GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 20, 2020

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

RE: License #: AS370011271
Investigation #: 2020A0867023
Adams Home

Dear Ms. Hart:

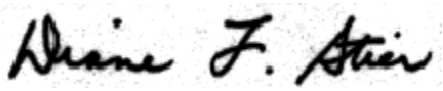
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (231) 922-5309.

Sincerely,



Diane L Stier, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0560

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370011271
Investigation #:	2020A0867023
Complaint Receipt Date:	01/27/2020
Investigation Initiation Date:	01/28/2020
Report Due Date:	03/27/2020
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	April Orser
Licensee Designee:	Amanda Hart, Designee
Name of Facility:	Adams Home
Facility Address:	208 S. Adams Street Mount Pleasant, MI 48858
Facility Telephone #:	(989) 317-8717
Original Issuance Date:	03/11/1987
License Status:	REGULAR
Effective Date:	10/04/2019
Expiration Date:	10/03/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 1/26/2020 Direct Care Worker (DCW) Raymond Miles was sleeping and the second staff person was unable to awaken him, leaving one staff with six residents. DCW Raymond Miles had also left the facility prior and went out to his car for 22 minutes. Three of the residents are two-person assist with a Hoyer lift.	No
On 1/26/2020, DCW Raymond Miles put Resident A to bed using a mechanical lift without a second staff person.	No
Additional Findings	Yes

III. METHODOLOGY

01/27/2020	Special Investigation Intake 2020A0867023
01/28/2020	Special Investigation Initiated - Telephone Complainant
01/28/2020	Contact - Document Received Information from residents' PCPs.
01/30/2020	Contact - Face to Face Staff interviews at Listening Ear
01/30/2020	Contact – Document Received Resident Assessment Plans, Mechanical Lift training documentation
01/31/2020	Inspection Completed – Onsite Review of records
02/06/2020	Contact – Telephone call received RRA Jane Gilmore
02/07/2020	Contact – Telephone call made Assistant Manager Eric Schmidt
02/07/2020	Exit Conference Licensee Designee Amanda Hart

ALLEGATION: On 1/26/2020 Direct Care Worker (DCW) Raymond Miles was sleeping and the second staff person was unable to awaken him, leaving one staff with six residents. DCW Raymond Miles had also left the facility prior and went out to his car for 22 minutes. Three of the residents are two-person assist with a Hoyer lift.

INVESTIGATION:

On 1/27/20, Recipient Rights Advisor (RRA) Jane Gilmore, from CMH for Central Michigan, informed the department that she had received an allegation that DCW Raymond Miles had fallen asleep during the 2nd shift (3 PM – 11 PM) on 1/26/20 and that the other staff person, DCW Taylor Beard, was unable to awaken Mr. Miles. RRA Gilmore reported that three of the residents of the home require a two-person transfer out of bed and that these residents were in bed at the time Mr. Miles could not be awakened, leaving the residents at risk in an emergency.

I received and reviewed an *Incident/Accident Report* dated 1/26/20, completed by DCW Taylor Beard on that date. According to the report, DCW Raymond Miles was asleep from 9 PM – 10 PM, and had been dozing on and off prior to that. The report noted that Mr. Miles went outside to his car after dinner for a 22-minute period as well. Ms. Beard wrote, "At 9 pm Ray [Miles] fell asleep at the dining room table. I tried multiple times to wake him up. I decided at 10 PM to text my PD [Program Director], Candy [McIvor] and tell her he was sleeping." According to the report, Mr. Miles did wake up briefly and moved to the couch, where he again fell asleep. Ms. Beard noted that Mr. Miles was on the couch sleeping when PD Candy McIvor arrived at the facility.

