GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 21, 2022

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

RE: License #: AS370011281
Investigation #: 2022A0466012
Mt Pleasant 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 (517) 284-9727.

Sincerely,

Julie Elkins, 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 #:	AS370011281
Investigation #:	2022A0466012
Complaint Receipt Date:	11/23/2021
Investigation Initiation Date:	11/23/2021
Report Due Date:	01/22/2022
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(231) 587-8688
Administrator:	Amy Spanne
Licensee Designee:	Amanda Hart
Name of Facility:	Mt Pleasant Home
Facility Address:	908 Sansote Mt Pleasant, MI 48858
Facility Telephone #:	(989) 772-0564
Original Issuance Date:	03/01/1988
License Status:	REGULAR
Effective Date:	07/31/2021
Expiration Date:	07/30/2023
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION:

	Violation Established?
Direct care worker (DCW) Julie Meyer refused to give Resident A anymore of her meal once she consumed her liquid on 11/19/2021.	No
Additional Findings	Yes

III. METHODOLOGY

11/23/2021	Special Investigation Intake-2022A0466012.
11/23/2021	Special Investigation Initiated – Telephone call, Complainant interviewed.
11/23/2021	Contact - Telephone call made to DCW Lisa Kappler, house manager interviewed.
11/23/2021	Contact - Telephone call made to Katie Hohner, ORR.
11/23/2021	Contact - Telephone call made to DCW Julie Meyer interviewed.
12/08/2021	Inspection Completed On-site.
12/08/2021	Contact - Telephone call made to ORR Katie Hohner.
01/20/2022	Exit Conference with licensee designee Amanda Hart, email sent.

ALLEGATION: Direct care worker (DCW) Julie Meyer refused to give Resident A anymore of her meal once she consumed her liquid on 11/19/2021.

INVESTIGATION:

On 11/23/2021, Complainant reported that DCW Kaylene Delfel called the office of recipient rights (ORR) and reported that on 11/19/21, DCW Julie Meyer refused to give Resident A anymore of her meal after she finished her liquids. Complainant reported Resident A is nonverbal. Complainant reported Resident A pushed her food away indicating she wanted her liquids. Complainant reported DCW Meyer told Resident A, “if I give you your fluids, you're not getting more food.” Complainant reported DCW Meyer gave Resident A her fluids but when Resident A reached for her food, DCW Meyer told her, "No, I told you if you had your liquid, you were done eating." Complainant reported DCW Meyer then directed DCW Delfel to take Resident A to her chair in the living room. Complainant reported DCW Delfel reported that Resident A was crying. Complainant reported DCW Delfel stated she

did not understand what difference it made if Resident A ate her food after she had her liquids. Complainant reported DCW Delfel is a new staff who took her recipient rights training on 11/20/21 and during that training this scenario came up. Complainant reported DCW Delfel was instructed to report this to her home manager who in turn told her to report this to ORR. Complainant reported DCW Delfel reported that she thought this situation was odd, but she did not know it was a recipient rights violation until the training the next day.

On 11/23/2021, I interviewed house manager Lisa Kappler who reported DCW Delfel reported the allegation to her. DCW Kappler reported that this was not typical behavior for DCW Meyer. DCW Kappler reported typically Resident A pushes her plate away when she is done and then liquids are given to her. DCW Kappler reported that after Resident A has liquids, she is typically done eating. DCW Kappler reported when DCWs feed Resident A it is typical to hold her liquids to the end otherwise she will not eat her food. DCW Kappler reported that if Resident A were to ask for food again after her liquids, the food should be provided to her.

On 11/23/2021, Office of Recipient Rights Officer Katie Hohner and I interviewed DCW Meyer who reported that she did not deny Resident A any food. DCW Meyer reported Resident A eats by herself, however liquids are kept to the side because if she is given the liquids first, she will not eat her food. DCW Meyer reported after Resident A pushed her plate away, liquids were given to her. DCW Meyer reported that if Resident A wanted her plate back, she would give it back to her but that typically does not happen as once Resident A drinks her liquids she is typically done eating. DCW Meyer reported that on 11/19/2021, she did not deny Resident A any food nor did she tell her “If you had your liquid, you were done eating."

On 12/08/2021, I conducted an unannounced investigation and I interviewed Taylor Beard, assistant program director (APD) who reported that she was on shift on 11/19/2021 with DCW Meyer and DCW Delfel. APD Beard reported she was in the office while DCW Meyer and DCW Delfel were giving the residents lunch. APD Beard reported DCW Delfel did not report anything to her about Resident A being denied food nor did she hear any conversation between DCW Meyer and DCW Delfel. APD Beard reported Resident A needs to be watched while she eats to make sure that she does not eat too fast or take too big of bites. APD Beard reported that typically Resident A is a good eater. APD Beard reported that it is standard procedure to give Resident A her liquids last and this is Resident A usual routine.

On 12/08/2021, I reviewed Resident A’s record which contained an *Assessment Plan for Adult Foster Care (AFC) Residents* that was dated 12/9/2020 and signed by house manager Lisa Kappler and Amy Spanne. In the “eating “section of the report it stated, “Pureed food and thicken liquid diet. Choking and aspiration concerns during meal intakes. Lunch and dinner is [sic] divided into 2 small meals.”

On 12/08/2021, I reviewed Resident A's record which contained an *Incident/Accident Report* (IR) written by DCW Delfel and signed off by Lisa Kappler. In the "Explain what happened" section of the report it stated "[Resident A] stopped eating her lunch. She indicated to Julie that she then wanted fluids. Julie made it clear I can give you your fluids if you're done eating. [Resident A] pushed food forward. Julie moved the plate to the middle of the table. Allowed [Resident A] her fluids. Once finished [Resident A] reached back for food. Julie told [Resident A] you are not eating anymore you wanted your fluids. She then had me ask [Resident A] if she wanted to go sit down. As I walked over to ask [Resident A] stood indicating that she wanted me to walk her to her chair. In the "Action Taken by staff" section of the report it stated "I made training staff aware once I learned that this is a rights violation. I then informed by PD. In the "Corrective Measures" section of the report it stated, "Recipient rights notified."

On 12/08/2021, I reviewed Resident A's record which contained a *Training Inservice* that Katelyn Campbell, OTR/L presented at on 11/18/2021. The topic covered was Activity of Daily Living (ADL) guidelines. The training log documented that DCW Meyer, DCW Delfel and DCW Beard were all in attendance.

Resident A was in the home on 12/08/2021 and I observed her. Resident A is non-verbal and therefore could not be interviewed.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Although Complainant and DCW Delfel reported that DCW Julie Meyer refused to give Resident A anymore of her meal once she consumed her liquid on 11/19/2021, DCW Meyer denied this allegation. Resident A is non-verbal therefore unable to be interviewed and there were no witnesses therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:
On 12/08/2021, I reviewed Resident A's record which contained an *Assessment Plan for Adult Foster Care (AFC) Residents* that was dated 12/9/2020 and signed by house manager Lisa Kappler and Amy Spanne. Resident A's record did not contain any documentation that Guardian A1 nor Resident A's responsible agency participated in the development of the written assessment plan.

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* did not contain any documentation that Guardian A1 nor Resident A's responsible agency participated in the development of the written assessment plan therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in the status of the license.

01/20/2022

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Julie Elkins Date
Licensing Consultant

Approved By:

01/21/2022

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Dawn N. Timm Date
Area Manager