GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 3, 2021

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

RE: License #: AS370307872
Investigation #: 2021A1029015
Briarwood

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,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370307872
Investigation #:	2021A1029015
Complaint Receipt Date:	06/16/2021
Investigation Initiation Date:	06/16/2021
Report Due Date:	08/15/2021
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois, Mt Pleasant, MI 48858
Licensee Telephone #:	(123) 158-7868
Administrator:	Jenny Jacobs
Licensee Designee:	Amanda Hart
Name of Facility:	Briarwood
Facility Address:	1506 Briarwood, Mt. Pleasant, MI 48858
Facility Telephone #:	(989) 317-0999
Original Issuance Date:	06/18/2010
License Status:	REGULAR
Effective Date:	01/03/2021
Expiration Date:	01/02/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

ALLEGATION(S)

	Violation Established?
On June 12, 2021, Resident A fell and was laying in feces and direct care staff members did not take care of it timely.	Yes
On June 12, 2021, direct care staff member, Susan Monroe called her husband who was not a Listening Ear employee to assist her in transferring Resident A.	Yes

II. METHODOLOGY

06/16/2021	Special Investigation Intake 2021A1029015-APS denied referral
06/16/2021	Special Investigation Initiated – Telephone call to Dawn Campbell to initiate investigation.
06/18/2021	Contact - Telephone call made to Angela Wend Recipient Rights
06/21/2021	Contact - Face to Face with Danielle Webster, home manager and Resident A
06/24/2021	Contact - Document Received - Email from Sean Boyle - schedules
06/25/2021	Contact - Telephone call made to Chelsea Bissett, left a voicemail
06/25/2021	Contact - Telephone call made to Susan Monroe, left a voicemail
06/25/2021	Contact - Telephone call made to Misty Campbell, home manager
06/25/2021	Contact - Document Received - Email with house procedures for Resident A - falls and seizures
06/28/2021	Contact - Telephone call made to Susan Monroe and Citizen 1
06/28/2021	Contact - Telephone call made to Angela Wend, Recipient Rights
07/12/2021	Contact - Telephone call made to Chelsea Bissett, left a voicemail
07/12/2021	Contact - Telephone call made to Sean Boyle, left a voicemail.

07/12/2021	Contact - Telephone call made to Guardian A1
07/12/2021	Contact - Telephone call made to Amanda Hart, left a voicemail
07/12/2021	Contact - Telephone call made to Briarwood and spoke to Danielle Webster, Susan quit working at Briarwood last Monday.
07/13/2021	Contact – Telephone call to Sean Boyle, Director of Residential Services
07/13/2021	Exit conference with Amanda Hart, licensee designee of Briarwood
07/23/2021	Contact – Telephone call to Chelsea Bissett, no answer

ALLEGATION:

On June 12, 2021, Resident A fell and was laying in feces and direct care staff members did not take care of it timely.

INVESTIGATION:

On June 16, 2021, a complaint was received via a denied referral from adult protective services centralized intake alleging that Resident A fell on June 12, 2021 and was laying in his own feces in the hallway.

On June 18, 2021, I interviewed Angela Wend from Community Mental Health of Recipient Rights. Ms. Wend stated the incident occurred around midnight on June 12, 2021. Ms. Wend interviewed direct care staff member, Susan Monroe, who was working and she mentioned she did not think to call 911 during the incident. Ms. Monroe stated she did not think 911 would come to assist in this situation and recognized during that interview that she made a “bad choice.” The other direct care staff member who was working, Chelsea Bissett, was new. Ms. Monroe told Ms. Wend that when Resident A fell he had a large bowel movement in the hallway but she was able to have him scoot back to his bedroom. Resident A has frequent falls and his health and kidneys are failing. After the fall, he was back in the bed around 2:00 a.m. He is not able to communicate about the incident. Ms. Bissett told Ms. Wend that she tried to help lift Resident A on her own as Ms. Monroe stated that she did not try to assist because she was pregnant.

