GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 15, 2024

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

RE: License #: AS370011281
Investigation #: 2024A1029033
Mt Pleasant 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 (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 #:	2024A1029033
Complaint Receipt Date:	03/04/2024
Investigation Initiation Date:	03/05/2024
Report Due Date:	05/03/2024
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois, Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	Jenny Jacobs
Licensee Designee:	James Boyd
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:	07/31/2023
Expiration Date:	07/30/2025
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided with adequate supervision by direct care staff members at Mt. Pleasant Home because she was able to ingest several large pieces of her brief and a six-inch section of tubing which needed to be surgically removed.	Yes

III. METHODOLOGY

03/04/2024	Special Investigation Intake 2024A1029033
03/05/2024	Special Investigation Initiated – Letter ORR Katie Hohner
03/06/2024	APS Referral Made to Centralized Intake
03/12/2024	Inspection completed on-site - Face to Face Kahlie Schuster and Resident A at Mt. Pleasant Home
03/14/2024	Contact - Face to Face with licensee designee Jim Boyd at another licensed facility.
03/25/2024	Contact - Document Received - APS assignment letter - Chuck Bradshaw assigned to investigate the concerns.
04/11/2024	Contact - Telephone call made to Lisa Kappler, PA Susanna Storeng, Alecea Olson, administrator Jenny Jacobs, direct care staff members Victoria Doane, Heather Brady, APS Chuck Bradshaw
04/11/2024	Contact - Document sent – Email to ORR Katie Hohner and APS Chuck Bradshaw
04/12/2024	Contact – Document received – Email from Jenny Jacobs.
04/12/2024	Exit conference with licensee designee Jim Boyd. Left message and sent an email.

ALLEGATION: Resident A was not provided with adequate supervision by direct care staff members at Mt. Pleasant Home because she was able to ingest several large pieces of her brief and a six-inch section of tubing which needed to be surgically removed.

INVESTIGATION:

On March 4, 2024, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns Resident A was not provided with adequate supervision by direct care staff members at Mt. Pleasant Home because on March 2, 2024, she vomited several large pieces of her brief and a six-inch section of tubing which needed to be surgically removed. The allegations include concerns that none of the direct care staff members knew how she ingested these materials, that tubing or briefs were missing, and there were no recent *AFC Incident / Accident Reports* explaining that Resident A had consumed these items or that the items were unaccounted.

I reviewed the *AFC Incident / Accident Report* completed on March 2, 2024 by Lisa Kappler which stated:

"On March 2, 2024 [Resident A] was at the table for breakfast and started putting her hand in her mouth this is what she does to make herself sick she started gagging herself. She then vomited a large brown emesis with chunks and upon reviewing the chunks it was believed to be material from a brief. Staff reached out to on call physician and spoke to Dr. Uppel who instructed staff to monitor her if she had anymore emesis she was to go into for evaluation and possible scan. Around 9:45 AM she was transported to ER for an evaluation due to more emesis. While at ER she had two more incidents and there was more brief material in these. ER they evaluated her and did a CT scan and chest X-ray. Chest X-rays showed pneumonia and Shelley Campbell, NP was going to speak to general surgeon about CT scan results showing a blockage and she was admitted."

On March 12, 2024, I completed an unannounced onsite investigation and interviewed direct care staff member Kahlie Schuster at Mt. Pleasant Home. Ms. Schuster stated she was working when Resident A gagged herself but since this is a behavior she typically has, she was not concerned until she started gagging at table and vomited what Ms. Schuster observed were ten pieces of Resident A's brief in her vomit. Ms. Schuster stated she has never observed Resident A ingest that much of her brief in the past two years however, Resident A does have a PICA diagnosis. Ms. Schuster stated she believes Resident A ripped the pieces of her brief of during third shift the evening prior. Ms. Schuster stated Ms. Kendra Vanalstine and Alecea Olson were the direct care staff members working. Ms. Schuster stated when Resident A is asleep, direct care staff members monitor her every hour for breathing and safety and provide personal care every two hours if needed, however, since this incident, direct care staff members are checking her every fifteen minutes. Ms. Schuster stated she does not believe Resident A ingested any tubing because she has never observed her taking apart the

