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STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 29, 2022

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

RE: License #: AS370011270
Investigation #: 2022A0466029
Isabella Home

Dear Mr. Carmichael:


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) 284-9730.

Sincerely,

A handwritten signature in cursive script that reads "Jana Lipps". The signature is written in black ink on a white background.

Jana Lipps, 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 #:	2022A0466029
Complaint Receipt Date:	03/07/2022
Investigation Initiation Date:	03/09/2022
Report Due Date:	05/06/2022
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(231) 587-8688
Administrator:	Timothy Carmichael
Licensee Designee:	Timothy Carmichael
Name of Facility:	Isabella Home
Facility Address:	2599 S Isabella Road Mount Pleasant, MI 48858
Facility Telephone #:	(989) 773-0326
Original Issuance Date:	10/10/1986
License Status:	REGULAR
Effective Date:	04/05/2020
Expiration Date:	04/04/2022
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED
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II. ALLEGATION:

	Violation Established?
Resident A's personal care needs were not met on 03/02/2022.	Yes

III. METHODOLOGY

03/07/2022	Special Investigation Intake- 2022A0466029.
03/09/2022	Contact - Document Sent email to Complainant.
03/09/2022	Special Investigation Initiated – Telephone with ORR Jane Gilmore.
03/16/2022	Inspection Completed On-site with AFC licensing consultant Julie Elkins. Interview with staff.
03/16/2022	Contact - Telephone call made, interviewed direct care staff, William Patterson.
03/16/2022	Contact - Telephone call made, interviewed Assistant Program Director (APD), Chelsea Hunter.
03/17/2022	Contact - Telephone call received- interviewed direct care staff, David Mascho.
03/21/2022	Contact - Telephone call made, interviewed direct care staff, Sarah McLeod.
03/29/2022	Exit conference with Timothy Carmichael.

ALLEGATION: Resident A's personal care needs were not met on 03/02/2022.

INVESTIGATION:

On 03/07/2022, Complainant reported that direct care staff (DCS) Sarah McLeod failed to check and/or change Resident A during her shift. Complainant reported DCS Christine Leavitt discovered Resident A's incontinence garment to be full of urine and feces when she arrived for work as DCS McLeod was leaving. Complainant reported that the other direct care staff on duty were males and were not authorized to complete personal care for Resident A.

On 3/16/2022, AFC licensing consultant Julie Elkins and I conducted an unannounced onsite investigation and interviewed program director (PD), Alicia Andrew, who stated she worked in the morning on 3/2/2022 however DCS David Mascho and DCS William Patterson reported to her that DCS McLeod did not provide care to Resident A during her scheduled shift, due to DCS McLeod being ill. PD Andrew reported DCS Mascho and DCS Patterson reported to her that DCS McLeod was “huffing and puffing” in pain during her shift while she sat in a chair. PD Andrew reported that the other staff members, who were on shift with DCS McLeod, were not able to meet Resident A’s needs during this time period as DCS McLeod was the only female DCS on duty and male DCS are not to provide Resident A with personal care as required by Guardian A1. PD Andrew reported that per agency policy female staff are the only staff allowed to provide personal care to female residents. PD Andrew reported that there was not another female staff on shift at this time. PD Andrew reported that another female staff was called in to assist and DCS McLeod was eventually replaced on the schedule.

On 03/16/2022, I reviewed Resident A’s record which contained a written *Assessment Plan for Adult Foster Care (AFC) Residents* which documented in the “toileting” section of the report “[Resident A] wears a brief and staff provides all of her toileting needs, which include changing her brief every 2 hours, and as needed.”

Resident A’s record also contained a document titled *[Resident A] Male Staff Guidelines* that stated “Male staff will not help female staff with these personal care items, changing brief, showering her, and changing her clothes. This is [Resident A] and her guardian’s preference. Female staff are only permitted to provide [Resident A] with the above personal cares.”

