GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 1, 2023

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

RE: License #: AS370011270
Investigation #: 2023A0466065
Isabella Home

Dear Mr. Boyd:

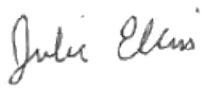
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2023A0466065
Complaint Receipt Date:	09/06/2023
Investigation Initiation Date:	09/06/2023
Report Due Date:	11/05/2023
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 709-8239
Administrator:	James Boyd
Licensee Designee:	James Boyd
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?
Resident A was transported to school without his lateral supports on his wheelchair.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/06/2023	Special Investigation Intake-2023A0466065.
09/06/2023	Referral - Recipient Rights Katie Hohner assigned.
09/06/2023	Special Investigation Initiated – Letter Jennifer Browning.
09/06/2023	APS Referral.
09/14/2023	Inspection Completed On-site.
10/30/2023	Exit Conference with licensee designee James Boyd.

ALLEGATION: Resident A was transported to school without his lateral supports on his wheelchair.

INVESTIGATION:
On 09/06/2023, Complainant reported that on 9/1/23, licensee designee James Boyd contacted the Office of Recipient Rights (ORR) to report a concern on behalf of Resident A. Complainant reported that licensee designee Boyd stated that on 8/30/2023, Resident A was transported to school without the lateral supports on his wheelchair. Complainant reported licensee Boyd stated that direct care worker (DCW) Sean Suda was responsible for getting Resident A ready for school/transport on the morning of 8/30/23. Complainant reported lateral supports are listed on Resident A's *Physician Order* to be used during transportation and listed on Resident A's checklist for getting Resident A ready for school. Complainant reported that Google stated, "Wheelchair lateral supports are most often used to increase the user's trunk stability and balance while in the wheelchair."

On 09/06/2023, AFC licensing consultant Jennifer Browning reported interviewing Katie Hohner from ORR who reported she is investigating a complaint that lateral supports weren't put on Resident A's wheelchair before he was transported to school. ORR Hohner reported lateral supports should have been placed on Resident A's wheelchair to support his trunk control but direct care staff didn't send the lateral supports because the direct care staff member on duty couldn't find them. ORR Hohner reported Resident A's school personnel do not have lateral supports

for Resident A to use but she thinks the facility may have brought them to school. ORR Hohner reported doing an investigation for Resident A previously regarding Resident A not having his neck brace on when he was sent to school. ORR Hohner reported she did an in-service training instructing direct care staff members about how residents need to be provided with their assistive devices. ORR Hohner stated this in-service training specifically addressed Resident A's checklist direct care staff are supposed to follow when getting Resident A ready for school or transport and there is a physician's order in place for the neck support.

On 09/14/2023 ORR Hohner and I conducted an unannounced investigation and we interviewed direct care staff member (DCW) Suda who reported that he did get Resident A ready for school on 8/30/2023 but he could not find Resident A's lateral supports for his wheelchair. DCW Suda reported that he asked DCW Celest Haines for help because he could not locate the lateral supports. DCW Suda reported DCW Haines was aware Resident A was sent on the bus without the lateral supports. DCW Suda reported he was not aware that the faiclity has a checklist for Resident A's assistive devices.

ORR Honer and I interievewed DCW Haines who reported that DCW Suda got Resident A ready on 8/30/2023 but neither could locate his lateral supports. DCW Haines reported that because the bus was already there to pick Resident A up they put him on the bus. DCW Haines stated she thought she mentioned to the bus driver that Resident A did not have his lateral supports. DCW Haines stated she was aware of the checklist for Resident A but reported that it would have been DCW Suda's responsibility to complete since he got Resident A ready that day.

ORR Honer and I interievewed DCW/assistant program director Chelsea Hunter who reported that she trained DCW Suda on Resident A's assistive devices when he was hired.

ORR Honer and I interievewed DCW/program director Alisha Andrew who reported all DCWs are trained that one DCW gets Resident A ready and the second DCW checks to make sure he has all his assistive devices. DCW Andrew reported both DCWs on duty are supposed to review and sign the checklist before he leaves. DCW Andrew reported Resident A was transported to school on 8/30/2023 without using the lateral supports. DCW Andrew reported school personnel called her about the lateral supports and Resident A's lateral supports were found in the foot box of his wheelchair but not utilized while transporting him on the bus. DCW Andrew reported that the lateral supports are put on each side of his body by his rib cage to support his trunk.

I reviewed Resident A's record which contained a *Physician's Medication Order* which documented "Use wheelchair with seat belt for positioning and safety, chest harness for positioning while being transported, head supports, pads/hip guides/laterals for support."

I reviewed Resident A's written *Assessment Plan for Adult Foster Care (AFC) Residents* which was completed and signed on 5/24/2023 and documented in the "special equipment used" section of the report, "wheelchair with headrest/supports/pads/hip guides/laterals for support, shower chair with seatbelt, suction machine, nebulizer, humidifier, Arjo lift."

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:	Licensee designee Boyd, DCW Suda, DCW Haines and DCW Andrew all reported that on 8/30/2023, Resident A was transported to school without the lateral supports on his wheelchair even though these supports were prescribed by a physician and documented in the written *Assessment Plan for AFC Residents.* Therefore, a violation has been established as the facility did not follow the instructions and recommendations in the Resident A's record.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:
On 09/14/2023, I reviewed Resident A's record and at the time of the unannounced investigation there was no documentation available to review verifying either DCW Suda or DCW Haines were trained in Resident A's needs. On 08/30/2023 while DCW Suda and DCW Haines were on duty, DCW Suda and DCW Haines both reported that Resident A was transported to school without the lateral supports on his wheelchair even though these supports were prescribed by a physician and documented in the written *Assessment Plan for AFC Residents*.

APPLICABLE RULE	
R 400.14806	**Staffing levels and qualifications**
	(b) An introduction to the special needs of clients who have developmental disabilities or have been diagnosed as

	having a mental illness. Training shall be specific to the needs of clients to be served by the home.
ANALYSIS:	DCW Suda and DCW Haines were the only two DCWs on duty on 08/30/2023 when Resident A was sent to school without his prescribed lateral support. There was no verification DCW Suda or DCW Haines were trained in Resident A's needs including assistive devices.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Elkins

10/30/2023

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Julie Elkins Date
Licensing Consultant

Approved By:

Dawn Timm

11/01/2023

_____

Dawn N. Timm Date
Area Manager