GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 11, 2023

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

RE: License #: AS370011281
Investigation #: 2023A1029008
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370011281
Investigation #:	2023A1029008
Complaint Receipt Date:	11/21/2022
Investigation Initiation Date:	11/21/2022
Report Due Date:	01/20/2023
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	Amy Spanne
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(S)

	Violation Established?
Resident A was not supervised adequately leading her to ingest a part of her brief.	Yes

III. METHODOLOGY

11/21/2022	Special Investigation Intake 2023A1029008
11/21/2022	Special Investigation Initiated – Letter Email to complainant
11/28/2022	Inspection Completed On-site- Face to face with Katie Hohner, ORR, Ms. Marek, Kahlie Schuster, Lisa Kappler, Resident A
01/06/2023	APS Referral made to Centralized Intake
01/06/2023	Contact - Document Sent - Emailed Ms. Spanne for numbers
01/09/2023	Contact - Document Received - Email from Ms. Spanne
01/10/2023	Contact – Telephone call to direct care staff member Taylor Beard and ORR Katie Hohner (left message)
01/11/2023	Exit conference with licensee designee, Timothy Carmichael.

ALLEGATION:

Resident A was not supervised adequately leading her to ingest a part of her brief.

INVESTIGATION:

On November 21, 2022, a complaint was received via the Bureau of Community and Health Systems online complaint system alleging Resident A was left alone by direct care staff member Ms. Marek which led to Resident A ingesting part of her brief while she was left alone.

On November 28, 2022, I completed an onsite investigation at Mt. Pleasant Home and completed joint interviews and reviewed records with Office of Recipient Rights advisor, Katie Hohner. During the onsite investigation, I reviewed the *AFC Accident / Incident*

Report that was sent to the licensing department. According to this report, the incident occurred with direct care staff member Ms. Marek on October 16, 2022.

> ***What happened:*** *"Staff were assisting {Resident A} was getting ready to stand up and staff was cleaning her behind. From her. Resident A had her brief still on when staff went to the next room over and assisted another resident who was on the toilet that needed help. Staff came to staff. Resident A had torn her brief in, ate a part of her brief and swallowed it.*
> ***Action taken by staff:*** *Staff will monitor Resident A for safety and health. Management has been notified and documentation was done on her behavior for PICA. Staff realizes the mistake to not let a reoccurrence happen and to always take Resident A's brief off when toileting.*
> ***Corrective measures taken to remedy the situation:*** *Staff realizes I can't save everybody. To never leave a brief on Resident A toileting to always remove her brief. This was reviewed by Ms. Schuster, APD on that day to Ms. Marek. Plus, it has been reviewed with all incoming staff again. Will review at staff meeting.*

I was also able to review Resident A's Community Mental Health for Central Michigan Person Centered Plan (PCP) that was prepared by Community Mental Health caseworker, Julie Oliver. There is an extensive section in her PCP that outlines PICA and the safety concerns that must be followed providing care for Resident A.

> According *to* Resident A's PCP, DESCRIPTION OF SAFETY CONCERNS: *Resident A has no personal safety skills so she has 24 hour staffing to see that she remains safe. Resident A has PICA and needs constant supervision by staff. Resident A needs line of site due to her PICA, Resident A will eat twigs and stones. If staff determine that the non-food item could be harmful or dangerous for Resident A, they must be available to do a mouth sweep, to remove the item. Resident A also engages in Pica, which is eating things that are not food. Home staff must monitor Resident A closely in all settings, observe and remove foreign objects that she could obtain and eat. (For example, leaves and sticks when outside.) Should Resident A obtain a non-edible object, she should be instructed to drop it and staff must try to determine if the item could be harmful to Resident A. (Resident A can move fast when she wants to.) If she puts a non-edible object in her mouth, home staff will perform a mouth sweep to remove the object from Resident A's mouth, if it is deemed to be harmful or dangerous.*

I was able to review the Training Inservice documentation which shows that Ms. Schuster reviewed the *Assessment Plan for AFC Residents* for Resident A on September 23, 2022 and Ms. Marek reviewed her plan on September 3, 2022.