On June 21, 2021, an unannounced on-site investigation was completed at Briarwood. Direct care staff member, Danielle Webster was working at the time getting the residents ready for an outing. Ms. Webster indicated that Ms. Bissett does not work for Briarwood any longer. She stated direct care staff members document falls for residents and given that Resident A’s health is declining he has been more falls lately. Ms.

Webster stated that typically, it takes two direct care staff members to transfer Resident A and a gait belt can be used to assist in transferring him. Ms. Webster stated Resident A also has a wheelchair available to use when on outings but the wheelchair can also be used to assist in transferring him after a fall.

I was able to review Resident A's resident record. According to the most recent *Health Care Appraisal (BCAL 3947)* dated December 10, 2020, Resident A uses a wheelchair to assist him with mobility.

Ms. Webster clarified she was not working at the time Resident A fell but thought based on previous experiences with Resident A that he likely had a bowel movement and then fell in the hallway. She stated home manager, Misti Campbell was called by Ms. Monroe around 12:30 a.m. and Ms. Monroe was told to call 911 but did not call 911. Ms. Webster stated there have been times in the past when direct care staff members have called 911 because they needed assistance after a resident fall. Ms. Webster was not sure what Resident A was wearing at the time of the fall or how they were able to clean him after the bowel movement.

Ms. Webster reported the usual protocol when the residents have a fall, is direct care staff members are required to document it on an Incident Report and if there is a fall where the resident hits their head, direct care staff members need to do a head assessment to check for further injuries. Ms. Webster reported there are two direct care staff members working on third shift at any time. Ms. Webster stated she was told Ms. Bissett told Ms. Webster she tried to help during the incident but could not because she was three months pregnant.

Resident A's room was also viewed during the on-site inspection. His room was free of any safety hazards on the floor that may cause Resident A to trip. Resident A had a wheelchair and gait belt in his bedroom that would have been easily accessible during the incident.

On June 25, 2021, I spoke with direct care staff member, Misty Campbell whose role is as home manager. Ms. Campbell stated that Ms. Monroe did call her around 1 a.m. after the fall occurred. Ms. Campbell said that she would come and help her, but she said that she lives 40 minutes out and that she would have to call 911 to assist with helping Resident A off the floor.

Ms. Campbell does not know why 911 was not called but Ms. Bissett told her that Ms. Monroe was upset about this and did not want to call 911. Ms. Campbell stated Ms. Monroe has had to call 911 more than once, so this is not a new task for Ms. Monroe. Ms. Campbell was upset because Resident A may have been naked and had only a sheet covered in feces. Ms. Campbell stated that to her knowledge, Resident A was on the floor for 2.5 hours after the fall. Ms. Campbell stated that according to their records, Ms. Monroe did not call her husband to help him up until after 1:30 a.m. Ms. Campbell reported the facility always have two direct care staff members working on third shift.

Ms. Campbell believed if she would have given Resident A a chance to relax and catch his breath, he could have gotten up on his own but maybe there was feces on his feet and he could not get up. Ms. Campbell stated Resident A was in his bedroom on the hardwood floors when this fall happened.

Ms. Monroe has been a direct care staff member at Briarwood for just under two years. Ms. Bissett is no longer working as a direct care staff member because she failed to report to work and did not call. She ended up resigning without notice.

Briarwood has a seizure protocol for Resident A. Typically, direct care staff member can get him up because there are two of them each night. If they cannot get them up, then the procedure is to call 911. Direct care staff members do not need the home managers permission to call 911.

When Ms. Campbell talked to Chelsea, she was told that Resident A hit his head on the wall. She did not pull the wheelchair over to him to give him the chance to crawl into it. Resident A has a wheelchair but they were told they picked him up “in a sheet” instead of using the gait belt and Ms. Bissett tried to clean him up once he was standing in an upright position.

