GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 22, 2020

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

RE: License #: AS050071211
Investigation #: 2020A0009026
North Limits

Dear Ms. Hart:

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

- How compliance with the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame for the violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing this issue, please contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (231) 922-5309.

Sincerely,

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS050071211
Investigation #:	2020A0009026
Complaint Receipt Date:	08/26/2020
Investigation Initiation Date:	08/26/2020
Report Due Date:	09/25/2020
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	Sherry Kidd
Licensee Designee:	Amanda Hart
Name of Facility:	North Limits
Facility Address:	1179 North Limits Mancelona, MI 49659
Facility Telephone #:	(231) 587-8688
Original Issuance Date:	05/16/1996
License Status:	REGULAR
Effective Date:	08/24/2019
Expiration Date:	08/23/2021
Capacity:	6
Program Types:	PHYS. HANDICAPPED, DEVELOP. DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A had a significant drop in her weight recently. Her weight records were falsified by staff.	Yes
The residents' personal care needs are not being met. They have poor hygiene, have not had their undergarments changed and sleep in soiled linens overnight.	No
Two staff in the home have used marijuana while on duty.	No
Masks are not always worn in the home by staff.	No

III. METHODOLOGY

08/26/2020	Special Investigation Intake 2020A0009026
08/26/2020	APS Referral
08/26/2020	Special Investigation Initiated – Telephone call with administrator Ms. Sherry Kidd
08/27/2020	Contact – Document received from administrator Ms. Sherry Kidd
09/01/2020	Contact - Telephone call made to Ms. Jacqueline Muzyl, adult protective services
09/01/2020	Inspection Completed On-site Interview administrator Sherry Kidd and manager Jennifer Beckner
09/03/2020	Contact - Document received from administrator Ms. Sherry Kidd
09/14/2020	Contact – Document received from Ms. Jacqueline Muzyl, adult protective services
09/21/2020	Contact – Telephone call made to former direct care worker Ms. Alicia Morden
09/21/2020	Contact – Telephone call made to former direct care worker Ms. Nada Mier
09/21/2020	Exit conference with licensee designee Ms. Amanda Hart

ALLEGATION: Resident A has had a significant drop in her weight recently. Her weight records were falsified by staff.

INVESTIGATION: I received an email from adult protective services worker Ms. Jacqueline Muzyl on August 26, 2020. She received information regarding North Limits which included the following: "(Resident A's) weight was documented on 07/29/20 at the AFC Home, weighing 120 lbs. On 08/10/20, (Resident A) weighed 93 lbs. at GTI. On 08/13/20, She weighed 96 lbs. at the doctor office. However, the AFC home recorded that (Resident A) weighed 120 on 08/15/20. The home has two scales at the home, claiming that they weigh her twice per month. There is a concern that (Resident A) may have a medical condition, to account for her losing so much weight."

I received a phone call from administrator Ms. Sherry Kidd by phone on August 26, 2020. She said that she wanted to report to me that Resident A had a weight drop of 26 pounds. She admitted that the facility's weight records were not consistent with Resident A's recorded weight at her doctor's office or the weight recorded by the Community Mental Health (CMH) nurse. Ms. Kidd also provided me with an Incident/Accident Report (BCAL-4607) regarding the issue. She said that they would be following Resident A closely medically and that she would also be looking into the reason for the discrepancy with their own weight record.

I spoke with protective services worker Ms. Jacqueline Muzyl by phone on September 1, 2020. She said that she has been speaking with both the administrator Ms. Sherry Kidd and the home manager Ms. Jennifer Beckner about the issue of Resident A's weight loss. There are two weight scales in the home and they initially believed that the scales might have been way off. Ms. Kidd weighed Resident A and she weighed 94.8 pounds on one scale and 92 pounds on the other. These are the only scales in the home and either one would have been used to weigh Resident A. The weight that Ms. Kidd weighed Resident A at is consistent with what Resident A weighed at her doctor's office. Obviously, the home's weight records were off, not the scales. They were at a loss about Resident A's weight loss, since her appetite is good. She is eating her meals and eating snacks throughout the day. They are following the doctor's orders and taking Resident A to her medical appointments.

