GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 19, 2023

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

RE: License #: AS370011270
Investigation #: 2023A0466034
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) 284-9727.

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 #:	AS370011270
Investigation #:	2023A0466034
Complaint Receipt Date:	03/23/2023
Investigation Initiation Date:	03/24/2023
Report Due Date:	05/22/2023
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:

	Violation Established?
On 03/21/23, Resident A's inner cannula was not placed in his trachea when he arrived at school.	No
On 03/20/2023 Resident A did not have his neck brace on that is required when being transported.	No
Additional Findings	Yes

III. METHODOLOGY

03/23/2023	Special Investigation Intake-2023A0466034.
03/24/2023	APS Referral- Alison Witucki assigned.
03/24/2023	Special Investigation Initiated – Telephone call to APS Alison Witucki interviewed.
03/24/2023	Referral - Recipient Rights.
03/29/2023	Inspection Completed On-site.
03/29/2023	Contact - Telephone call made to DCW Neviah Young, interviewed with ORR Katie Hohner.
03/29/2023	Contact - Telephone call made to DCW Erica Totten with ORR Katie Hohner, no answer.
05/17/2023	Contact - Telephone call made to case manager Lorene Crawford interviewed.
05/18/2023	Exit Conference with licensee designee/administrator Timothy Carmichael attempted, phone message left and email sent requesting a return call to conduct the exit conference.

ALLEGATION: On 03/21/23, Resident A's inner cannula was not placed in his trachea when he arrived at school.

INVESTIGATION:
On 03/21/23, Complainant reported Resident A came to school with his inner cannula not placed in Resident A's trachea rather it was sitting in his lap. Complainant reported the facility was contacted but the direct care workers (DCW) on duty were allegedly not willing to go to the school to place it correctly. Complainant reported direct care staff (names unknown) reported that once Resident A is at school Resident A's personal care is the school's the responsibility. Complainant reported direct care staff members are responsible/required to put the inner cannula in Resident A's trachea. Complainant reported failure to put that inner cannula in the trachea causes mucus build up.

On 03/24/2023, I interviewed adult protective services (APS) specialist Alison Witucki who reported Resident A attends the ESD program at school. APS Witucki reported that on 03/21/23, Resident A came to school with his inner cannula not placed in the trachea as required rather it was sitting in his lap. APS Witucki reported that when Resident A gets off the bus school personnel go through a checklist to assure he has all the assistive devices he needs with him for the day. APS Witucki stated it was during this checklist process, school personnel noticed the inner cannula was not in his trachea, rather it was found on his lap. APS Witucki reported school personnel told her they contacted a DCW, but that DCW was not willing to go to the school to place the inner cannula in the trachea because it was the responsibility of school personnel since Resident A was at school. APS Witucki stated school personnel reported they are responsible to meet the personal care needs of Resident A while he is in school.

On 03/29/2023, Katie Hohner, officer of recipient rights (ORR), APS Witucki and I conducted an unannounced investigation and we interviewed house manager Alicia Andrew, who reported that she has worked at the facility for five years. DCW Andrew reported DCW Chelsea Hunter put Resident A on the bus for school on 03/21/2023. DCW Andrew reported DCW Erica Totten worked the midnight shift and that she could have also helped get Resident A ready to leave for the day. DCW Andrew reported that although the inner cannula was found on Resident A's lap when he arrived at school, DCW Andrew reported that does not mean it was not put in correctly. DCW Andrew reported if the inner cannula is not locked, Resident A can cough it out. DCW Andrew reported during the day the facility has two DCWs on shift to care for the residents that remain in the facility. DCW Andrew reported Resident A's school program has a nurse available to address any personal care needs Resident A might experience while at school including re-inserting this tube. DCW Andrew reported there is a checklist for DCWs to use, but it is not required, when getting Resident A ready because he requires several assistive devices. DCW Andrew reported that the checklist was not utilized on 03/21/2023.

ORR Hohner, APS Witucki and I interviewed DCW Hunter who reported that on 03/21/2023, DCW Totten got Resident A ready for program. DCW Hunter reported this was not the first time DCW Totten got Resident A ready as typically midnight direct care staff get residents ready that leave early in the morning. DCW Hunter reported all DCWs have been trained on Resident A and his assistive devices. DCW Hunter reported Resident A's inner cannula is a metal piece that goes in the trachea that also needs to be taken out and cleaned twice a day. DCW Hunter reported sometimes the inner cannula is soaking, as part of the cleaning process, and direct care staff forget to put that piece back in as the morning routine can be chaotic. DCW Hunter reported the inner cannula helps assure mucus remains clear from the tube. DCW Hunter reported that if the inner cannula was found on Resident A's lap, it was put into his trachea on 03/21/2023. DCW Hunter reported she checked to make sure that Resident A had the inner cannula in the trachea on 03/21/2023 before putting him on the bus. DCW Hunter reported Resident A does sometimes cough the inner cannula tube out. DCW Hunter reported they had a staff meeting last week and discussed using the checklist for Resident A to make sure that they are sending all his assistive devices to program.

