GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 22, 2024

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

RE: License #: AS370084055
Investigation #: 2024A1029066
Broadway 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 #:	AS370084055
Investigation #:	2024A1029066
Complaint Receipt Date:	09/03/2024
Investigation Initiation Date:	09/04/2024
Report Due Date:	11/02/2024
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois, Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	James Boyd
Licensee Designee:	James Boyd
Name of Facility:	Broadway Home
Facility Address:	1710 E. Broadway, Mt. Pleasant, MI 48858
Facility Telephone #:	(989) 773-3329
Original Issuance Date:	04/12/1999
License Status:	REGULAR
Effective Date:	10/22/2023
Expiration Date:	10/21/2025
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Broadway Home is understaffed because direct care staff member Ms. David is working alone even though she is on medical restriction and cannot lift Resident C who has an injury.	No
Resident A slapped Resident B in the kitchen and the direct care staff members did not intervene.	No
Resident C has an infection on her hands that has not been treated.	No
There are medication errors at Broadway Home.	Yes

III. METHODOLOGY

09/03/2024	Special Investigation Intake 2024A1029066
09/04/2024	Special Investigation Initiated – Letter to ORR Katie Hohner.
09/25/2024	Inspection Completed On-site – face to face with direct care staff members Robin Boughton, Lexie Bushong, Resident A at Broadway Home.
10/04/2024	Contact - Telephone call made to direct care staff member Morgan Monte, Delicia Hill, licensee designee Jim Boyd.
10/11/2024	Contact - Telephone call made to direct care staff member Morgan Monte.
10/15/2024	APS Referral - Made APS referral to Centralized Intake.
10/17/2024	Contact - Telephone call made licensee designee Jim Boyd.
10/17/2024	Contact – Email sent to Jim Boyd and Morgan Monte.
10/21/2024	Contact – Document received from Jim Boyd.
10/22/2024	Exit conference with licensee designee Jim Boyd.

ALLEGATION: Broadway Home is understaffed because direct care staff member Ms. David is working alone even though she is on medical restriction and cannot lift Resident C who has an injury.

INVESTIGATION:

On September 3, 2024, a complaint was received via Bureau of Community and Health Systems online complaint system with allegations Broadway Home is understaffed because they have shifts with only one direct care staff member scheduled on third shift who was on medical restrictions and cannot provide care.

On September 3, 2024, I received an email from Community Mental Health Office of Recipient Rights (CMH ORR) advisor, Katie Hohner. Ms. Hohner stated she was unaware of any direct care staff members at Broadway Home placed on medical restrictions currently. Ms. Hohner also stated there are no residents who require two-person assistance for transferring or mobility currently living at the facility.

On September 25, 2024, I completed an unannounced on-site investigation at Broadway Home and interviewed direct care staff members Robin Boughton and Lexie Bushong. Resident C and Resident D were also at home however, due to their diagnosis I was not able to complete an interview. I noted both appeared to be in good spirits. I reviewed all four *Assessment Plan for AFC Residents* and found none of the residents at Broadway Home require two-person assistance.

During the on-site investigation, I reviewed the September 2024 schedule on the wall which showed there was usually two direct care staff members assigned for third shift. I reviewed the *Physician's Orders / Progress Note* for Resident C which confirmed she had a right fibula fracture and fourth and fifth toe fractures and was required to wear a splint and follow up with the orthopedic doctor on October 1, 2024.

Ms. Boughton stated they do not usually have any residents who require two-person assistance for transferring. However, Ms. Boughton stated Resident C broke her leg a month ago and it has been easier and safer to transfer Resident C with two direct care staff members. Ms. Boughton stated typically there are two direct care staff members during third shift to assist Resident C with transferring due to her broken leg but this is not required because Resident C's *Assessment Plan for AFC Residents* did not change. Ms. Boughton stated Resident C is doing much better and able to transfer herself now without issue. Ms. Boughton and Ms. Bushong both denied a shift where a direct care staff member worked alone and denied knowing if any of the direct care staff members were currently on a medical restriction.