tubing. Ms. Schuster stated when Resident A was in the hospital in January 2024, she did not have a direct care staff member in her room or any hospital personnel providing supervision so it is very possible she ingested tubing while in the hospital. Ms. Schuster stated there has been no tubing missing at Mount Pleasant Home. Ms. Schuster stated hospital personnel contacted facility staff and informed them Resident A was pulling at the tubing while in the hospital. Ms. Schuster stated she has never noticed any briefs missing since this incident. Ms. Schuster stated when Resident A was assisted with personal care the morning of March 2, 2024, by Ms. Kappler and herself, the brief was fully intact then, so she does not believe it was ingested on March 2, 2024 Ms. Schuster stated Resident A is usually in the common area or dining room table, so provided supervision throughout the day. Ms. Schuster stated Resident A's primary doctor is Susanna Storeng, DMSC, PA-C.

During the on-site I was able to observe the cabinet in the bathroom where extra briefs are stored in packages. I also observed Resident A's bedroom and did not see any briefs that were left out or tubing that would cause harm to Resident A or that she could ingest. I also observed Resident A at the dining room table, however she was not able to complete an interview regarding the allegations because she is non-verbal.

I reviewed Resident A's resident record. According to Resident A's *Assessment Plan for AFC Residents* under the section entitled, "Other Difficulties," Resident A's *Assessment Plan for AFC Residents* documented Resident A has "Risk of choking during meals. High risk of choking due to PICA behaviors will pick up and eat anything on floor or outside." Under the section entitled, 'Self Injurious Behavior' it documented that Resident A: "Does self-abuse: pinching, scratching, hits herself in the head, stomach area, self induces vomiting and pulling hair to the point of pulling it out. PICA." Under the section entitled, 'Toileting' it documented: "*Staff should be closely monitoring her for signs of picking it or clothing for strings. At no time is she to be left unattended with a brief on while in the bathroom due to PICA nor does she wear brief to bed briefs are considered a choking hazard (examples toilet paper, cleansing wipes, briefs, liners). Nothing is to be left for her to get a hold of. This is due to her having a diagnosis of PICA and eating nonfood items."*

I reviewed Resident A's discharge instructions from McLaren Bay Region included the following diagnosis: "*Gastric outlet obstruction, pneumonia, sepsis, acute kidney injury, heart failure with preserved ejection fraction, chronic constipation, chronic kidney disease, GERD, hyperlipidemia, hypothyroidism, iron deficient anemia, mental impairment and shock."*

I reviewed Resident A's *Community Mental Health Person Centered Plan (PCP)* completed on January 27, 2024, which included an extensive section outlining PICA and the safety concerns that must be followed providing care for Resident A. According to Resident A's PCP under the section entitled, DESCRIPTION OF SAFETY CONCERNS the following directions/guidance was listed so direct care staff members knew how to provide care to Resident A:
"*[Resident A] has no personal safety skills and requires monitoring and supervision on a*

continual basis to maintain her safety. [Resident A] also engages in PICA (eating things that are not food). Home staff must monitor [Resident A] closely in all settings, observe and attempt to remove foreign objects that she could obtain and eat. If [Resident A] obtains a non-edible object and attempt to eat it staff will follow the following protocol:

- *If [Resident A] should happen to place something in her mouth staff are to ask her to spit it out or open her mouth.*
- *If she opens her mouth staff can use a toothette (foam end) to swipe around in her mouth to assist in removing the item.*
- *Staff may not force [Resident A] to open her mouth or shove a toothette in her mouth to remove the item.*
- *If she won't open her mouth so staff can use a toothette and she won't spit out the item, staff will monitor* her (for safety).*
- *If the item is something that can or could cause harm then staff, along with [Resident A], will seek medical treatment.*
- *Staff must follow all safety protocols in place to assist in preventing PICA incidents.*

According to Resident A's *Behavior Guidelines* developed by the CMH Behavior Treatment Committee, Resident A does not require 1:1 supervision any longer due to her decrease in mobility, however, she still requires "periodic monitoring" to ensure her health and safety.

