GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 28, 2022

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

RE: License #: AS370011270
Investigation #: 2022A0790027
Isabella Home

Dear Mr. Carmichael:

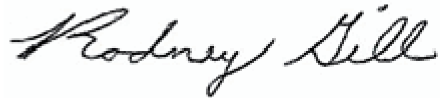
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Rodney Gill, 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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS370011270
Investigation #:	2022A0790027
Complaint Receipt Date:	07/06/2022
Investigation Initiation Date:	07/06/2022
Report Due Date:	09/04/2022
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
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:	04/05/2022
Expiration Date:	04/04/2024
Capacity:	6

Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Christine Leavitt was very forceful with and physically abused Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

07/06/2022	Special Investigation Intake 2022A0790027
07/06/2022	Special Investigation Initiated - Telephone
07/12/2022	Inspection Completed On-site with recipient rights advisor Katie Hohner. Interviewed direct care staff member Alicia Andrew who functions as the program director at Isabella Home, direct care staff member Deana Prout, direct care staff member Christine Leavitt, Resident B, and direct care staff member Bill Patterson.
07/12/2022	Inspection Completed-BCAL Sub. Compliance
07/18/2022	Exit Conference with licensee designee Timothy Carmichael.
07/29/2022	APS Referral

ALLEGATION:

Direct care staff member Christine Leavitt was very forceful with and physically abused Resident A.

INVESTIGATION:

I initiated this investigation by speaking with recipient rights advisor Katie Hohner via phone on 07/06/2022. Ms. Hohner said she has spoken with the executive director for Isabella Home Jenny Jacobs and Ms. Jacobs indicated direct care staff member Christine Leavitt will be taken off the schedule pending the outcome of our joint investigations. Ms. Hohner said she is attempting to arrange interviews in person next week on Tuesday 07/12/2022. Ms. Hohner said Resident A is blind and

developmentally disabled and will not be able to provide any information regarding the allegations.   Ms. Hohner said direct care staff member Christine Leavitt has never been substantiated by Office of Recipient Rights.

I conducted an onsite investigation with recipient rights advisor Katie Hohner on 07/12/2022. We interviewed direct care state member Alicia Andrew who functions as the program director at Isabella Home. Ms. Andrew said she received a call from direct care staff member Deana Prout the morning of 07/05/2022 informing her of the allegations. She said she was not present when the allegations occurred.

Ms. Andrew said Resident A is blind and somewhat independent. She explained Resident A can walk by himself throughout the home. Ms. Andrew said he does not talk but will randomly make a loud squawking noise out of the blue.

Ms. Andrew said Resident A likes to sleep on the loveseat located in the living room. She said it is their protocol to encourage Resident A to go to his bedroom at nighttime to sleep because they feel it is more comfortable for him to sleep in his bed. Ms. Andrew said DCWs do not force him to go to his bedroom to sleep. She said there has never been a directive to ensure Resident A stays in his room at night and sleeps in his bed. Ms. Andrew stated if DCWs ask Resident A if he would like to go to his bedroom to sleep and if he does not appear to want to go, DCWs are to allow him the independence to remain in the living room, common areas, and to sleep on the loveseat. She explained Resident A can become volatile and it is like “trying to move a brick wall” to get him to go somewhere or do something he does not want to do. Ms. Andrew said this can create a dangerous and unsafe situation so DCWs are encouraged not to force Resident A to go to his room.

Ms. Andrew said she has never seen Ms. Leavitt be forceful, slap, or pull Resident’s A’s arm or his hair. She said she has never witnessed Ms. Leavitt harm Resident A nor any of the residents. Ms. Andrew stated she has witnessed Ms. Leavitt link arms with Resident A to assist him to where he wants to go. She said Ms. Leavitt has never been written up or disciplined for any inappropriate actions with residents.

Ms. Hohner and I interviewed direct care staff member Deana Prout who said she is a DCW in training. Ms. Prout said she began working at the home on 06/15/2022.
Ms. Prout said she mainly works third shift and has noticed Ms. Leavitt likes Resident A in his room at night. She said on the night in question Resident A came out of his room. Ms. Prout said Resident A was adamant he was coming out and explained he gets forceful and aggressive if he wants to do something and is asked and directed not to.