ORR Hohner and I interviewed DCW Neya Young by phone who reported that although she did not get Resident A ready on 03/21/2023, she does get Resident A ready in the morning. DCW Young reported the inner cannula tubing does fall out after it has been put in place sometimes. DCW Young reported that because Resident A is non-verbal and the metal piece going into the trachea is difficult to insert it correctly while trying not to hurt Resident A as he cannot communicate if something is hurting him.

I reviewed Resident A's record which contained a *Who's Charting Form* and documented on 03/20/2023 from 11p-7a, DCW Totten was assigned to Resident A and on 03/21/2023 from 7am-3pm, DCW Hunter was responsible for Resident A.

I reviewed Resident A's written *Assessment Plan for Adult Foster Care (AFC) Residents* dated 12/07/2022 and signed by Guardian A1. This document stated that "staff provide total care" for eating, feeding, bathing, grooming, dressing, personal hygiene and mobility. In the "assistive devices" section of the report it stated, "wheelchair and arjo lift." In the "special equipment used" section of the report it stated, "wheelchair, arjo lift, suction machine, misty machine."

I reviewed a *Prescription for Personal Care Services* dated 3/22/2023 which documented in the "adaptive equipment" section of the report, "tilt in space wheelchair with seat belt for safety. Shower chair with seat belt for safety. Suction." This was signed by Ashhok Vashista, MD. I reviewed Resident A's file and did not find any documentation about the inner cannula and care/ instructions for insertion.

On 05/17/2023, I interviewed Resident A's case manager Lorine Crawford by phone and she reported that she was told by the school that on 03/21/23, Resident A's inner cannula was not placed in his trachea when he arrives at school. Case

manager Crawford reported that the inner cannula tubing can come out of the trachea when Resident A coughs and that she has witnessed this happen.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Complainant reported that Resident A came to school with his inner cannula tubing not placed in the trachea as required on 03/21/2023. DCW Hunter reported that on 03/21/2023 she checked Resident A before putting him on the bus to make sure Resident A's inner cannula tubing was in his trachea and it was. DCW Andrew, DCW Hunter and case manager Crawford all stated Resident A inner cannula tubing can dislodge while he is coughing. This is a possible explanation for the tube being in Resident A's lap upon arrival at school program on 03/21/2023 rather than direct care staff not performing care as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On 03/20/2023 Resident A did not have his neck brace on that is required when he is being transported.

INVESTIGATION:
Complainant reported Resident A did not have his neck brace on while he was transported to school on 03/20/2023. Complaint reported Resident A is non-verbal and a wheelchair user who requires a neck brace to hold his head up. Complainant reported Resident A has difficulty holding his head up and without the brace he can suffocate due to having a tracheotomy. Complainant reported a direct care worker came to the school with the neck brace an hour and a half after they were notified Resident A did not wear his brace to school.

On 03/24/2023, I interviewed APS specialist Witucki who reported that Resident A did not have his neck brace when he was transported to school on 03/20/2023.

On 03/29/2023, ORR Hohner, APS Witucki and I conducted an unannounced investigation and we interviewed DCW Andrew who reported that on 03/20/2023, DCW Kyle Carter got resident A ready for school. DCW Andrew reported DCW Hunter receive a call from the school on 03/20/2023 stating that Resident A arrived

at school without his neck brace. DCW Andrew reported school personnel have Resident A wear the neck brace all of the time and the facility has a physician order that states that Resident A just need to wear the neck brace when he is being transported in a vehicle. DCW Andrew reported that Resident A was sent to school on 03/20/2023 without his neck brace and once notified, brought the neck brace to Resident A.

ORR Hohner, APS Witucki and I interviewed DCW Hunter who reported DCW Totten got Resident A ready on 03/20/2023 and forgot to send him to school with his neck brace. DCW Hunter reported Resident A is prescribed a neck brace to be worn while he is being transported in a van/car. DCW Hunter reported that when the school called about Resident A's neck brace, she took it to the school. DCW Hunter reported this is not the first time that the neck brace has not been sent to school with Resident A, she believes that this has happened 2-3 other times within the past month.

I reviewed Resident A's record which contained a *Whos' Charting Form* and documented on 03/19/2023 from 11p-7a, DCW Carter was assigned to Resident A and on 03/20/2023 from 7am-3pm, DCW Hunter was responsible for Resident A personal care needs.

