GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 15, 2023

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

RE: License #: AS370011270
Investigation #: 2023A1038006
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.
- 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. 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,

Johnnie Daniels, 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 #:	2023A1038006
Complaint Receipt Date:	09/26/2023
Investigation Initiation Date:	09/26/2023
Report Due Date:	11/25/2023
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(S)

	Violation Established?
Direct care staff members are altering residents' medications by crushing the medications before giving to residents.	No
Direct care staff members are not giving residents their medication per the label and physician instruction.	Yes

III. METHODOLOGY

09/26/2023	Special Investigation Intake 2023A1038006
09/26/2023	Special Investigation Initiated – Telephone contact was made with complainant.
09/26/2023	Contact - Telephone call made with ORR worker Katie Hohner.
09/27/2023	Contact - Telephone call made with home manager Alicia Andrew.
10/03/2023	Contact - Face to Face interviews were conducted with DCW Mariah Chagoya, DCW Neviah Young, DCW Donna Warren, DCW Chelsea Hunter and Licensee Designee Jim Boyd.
10/03/2023	Contact - Face to Face interview was conducted with Resident A.
10/03/2023	Exit Conference was conducted with Licensee Designee Jim Boyd.
10/03/2023	Inspection Completed-BCAL Sub. Compliance
10/03/2023	Inspection Completed On-site

ALLEGATION: Direct care staff members are altering residents' medications by crushing the medications before giving to residents.

INVESTIGATION:

On 9/26/2023 I received a complaint from BCHS Online Complaints which alleged that on 9/22/23, DCW Mariah Chagoya prepared Resident A's medications by crushing them, then did not pass the medications to Resident A.

On 9/26/23 I interviewed Complainant who verified Resident A's medications are being crushed before given to her which is not per the label or physician instruction. According to Complainant, direct care staff member, whose role is as home manager, Alicia Andrew is responsible of overseeing the Medication Administration Records (MARs) for residents.

I conducted a telephone interview with direct care staff member Alicia Andrew on 9/27/2023 with Recipient Rights Advisor Katie Hohner also present on the phone. Ms. Andrew confirmed Resident A's medications were being crushed per Resident A's physicians' orders, which is documented on Resident A's *Health Care Appraisal* and *Assessment Plan for AFC Residents*.

On 10/03/2023, I conducted an unannounced onsite visit to Isabella Home (facility) and interviewed direct care staff members (DCSM) Mariah Chagoya, DCSM Neviah Young, DCSM Donna Warren, DCSM Chelsea Hunter and Licensee Designee Jim Boyd. An interview was also conducted with Resident C. Recipient Rights Advisor Katie Hohner and Licensee Designee Jim Boyd were present during the interviews. I was unable to interview other residents as they were not verbal.

On 10/3/2023 I was provided with a Physician's Medication Order from Dr. Ashok Vashishta which directed Resident A's medications be crushed before administered to her. I was also able to verify this order was documented in Resident A's *Assessment Plan for AFC Residents* which also stated medication is to be crushed before administered to Resident A.

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: **(a) Medications.**

ANALYSIS:	Based upon my review of Resident A's resident record, I verified a physician's order directing for Resident A's medications be crushed prior to administration. This order to crush Resident A's medication was also documented in Resident A's *Assessment Plan for AFC Residents and Health Care Appraisal.* Direct care staff members are following the physician's order to crush Resident A's medications.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff members are not giving residents their medication per the label and physician instructions.

INVESTIGATION:

On 9/26/2023 I received a complaint from BCHS Online Complaints which alleged Resident A was not given her Fluticasone Propionate (nose spray) between the dates of 9/1/23 and 9/9/23 due to it not being added to the Medication Administration Record (MAR). DCW Bill Patterson was allegedly the second medication passer on 9/22/23 and failed to catch the error according to the complaint. The complaint alleged on 9/20/23, DCW Donna Waren failed to pass Resident B her medications. Resident B's pharmacy was contacted and not all her medications were able to be passed that day.

On 9/26/23 I interviewed Complainant who verified Resident A's medications who verified they believe the dates of the missed medications for Resident A is from 9/1-9/9/2023.