On October 11, 2024 I interviewed direct care staff member whose current role is home manager, Morgan Monte. Ms. Monte stated they have four residents and they typically have two direct care staff members per shift but sometimes they only have one between 7 PM – 10 AM because that is sleeping hours. Ms. Monte stated there are no residents who require two-person assistance for transferring or mobility now but for a short time

Resident C did after she broke her leg because it was easier to have two direct care staff members assist her. Ms. Monte stated nothing in Resident C's plan changed to require two direct care staff members to assist with mobility. Ms. Monte stated the physician wants Resident C to use her leg more and transfer on her own.

On October 17, 2024, I interviewed licensee designee Jim Boyd. Mr. Boyd stated there was one staff member Jill David who did have surgery and she was not supposed to lift anyone. Mr. Boyd stated he does not recall the dates she was under this restriction but she did not work alone during the daytime during this timeframe.

I reviewed the following documentation sent by Mr. Boyd regarding direct care staff member Ms. David's restrictions:

1. Written documentation confirming Ms. David was transferred on September 17, 2024 to another licensed AFC operated by Listening Ear due to her restrictions and the changes in consumer care at Broadway Home until the consumer care improves or she no longer had restrictions.
2. Restriction accommodations from August 8, 2024 from her physician stating as of July 30, 2024 Ms. David should not use stairs or lift / carry over 15 pounds. Listening Ear confirmed they were able to accommodate her restrictions as long as she did not operate a lift on her own and did not work alone without another trained direct care staff member on shift.
3. I reviewed the staffing schedule for September 2024. Resident C's injury was not identified until September 10, 2024 so there was one week where Ms. David was working there before she was transferred and she never worked alone during that time.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Broadway Home had adequate staffing during the time period Resident C had her injury and Ms. David was on medical restriction. I reviewed all four resident *Assessment Plans for AFC Residents* and none of the residents at Broadway Home require two-person assistance and all resident care was provided as required. Ms. David was on a medical restriction however Resident C's injury was not identified until September 10, 2024 so there was one week where Ms. David was working before she was transferred to another facility and she never worked alone during that time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A slapped Resident B in the kitchen and the direct care staff member did not intervene.

INVESTIGATION:

On September 3, 2024, a complaint was received via Bureau of Community and Health Systems online complaint system with allegations that Resident A slapped Resident B in the kitchen and direct care staff members did not intervene.

On September 3, 2024, I received an email from Community Mental Health Office of Recipient Rights (CMH ORR) advisor, Ms. Hohner. Ms. Hohner sent me the *AFC Incident / Accident Report* regarding this incident which I reviewed.

According to the AFC Incident / Accident Report:

Explain what happened: "[Resident A] became very upset when [Resident B] moved her cup and silverware. She started yelling at [Resident B]. Staff prompted [Resident A] and gave guidance about how to communicate being upset without yelling. Yelling upset the other residents. [Resident A] stated if [Resident B] made her upset again then she would smack her again.
Action taken by staff: Staff explained the natural consequences of this and then [Resident A] shoved the table into [Resident B].
Corrective measures taken to remedy: Staff asked [Resident A] if she wanted to go for a walk and she said "yes". Contacted member of the BTC for consult."

On September 25, 2024, I completed an unannounced on-site investigation at Broadway Home and interviewed direct care staff members Ms. Boughton and Ms. Bushong. Ms. Bushong stated she was here, witnessed the incident, and then wrote the *AFC Incident / Accident Report* for documentation of the incident. Ms. Bushong stated this occurred on July 29, 2024 when the afternoon direct care staff members were starting their shift and Resident A was trying to get into the closet at the same time Resident B was and she ended up hitting her because she was mad. Ms. Bushong stated this is not a regular occurrence but Resident A will sometimes accuse other

people of hitting her if she is upset. Ms. Bushong stated she did intervene by asking Resident A if she wanted to go to her bedroom or take a walk. Ms. Bushong stated it was also documented in her *A-B-C (Antecedent, Behavior, and Consequences)* chart according to her *Person Centered Plan*. Ms. Bushong stated she also checked Resident B to make sure she had no injuries and she did not other than a red mark on her face that faded quickly.