On 3/16/2022, I interviewed DCS Patterson who reported that he worked on 3/2/2022. DCS Patterson reported he arrived for work on 3/2/2022 at 5pm. DCS Patterson reported DCS McLeod was sitting in a chair “bawling” when he arrived. DCS Patterson reported DCS Mascho told him that DCS McLeod had been in this condition since she arrived at 3pm and that she had not taken care of Resident A even though she was the only female DCS on duty and Resident A needed personal care attention. DCS Patterson reported that he contacted DCS Leavitt to get another female DCS to come in and around 8:30pm, DCS Leavitt arrived to relieve DCS McLeod. DCS Patterson reported that he did not provide any personal care to Resident A during this shift due to Resident A’s restrictions. DCS Patterson reported he did not observe that any personal care was provided to Resident A between the hours of 5pm – 8:30pm on 3/2/2022 by any direct care staff member including DCS McLeod.

On 3/16/2022, I interviewed Assistant Program Director (APD), Chelsea Hunter, who reported working on 3/2/2022 from 7am to 3pm. APD Hunter reported being present when DCS McLeod arrived for her shift on this date. APD Hunter reported DCS McLeod did not present as though she was ill or unable to perform the duties of her job description. APD Hunter reported that DCS McLeod did not ask to go home due

to being ill/injured and DCS McLeod did not try to call in sick to work either. APD Hunter reported that DCS McLeod was “moaning and groaning” but noted this is typical behavior for DCS McLeod. APD Hunter noted that she had cared for Resident A on 3/2/2022 from 7am to 3pm and when she left work at 3pm Resident A was dry and changed.

On 3/17/2022, I interviewed DCS Mascho, by telephone. DCS Mascho confirmed he worked with DCS McLeod on 3/2/2022. DCS Mascho reported they arrived for work at the same time, 3pm. DCS Mascho stated that he cares for the male residents while working, due to agency policy. DCS Mascho reported that he discovered a “puddle” of urine under Resident A’s wheelchair between 6pm- 7pm on 03/02/2022 but Resident A was not changed as DCS McLeod, the only female DCS, was “almost crying.” DCS Mascho reported he fed Resident A but did not provide personal care, per agency policy. DCS Mascho reported that DCS Patterson arrived around 5pm and began calling for a replacement for DCS McLeod as she was not able to perform the duties of her job description.

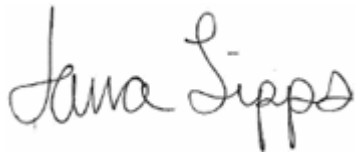
On 3/21/2022, I interviewed DCS, Sarah McLeod, by telephone. DCS McLeod noted she recalled working on 3/2/2022 and noted she had been ill and was recovering from bronchitis. DCS McLeod noted that she felt her rib had “popped out” and she was in pain on this date. She reported she had expressed this concern to PD Andrew on this date. DCS McLeod stated she told PD Andrew and “she just clocked out and went home.” DCS McLeod reported that on the date of 3/2/2022 she was not able to provide personal care to Resident A per her job duties. DCS McLeod reported that she did not provide Resident A’s personal care needs during her shift on 3/2/2022. DCS McLeod reported she was replaced on this shift, around 7pm by DCS Leavitt. DCS McLeod stated she was not aware of the puddle of urine, reported by DCS Mascho, under Resident A’s wheelchair. DCS McLeod reported that she did not provide Resident A with brief changes every two hours as instructed in Resident A’s 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.
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: (a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.

ANALYSIS:	Based on interviews with PD Andrew, DCS Patterson, DCS Mascho, APD Hunter and DCS McLeod the allegation that DCS McLeod did not provide for Resident A's personal care needs on 03/02/2022 has been established. DCS McLeod admitted that she did not provide Resident A with personal care for at least four hours and therefore did not provide Resident A with the personal care that she requires.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



03/29/2022

Jana Lipps
Licensing Consultant

Date

Approved By:



03/29/2022

Dawn N. Timm
Area Manager

Date