I made an unannounced site visit at the North Limits facility on September 1, 2020. I wore personal protection equipment at the time to protect myself and others. I spoke with administrator Ms. Sherry Kidd about the concerns. She stated that Grand Traverse Industries (GTI) where Resident A works called because they noticed a weight decrease. Three days later, Resident A was weighed at her doctor's office and a weight decrease was also noted there. Ms. Kidd stated that she checked their weight record which showed the Resident A weighed around 120 pounds. She said that she could not explain the discrepancy. She said that the former direct care worker Ms. Alicia Morden took it upon herself to always record Resident A's weight. It seemed that she was the only worker recording the weights.

Ms. Kidd agreed that it seemed most likely that Ms. Morden was not actually weighing Resident A, just writing down weights in the log. Ms. Kidd also acknowledged that there did not seem to be any double-check system and could not explain why the home manager was not checking that this was being done correctly. Ms. Kidd also agreed that someone in the home should have noticed that Resident A had lost that much weight. She did not think that Resident A was resistant to being weighed since she did not fight her, Ms. Kidd, when she recently weighed her.

I then spoke with home manager Ms. Jennifer Beckner. She acknowledged that Resident A had lost a lot of weight. Her CMH nurse stated that she believed that it is a thyroid issue. Resident A does have a good appetite. Ms. Beckner could not explain Resident A's weight records being so erroneous. She said that Ms. Morden was the one who recorded Resident A's weight. It was not something that was assigned to her necessarily, she just did it. Ms. Beckner stated that she believed Resident A was probably not being weighed at all. Ms. Beckner stated that she guessed that Ms. Morden was just writing down a weight close to what the last recorded weight for Resident A was. Ms. Beckner denied that she was checking the weights herself or that she looked at the logs closely. She stated that she was only checking to see that they were completed. Ms. Beckner stated that they did not notice her weight decrease. She said that she they did not notice her weight dropping because it happened over time and incrementally. When she went back to work at GTI, they may have noticed it more readily since they had not seen Resident A in several months. Resident A does not seem sickly.

Ms. Beckner denied that any other paperwork in the home has ever been falsified as far as she knew.

On August 27, 2020, Ms. Kidd sent me copies of Resident A's weight records. Her weight record for 2019 indicated that she weighed 119.6 pounds on January 1, 2019 and 124.9 pounds on December 15, 2019. According to the record, there was little variation in her weight during the year. In 2020, she was recorded as weighing 124.7 pounds on January 1, 2020 and 121.2 pounds on August 15, 2020. Again, there was little variation in her recorded weight with her lowest recorded weight being 120 pounds in June of 2020.

On September 3, 2020, Ms. Kidd sent an email saying, "As of today (Resident A) has seen her primary physician. An order was written for her weight to be taken daily and to start 1-Ensure every day. She has a follow up by video on 9/17/2020 for AIMS. We started weighing all consumers once a week with two staff verifying and documenting all consumers' food and drink intake daily."

On September 14, 2020, I received a document from adult protective services worker Ms. Jacqueline Muzyl. The document was from Resident A's doctor visit at the Mancelona Family Practice on August 13, 2020. It showed that Resident A's weight was recorded as being 96 pounds at the time of the visit.

I spoke with former direct care worker Ms. Alicia Morden by phone on September 21, 2020. She informed me that she quit working at North Limits on August 28, 2020. I asked her about Resident A's weight record. She stated that she did record the last weight that was in the weight log. I asked her why it would have been off by 25 pounds. She said that she thought that the scale was "way off". Ms. Morden said that she just wrote down what the scale said. She stated that she had not been the only one who recorded weights for Resident A.

I spoke with former direct care worker Ms. Nada Mier by phone on September 21, 2020. I asked her about Resident A's weight record. She said that she did not know much about it since she was not the one who did most of the weighing. She said that they hadn't realized that Resident A lost so much weight even though they worked with her almost every day.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	It was confirmed through this investigation that the home's weight records were falsified. Resident A was weighed at her doctor's office on August 13, 2020 at 96 pounds. It was recorded on the home's weight log that Resident A weighed 121 pounds on August 15, 2020. The weight log for Resident A varied little during 2019 and 2020. It is unknown when she started losing weight and how long the log had been falsified. The administrator and home manager both admitted that the log being falsified was the most logical explanation for the discrepancy. The scales were checked by weighing Resident A again, both scales showed her within 1 to 4 pounds respectively of what she weighed at the doctor's office.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The residents' personal care needs are not being met. They have poor hygiene, have not had their undergarments changed and sleep in soiled linens overnight.