On 1/30/20, Program Director Candy McIvor reported that she received a text message from DCW Taylor Beard on Sunday night (1/26/20) at 10 pm which read in part, "Ray has been sleeping for a while now at the dining room table." Ms. McIvor reported that she told Ms. Beard she would come to the facility. Ms. McIvor said, "When I got to the home, (DCW Raymond Miles) was laying on the couch sleeping." Ms. McIvor said that Mr. Miles did not rouse when she came in, and that she had to "yell at him twice" to get him to waken. Ms. McIvor said, "I walked in and hollered, 'Raymond!' and he didn't move. I came closer, next to the couch, and yelled again, and he woke up and looked dazed." Ms. McIvor said that she told Mr. Miles, "If you can't stay awake, then clock out and go home." Ms. McIvor said she then went to the home's office and Mr. Miles did clock out and leave. Ms. McIvor said that Ms. Beard had told her she had tried repeatedly to waken Mr. Miles without success. Ms. McIvor said that having two staff on duty and alert is required in this home to assure the safety of the residents. Ms. McIvor said, "Four of the residents use wheelchairs, and three of those require a two-person assist with a Hoyer lift to transfer." Ms. McIvor identified Residents A, C, E, and F as the residents who use wheelchairs, with all but Resident F being two-person assists. Ms. McIvor said that the four residents who use wheelchairs were all in bed at the time of this incident and would have needed two staff to move them into their wheelchairs to evacuate in case of emergency.

On 1/30/20, DCW Taylor Beard identified the *Incident/Accident Report* dated 1/26/20 as her written statement. Ms. Beard said that DCW Raymond Miles was "irritated when he came in, very grumpy." Ms. Beard said, "The only work thing he did was put (Resident A) to bed by himself." Ms. Beard said she had been outside on a break and when she came back in, Resident A was in bed. Ms. Beard said that around 8:30 PM, after Mr. Miles had put Resident A to bed, Mr. Miles went out to his car for more than twenty minutes and then went into the bathroom for about five minutes when he returned to the house. Ms. Beard said, "Then he went to the dining room table and fell asleep." Ms. Beard said that just before Mr. Miles fell asleep, Resident D asked Mr. Miles to make a cake while holding a box of cake mix toward him. Ms. Beard said that Mr. Miles said, "No," and then went to sleep. Ms. Beard said that she proceeded to start making the cake. Ms. Beard said, "By the time I got done mixing the cake and turned around, he [Mr. Miles] was sleeping." Ms. Beard said that Residents B and D were at the table at the time. Ms. Beard said that Resident D moved his chair once, and Mr. Miles woke up and then went to the couch in the living room and fell asleep again. Ms. Beard said that she tried to wake DCW Raymond Miles "multiple times." Ms. Beard said, "I went over to stand next to him and said his name, but I did not touch him." Ms. Beard said she did not think that Mr. Miles could or would have responded in an emergency. Ms. Beard said, "Some of that time (Resident B) had his drumstick and was banging on the table and chair with it and Ray didn't budge." Ms. Beard said she finally texted Ms. McIvor, who came to the facility. Ms. Beard said that Ms. McIvor yelled out to Mr. Miles when she first came in but got no response. Ms. Beard said that Ms. McIvor then came to the couch and called out his name. Ms. Beard said that Mr. Miles then woke. Ms. Beard said, "He looked stunned and confused but didn't say anything." Ms. Beard said that Mr. Miles got up and clocked out. Ms. Beard said that as he was leaving, Mr. Miles mumbled, "I wasn't even sleeping."

On 1/30/20, DCW Raymond Miles was asked about his shift on Sunday, 1/26/20, when he left early. Mr. Miles reported that he has been having problems with school, family, and finances. Mr. Miles said he was under a lot of stress that came into his work. Mr. Miles said, "Toward the end of the shift, I fell asleep. My body just gave out, I guess. Candy [McIvor, Home Manager] came in. She told me to just go home. I didn't have any excuse." Mr. Miles said that he fell asleep on the couch. When asked if he had fallen asleep prior to that point at the dining room table, Mr. Miles said that he was not aware of that. Mr. Miles said that no one tried to wake him or prompt him about sleeping prior to Ms. McIvor waking him when he was asleep on the couch. Mr. Miles said that if an alarm had sounded, however, or "even if there was a sound on one of the [resident] monitors, I would have heard it." Mr. Miles said he had no idea how long Ms. McIvor was in the home or trying to wake him before he heard her. Mr. Miles said, "She told me to get up and told me to go home." Mr. Miles said he did not remember going out to his car for twenty minutes during the shift. Mr. Miles said, "I probably went out to the car a couple of times but not for that long."

On 2/7/20, Assistant Manager Eric Schmidt confirmed that the three residents who needed two-person assist when being transferred using a mechanical lift at the time of this incident on 1/26/20 were Residents A, C, and E.

