GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

April 18, 2024

RE: License #: AS180010526
Investigation #: 2024A1038034
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,

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

License #:	AS180010526
Investigation #:	2024A1038034
Complaint Receipt Date:	04/03/2024
Investigation Initiation Date:	04/03/2024
Report Due Date:	06/02/2024
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Licensee Designee:	James Boyd
Name of Facility:	Oakleaf Home
Facility Address:	2032 Seelinger Harrison, MI 48625
Facility Telephone #:	(989) 539-2803
Original Issuance Date:	01/27/1985
License Status:	REGULAR
Effective Date:	10/30/2023
Expiration Date:	10/29/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A suffered a lip injury.	Yes

III. METHODOLOGY

04/03/2024	Special Investigation Intake 2024A1038034
04/03/2024	Special Investigation Initiated - Telephone call made to Complainant
04/05/2024	Contact - Face to Face interviews were conducted with senior home manager William Brewer and DCS Heather Brady.
04/05/2024	Contact - Face to Face interviews were conducted with Resident A and Guardian A1.
04/16/2024	Contact- Telephone contact- with Community Mental Health for Central Michigan case manager Amanda Kibler
4/18/2024	Exit conference-Sherry Kidd

ALLEGATION:

Resident A suffered a lip injury.

INVESTIGATION:

On 4/3/24, I received a complaint from Bureau of Community and Health Systems regarding the home. The complaint alleged Resident A has stitches on her lip due to the home not providing proper supervision.

On 4/3/24, I interviewed Complainant who verified the information and had nothing to add.

On 4/5/24, I conducted an unannounced onsite investigation to the home, which recipients rights officer Katie Hohner and administrator Sherry Kidd was present for

all interviews. I interviewed senior home manager William Brewer who stated that on 4/1/24 he was watching Resident A as part of her one-on -one, when he went outside for a smoke break. Mr. Brewer stated he told Heather Brady he was going outside and to take over Resident A's one-on-one. Mr. Brewer stated when he returned into the home, Resident A was bleeding from her mouth area. Mr. Brewer stated Ms. Brady stated she did not know how it happened. Mr. Brewer stated he was only outside for around five minutes. Mr. Brewer stated Resident A is non-verbal and has a heavy history of falling. Mr. Brewer stated Resident A was taken to the emergency room for follow-up where she received stitches. Mr. Brewer stated Resident A did not have any bruises on her person. Mr. Brewer stated there was blood only on Resident A's shirt and on the chair, she was sitting in.

On 4/5/24, I interviewed direct care staff (DCS) Heather Brady whose statements were consistent with Mr. Brewer. Ms. Brady stated Resident A she was sitting at the living room table and Resident A was sitting behind her in her chair. Ms. Brady stated when she turned around Resident A was bleeding from her mouth and Mr. Brewer walked back in from outside. Ms. Brady stated she did not hear Resident A fall, make a sound, get up from her chair or make any noise of any kind. Ms. Brady stated she followed Resident A's, Adult Foster Care Assessment, Resident Care agreement and her primary care physician's supervision agreement. Ms. Brady stated she is only required to be in the same room as Resident A and not have eyes on her at all times.

On 4/5/24, I interviewed Guardian A1 whose statement was consistent with those made by Mr. Brewer and Ms. Brady regarding the incident. Guardian A1 added Resident A does not have any bruising, nor did she have any after the incident. Guardian A1 stated Resident A has lived at the home for 16 years and has not had any issues with others while at the home. Guardian A1 stated she does not believe Ms. Brady would ever purposefully hurt Resident A. Guardian A1 stated Resident A has a history of "being a ninja with her sneaking up on you". Guardian A1 stated Resident A, when eyes are taken off of her, can move very quickly and quietly.

On 4/5/24, I reviewed Resident A's, *Adult Foster Care Assessment*, *Resident Care agreement* and her primary care physician's (PCP) supervision agreement which states she is to have one on one supervision. The PCP documents read Resident A does not have to have "arms reach supervision", but staff have to be close enough to see and hear what Resident A is doing. The PCP records show Mr. Brewer followed proper protocol with asking another staff to watch Resident A while he took a break. I was able to view pictures of Resident A at the time of the incident and after she received stitches. Resident A did not appear to have any bruising around her lip area, face area or anywhere else on her person. The injury was in line with Resident A's teeth which slightly protrude which is consistent with Ms. Brady's statements of Resident A possibly biting her lip. I reviewed the incident report which verified all staff recollection of what occurred. I reviewed the homes policy and procedures which indicated proper protocol was followed in the events leading up to the incident and after.

On 4/16/24, I interviewed Community Mental Health for Central Michigan case manager Amanda Kibler who stated “line of sight” means the worker should be able to see the resident at all times. Ms. Kibler stated she spoke with someone regarding the incident and it was explained to her the worker was sitting slightly turned, still being able to see the Resident.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on my interview with staff, Guardian A1 and review of all documentation, the home appeared to not follow proper procedure when caring for Resident A. The PCP documents read the staff should be close enough to see and hear what Resident A is doing. Due to the staff not knowing how Resident A was injured, the staff did not maintain Resident A’s whereabouts and movement to make that determining factor.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

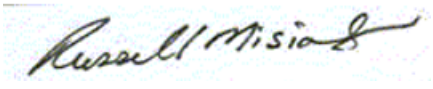
I recommend the license status remain unchanged.

4/15/24

_____

Johnnie Daniels Date
Licensing Consultant

Approved By:



4/16/24

_____

Russell B. Misiak Date
Area Manager