GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 11, 2024

Michael Crosby
Country Easy Living, LLC
5478 210th Ave.
Reed City, MI 49677

RE: License #: AM670280009
Investigation #: 2024A0870027
Country Easy Living

Dear Mr. Crosby:

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 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,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM670280009
Investigation #:	2024A0870027
Complaint Receipt Date:	05/22/2024
Investigation Initiation Date:	05/23/2024
Report Due Date:	07/21/2024
Licensee Name:	Country Easy Living, LLC
Licensee Address:	1030 Cotey St. Cadillac, MI 49601
Licensee Telephone #:	(231) 920-9003
Administrator:	Michael Crosby
Licensee Designee:	Michael Crosby
Name of Facility:	Country Easy Living
Facility Address:	5478 210th Avenue Reed City, MI 49677
Facility Telephone #:	(231) 465-4020
Original Issuance Date:	03/17/2006
License Status:	REGULAR
Effective Date:	10/30/2022
Expiration Date:	10/29/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Direct Care Worker Teresa Perry used a “wrap” restraint with Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

05/22/2024	Special Investigation Intake 2024A0870027
05/23/2024	Special Investigation Initiated - Telephone Telephone call with Community Mental Health for Central Michigan, Program Supervisor Becky Wemple.
05/23/2024	APS Referral Referral made to the Michigan Department of Health and Human Services, Adult Protective Service Centralized Intake unit.
05/24/2024	Contact - Telephone call received. Case discussion with Adult Protective Services worker Sam Talaski.
05/28/2024	Inspection Completed On-site Interview with Licensee Designee Mike Crosby and staff.
05/28/2024	Contact - Telephone call received. Email received from APS worker Sam Talaske.
05/31/2024	Contact - Telephone call received. Telephone call and email from Karen Bressette, CMHCM.
06/07/2024	Inspection Completed On-site Interview of facility staff and Resident A.
06/10/2024	Contact - Telephone call made. Telephone interview with Licensee Designee Mike Crosby.
06/10/2024	Exit Conference Completed with Licensee Designee Mike Crosby.

ALLEGATION: Direct Care Worker Teresa Perry used a "wrap" restraint with Resident A.

INVESTIGATION: On May 23, 2024, I spoke with Becky Wemple, Program Supervisor with Community Mental Health for Central Michigan. I spoke with Ms. Wemple regarding the services provided to Resident A and any history of aggressive behaviors. Ms. Wemple stated that Resident A does not have a behavior treatment plan and she does not have a history of aggressive behaviors. She noted that the agency behavior treatment team had a meeting earlier this day with Licensee Designee Mike Crosby and staff member Teresa Perry. Ms. Wemple noted that the treatment team suggested to Mr. Crosby and Ms. Perry that a "wrap" should have been used as a last resort and other steps could have been taken. Ms. Wemple noted that the wrap was described to her as "putting arms around (Resident A) and sitting her in a chair to help calm her down."

On May 24, 2024, I spoke by telephone with Michigan Department of Health and Human Services, Adult Protective Services (APS) worker Sam Talaske. Mr. Talaske noted that he has opened an APS investigation into the above allegations and conducted an in-person interview, at the AFC home, with Ms. Perry. He stated Ms. Perry informed him that Resident A had "swung" at her, so she held Resident A with both arms and sat her in a chair. Mr. Talaske stated he intends to meet with and interview Resident A later this day.

On May 28, 2024, I conducted an on-site special investigation at the Country Easy Living AFC home. I met with Licensee Designee Mike Crosby and staff member Teresa Perry informing them of the above stated allegation. Mr. Crosby stated Resident A does not have a specific behavior treatment plan and although she had occasional instances of aggressive behavior in the past, her aggression has increased recently. He noted he has been advocating with CMH to develop a more specific behavior treatment plan and/or an Individualized Plan of Service (IPOS) for Resident A. Mr. Crosby noted that he did not see the incident involving Resident and Ms. Perry as he was not present in the facility at the time.

Mr. Crosby provided Resident A's Assessment Plan for AFC Residents (BCAL-3265) for my review. This assessment notes that for the question "controls aggressive behaviors" it is marked "no" but does not document any "description of need" or "how need will be met."

Mr. Crosby provided for my review the AFC Licensing Division – Incident/Accident Report (BCAL-4607). This report documents an incident on May 20, 2024, involving Resident A and states: An argument started in the front room. Staff TP (Teresa Perry) intervened. TP asked Resident A to use her coping skills, meaning get your coloring book and spinners. She said no and hit staff in the face. Staff wrapped her, Resident A then bit staff in the arm. The report notes that 911 was called along with guardian. State police was dispatched as well as sheriff. Staff did not want to press

charges. State police explained if they got a return call, she (Resident A) would be going to jail.

Ms. Perry described and demonstrated for me what was meant by “wrapped”. She demonstrated that this involves grabbing Resident A’s forearms, crisscrossing the arms in front of Resident A’s chest, and then sitting with her on the chair while she deescalates. Ms. Perry and I reviewed the incident report. She noted that what is documented is what happened. Additionally, Ms. Perry noted that when Resident A let go of the bite on her arm, she backed away, another staff came into the room and Resident A began to calm down and went to her bedroom shortly after. She denied abusing Resident A or inappropriately restraining her.