I received and reviewed copies of resident assessment plans and *Person-Centered Plan*s. According to information in the *Person-Centered Plan*s, Residents A, C, E, and F need "assistance" (unspecified) when transferring to or from wheelchair and bed. The *Assessment Plan for AFC Residents* for each resident noted the following:

- Resident A – is non-ambulatory and uses an electric and manual wheelchair, a "grabber," and a shower chair. Needs staff assistance in transferring.
- Resident C – Is noted as needing help with all areas of self-care (e.g., eating, toileting, bathing, dressing), but nothing more is specified. Uses wheelchair, gait belt, mechanical lift, sling, two-person transfer.
- Resident E – has unsteady gait, mainly uses wheelchair independently [scoots around himself]. Uses wheelchair.
- Resident F – is noted as needing help with all areas self-care, with no mention of the specific need or how it will be met. Uses wheelchair, shower chair, shower table, lift, and slings.

No residents of this home were able to provide information useful for the investigation due to cognitive and physical limitations.

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:	Despite the fact that one staff person was asleep and four residents of the home use wheelchairs and were in bed at the time when only one staff was awake, there is no evidence that any resident's needs were not met during this incident. There is insufficient evidence to conclude that DCW Miles would not have been able to respond if needed in an emergency.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On 1/26/2020 Direct Care Worker (DCW) Raymond Miles put Resident A to bed using a mechanical lift without a second staff person.

INVESTIGATION:

On 1/30/20, DCW Taylor Beard reported, "The only work thing (DCW Raymond Miles) did [on 2nd shift on 1/26/20] was put (Resident A) to bed by himself." Ms. Taylor reported that she was outside on a break and when she came back into the house, Mr. Miles had already put Resident A to bed by himself.

On 1/30/20, Administrator April Orser stated that when transporting Resident A from his bed to chair or chair to bed, there has to be two staff present. Ms. Orser said, “The standard at that time was two people transferring.”

On 1/30/20, DCW Raymond Miles reported that he put Resident A to bed on 1/26/20 around 8:30 PM by himself after Resident A had asked to go to bed. When asked if he would have asked a second staff to assist him if his co-worker had not been out on a break, Mr. Miles said, “No. I’m comfortable I can move him by myself.” When asked if staff were recently in-serviced on the need for a second staff person to be present when transferring residents in the lift, Mr. Miles said, “No.” At this point in the interview, Administrator April Orser said, “You were all in-serviced on using the shower bed and lift with two staff.” Mr. Miles then responded, “But Brandon [Garber, DCW] used it by himself all the time!” RRA Jane Gilmore then said she would recommend having a second staff present to “spot” the person using the lift and not to use the lift without a second staff.

I received and reviewed a copy of the *Mechanical Lift Orientation* used at the staff in-service training referred to by Ms. Orser. DCW Raymond Miles had initialed each item on the list of steps to be used and had dated the form on 1/20/20. I noted that one of the items states: “2 staff *should* be used when moving someone in the lift *(if possible)*, and the lift used for only short distances.” [Emphasis added.]

On 1/31/20, Assistant Home Manager Eric Schmidt stated, “Prior to last week, everyone [needing to be transferred using a mechanical lift] was a one-person transfer if you were comfortable with that.” Mr. Schmidt said that new staff were usually trained to do two-person transfers initially and then do one-person transfers once they were comfortable with the lift. Mr. Schmidt said, “(Resident A) has needed a lift since before I came here. One of our senior workers [DCW Brandon Garber] who has been here for nine years said that (Resident A) has always used a lift.”

I received and reviewed a copy of Resident A’s *Assessment Plan for AFC Residents* and *Person-Centered Plan*. According to information in the *Person-Centered Plan*, Residents A needs staff assistance to transfer. The *Assessment Plan for AFC Residents* notes that Resident A is non-ambulatory and uses an electric and manual wheelchair, a “grabber,” and a shower chair. The need for staff assistance in transferring is noted. However, no mention is made in this assessment plan (or in his *Person-Centered Plan*) that a mechanical lift is used in transferring Resident A. There is also no requirement list that two persons are required when a lift is used.