I reviewed Resident A's *Physician Medication Order* dated 3/24/2022 and did not find any order related to a neck brace being worn during transportation or for any other reason.

I reviewed Resident A's written *Assessment Plan for Adult Foster Care (AFC) Residents* dated 12/07/2022 and signed by Guardian A1. Based on my review of this document, I also did not find any directions or guidance related to the need for Resident A to wear a neck brace during transportation. This document stated that "staff provide total care" for eating, feeding, bathing, grooming, dressing, personal hygiene and mobility. In the "assistive devices" section of the report it stated, "wheelchair and arjo lift." In the "special equipment used" section of the report it stated, "wheelchair, arjo lift, suction machine, misty machine."

ORR Hohner and I called DCW Totten by phone and left a message. DCW Totten never returned the phone call.

On 05/17/2023, I interievewed case manager Crawford by phone and she reported that she was told by the school that on 03/20/2023 that Resident A was sent to school without his neck brace. Case manager Crawford reported that the school utilizes Resident A's neck brace for the duration of time he is at school while the facility has an order for Resident A to wear the neck brace only when he is being transported in car/van.

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization
ANALYSIS:	Despite multiple individuals stating there was a physician's order for Resident A to wear a neck brace, Resident A's *Physician Medication Order* dated 3/24/2022 did not prescribe a neck brace for any reason including transportation. Consequently, there is no *requirement* for Resident A to wear this device.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

On 03/27/2023, I conducted an unannounced investigation and I reviewed Resident A's *Physician Medication Order* dated 3/24/2022 which stated:

- *"Use of van tie downs to be used on wheelchair for safety only, not for restraints. Use of w/c lift on bus.*
- *24 cans of Jevity 1.5 daily via PEG tube. Bolus feedings 4 times daily. Bolus feedings will take 15-20 minutes.*
- *Flush tube with 60 ml before feeding and 60ml after feeding (120ml total).*
- *Briefs, disposable soakers, wipes, medium gloves, brief liners/ male guards.*
- *OT services*
- *Hospital bed with rails for safety only, not as restraints.*
- *Shower/ toileting chair with seat belt for safety only, not to as restraints.*
- *Tilt- in space wheelchair with seatbelt for safety only, not as restraints. Chest strap on w/c to be used for 8 positioning while being transported in vehicle, not to be used as a restraint.*
- *9 Clothing protector/ bibs.*
- *Trach cover to be used while he is being transported in vehicle.*
- *Arjo lift and slings for transfers.*
- *All nursing ancillary orders.*
- *Hold BM medications during episodes of diarrhea.*
- *Clean with saline spray or soap and water around PEG tube site BID. Dry area and apply Calmoseptine BID 14 and change peg tube dressing BID.*
- *Trach should be lightly covered when going outside in cold temperatures with scarf or poncho.*
- *Checked every hour for breathing; wet checks every 2 hours; repositioned every 2 hours.*
- *Showered every other day due to sensitive skin.*

- *Lungs checked BID, temperature checked BID, Oxygen level checked BID.*
- *19 2 oz. (60ml) Syringes with catheter tips.*
- *Blood drawn for labs as ordered by doctor.*
- *Percussion Vest BID and as needed.*
- *Staff will check for residual before bolus feeding. If more than 150ml residual, hold feeding for 2 hrs. Re-check residual after 2 hours; If it continues to be higher than 150ml, notify Doctor. Allow any residual to go back into stomach."*

I reviewed Resident A's written *Assessment Plan for AFC Residents* that was dated 12/07/2022 and signed by Guardian A1. This document stated that "staff provide total care" for eating, feeding, bathing, grooming, dressing, personal hygiene and mobility. In the "assistive devices" section of the report it stated, "wheelchair and arjo lift." In the "special equipment used" section of the report it stated, "wheelchair, arjo lift, suction machine, misty machine." Based on Resident A's *Physician Medication Order* dated 3/24/2022, not all the therapeutic supports/checks were documented in Resident A's written *Assessment Plan for AFC Residents.*

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 *Physician Medication Order* dated 3/24/2022 documented several assistive devices that are ordered for Resident A that were not documented in Resident A's written assessment plan and therefore these devices have not been agreed upon in writing by Guardian A1 and the licensee designee.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization

ANALYSIS:	Resident A's physician order for the therapeutic support order states, "*Hospital bed with rails for safety only, not as restraint."* The order does not state the reason for the support nor the term of the authorization. There were no other documents in Resident A's record that contained this information.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/18/2023

_____

Julie Elkins Date
Licensing Consultant

Approved By:

05/19/2023

_____

Dawn N. Timm Date
Area Manager