I reviewed Resident A's resident record. According to her *Assessment Plan for AFC Residents* dated August 16, 2022 for toileting, Resident A "receives verbal prompting by staff to use the bathroom and is encouraged to complete as much as possible. If she is incontinent in bladder or bowel, she requires staff to assist her because she cannot complete personal care needs. Uses adult attends while in the home and during

outings. Checked frequently and prompted to use bathroom to be changed." Under Other difficulties, "Risk of choking during meals. High risk of choking due to PICA behaviors will pick up and eat anything on floor or outside."

According to Resident A's *Behavior Guidelines*, the three main concerns are physical aggression, high anxiety, and PICA. These guidelines state "The primary intervention for Resident A's PICA is observation and supervision. Staff will provide line of sight supervision through all waking hours."

Ms. Hohner and I interviewed direct care staff member Ms. Marek at Mt. Pleasant Home. Initially, Ms. Marek stated she was training a newer direct care staff member day and "it was foggy" to remember. Ms. Marek stated the direct care staff members assist Resident A with toileting because she is unable to complete her own personal care. Ms. Marek reviewed the Incident Report that was completed on October 16, 2022 so she could review the incident. Ms. Marek stated she "was helping her coworker and left Resident A in the bathroom. Ms. Marek stated she forgot to do the task of removing the brief and she was sorry for doing that." Ms. Marek stated she was trying to help and she made a mistake because she did not see Resident A swallow part of the brief. Ms. Marek stated she did not hear Resident A choking but Ms. Schuster brought it to her attention.

Ms. Marek stated Resident A does not like having the door closed. Ms. Marek stated she stands right outside the door typically and keeps line of sight while she is in the bathroom. Ms. Marek said there was emergency with another resident and she went away. Ms. Marek stated the line on the IR stating "Staff realizes that I can't save everybody" means that she was multi-tasking to make sure that everything gets done. Ms. Marek stated she tried to maintain what she needs but she is overwhelmed. Ms. Marek stated Ms. Schuster coached her through the process of keeping an eye on Resident A to make sure she was not going to choke or stop breathing.

Ms. Hohner and I interviewed administrator, Ms. Spanne. Ms. Spanne clarified there was no line of sight while Resident A was in the bathroom because Ms. Marek walked away. Ms. Spanne stated she was just supposed to make sure the brief was off before she did this. Ms. Spanne stated Ms. Marek has been an employee since August 8, 2022 and has never dealt with PICA before however, when she first began her employment she reviewed the *Treatment Plan* for Resident A and knew she had PICA. Ms. Spanne stated it was in her *Assessment Plan for AFC Residents* and her *Treatment Plan*. Ms. Spanne clarified that on midnights Resident A does not wear briefs but it was on after her shower / personal care. Administrator, Ms. Spanne stated the policy for Resident A's PICA is when there are three direct care staff members working, they are supposed to be wearing an apron to designate they are the person providing line of sight supervision to Resident A so it is clear.

On November 28, 2022, I interviewed Kahlie Schuster, APD at Mt. Pleasant Home. Ms. Schuster stated Resident A ingested her brief in October 2022. Ms. Schuster stated before she went to administer medications and was working with another direct care

staff member Ms. Marek. Ms. Schuster stated she put a brief back on Resident A, and then ran to get another resident who was in the other bathroom, then went back to Resident A. Ms. Schuster stated there was a miscommunication about the brief with Ms. Marek because when she came out she told Ms. Schuster she already had a brief back on Resident A and they just needed to get her up and Ms. Schuster was alarmed. Ms. Schuster prompted Resident A to open her mouth and noticed she swallowed some of her brief that was slightly larger than a quarter. Ms. Schuster stated she knew that she ingested some of the brief because she noticed a chunk of the brief missing when she went into the bathroom. Ms. Schuster stated Ms. Marek told her she was so busy that it slipped her mind that she needed to have the brief removed and it slipped her mind.