Ms. Prout said when she saw Resident A come out of his room, she got up to assist him and he pushed her out of the way. Ms. Prout stated she turned and stepped out of the way and noticed Ms. Leavitt come up behind her. She said she heard a slap and turned and saw Ms. Leavitt grabbing Resident A’s arm. Ms. Prout said Ms. Leavitt was using her left arm and grabbing his right upper arm. Ms. Prout stated Resident A then pushed Ms. Leavitt and she fell over the loveseat. Ms. Prout said Ms. Leavitt got back up and

pushed Resident A back in his room. She said Ms. Leavitt grabbed Resident A by the right arm, turned him around, and placed one hand on his left shoulder and the other on his neck and forcefully directed Resident A back to his room. Ms. Prout denied seeing Ms. Leavitt pull Resident A's hair. Ms. Prout said she then heard Ms. Leavitt say in a loud tone of voice, "And don't come out again!"

Ms. Prout stated Ms. Leavitt had forcefully guided Resident A back to his room three times that night and would not allow him to sleep on the loveseat. She said at one point she heard Ms. Leavitt say, "Sometimes I can't even stand looking at his f---ing face." Ms. Prout said she has never heard Ms. Leavitt cuss at Resident A nor any of the other residents.

Ms. Prout said she asked Ms. Andrew to look for bruising on Resident A's arms and neck, which she did. She said there was no bruising found. Ms. Hohner and I asked Ms. Andrew if she checked for and/or found any bruises on Resident A. Ms. Andrew stated she looked for bruising after speaking to Ms. Prout the next morning but did not observe any bruising. She said she thoroughly examined Resident A's arms and neck and witnessed no bruises nor injuries of any kind.

Ms. Hohner and I interviewed direct care staff member Christine Leavitt who said it has been a challenge to keep Resident A in his room for weeks. She said he wants to come out and sleep on the loveseat. Ms. Leavitt stated Resident A had already come out of his room a couple times the night in question and she directed him back in his room. Ms. Leavitt said there is no reason why Resident A cannot sleep on the loveseat, but he is all scrunched up when sleeping on it and she feels he would be more comfortable sleeping in his bed.

Ms. Leavitt stated sometime during the night in question, she heard Ms. Prout say Resident A got up and is standing in the hallway naked. She said she got him in the bathroom, cleaned him up, dressed him, and got him back in bed. Ms. Leavitt stated a little later Resident A came out of his room again and Ms. Prout got up to assist him back to his room but sometimes Resident A will go after the DCWs. She explained Resident A is a small guy but very strong. She saw Resident A was mad, so she jumped up to catch him from falling. Ms. Leavitt said she grabbed his arm so he would not fall.

Ms. Leavitt said Resident A sat down on the loveseat and she attempted to help him up. She said Resident A is so strong when he does not want to do something or go somewhere. Ms. Leavitt stated as she was attempting to help Resident A up off the loveseat, Resident A grabbed her breast. She said she took his hand off her breast and sat him back down on the loveseat. Ms. Leavitt stated she noted this on Resident A's Community Mental Health for Central Michigan - Specialized Residential Progress Note Form A.

Ms. Leavitt denied grabbing Resident A by the arm, turning him around, placing her arm on his shoulder and neck and attempting to get Resident A back in his room when this

incident occurred. She said when Resident A gets in these moods and wants to stay on the loveseat, he is going to stay on the loveseat. Ms. Leavitt said there is no use trying to get him into his room.

Ms. Leavitt stated she does not know what Resident A's Community Mental Health for Central Michigan Person Centered Plan, nor his *Assessment Plan for AFC Residents* say regarding his ability to move throughout the home. I reviewed Resident A's Community Mental Health for Central Michigan Person Centered Plan which does not indicate Resident A should have any restrictions placed on his movement within the home.

Resident A's *Assessment Plan for AFC Residents* was reviewed, and the following information was garnered:

- D. Alert to Surroundings: [Resident A] moves freely around the home without any problem.

- C. Communication Needs: [Resident A] is nonverbal but does some signing and usually can make his needs / wants known.

- D. Alert to Surroundings: [Resident A] does understand verbal communication, he can follow 2 to 3 step requests.

- I. Controls Aggressive Behavior: [Resident A] is not aggressive.

Ms. Leavitt reiterated she did not attempt to get Resident A into his room when this happened. She said she just let him stay on the loveseat. She said she did not touch him or grab his neck. Ms. Leavitt stated when he "gets mean like that", she lets him stay on the couch. Ms. Leavitt denied Resident A pushed her and denied she fell during the incident. She also denied she told Resident A, "And do not come out again!" or that she said, "Sometimes I cannot even stand looking at his f---ing face." Ms. Leavitt said she loves the residents and treats them like she would want to be treated.