INVESTIGATION: I received an email from adult protective services worker Ms. Jacqueline Muzyl on August 26, 2020. She received information regarding North Limits which included the following: “Residents personal care needs are not being met, as they have poor hygiene, have not had their undergarments changed and sleep in soiled linens overnight.”

I made an unannounced site visit at the North Limits facility on September 1, 2020. The home manager Ms. Jennifer Beckman took me around the facility at my request. I checked Resident A’s room initially. Her soaker pad was observed to be clean and dry as well as her bedding. Resident A’s room appeared clean during the time of my visit. I also observed the other resident rooms during my visit. The soaker pads and bedding in the rooms were clean and dry. The bedrooms appeared clean and well-maintained. Resident A was not present during the time of my visit but I did observe the other residents who were present. They appeared clean and well-cared for at that time. Ms. Beckner reported that “basic hygiene” is completed daily for each resident who has full mobility and every other day for the residents who have limited mobility. She also reported that residents who wet throughout the night are checked at least every two hours through the night to determine whether their adult undergarment needs to be changed.

I spoke with former direct care worker Ms. Alicia Morden by phone on September 21, 2020. I asked her about resident hygiene. She stated that the residents’ hygiene was not always good when she came in early for her morning shift. She said that sometimes their soak pads were soaked with urine. Ms. Morden stated that the midnight shift did not do their job. She said that she and the rest of the day staff did take care of the residents’ hygiene. This included cleaning their beds, showering the residents, shaving them and brushing their teeth. She named three other direct care workers whom she said were very good at taking care of the residents’ hygiene every day. Ms. Morden said that the residents’ hygiene was always taken care of when she was present.

I spoke with former direct care worker Ms. Nada Mier by phone on September 21, 2020. I asked her about the residents’ hygiene. She said the midnight shift would often leave a “mess” and then she and the rest of the day shift would have to do everything. This included taking care of the residents’ hygiene which they did every day. Ms. Mier stated that the residents’ hygiene was taken care of each day that she was present.

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:	It was confirmed through this investigation that the residents' hygiene was attended to. During my unannounced home visit, I did not detect any evidence of the residents' hygienic needs not being met. Their beds were clean and dry. The residents on site seemed clean and well-cared for. All of the staff interviewed reported that hygiene was attended to on a daily or at least once every other day basis.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Two staff in the home have used marijuana while on duty.

INVESTIGATION: I received an email from adult protective services worker Ms. Jacqueline Muzyl on August 26, 2020. She received information regarding North Limits which included the following: "Staff members (Alicia Morden and Nada Meir) use marijuana while on duty."

I spoke with adult protective services worker Ms. Jacqueline Muzyl by phone on September 1, 2020. She said that she had been making contacts regarding this case including contact with administrator Ms. Sherry Kidd. She stated that Ms. Kidd confronted both staff accused of using marijuana while on duty, Ms. Alicia Morden and Ms. Nada Meir. She told them that they would both need to submit to a drug test. Ms. Morden resigned after being told this. Ms. Meir is off work until the results of the drug test are received.

I asked administrator Ms. Sherry Kidd about the report of two staff members using marijuana while working. She said that she responded immediately to the complaint by making sure that the two of them would not work together and that they would take drug tests. They were both immediately taken off medication duties. They also were not allowed to transport residents. Ms. Morden resigned when asked to take the drug test and Ms. Meir is off work until the results of the drug test come back. Ms. Kidd stated that there had been no previous reports up until now that they or any other staff were using marijuana. She also had no other reason to believe that they were using marijuana. They did not appear to be under the influence of any narcotic while working. Ms. Kidd did report that Ms. Morden tested positive for marijuana in 2018. A safety plan of her being retested was put in place and she tested negative after that. They do test employees when they are hired and can test again when there is any reason to believe they are using or if there is any accident involving a resident.

Ms. Beckner stated that she had never known any staff to use marijuana on the job. She said that she had never observed it being used or smelt marijuana at work. She has not observed any behavior that has concerned her as if any of the staff were under the influence of marijuana. She did say that Ms. Morden was "moody" near the end of her employment with them. Ms. Morden had admitted in the past that she

used marijuana away from work but never said that she used during work hours. Her and some of the other staff did smoke cigarettes outside the residence.