On May 28, 2024, I received an email from APS worker Sam Talaske. Mr. Talaske stated that he was able to conduct an in-person interview of Resident A on May 24, 2024. He provided the following notes from his interview for my review. *‘I met with (Resident A) at MOISD Education Center. (Resident A) was interviewed on the allegations. (Resident A) stated she was upset and mad because she was trying to play with another resident who didn't want to play with her. (Resident A) stated Theresa told her to get out her fidget toys but then she put her hands up so Theresa didn't hit her. (Resident A) stated Theresa never hit her before. (Resident A) stated Theresa held (Resident A) arms crossed to her chest to "pin me down" and this upset (Resident A) so she bit Theresa on the arm. (Resident A) stated Theresa called the police who almost took her to jail. (Resident A) stated this hasn't happened before. (Resident A) stated she didn't feel safe at home. (Resident A) stated her guardian is aware of this. (Resident A) denied there being anything else that I should be aware of.’*

On June 7, 2024, I conducted a follow-up on-site special investigation at the AFC home. Mr. Crosby and Ms. Perry were not present in the facility at this time. I met with staff members Katie Cerbantes and Sherie Keller. Both Ms. Cerbantes and Ms. Keller stated they were not working and not present in the home during the May 20, 2024, incident involving Resident A. They both stated that Resident A had told them that she had attacked “mom” (Teresa Perry). They stated Resident A told them that she had “screamed at” and “swung at and bit” Ms. Perry. Ms. Cerbantes and Ms. Keller stated that Resident A did not indicate that Ms. Perry had done anything wrong to her and that Resident A seemed “remorseful” for her actions towards Ms. Perry. They also noted that when Resident A has a “bad day” at school she “brings it back home.” They further said that when Resident A does not have school, she has no issues at home. They both noted that Resident A does not have a specific behavioral treatment plan in place. Each stated that from what they were told, Ms. Perry did nothing wrong and did not abuse Resident A.

On June 7, 2024, I conducted an in-person interview of Resident A. Resident A stated that Ms. Perry “took me down.” I asked her to further explain what that meant. Resident A stated, “put me in the chair.” She noted that this has only occurred one time. Resident A noted that she “likes the staff here.”

On June 10, 2024, I spoke by telephone with Mr. Crosby. He stated that a worker from CMHCM is coming to the facility to further evaluate Resident A and develop a behavioral treatment plan and/or an Individualized Plan of Service for Resident A.

R 400.14102(1)(p) defines "Physical restraint" as "the bodily holding of a resident with no more force than is necessary to limit the resident's movement."

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Ms. Perry and Resident A both stated that Ms. Perry sat Resident A in a chair, holding her arms in front of Resident A's chest, following an aggressive action by Resident A. Resident A does not have a behavioral treatment plan, or IPOS, which provide instructions to staff if Resident A is aggressive to others. Ms. Perry did not use a form of physical force, other than physical restraint, as defined by rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14309	**Crisis intervention.**
	(1) Crisis intervention procedures may be utilized only when a person has not previously exhibited the behavior creating the crisis or there has been insufficient time to develop a specialized intervention plan to reduce the behavior causing the crisis. If the resident requires the repeated or prolonged use of crisis intervention procedures, the licensee shall contact the resident's designated representative and the responsible agency or, in the absence of a responsible agency, a professional who is licensed or certified in the appropriate scope of practice

	to initiate a review process to evaluate positive alternatives or the need for a specialized intervention plan. **(2) Crisis intervention may be used only for the following reasons:** **(a) To provide for self-defense or the defense of others.** **(b) To prevent a resident from harming himself or herself.** **(c) To quell a disturbance that threatens physical injury to any person.** **(d) To obtain possession of a weapon or other dangerous object that is in the possession or control of the resident.** **(e) To prevent serious property destruction.**
ANALYSIS:	Ms. Perry and Resident A both stated that Ms. Perry sat Resident A in a chair, holding her arms in front of Resident A's chest, following an aggressive action by Resident A. Resident A does not have a behavioral treatment plan, or IPOS, which provide instructions to staff if Resident A is aggressive to others. Ms. Perry appropriately used a form of crisis intervention, namely "physical restraint" with Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: During the course of this special investigation, I noted a large hole in the drywall of the northeast resident bathroom. This same bathroom has several cracked and chipped floor tiles in front of the shower stall. I also noted a large dead branch from a tree resting against the roof of the facility. I observed missing and damaged facia along the roofline of the facility near where the dead branch was noted resting on the roofline. I observed a photo of a shower chair used by Resident B which showed mold on the lower portion of the chair legs. I also observed a photo of an electronic "lift" used by Resident B which had exposed wiring.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants. **Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.**

	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair. **(7) All water closet compartments, bathrooms, and kitchen floor surfaces shall be constructed and maintained so as to be reasonably impervious to water and to permit the floor to be easily kept in a clean condition.**
ANALYSIS:	Broken drywall and flooring in the resident bathroom and a dead tree branch on the roofline, along with broken/missing facia, indicate that the home is not being maintained adequately for the health, safety, and well-being of the residents. Nor does it indicate the floor and wall are easily cleanable, impervious to water and in good repair. Having mold on a shower chair indicates that housekeeping standards do not present a clean appearance.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/10/24, I conducted an exit conference with Licensee Designee Mike Crosby. I explained my findings as noted above. Mr. Crosby stated he understood the finding and had no further information to provide or additional questions concerning this investigation. Mr. Crosby stated he will submit a corrective action plan which will address repairs to the building and cleanliness of resident belongings.

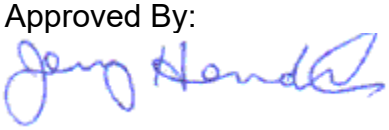
IV. RECOMMENDATION

I recommend, contingent upon the submission of an acceptable corrective action plan, that the status of the license remain unchanged.

June 11, 2024

Bruce A. Messer — Date
Licensing Consultant

Approved By:



June 11, 2024

Jerry Hendrick — Date
Area Manager