On June 25, 2021, documents were sent regarding the fall and seizure protocol for Briarwood for Resident A. The following protocols were designed for direct care staff members to follow if Resident A has either a seizure of experiences a fall:

<u>Protocol for assisting [Resident A]:</u>

- To prevent falling staff will keep all paths clear that [Resident A] may use.
- If staff observes that [Resident A] is unsteady then they will walk side by side with him
- If he is unsteady then staff may use the gait belt and /or wheelchair.
- Staff will remind him to walk slower.
- During sleeping hours staff will check him every hour
- During sleeping hours staff will use an audio monitor for safety to hear when he is getting up.

<u>General fall protocol:</u>

- Not move them immediately
- Obtain a full set of vitals
- Assess for signs of head and major injuries
- If a head injury is found, call 911 immediately and do not allow them to move.
- If no head injury is found but they hit their head, complete the head injury assessment sheet.
- If a major injury is found call 911 immediately and do not allow them to move.
- If no major injury is found, with a gait belt, 2 staff will assist them to a sitting /standing position.

- Notify on call (and call PD/AFD if needed to call 911)
- Notify primary doctor, if necessary
- Notify guardian / family, if necessary
- Document in progress notes, staff log, and complete an IR.

On June 28, 2021, I interviewed direct care staff member Susan Monroe. She stated that one night that she worked she got him up to go to the bathroom and he started walking to the bathroom and went down on his hands and knees. Ms. Monroe could not get him up off the floor and Ms. Bissett said she could not lift him at all. Ms. Monroe could not do it by herself. He scooted back to his bedroom. He was in the living room almost to the hall about three steps out of his room. He was covered in feces during the incident. She did not know when he had the bowel movement. Resident A is very unsteady at night due his evening medication. Ms. Monroe stated that she panicked during the incident. She stated she was unable to clean him completely due to how he was sitting on the floor without getting him to a standing position first. She did try to clean some of the feces off of him while he was on the floor.

Ms. Monroe stated she called home manager Ms. Campbell to report Resident A's fall and to obtain a coworker's phone number so that person could assist with transferring Resident A from the floor back to his bed. Ms. Monroe stated she did not remember if Ms. Campbell told her to call 911 for assistance. Ms. Monroe also stated she did not even think about using the gait belt or wheelchair when they were working to lift him. Ms. Monroe stated she uses the gait belt when it is "really bad" but she said that she did not think that this fall was that bad.

On July 12, 2021, I made a telephone call to Guardian A1 who stated she was aware of the fall that occurred that night. She talked to a couple of the different direct care staff members. She stated that he was up at night, they could not get him up. Ms. Monroe told her she could not reach Briarwood administration. Guardian A1 thinks it would depend on the circumstances of the fall and then they would call 911 if it were serious enough. Sometimes he will go down on his knees and they can pick him up. Resident A has a harder time at night with steadiness. She did not know how long he had fallen and was on the floor. She was informed that the Ms. Monroe called her husband to assist after the fall but does not know if this has happened any other time.

On July 13, 2021, I spoke to Sean Boyle, Director of Residential Services. Mr. Boyle stated there is a crisis center number and the procedure is to call that number who will then call the on call staff for the week. The on call staff will then contact the direct care staff member that needs assistance. There are three directors and three long term staff that are on call that rotate week by week. In this situation, Ms. Monroe should have called the crisis center number for assistance. Listening Ear administration just trained direct care staff members regarding when to call on call a month ago at the last staff meeting. Ms. Monroe was in this training and was fully trained. She should have known call the on call number after this incident for assistance and she did not do so. This number is active from 5 p.m. Friday evening to 8 a.m. Monday morning and during the weekday evenings. Mr. Boyle also stated if she could not have gotten Resident A

up, then Ms. Monroe or Ms. Bissett could have called 911 for assistance. However, if he were not in feces and he was clean and comfortable, the on call number would have been more appropriate. From his understanding, Ms. Monroe was instructed to call 911 and she failed to call 911. Chelsea Bissett resigned from her position with no notice. Mr. Boyle does not know if Ms. Bissett tried to assist in the situation by lifting him. Mr. Boyle stated Ms. Bissett told him when he hired her that she was cleared to lift and work while she was pregnant. He has not received any documentation that information changed and she was not suitable to work. Mr. Boyle stated Ms. Bissett made the conscious decision to not lift Resident A after he fell. Ms. Monroe also resigned from her position at Briarwood on July 5, 2021.