Ms. Leavitt said she places her hand on Resident A's shoulder or has him wrap his arm around her arm when helping him ambulate through the home. She said she wishes he would stay in his room and sleep at night. Ms. Leavitt said because he is blind, he gets his days and nights mixed up.

Ms. Hohner and I interviewed direct care staff member Bill Patterson who said when he works with Ms. Leavitt, he provides care for the residents in the home. Mr. Patterson said he has never seen Ms. Leavitt mistreat or mishandle a resident. He said he has never heard her raise her voice, cuss, or yell at a resident.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on the information gathered during this special investigation, there is a lack of evidence indicating Ms. Leavitt physically forced or physically restrained Resident A. Ms. Andrew stated she looked for bruising after speaking to Ms. Prout but did not observe any bruising or injuries of any kind. Ms. Leavitt denied grabbing Resident A by the arm, turning him around, placing her arm on his shoulder and neck and attempting to get Resident A back in his room when this incident occurred. She also denied she told Resident A, "And do not come out again!" or that she spoke to Resident A in a demeaning manner.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the interview with direct care staff member Deana Prout, Ms. Prout stated Ms. Leavitt had forcefully guided Resident A back to his room three times that night and would not allow him to sleep on the loveseat.

During the interview with direct care staff member Christine Leavitt, she said it has been a challenge to keep Resident A in his room for weeks. Ms. Leavitt stated Resident A had already come out of his room a couple times the night in question and she directed him back in his room. Ms. Leavitt said there is no reason why Resident A cannot sleep on the loveseat, but he is all scrunched up when sleeping on it and she feels he would be more comfortable sleeping in his bed. Ms. Leavitt said Resident A is so strong when he does not want to do something or go somewhere. Ms. Leavitt stated as she was attempting to help Resident A up off the loveseat to guide him back to his room, Resident A grabbed her breast. She said she took his hand off her breast and sat him back down on the loveseat. Ms. Leavitt stated she noted this on Resident A's Community Mental Health for Central Michigan - Specialized Residential Progress Note Form A.

Resident A's Community Mental Health for Central Michigan - Specialized Residential Progress Notes Form A were reviewed. There was not a form found for the night in question, which is 07/04/2022. There was a Community Mental Health for Central Michigan - Specialized Residential Progress Note Form A found and reviewed for the night of 07/05/2022, and Ms. Leavitt noted the following: "[Resident A] did not sleep much last night. He was trying to get outside 3x."

Resident A's Community Mental Health for Central Michigan *Person Centered Plan* does not indicate Resident A has any restrictions placed on his movement within the home.

Resident A's *Assessment Plan for AFC Residents* was reviewed, and the following information was garnered:

- **D. Alert to Surroundings:** [Resident A] moves freely around the home without any problem.

- **I. Controls Aggressive Behavior:** [Resident A] is not aggressive.

Ms. Leavitt stated she does not know what Resident A's Community Mental Health for Central Michigan Person Centered Plan, nor his *Assessment Plan for AFC Residents* say regarding his ability to move freely throughout the home.

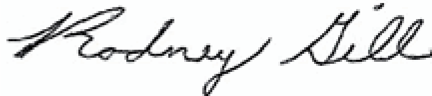
I conducted an exit conference with licensee designee Timothy Carmichael informing him that a violation was established because of this special investigation. Mr. Carmichael agreed with the findings and indicated a corrective action plan will be written up and implemented as soon as administratively possible.

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 a 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 the following resident rights: **(b) The right to exercise his or her constitutional rights, including the right to vote, the right to practice religion of his or her choice, the right to freedom of movement, and the right to freedom of association.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	Based on the information gathered during this special investigation, there is evidence indicating Ms. Leavitt restricted Resident A from freely moving around the home during the nighttime hours of 07/05 by forcing him to go to his room and sleep in his bed. This contradicts the protocol followed by DCWs in the home. According to Ms. Andrew, DCWs are to encourage Resident A to go to his bedroom at nighttime to sleep because they feel it is more comfortable for him to sleep in his bed. Ms. Andrew said DCWs are not to force him to go to his bedroom and sleep. According to Resident A's *Assessment Plan for AFC Residents,* [Resident A] moves freely around the home without any problem.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

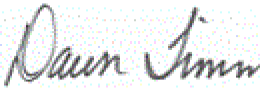
Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.



07/18/2022

Rodney Gill Date
Licensing Consultant

Approved By:



07/28/2022

Dawn N. Timm Date
Area Manager