On 10/03/2023 I was provided with three *AFC Licensing Division-Incident/Accident Reports* (IR) which documented three different incidents of medication not being given to residents per physician or label instructions. The first IR stated Resident C's blood sugar readings were not documented due to no lances being available on 9/20/2023. The second IR documented on 9/20/2023 Resident B's medication was not passed and documented on Resident B's Medication Administration Records (MAR). The third IR dated on 9/23/2023 documented DCSM Chelsea Hunter found Resident A's medication sitting within the medication crusher and not administered on 9/22/2023.

I conducted a telephone interview with direct care staff member Alicia Andrew, whose role is home manager, on 9/27/2023 with Recipient Rights Advisor Katie Hohner also present on the phone. Ms. Andrew stated, "I am responsible for [Resident A] not getting her nose spray." Ms. Andrew stated this was due to a computer error in which the medication documents were not updated in the system to add the nose spray. Ms. Andrew stated she does not believe medications would be given out without being documented on the MAR. Ms. Andrew stated on 9/22/2023 medications for Resident A were not administered as prescribed by DCSM Mariah Chagoya and DCSM Bill Patterson. Ms. Andrew also stated on 9/20/2023 DCSM Donna Warren did not administer Resident B's medication as prescribed. Ms. Andrew stated DCSM Neviah

Young did not notice the error even though her role was to double check the work of the direct care staff member responsible for administering resident medications for the day. Ms. Andrew stated once the missing medication error was discovered, a direct care staff member contacted Resident B's pharmacist who advised not to give any of Resident B's medication to her that day.

I interviewed DCSM Ms. Chagoya with Recipient Rights Advisor Katie Hohner also being present. DCSM Ms. Chagoya stated Resident A's blood sugar was not written down in the MAR on 9/20/2023 but the blood was drawn. DCSM Ms. Chagoya stated that on 9/22/2023 Resident C's medication was not given to her.

I interviewed DCSM Ms. Young who stated Resident C's medication was not passed on 9/20/2023. DCSM Ms. Young stated the error was not noticed until later in the evening. DCSM Ms. Young stated Resident A's nose spray medication was not written down on the MAR and it is unknown if it was given to Resident A as prescribed by the physician. DCSM Ms. Young stated the medication was not documented from 9/1/2023-9/9/2023. DCSM Ms. Young stated no one noticed the error or reported the error from the MAR.

I interviewed DCSM Ms. Warren who stated Resident B's medication was missed due to not being advised by the overnight DCSM ON 9/20/2023. DCSM Ms. Warren stated on 9/20/2023 the facility no longer had a supply of finger sticks for Resident C to get her blood sugar measured. DCSM Ms. Warren stated Resident A's nose spray was not given due to DCSM Ms. Warren being told the nose spray was discontinued by DCSM Ms. Hunter who is the assistant manager of the facility.

I interviewed DCSM Ms. Hunter who stated Resident C was out of lances used to draw blood to measure her blood sugar. DCSM Ms. Hunter stated Resident A was not given her nose spray from 9/1/2023-9/9/2023 because the medication was not listed on Resident A's MAR. DCSM Ms. Hunter stated she noticed Resident A's medication still sitting in the crusher on 09/23/2023 and not given to her on 09/22/2023.

I interviewed Licensee Designee Jim Boyd who stated all employees go through proper medication pass training when they are hired in the facility. Mr. Boyd was able to show me the trainings done by direct care staff members. Mr. Boyd stated all employees should be looking at the MAR's before and after they pass medication to residents. I was able to view the MAR and verified Resident A's missed medication pass for 9/1/2023-9/9/2023. I also was able to view the MAR for Resident B which verified she was not given her Citalopram 40mg AM dose on 9/20/2023. I was able to view Resident C's blood sugar administration chart which verified it was not taken on 9/20/2023. I was able to conduct an exit conference with Mr. Boyd regarding the violations within the facilities. Mr. Boyd stated he will be conducting another training this month regarding medications to all the employees.

I interviewed Resident C, who stated there have been times she was not given her medication daily. Resident C stated have been times where she does not get her blood sugar measured. Resident C was unable to provide time frames of missed medications.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon interviews I conducted with DCSM Mariah Chagoya, DCSW Neviah Young, DCSM Donna Warren, DCSM Chelsea Hunter, Licensee Designee Jim Boyd along with viewing the MAR, there was evidence Resident A, Resident B and Resident C were not given their daily medication daily as instructed by the labels and their physicians.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/30/2023

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Johnnie Daniels Date
Licensing Consultant

Approved By:

11/14/2023

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Dawn N. Timm Date
Area Manager