The pre-employment physical exam clearance for Chelsea Bissett from McLaren Medical Group was received from Mr. Boyle. When Ms. Bissett was hired for employment and there were no lifting restrictions noted and documented that she could occasionally lift over 50 pounds. Mr. Boyle has not received any additional documentation that she could not assist a resident after a fall due to medical restrictions.

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:	Resident A was not treated with dignity and his personal needs were not met during this incident. Resident A fell at Briarwood and the direct care staff members, Ms. Monroe and Ms. Bissett could not transfer him so he was left on the floor in his fecal matter for an extended period of time. Briarwood has an extensive on call procedure with an after hours crisis number that could have assisted as well as written procedures to follow when a resident falls. There is also a separate document on how to assist Resident A when his gait is unsteady. Despite these policies, Ms. Monroe and Ms. Bissett failed to follow any of these policies and procedures and instead Resident A sat in his bowel movement for over two hours on the floor. Ms. Monroe and Ms. Bissett waited to clean Resident A and change him until he was in a standing position.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On June 12, 2021, direct care staff member, Susan Monroe called her husband, who was not a Listening Ear employee, to assist her in transferring Resident A.

INVESTIGATION:

On June 16, 2021, a complaint was received that direct care staff member Susan Monroe called her husband, who is not an employee if Listening Ear, to help her lift Resident A off the floor. On June 18, 2021, I spoke to Angela Wend from Recipient Rights. Ms. Wend completed the interviews with direct care staff members Susan Monroe and Chelsea Bissett. Ms. Wend stated that Ms. Monroe told her that she called her husband and she "made a bad choice."

On June 21, 2021, an unannounced on-site investigation was completed at Briarwood adult foster care home. Direct care staff member, Danielle Webster stated that Ms. Monroe panicked and called her husband instead of calling 911 for assistance like Ms. Campbell told her to do when she called for assistance.

On June 25, 2021, I spoke with Misty Campbell. Ms. Campbell stated that she was called by Ms. Monroe around 1 a.m. and directed Ms. Monroe to call 911 for assistance with lifting Resident A from the floor. Ms. Campbell stated according to her documents, Ms. Monroe called her husband 2:30 am and he came to help Resident A up and transfer him back to his bed. Ms. Campbell stated Ms. Monroe is still working in the home and has not been suspended.

On June 28, 2021, I interviewed direct care staff member, Susan Monroe. She has worked there for about two years at Briarwood and works third shift. Ms. Monroe first stated that she did not know what happened that night other than him falling. She stated that she panicked. Ms. Monroe tried to call a couple different coworkers. After no one answered, she called Ms. Campbell the home manager. Ms. Monroe stated several times during the interview she did not know what happened. After that she called her husband who came to the AFC home around 1:30 am. Ms. Monroe stated that he helped her pick him up. Before arriving, her husband asked if Resident A was covered up so she put a sheet around him "like a toga" for privacy. Resident A was wearing a pair of shorts and a T-shirt. She stated Resident A had some bruising on him from the blood pressure cuff when he was last in the hospital and she did not want to grab him on his arm.

Ms. Monroe and her spouse held Resident A up and Ms. Bissett cleaned his bottom from the bowel movement before they were able to transfer him to the bed around 2 a.m.

When asked if Ms. Bissett assisted during the incident, she stated Ms. Bissett stated that she did not know what to do and did not pick Resident A up because she was pregnant.