On November 28, 2022 I interviewed direct care staff member, Lisa Kappler at Mt. Pleasant Home. Ms. Kappler stated there were two other incidents that Resident A was able to ingest items. Ms. Kappler stated on November 24, 2022 Resident A was found with direct care staff member Danielle Shroyer's meal box in her hand and Resident A managed to eat some of the chicken. Ms. Kappler stated she noticed there was chicken in her mouth and there were two pieces bigger than a .50 piece. Ms. Kappler stated they did a mouth swab to get the chicken out of her mouth. Ms. Kappler stated Ms. Shroyer left the food out on the table when she came into the medication room with another direct care staff member leaving Resident A unsupervised and giving her the opportunity to ingest the chicken.

Ms. Kappler stated there was another incident on July 28, 2021 when Resident A was able to eat a piece of her brief while she was sitting in the living room while a former direct care staff member Pam Micko was working. Ms. Kappler stated Ms. Beard was also working during that shift and she was able to get Resident A to spit the brief out of her mouth.

I reviewed the *AFC Accident / Incident Report* that was sent to the licensing department. According to this report, the incident occurred with direct care staff member Ms. Beard on July 28, 2021.

> ***What happened:*** *"Staff 1 (Ms. Marek) walked into the room and noticed Resident had a big handful of her brief in her hand and some in her mouth. Staff 2 (Ms. Micko) was sitting in the recliner watching her eat her brief.*
> ***Action taken by staff:*** *Staff 1 got what she was able to get. Staff 1 asked Resident A to spit what was in her mouth. Staff 1 told Staff 2 that it was also her responsibility to ensure Resident A's safety and well-being. Staff 1 continues to monitor.*
> ***Corrective measures taken to remedy the situation:*** *Will continue to monitor Resident A for any changes and any further incidents like above.*

On January 10, 2023, I called direct care staff member, Taylor Beard. Ms. Beard stated she went outside during the July 2021 incident to smoke and she turned around because she was still near the door. Ms. Beard stated she could hear Resident A doing

a sucking sound and she realized she had some of the brief in her mouth. Ms. Beard stated while this was occurring Ms. Micko sat in the chair and watched her suck on the brief and they realized Resident A swallowed some of the brief. Ms. Beard stated after this incident Resident A went to the hospital to ensure safety. Ms. Beard stated Ms. Micko was not there very long at the time but she had completed training. Ms. Beard stated there has been several staff meetings that have discussed what PICA is and that Resident A also requires "line of sight" supervision. Ms. Beard stated when she goes to the bathroom, they do not need to stay with her at all times, but they make sure there is no toilet paper or brief around that she could put in her mouth. Ms. Beard stated they will check on her but still allow her the privacy to use the restroom.

On January 11, 2023, I contacted Community Mental Health recipient rights advisor, Ms. Hohner. Ms. Hohner went out to Mt. Pleasant Home with her supervisor for a staff meeting to remind the direct care staff members and managers regarding following the safety procedures regarding PICA and Resident A to ensure that she does not ingest any more items.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A was not provided supervision according to her *Assessment Plan for AFC Residents.* During the onsite investigation, I was able to review staff meeting documentation, Resident A's *Assessment Plan for AFC Residents*, Resident A's *CMH Treatment Plan*, and *CMH Behavioral Plan* and each of these documents has clear documentation regarding PICA and the need for line of sight supervision for Resident A. On two different occasions, July 28, 2021 and October 16, 2022, Resident A was not supervised and as a result she managed to ingest some of her brief. On November 24, 2022, Resident A was not supervised appropriately leading her to ingest pieces of chicken that were left out by a direct care staff member.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

_____1/11/2023_____

Jennifer Browning — Date
Licensing Consultant

Approved By:

_____

Dawn N. Timm — Date
Area Manager