GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 13, 2022

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

RE: License #: AS370011281
Investigation #: 2022A0466042
Mt Pleasant 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) 284-9727.

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 #:	2022A0466042
Complaint Receipt Date:	05/20/2022
Investigation Initiation Date:	05/20/2022
Report Due Date:	07/19/2022
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:	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) Donna Stone refused to use Resident A's prescribed gait belt when assisting Resident A with ambulation.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/20/2022	Special Investigation Intake-2022A0466042.
05/20/2022	Special Investigation Initiated – Telephone call to ORR Katie Hohner.
05/20/2022	Contact - Document Received from ORR Katie Hohner.
05/26/2022	Contact - Telephone call made to DCW Chelsea Corrigan interviewed.
05/26/2022	Contact - Telephone call made to DCW Madison Hincka interviewed.
05/26/2022	Contact - Telephone call made to DCW Bonnie Dodd interviewed.
05/26/2022	Contact - Telephone call made to DCW Donna Stone interviewed.
05/26/2022	Contact - Telephone call made to Amy Spanne; director of residential services interviewed.
05/27/2022	Inspection Completed On-site.
05/27/2022	Contact - Face to Face, Lisa Kappler interviewed.
07/07/2022	Exit conference with Timothy Carmichael.

ALLEGATION: Direct care worker Donna Stone refused to use Resident A's prescribed gait belt when assisting Resident A with ambulating.

INVESTIGATION:
On 05/20/2022, Complainant reported that since 5/3/2022, it has been required direct care workers (DCWs) use a gait belt to assist Resident A with ambulation. Complainant reported DCW Bonnie Dodd reported on 5/10/22 and 5/11/22, DCW

Donna Stone "refused to use the gait belt" when she assisted Resident A with ambulating.

On 05/20/2022, Katie Hohner from the Office of Recipient Rights (ORR) sent an email that contained the following documents:

- Communication Log dated 5/3/2022 which documented that Resident A received a “new order to use gait belt while ambulating.”.
- McLauren Central Michigan prescription written by Malathy Tharumarajah; M.D. dated 5/03/2022 which stated “use gait belt while ambulating only.”
- *Adult Foster Care (AFC) Incident/Accident Report* dated 5/10/5/11 written by Bonnie Dodd that stated in the “explain what happened” section of the report “Donna Stone refused to use gait belt transporting [Resident A] to the bathroom for bed check on two occasions, 5/10-5/11.” In the corrective measures section of the report, it stated “Report to PD, notified Des and will continue to monitor this and remind of protocol-RR’s notified.”
- Training Inservice dated 5/12/2022 which stated, “read attached protocol and sign below.” DCW Stone signed this document acknowledging being trained.
- Ambulation Protocol dated 5/12/2022, “Per physician’s order dated 5/02/2022, [Resident A] is to use or wear her gait belt when she is ambulating.” Please note, the date of this physician’s order is not correct.

On 05/26/2022, ORR Hohner, ORR Sarah Watson and I interviewed DCW Chelsea Corrigan who reported Resident A has been using a gait belt as needed since June 2021 as needed for ambulation. DCW Corrigan reported she was trained on the use of the gait belt in June 2021. DCW Corrigan reported she saw the communication in the communication log on 5/3/2022 requiring the use of the gait belt from Resident A’s physician for ambulation. DCW Corrigan reported Resident A’s ability to ambulate has declined. DCW Corrigan reported the message in the communication log was clear so she is not sure why DCW Stone did not follow it. DCW Corrigan reported DCW Stone told her that she does not think it is necessary to use the gait belt all of the time with Resident A. DCW Corrigan reported she did not witness DCW Stone helping Resident A ambulate on 5/10/2022 or 5/11/2022.