I spoke with former direct care worker Ms. Alicia Morden by phone on September 21, 2020. I asked her about the report of her and a coworker using marijuana while working. She said that it was untrue. Ms. Morden went on to tell me that a male coworker was sexually harassing her and he quit before getting fired. After he quit, he made the report to try to get him and Ms. Nada Mier in trouble. Ms. Morden said that she never smoked marijuana on the premises.

I spoke with former direct care worker Ms. Nada Mier by phone on September 21, 2020. I asked her about the report of her and a coworker using marijuana while working. She told me the same story of a male coworker sexually harassing her and Ms. Morden. She said that he left and wanted to get them in trouble because “we wouldn’t give him what he wanted”. Ms. Mier said that she would never use marijuana on duty and that she is pregnant and hasn’t used marijuana at all.

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:	It was confirmed through this investigation that the report of two direct care workers at the facility using marijuana was vague. They were confronted and a safety plan was put in place until the results of their drug tests were known. Both workers quit in the meantime. All staff interviewed denied any knowledge or use of marijuana in the home. None of the staff seemed under the influence of any narcotic during the time of my unannounced visit at the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Masks are not always worn in the home by staff.

INVESTIGATION: I received an email from adult protective services worker Ms. Jacqueline Muzyl on August 26, 2020. She received information regarding North Limits which included the following: “There is a concern that no staff members, other than the director, are wearing a face mask or shield. The staff members are only wearing them around the director.”

I spoke with protective services worker Ms. Jacqueline Muzyl by phone on September 1, 2020. She said that the home manager Ms. Jennifer Beckner reported to her that staff are wearing masks at all times while working in the home. She said that she did not know why someone would report that masks were not being worn.

I made an unannounced site visit at the North Limits facility on September 1, 2020. I observed a sign on the door that read: “Masks must be worn at all times while working.” The direct care worker who answered the door was wearing a mask at the time. Both the administrator Ms. Sherry Kidd and the home manager Ms. Jennifer Beckner were also wearing masks.

I asked Ms. Kidd about the report of staff not wearing masks. She admitted that she was also told that the only person who wears a mask is Ms. Beckner when she, Ms. Kidd, is not present. Ms. Kidd stated that she did have to remind some of the staff early on during the Covid-19 pandemic that they are required to wear masks. She said that since that time, she has believed that masks were being worn. She said that the staff she has seen since that time were wearing masks in the facility. Ms. Kidd stated that she would ensure that staff were wearing masks from this point forward.

Ms. Beckner admitted that staff were resistant to wearing masks in the beginning of the Covid-19 pandemic. She said that she was a little bit too in the beginning until she was shown the Governor’s order which specifically stated that masks must be worn. Ms. Beckner stated that she has always worn a mask since that time. She stated that the rest of the staff are “pretty good” about wearing masks. She said that sometimes they will take off their masks when they smoke cigarettes outside during their breaks. They then sometimes forget to put their masks back on when they come inside. When she has reminded them, the staff have always put their masks back on. She has never had anyone refuse to wear their mask when she has reminded them about the requirement.

I spoke with former direct care worker Ms. Alicia Morden by phone on September 21, 2020. I asked her about mask-use by staff in the home. She said that it was “tough in the beginning”. They were then shown the Governor’s order that said they needed to wear masks. They all signed something saying they would wear their masks. She said that they had been fairly consistent wearing masks after that.

I spoke with former direct care worker Ms. Nada Mier by phone on September 21, 2020. I asked her about the use of masks by staff in the home. She said that she always wore her mask while working there. She said that some of the staff needed to be reminded about it. After quite a bit of reminding, everyone was wearing their masks by the time she left her employment there.

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:	It was confirmed through this investigation that masks are being worn by staff in the facility. During my unannounced site visit, all staff were seen wearing masks. A sign on the door stated that workers must all wear masks in the facility. It was reported that compliance was spotty in the beginning of the pandemic but that mask-use increased after staff were shown the Governor's order requiring mask use. The home manager admitted that staff need to reminded and can forget when coming in from a break. She reported that they have always masked-up after being reminded.
CONCLUSION:	VIOLATION NOT ESTABLISHED

An exit conference was conducted by phone with licensee designee Ms. Amanda Hart on September 21. 2020. I told her of the findings of my investigation and gave her the opportunity to ask questions.

IV. RECOMMENDATION

I recommend no change in the license status.

09/22/2020

Adam Robarge Date
Licensing Consultant

Approved By:

09/22/2020

Jerry Hendrick Date
Area Manager