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:	The use of a lift is not mentioned in any written assessment for Resident A, and the need for two persons in transferring Resident A is not mentioned. Additionally, the in-service training for the *Mechanical Lift Orientation* notes that "2 staff *should* be used…if possible." Thus, there is insufficient evidence to conclude that DCW Raymond Miles failed to provide services according to Resident A's written assessment plan when he transferred Resident A to bed using the lift without the assistance of another staff person.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 1/30/19, Home Manager Candy McIvor, DCWs Taylor Beard and Raymond Miles, and Administrator April Orser all spoke of Resident A's use of a mechanical lift in transfers to and from bed, chair, or shower appliance.

I received and reviewed a copy of a list of *Physician Orders* for Resident A, dated 8/28/19. The list of items ordered for Resident A includes "Arjo lift, battery and sling: for transferring." The list also includes an electric and manual wheelchair, a "grabber to help reach items," a wheeled shower chair/table for safety reasons, and several other non-medication items. A similar list dated 6/8/17 also includes the Arjo lift, battery and sling for transferring.

I received and reviewed a copy of Resident A's *Assessment Plan for AFC Residents* (dated 3/28/19) and *Person-Centered Plan*. According to information in the *Person-Centered Plan*, Residents A needs staff assistance to transfer. The *Assessment Plan for AFC Residents* notes that Resident A is non-ambulatory and uses an electric and manual wheelchair, a "grabber," and a shower chair. The need for staff assistance in transferring is noted. However, no mention is made in this assessment plan (or in his *Person-Centered Plan*) that a mechanical lift is used in transferring Resident A. There is also no requirement indicated that two persons are required when a lift is used.

On 1/31/20, I received a newly completed *Assessment Plan for AFC Residents* for Resident A from Administrator April Orser. This plan did include information about Resident A's use of a mechanical lift and sling in addition to other assistive devices. The plan notes that Resident A may be transferred by one staff using the mechanical lift, unless the staff wishes to have the assistance of a second staff.

At the time of my inspection and on 2/7/20 (when I checked with Assistant Manager Eric Schmidt), the facility had no completed written assessment for Resident E for 2019, except for the last page with the guardian's signature dated 3/28/19 and the CMH case worker's signature on 3/6/19. There was no signature for the licensee or licensee

representative. Resident E's 2018 *Assessment Plan for AFC Residents* was completed and was signed by the guardian on 10/22/18 and by Administrator April Orser on 10/18 and was on file in the home.

On 2/8/20, I received a copy of Resident E's *Assessment Plan for AFC Residents* by fax (faxed on 2/7/20) from Assistant Manager Eric Schmidt). On the cover page for the fax, Mr. Schmidt reported that he had found the missing pages for Resident E's assessment.

As noted above, the *Assessment Plan for AFC Residents* for Resident C and Resident F both note that these residents need help with all areas of self-care, including eating/feeding, toileting, bathing, dressing, and personal hygiene, but nothing is described regarding the specific needs of the residents or how the needs will be met.

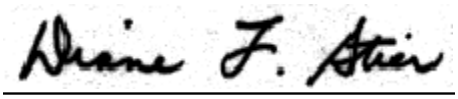
On 1/31/19, Home Manager Candy McIvor reported that she was not aware of the department website where resident forms could be accessed. Ms. McIvor said she would familiarize herself with the website and would assure that resident assessments were kept current.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A's *Assessment Plan for AFC Residents* in the home at the time of the incident under investigation did not contain any mention of the use of a mechanical lift to transfer the resident, despite all witnesses' acknowledgement that a lift was used to transfer Resident A. The *Assessment Plan for AFC Residents* for Residents C and F were incomplete. No current *Assessment Plan for AFC Residents* was available for Resident E at the time of my inspection, although it was found later that day. An accurate, current written assessment plan was not completed annually (or as needed) for three of these four residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

In an exit conference on 2/7/19, Licensee Designee Amanda Hart agreed with the findings of the report. Ms. Hart said that complete and accurate assessment plans are extremely important, and she would assure that written assessment plans for each resident were complete and accurate. Ms. Hart stated that she would submit a written corrective action plan addressing the violation cited.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, I recommend continuation of the current status of the license of this AFC adult small group home (capacity 1-6).



Diane L Stier
Licensing Consultant

February 18, 2020
Date

Approved By:

02/20/2020

Dawn N. Timm
Area Manager

Date