On 05/26/2022, ORR Hohner, ORR Sarah Watson and I interviewed DCW Madison Hincka who reported Resident A has used a gait belt since she began working at the facility and that is when she was trained on how to use a gait belt. DCW Hincka reported the gait belt has to be used now every time Resident A is ambulating. DCW Hincka reported the new protocol went into effect about a month ago. DCW Hincka reported Resident A’s new protocol for using the gait belt was also posted on Resident A’s door but she was not sure of the date that occurred. DCW Hincka reported it was clear Resident A should not sleep wearing the gait belt and that all DCWs should be using it every time Resident A ambulates. DCW Hincka reported that typically to her knowledge, DCW Stone does use the gait belt to ambulate Resident A. DCW Hincka reported she has not witnessed any DCW ambulating Resident A without the gait belt since the new protocol and physician order was

posted in the *Communication Log*. DCW Hincka reported that the first time she saw the notice in the *Communication Log* she read the protocol and signed it.

On 05/26/2022, ORR Hohner, ORR Sarah Watson and I interviewed DCW Donna Stone who reported she did take Resident A to the bathroom without the gait belt as the bathroom was close by, right next door to her bedroom and she did not think Resident A needed the gait belt. DCW Stone reported Resident A has always had a gait belt, but previously the use of the gait belt was not required. DCW Stone reported she was trained in how to use a gait belt when she was hired. DCW Stone first reported she was not aware that the use of Resident A's gait belt had changed, then DCW Stone reported that she did see the new prescription for the gait belt on 5/03/2022 in the *Communication Log* but reported it was confusing as the order read use gait belt while ambulating only. DCW Stone inferred that meant during the day however second shift was leaving the gait belt on Resident A when she went to bed because third shift would be getting Resident A up to use the bathroom. DCW Stone reported that although she did not use the gait belt on Resident A on 5/10/2022 and 5/11/2022 she has since started to use the gait belt every time she ambulates Resident A as she learned that there are no exceptions to using the gait belt while ambulating Resident A. DCW Stone also reported second shift has stopped leaving the gait belt on Resident A when she is in bed and third shift puts the gait belt on when they take her to the bathroom.

On 05/26/2022, ORR Hohner, ORR Sarah Watson and I interviewed DCW Bonnie Dodd who reported she witnessed DCW Stone not using the gait belt with Resident A on 5/10/2022 and 5/11/2022. DCW Dodd reported she had gotten Resident A up to use the restroom and second shift had left the gait belt on Resident A. DCW Dodd reported DCW Stone directed her to take the gait belt off Resident A. DCW Dodd reported she was concerned for Resident A's safety because she was disoriented, not wearing shoes and unsteady on her feet. DCW Dodd reported after she took the gait belt off Resident A, DCW Stone took her to the bathroom without the gait belt. DCW Dodd reported she took the gait belt off because DCW Stone was getting upset and she did not want to argue with her about it. DCW Dodd reported DCW Stone took Resident A to the bathroom on 05/10/2022 and 05/11/2022 without the gait belt. DCW Stone reported that she completed an *Incident Report* and brought this to the attention of her supervisor, Lisa Kappler. DCW Dodd reported that after 5/11/2022, a note went up on Resident A's door about using the gait belt for ambulation. DCW Dodd reported she saw the new prescription on 5/03/2022 when it was posted in the *Communication Log* with the new protocol. DCW Dodd reported that Resident A has been using a gait belt for over a year and that she was trained on how to use the gait belt when she was hired.

On 05/26/2022, ORR Hohner, ORR Sarah Watson and I interviewed Amy Spanne, director of residential services (DRS) who reported that for two nights in a row Resident A's gait belt had been worn during sleeping hours. DRS Spanne reported that practice has stopped as the order read for the gait belt to be used for

ambulation only which meant for it not to be worn in bed even for short durations of time. DRS Spanne reported DCW Stone told another DCW to take the gait belt off while taking Resident A to the bathroom. DRS Spanne reported that the house manager did not do a training on Resident A's new gait belt order until 5/12/2022. DRS Spanne reported house manager/direct care staff member Lisa Kappler should have done the training sooner and/or had the DCWs sign off on the new procedure on 5/3/2022 in the *Communication Log* to avoid confusion.