On March 14, 2024, I interviewed licensee designee Jim Boyd regarding the concerns. Mr. Boyd stated he did not know how Resident A was able to ingest part of her brief but he believes the tubing was ingested while she was in the hospital. Mr. Boyd stated the hospital did not have anyone sitting in the room with Resident A when she was admitted in January 2024. Mr. Boyd stated there has never been tubing or briefs missing at Mt. Pleasant Home.

On April 11, 2024, I interviewed direct care staff member, whose role is currently home manager, Lisa Kappler. Ms. Kappler stated the morning of March 2, 2024, she noticed Resident A was acting funny. Ms. Kappler stated shortly after, Resident A was vomiting and she noticed there were chunks of brief in the vomit. Ms. Kappler stated she took Resident A to the hospital. Ms. Kappler stated Resident A never ingested her brief while Ms. Kappler was working because she is monitored closely. Ms. Kappler stated, "she is floored and blown away by this." Ms. Kappler stated the chunks of brief were large and they were from the side panel of the brief but she does not know when it was ingested. Ms. Kappler stated Resident A only wears briefs when she is awake and during that time frame, she is usually in the recliner or with the other direct care staff members where she can be observed. Ms. Kappler stated resident briefs are stored in the bathroom cabinet but she has never observed Resident A trying to get into the cupboard. Ms. Kappler stated she does not understand where the tubing came from because although Resident A sometimes uses oxygen, she has never had a direct care staff member come to her and say there was tubing missing from this. Ms. Kappler stated in January 2024 Resident A spent time in the hospital with pneumonia and she told the hospital staff Resident A had PICA and that she needed to be supervised. Ms. Kappler stated she is unsure if

Resident A was supervised by hospital personnel during the duration of her stay. Ms. Kappler stated she did not know how long this brief could stay in her system. Ms. Kappler stated the tubing is stored in the closet shelf in a closed box to which direct care staff members have access but due to Resident A's height and lack of mobility, she could not have access. Ms. Kappler stated she does not know how Resident A could have ingested this.

On April 11, 2024, I interviewed Resident A's primary medical provider, Susanna Storeng, DMSC, PA-C. PA Storeng stated she is not sure where Resident A ingested the tubing whether it was a time she did not have 1:1 supervision in the hospital or at the home. PA Storeng stated Resident A does have PICA and she picks at her briefs or her clothes. PA Storeng stated when Resident A is in her physician office, direct care staff will hold her hand or else she will find something to put in her mouth. PA Storeng stated Resident A has significant PICA and Resident A does try to ingest a lot of things. PA Storeng stated the prior hospital admission was for pneumonia on January 6, 2024. PA Storeng stated the tubing could have stayed in her system for that long if it did not pass completely because the tubing was six inches long, this would have been hard for her to pass, and it needed to be surgically removed. PA Storeng stated the pieces of the brief would not have stayed in her system since January 2024 so the brief was ingested at Mt. Pleasant Home. PA Storeng stated Ms. Schuster showed pictures of Resident A's emesis and she could see the size of the brief pieces and she noticed there was coffee ground like substance in her emesis at the time of the incident on March 2, 2024, showing irritation in her stomach.

On April 11, 2024, I interviewed direct care staff member Alecea Olson. Ms. Olson stated she worked the evening before Resident A became sick however Resident A did not have a brief on when sleeping. Ms. Olson stated she has observed Resident A picking at her brief when she gets her out of the shower but she never observed her doing this with big pieces and Ms. Olson stated she has always been able to get the pieces away from her before she swallows it. Ms. Olson stated she does not remember if she provided personal care to Resident A that morning "because it was long ago." Ms. Olson stated she was not picking at her brief the morning she threw up. Ms. Olson stated Resident A basically requires them to "keep an eye on her 24/7" especially when she is in the bathroom, and they make sure everything is out of sight which she could grab and put in her moth. Ms. Olson stated when Resident A is in bed direct care staff members check her every fifteen minutes while she was asleep instead of every two hours. Ms. Olson stated she has never observed Resident A trying to ingest the tubing at all. Ms. Olson stated she has never observed a direct care staff member not following the protocol of line-of-sight supervision. Ms. Olson stated there are always at least two direct care staff members working at a time so there is always someone that can watch Resident A.