During the on-site investigation, I reviewed the following documents in Resident A's resident record:

1. According to her *CMH Person Centered Plan*, Resident A "gets angry easily and feels triggered when she feels others are bossing her around. AFC staff will model appropriate kind respectful actions, while demonstrating boundaries. When redirection is necessary, the AFC staff will redirect [Resident A] in a manner that preserves her dignity, speaking to her calmly, with respect, and in a private place. [Resident A] should be redirected to an alternative task. When [Resident A] is escalated she may need gentle reminders to separate herself from the situation."
2. I reviewed the *A-B-C Data Collection chart* which also included documentation of the incident on July 29, 2024 indicating Resident A hit Resident B in the face, pushed the table, and threw a pen across the room. Resident A went outside to calm down and then for a walk with a friend.

On October 11, 2024 I interviewed direct care staff member whose current role is home manager, Morgan Monte. Ms. Monte stated Resident A did slap Resident B because she was upset with her on July 29, 2024 and after this incident the Behavior Psychologist and case manager, Andrea Cotter were both notified. Ms. Monte stated as a result of this incident, Resident A had a medication change and they cut caffeine out of her diet which has helped. Ms. Monte stated there were no injuries to Resident B and this is not a regular occurrence for Resident A.

On October 17, 2024, I interviewed licensee designee Jim Boyd. Mr. Boyd stated this is not a common occurrence for Resident A and he felt the direct care staff member Ms. Bushong handled the situation appropriately. Mr. Boyd stated the behavior plan instructs the direct care staff members to redirect Resident A as needed when she shows aggression which is what Ms. Bushong did in this situation. Mr. Boyd stated Resident A's CMH case manager, Ms. Cotter was also notified of the situation.

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:	Resident A and B's personal needs including protection and safety were attended to at all times. Resident A did get upset and slap Resident B, however Ms. Bushong looked at Resident B for injuries, separated the two of them, encouraged Resident A to go for a walk, and contacted CMH to report the incident. Ms. Bushong stated she also completed an *AFC Incident / Accident Report.* Ms. Bushong stated she redirected Resident A and asked her if she wanted to go for a walk which is consistent with the directions in her *Person Centered Plan* to take a break and separate herself from the situation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident C has an infection on her hands that has not been treated.

INVESTIGATION:

On September 3, 2024, a complaint was received via Bureau of Community and Health Systems online complaint system with allegations a resident has an infection on her hands that is not being treated. The initial complaint did not include a timeframe or which resident had the rash on their hand.

On September 3, 2024, I received an email from Community Mental Health Office of Recipient Rights (CMH ORR) advisor, Ms. Hohner. Ms. Hohner stated Resident C is the resident with the hand infection and she was receiving two oral antibiotics and a prescribed hand cream for this issue. Ms. Hohner stated she verified all Resident C's medications were administered. Ms. Hohner stated Resident C had gone to the doctor at least two times for the rash and she did not have any concerns they were not addressing the rash on Resident C's hands.

On September 25, 2024, I completed an unannounced on-site investigation at Broadway Home and met with direct care staff members Ms. Boughton and Ms. Bushong. Ms. Boughton stated Resident C had an antibiotic for her hands and they were very red. Ms. Bushong stated she also took Resident C to a physician appointment to have her hands checked because they were cracking.

During the on-site investigation, I reviewed the following documents:

1. *Physician's Orders / Progress Notes* from Resident C dated July 25, 2024, indicated Resident C had a bump on her right thumb area which appeared that week and she had redness up her arm and she was diagnosed with cellulitis and eczema on her forearm and hands.
2. Reviewed the physicians order from July 25, 2024 for the Betamethasone Diproplonate .05% External cream to be applied two times per day.
3. Reviewed the physicians order from August 27, 2024 for Mupirocin 2% topical ointment to be applied three times per day to affected areas.

4. There was also *Physician's Orders / Progress Notes* from July 29, 2024, August 20, 2024, and an *After Visit Summary* from August 27, 2024 confirming Resident C was taken for medical treatment regarding the rash on her hand.

