



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 20, 2024

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

RE: License #: AS180010526  
Investigation #: 2024A1038029  
Oakleaf 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.

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) 241-2758.

Sincerely,

A handwritten signature in black ink that reads "Johnnie Daniels". The signature is written in a cursive style with a large initial "J" and "D".

Johnnie Daniels, Licensing Consultant  
Bureau of Community and Health Systems  
1999 Walden Dr.  
Gaylord, MI 49735

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS180010526
<b>Investigation #:</b>	2024A1038029
<b>Complaint Receipt Date:</b>	03/05/2024
<b>Investigation Initiation Date:</b>	03/06/2024
<b>Report Due Date:</b>	05/04/2024
<b>Licensee Name:</b>	Crisis Center Inc - DBA Listening Ear
<b>Licensee Address:</b>	107 East Illinois Mt Pleasant, MI 48858
<b>Licensee Telephone #:</b>	(989) 773-6904
<b>Licensee Designee:</b>	James Boyd
<b>Name of Facility:</b>	Oakleaf Home
<b>Facility Address:</b>	2032 Seelinger Harrison, MI 48625
<b>Facility Telephone #:</b>	(989) 539-2803
<b>Original Issuance Date:</b>	01/27/1985
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	10/30/2023
<b>Expiration Date:</b>	10/29/2025
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A was not provided his physician ordered diet.	Yes

**III. METHODOLOGY**

03/05/2024	Special Investigation Intake 2024A1038029
03/06/2024	Special Investigation Initiated - Telephone call made to Complainant.
03/08/2024	Contact - Face to Face interviews were conducted with Resident A.
03/08/2024	Contact - Face to Face interviews were conducted with home manager Bill Brewer and Administrator Sherry Kidd.
03/08/2024	Contact - Face to Face interviews were conducted with DCS Terry Filipek, DCS Sabrina Schick, DCS Makaila Sprague and DCS Mark Steinke.
03/08/2024	Contact - Document Received from home manager Bill Brewer
03/12/2024	APS Referral was not needed as there was no suspected abuse or neglect.
03/12/2024	Inspection Completed-BCAL Sub. Compliance
03/13/2024	Exit Conference with LD Jim Boyd.

**ALLEGATION:**

**Resident A was not provided his physician ordered diet.**

**INVESTIGATION:**

On 3/6/24, I received a complaint from the Bureau of Community and Health Systems regarding the home. The complaint alleged a staff member was not following a resident's primary care physicians diet recommendations.

On 3/5/24, I interviewed Complainant who verified the information and had nothing else to add.

On 3/8/24, I conducted an unannounced onsite investigation at the home. Recipients Rights Officer Sarah Watson and administrator Sherry Kidd was present for all the interviews. I interviewed senior home manager Bill Brewer who stated he was not present for the incident. Mr. Brewer stated it was reported to him Resident A swallowed an entire meatball, to which the Heimlich maneuver had to be used. Mr. Brewer stated all staff members have gone through the training and know Resident A has a special diet that must be followed. Mr. Brewer stated Resident A has a mechanically altered moistened food diet. Mr. Brewer stated direct care staff (DCS) Terry Filipek, DCS Sabrina Schick, DCS Makaila Sprague and DCS Mark Lalone was at the home during the incident on 3/3/24.

On 3/8/24, I interviewed DCS Terry Filipek who stated he was working at the home at the time of the incident but did not witness anything. Mr. Filipek stated he was helping another resident in the bathroom while the incident took place on 3/3/24.

On 3/8/24, I interviewed DCS Sabrina Schick who stated she was preparing Resident A's food on 3/3/24. Ms. Schick stated she first showed Resident A his food before it was chopped up due to him being on the special diet. Ms. Schick stated DCS Mark LaLone was assigned one on one with Resident A and feed him a whole meat ball. Ms. Schick stated Resident A required the Heimlich maneuver. Ms. Schick stated Resident A cannot swallow hard or whole foods. Ms. Schick stated the mechanically altered diet Resident A is on requires food to be chopped moist or put into a food processor. Ms. Schick stated Mr. Lalone took Resident A to the hospital that same day. Ms. Schick stated every staff member is required to go through training on how to properly feed residents with special diets in the home. Ms. Schick stated all special diets are hanging up on the refrigerator and on the kitchen cupboards as reminders to staff.

On 3/8/24, I interviewed DCS Makaila Sprague whose statements were consistent with those made by Ms. Schick. Ms. Sprague added there is a choking protocol all staff follow in the home. Ms. Sprague also stated the staff member assigned one on one with a resident is required to make sure the resident's food is altered to the correct diet.

On 3/8/24, I interviewed DCS Mark Lalone whose statements were consistent with those of Ms. Sprague and Ms. Schick. Mr. Lalone verified he was assigned one on one with Resident A. Mr. Lalone added he did get Resident A to cough up the whole meatball. Mr. Lalone verified he thought he chopped up the meatball, but it was not. Mr. Lalone also added he followed the choking policy.

On 3/8/24, I reviewed the Incident Report (IR), which verified the incident happened on 3/3/24 and Resident A had a meatball stuck in his throat. I reviewed Resident A's Individual plan of service which was signed by all staff acknowledging they understood Resident A's special diet. I reviewed Resident A's *Assessment Plan for AFC Residents, Resident A's community mental health prescription for personal care services and primary care physician records* which verified Resident A's special diet.

On 3/8/24, I was unable to interview Resident A due his inability to communicate.

<b>APPLICABLE RULE</b>	
<b>R 400.14313</b>	<b>Resident nutrition.</b>
	<b>(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.</b>
<b>ANALYSIS:</b>	Based on my interviews with staff and review of documents, it verified the home did not follow Resident A's physician recommended diet. The staff fed Resident A, a whole meatball which caused him to choke necessitating implementation of the Heimlich maneuver.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Contingent upon receipt of an acceptable corrective action plan, I recommend the license remains unchanged at this time.

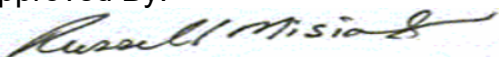


3/20/24

Johnnie Daniels  
Licensing Consultant

Date

Approved By:



3/25/24

Russell B. Misiak  
Area Manager

Date