On 05/27/2022, I conducted an unannounced investigation and I interviewed house manager Lisa Kappler who reported that as of 5/03/2022, Resident A's physician put an order into effect requiring the use of a gait belt for all ambulation. DCW Kappler reported that although the facility was using a gait belt with Resident A previously, it was only on an as needed basis. DCW Kappler reported the previous order was from a physical therapy evaluation recommending the use of the gait belt. At the time of the inspection, DCW Kappler could not provide me with that evaluation. DCW Kappler reported she would email me that evaluation if she located it. The physical therapy evaluation has not been received as of the writing of this report. DCW Kappler reported that her mistake on 5/03/2022 was not putting a sign-off sheet attached to the new protocol and physician order for Resident A's gait belt for the DCWs to acknowledge when she posted that in the *Communication Log*. DCW Kappler reported that she conducted a training for the DCWs on 5/12/2022 about the new requirements for Resident A's gait belt. DCW Kappler reported she also posted the protocol to the outside of Resident A's bedroom door. DCW Kappler reported all DCWs are trained on the use of assisted devices upon hire. DCW Kapper reported no DCW talked to her about not being comfortable using a gait belt with Resident A.

While I was at the facility on 05/27/2022, I witnessed DCWs using the gait belt while ambulating Resident A. Resident A is non-verbal and therefore could not be interviewed. All of the residents at the facility were non-verbal so they could not be interviewed either.

On 05/27/2022, I reviewed Resident A's record which contained a written *Assessment Plan for Adult Foster Care (AFC) Residents* which was dated 12/09/2021. In the "Walking/Mobility" section of the report it stated, "Is able to ambulate with minimal assistance (staff are next to her). Uses a wheelchair for long distances and sedated doctors appointments. Per O.T staff are to hang onto her gait belt and let her know you are there but give her as much encouragement to continue walking, she is not to hold onto staffs [sic] hands and be guided (this could become a safety concern for all parties), may hold onto staff hands as a means of providing support (but not to be led). [Resident A's] left hip is bone on bone and per [Relative A1] won't be having any hip replacements due to [Resident A's] inability to understand rehab instructions."

I observed the following posted to Resident A's bedroom door: "Ambulation Protocol, 05/12/2022, Per physician order dated 05/02/2022, [Resident A] is to use or wear her gait belt whenever she is ambulating."

AP/PLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(1) An assistive device shall only be used to promote the enhanced mobility, physical comfort, and well-being of a resident.
ANALYSIS:	On 05/03/2022, the facility received a prescription for Resident A written by Malathy Tharumarajah, M.D. dated 5/03/2022 which stated "use gait belt while ambulating only." House manager Kappler posted the prescription and protocol in the *Communication Log* but did not verify that all of the DCWs read and understood the new protocol until 5/12/2022. On 05/10/2022 and 5/11/2022, DCW Stone admitted to ambulating Resident A without the use of the gait belt and this was witnessed by DCW Dodd. Additionally, DCW Dodd, DCW Stone and DRS Spanne reported second shift was leaving the gait belt on Resident A while she was in bed. According to the physician order the gait belt was to be used while ambulating only. A violation has been established because the facility did not promote the physical comfort of Resident A while leaving the gait belt on her while in bed. Additionally, the wellbeing of Resident A was not attended to when DCW Stone did not use the prescribed gait belt on 5/10/2022 and 5/11/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 05/27/2022, I reviewed Resident A's record which contained a written *Assessment Plan for AFC Residents* which was dated 12/09/2021. Although Resident A's record contained a physician order for a gait belt on 05/03/2022, Resident A's *Assessment Plan for AFC Residents* was not updated to reflect that change. The only *Assessment Plan for AFC Residents* in Resident A's file at the time of the unannounced inspection was dated 12/09/2021.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	Resident A's *Assessment Plan for AFC Residents* was dated 12/07/2021. Resident A's record contained a physician order for a gait belt on 05/03/2022, however Resident A's Assessment Plan for AFC Residents was not updated to reflect that change.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/07/2022

_____

Julie Elkins Date
Licensing Consultant

Approved By:

07/13/2022

_____

Dawn N. Timm Date
Area Manager