I observed Resident C's hands to be red and cracked however, there were no open sores or bleeding observed. Resident C appeared to be able to use her hands without issue and was observed eating and coloring. Resident C did not appear to be in any pain during the visit. I reviewed the MAR for Resident C which confirmed Resident C received both ointments including Mupirocin Ointment which was stopped September 10, 2024 and Bethamethason Dipropionate Cream which was stopped September 15, 2024 and after that time she was given Vaseline / Eucerin.

On October 11, 2024 I interviewed direct care staff member whose current role is home manager, Ms. Monte. Ms. Monte stated Resident C has had a rash on her hand and it's from eczema and cracked skin which they are now treating with Eucerin. Ms. Monte stated Resident C's hand looks better than it did in the past.

On October 17, 2024, I interviewed licensee designee Mr. Boyd. Mr. Boyd stated Resident C has had a rash on her hand but he has no concerns direct care staff members were not administering the creams as prescribed and taking Resident C to the physician as necessary. Mr. Boyd stated Resident C has been to the physician at least two times and he does not believe there was a lapse in follow up.

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: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**

ANALYSIS:	There is no indication direct care staff members at Broadway are not following the recommendations given for the rash on Resident C's hand. I reviewed the MAR for Resident C to confirm she was administered an ointment on her hands as prescribed by her physician and since September 15, 2024 she has been administered Vaseline / Eucerin. There was also *Physician's Orders / Progress Notes* from July 29, 2024, August 20, 2024, and an *After Visit Summary* from August 27, 2024 confirming Resident C was taken for medical treatment regarding the rash on her hand so there are no concerns she has not received medical follow up for this issue.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: There are medication errors at Broadway Home.

INVESTIGATION:

On September 3, 2024, a complaint was received via Bureau of Community and Health Systems online complaint system with allegations there are medication errors at Broadway Home.

On September 3, 2024, I received an email from Community Mental Health Office of Recipient Rights (CMH ORR) advisor, Ms. Hohner. Ms. Hohner stated there was one medication error on August 3, 2024 that was reported recently to Community Mental Health. Ms. Hohner sent me the *AFC Incident / Accident Report* for this error:

"Explain what happened: During med count, it was discovered that [Resident A] was passed 2 tabs of Clonidine .01 mg and was not passed Levothyroxine .25 mcg. Morgan Monte was the med passer. There was no 2nd checker.
Action taken by staff: Missed med protocol followed, contacted on call, Drs, and pharmacy.
Corrective Measures: Implement second checker for medications."

On September 25, 2024, I completed an unannounced on-site investigation at Broadway Home and met with direct care staff members Ms. Boughton and Ms. Bushong. Ms. Boughton stated there were no medication errors at Broadway Home in the last month and stated Ms. Monte keeps track of all medications that come into the home but they are all responsible for ordering medications if necessary. Ms. Boughton stated they track the medications on a paper Medication Administration Record (MAR) and administrator, Candy Gath has copies of all the *AFC Incident / Accident Reports* regarding any medication errors.

On October 11, 2024 I interviewed direct care staff member whose current role is home manager, Ms. Monte. Ms. Monte stated there was a medication error on August 3, 2024 that she was responsible for and there has not been another since that time. Ms.

Monte stated Resident A was passed two medications instead of one and did not receive another of her medications. Ms. Monte stated there was another time on an unknown date Resident C received her Aricept in the AM instead of PM because the order had recently changed.

On October 17, 2024, I interviewed licensee designee Mr. Boyd who stated there were some direct care staff members who received discipline or coaching recently due to medication errors. Mr. Boyd sent a copy of the *Counseling Statement* that was completed for Ms. Monte after this medication error on October 21, 2024 which confirms Ms. Monte administered two Clonodine instead of one and did not receive her AM Levothyroxine.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the interview with Ms. Hohner and Ms. Monte there was a medication error on August 3, 2024 where it was discovered that Resident A was administered two tablets of Clonodine.01 mg and was not administered Levothyroxine .25 mcg as prescribed. Ms. Monte was the direct care staff member who administered her medications and there was no second checker for medication at that time which is the policy for Listening Ear. According to Mr. Boyd, Ms. Monte did receive a counseling statement for this medication error.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Jennifer Browning _____10/22/2024_____

Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 10/22/2024

_____

Dawn N. Timm Date
Area Manager