On April 11, 2024, I interviewed administrator, Jenny Jacobs. Ms. Jacobs stated she does not know how Resident A ingested the tubing because there has not been any missing. Ms. Jacobs stated the day she went to the hospital, direct care staff member Julie Meyer said she was picking at her brief that morning but they took it from her. Ms.

Jacobs stated Resident A does not wear a brief at night for this reason and she does not have pads on her bed. Ms. Jacobs stated none of the direct care staff members reported there were briefs or tubing missing. Ms. Jacobs stated Resident A is still requiring line of sight supervision due to PICA. Ms. Jacobs stated she has not had issues with direct care staff members not providing direct line of sight supervision with Resident A because she is very quick and they need to be timely to get items away from her. Ms. Jacobs stated she believes the tubing came from her hospitalization in January 2024 because hospital personnel did not provide 24-hour supervision. Ms. Jacobs stated they are not allowed to provide one on one supervision at the hospital because it is “double billing” and they are no longer able to provide this.

On April 11, 2024, I interviewed direct care staff member Victoria Doane who stated although she was not working the morning Resident A went to the hospital but was aware Resident A threw up multiple pieces of large brief and was hospitalized after this. Ms. Doane stated she talked to one of the doctors at the hospital and learned a tube-like structure was found in her stomach. Ms. Doane stated occasionally Resident A will have a small piece of brief in her mouth but will typically take it out of her mouth and hand it to them if direct care staff members ask for it. Ms. Doane stated if Resident A rips off the brief, she will give it to them instead of putting it into her mouth. Ms. Doane stated Resident A does not sleep with a brief and has not for the last year she has worked there. Ms. Doane stated Resident A requires line of sight supervision, so she is always supposed to be within someone’s line of sight unless she is sleeping. Ms. Doane stated since the hospital visit, she is checked every 15 minutes during sleeping hours instead of the regular two hour bed checks. Ms. Doane stated she has never had concerns that other direct care staff members or herself did not provide line of sight supervision. Ms. Doane stated Resident A is usually out in the main area with everyone else in her recliner or at the dining room table during awake hours. Ms. Doane stated she does not have any information how Resident A ingested such large pieces of brief as what she had in her mouth.

This incident is a repeat violation as Special Investigation #2023A1029008 cited Rule 400.14303.2 when a similar incident occurred because Resident A was not supervised in the bathroom on October 16, 2022, and she ingested part of her brief. A corrective action plan was completed and submitted on January 24, 2023, which stated: “*Residents Assessment Plan and CMH PCP was reviewed with staff regarding PICA diagnosis and her requirement for line-of-sight supervision. Staff will continue with ongoing training on Assessment Plan, CMH PCP and consumers specific protocols.”* ORR advisor Katie Hohner also went to Mount Pleasant Home with her supervisor for a staff meeting to remind direct care staff members about following safety procedures regarding PICA and Resident A to ensure 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* after Resident A ingested a portion of her brief. While at the hospital, it was found Resident A also had a six-inch piece of tubing in her stomach, however, there is no information where or how this was ingested. PA Storeng stated although the tubing could have been ingested during her hospital stay in January 2024, the brief material was recently ingested so while Resident A was at Mt. Pleasant Home. PA Storeng stated it was possible for the tubing to remain in Resident A's system while the brief would have cleared quickly as it did via vomiting. During the onsite investigation, I reviewed Resident A's *Assessment Plan for AFC Residents*, Resident A's *CMH Treatment Plan,* and *CMH Behavioral Plan* and each of these documents had clear instruction regarding Resident A's PICA diagnosis and her requirement for regular supervision. Consequently, Resident A was not provided with supervision, protection and personal care as specified in her written plans given that she had ingested large section of an incontinence brief requiring surgery to remove.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SIR # 2023A1029008 DATED January 18, 2023. CAP COMPLETED.]**

IV. RECOMMENDATION

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

04/12/2024

Jennifer Browning Date
Licensing Consultant

Approved By:

04/15/2024

Dawn N. Timm Date
Area Manager