, attempted to clean her tracheostomy tube, and had put [Resident A] on a "mister" to help with dryness for the tracheostomy tube." The police report documented an interview with direct care worker William Patterson. The following was documented: "William stated he called 911 after Donna had found [Resident A] not breathing and had no pulse. William stated Donna had checked on [Resident A] around 1200 hours. William stated he last saw [Resident A] when he had checked her blood sugar level and found it at 299. William stated he

gave [Resident A] a shot of her insulin which was .03mL. William showed me the needles used to give [Resident A] the insulin which was a 1cc needle. William indicated he filled the needle up so it contained 3 units which was up to the first three lines on the 1cc needle. William stated [Resident A] was alert and responsive during his interaction with [Resident A]. The police report documented an interview with direct care worker, Donna Warren. The following was documented: “Donna stated she had last seen [Resident A] alive when she had changed her diaper due to a bowel movement. Donna stated she also attempted to clean [Resident A’s] tracheostomy tube and put her on a “mister” to help with dryness from the tracheostomy tube. Donna stated she then left [Resident A] to attend to other residents. Donna was asked if [Resident A] needs the ventilator to breathe or if she can breathe on her own. Donna stated [Resident A] can breathe on her own. Donna stated [Resident A] is only put on her ventilator a few times a day which is to help with clearing [Resident A’s] tracheostomy tube. I asked Donna if [Resident A] is on oxygen. Donna stated [Resident A] only uses oxygen when her oxygen levels are low. I asked what low oxygen levels are for [Resident A]. Donna stated 95% and below are low oxygen levels.” The police report documented the following: “It was determined [Resident A] would be transported to Sparrow Hospital of Lansing for an autopsy. A copy of the autopsy report will be obtained.”

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14305** | **Resident Protection** |
| | **(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.** |
| **ANALYSIS:** | Based upon review of documentation and interviews with direct care workers, there was not enough evidence to determine if direct care workers neglected Resident A’s personal needs, protection and safety at the time of her death. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14204** | **Direct care staff; qualifications and training.** |
| | **(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas:**<br>**(c) Cardiopulmonary resuscitation.** |

| | |
|---|---|
| **ANALYSIS:** | Based upon an interview with DCW Donna Warren, she admitted to not being fully competent in providing cardiopulmonary resuscitation to a resident with a tracheostomy and also stated that she only used one hand while providing chest compressions to Resident A. A violation was established as DCW Donna Warren did not complete cardiopulmonary resuscitation on Resident A per the in-person training provided by the American Heart Association completed on 2/28/2025. DCW Donna Warren did not perform two handed chest compressions, nor was she fully competent on how to connect the Ambu bag to Resident A's tracheostomy when she was found unresponsive on 9/14/25. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **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:**<br>**(a) Medications**<br>**(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:** | Upon review of documentation collected during the unannounced onsite investigation, it was determined that during a visit with Dr. Ashwini on 9/2/25, Resident A's insulin sliding scale was changed, as her insulin levels were reaching 400 during feeding times. This information was documented on a monthly provider note report that is given to Community Mental Health. No further documentation of this recommendation was available for review, nor was any documentation confirming that direct care workers followed up with Dr. Ashwini to obtain further guidance or an updated Insulin order to reflect the new sliding scale. During an interview with DCW Kristy Bruechert, she stated that she did not provide direct care workers with the new sliding scale for insulin as it did not match the current order prescribed in the medication administration record. A violation was established because there was no documentation that Resident A's most recent sliding scale insulin order was being provided to Resident A. Dr. Ashwini issued a new sliding scale insulin order on 09/2/2025, 12 days prior to Resident A's death, and there is no documentation of action taken by direct care staff to determine what is the most current order. Furthermore, it was documented on Resident A's treatment sheet that Resident A did not receive flushing of her tracheostomy tube at 10am on 9/13/25 and 6:30am and 10am on 9/14/25. Dr. Ashwani provided an order that water flushing should occur every four hours during Resident A's feedings. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

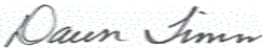
Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same. Another special investigation may be opened pending the results of Resident A's autopsy.

11/04/2025

_____

Amanda Blasius Date
Licensing Consultant

Approved By:



11/04/2025

_____

Dawn N. Timm Date
Area Manager