Ms. Monroe stated that she has never called her husband before to help with the residents. She said she does not know what was going on in her head. Two days before she called 911 because he had a seizure and needed help. She cannot remember if Ms. Campbell told her to call 911 or not so she is not going to say one way or the other. Now when she gets Resident A out of bed, she always uses the wheelchair because she is not taking any chances of him falling.

On June 28, 2021, I interviewed Citizen 1 who stated he received a call around 1:00 a.m. saying Resident A fell and she could not get him up because her coworker was pregnant and could not lift him.

Citizen 1 stated Resident A was "covered in crap" when they got him up. Ms. Monroe had a sheet wrapped around him and used the sheet to assist with picking him up because they did not want to bruise him at all. When he was standing up, Ms. Bissett was cleaning his back side. He said he talked to Resident A during that time to try and keep him calm.

Once they got him standing, he was swaying back and forth and then fell again. They had to keep telling him to stand up. After they were able to get Resident A sitting on the edge of the bed, he left the home. Citizen 1 denied that he has ever been over to help with the residents before. His wife told him she called other people, and no one would help her. Citizen 1 stated he felt bad because his wife was crying and panicked so he wanted to assist.

On June 28, 2021, I contacted Angela Wend from Recipient Rights regarding the incident. She did receive an incident report for the fall and will send a copy to licensing.

On July 12, 2021, I made a telephone call to Guardian A1. Guardian A1 was informed by the Briarwood staff that one of the direct care staff members called her husband to assist with getting him up instead of having 911 called. They had a procedure for his falls in place. Guardian A1 does not have any concerns Ms. Monroe's husband was unsafe for Resident A to be around but is concerned that the procedure was not followed.

On July 13, 2021, I made a telephone call to licensee designee, Amanda Hart. She explained the process for someone receiving medical accommodations regarding Ms. Bissett. She stated that she does not believe the medical form indicated that Ms. Bissett had any medical restrictions for lifting. If she did have a restriction, they would have reviewed this and she would have had another direct care staff member working during this incident. Ms. Bissett has not worked since June 19, 2021. Ms. Hart was unaware that Ms. Monroe has ever called her husband to assist with the residents in the home. Ms. Hart was surprised that Ms. Monroe would have called her husband for assistance because she was directed to call 911 by Misti Campbell and failed to do so.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Briarwood did not have sufficient direct care staff members on during the third shift on June 12, 2021. There were two direct care staff members on but one of them could not lift Resident A due to her pregnancy. After Resident A fell, instead of calling the on call crisis number to receive assistance, Ms. Monroe called her husband who was not an employee of Listening Ear to assist her in transferring, cleaning, and dressing Resident A. Ms. Bissett did not assist in transferring Resident A even though she did not have any restrictions for lifting in her physical examination prior to being hired. She was also asked before her hire date if she was able to perform the job duties and she stated she could.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

Ms. Monroe stated in her interview on June 28, 2021 that Ms. Bissett and she were unable to get Resident A up after the fall. Instead of calling 911 as directed by Ms. Campbell, she contacted Citizen 1 to assist. Ms. Bissett confirmed that Citizen 1 is not an employee of Listening Ear.

Citizen 1 stated he went to Briarwood to provide assistance after the fall. With his help, Resident A was able to stand up and Ms. Monroe and Citizen 1 were able to get him back into the bed safely. Citizen 1 stated he left the home once Resident A was returned to his bed.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Ms. Monroe called Citizen 1 to aid with transferring Resident A after the fall. Citizen 1 was not suitable to meet the needs of Resident A because he was not employed by Listening Ear. Citizen 1 has not completed any training required of direct care staff members and has not completed a criminal history clearance to determine if he was suitable to provide direct care to residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license.

Jennifer Browning 7/26/2021

Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 08/03/2021

Dawn N. Timm Date
Area Manager