GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 02, 2024

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

RE: License #: AS180010525
Investigation #: 2025A1038008
Weatherhead 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 (616) 356-0100.

Sincerely,

Johnnie Daniels, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa Ave NW
Grand Rapids MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS180010525
Investigation #:	2025A1038008
Complaint Receipt Date:	11/06/2024
Investigation Initiation Date:	11/07/2024
Report Due Date:	01/05/2025
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:	Weatherhead Home
Facility Address:	749 Richard St Harrison, MI 48625
Facility Telephone #:	(989) 773-6904
Original Issuance Date:	02/06/1985
License Status:	REGULAR
Effective Date:	07/30/2023
Expiration Date:	07/29/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff were not following Resident A's plan of service.	Yes
An employee has been physically violent with Resident B.	No
Additional findings	Yes

III. METHODOLOGY

11/06/2024	Special Investigation Intake 2025A1038008
11/07/2024	Special Investigation Initiated - Telephone call made to complainant
11/14/2024	Inspection Completed On-site
11/14/2024	Contact - Face to Face interviews were conducted with DCS Lilly Mcguire, DCS Amelia Abraham and Keli Comer.
11/14/2024	Contact - Face to Face interviews were conducted with Jennifer Morrison and DCS Bille Thomas.
11/14/2024	Contact - Face to Face interview was conducted with Resident A.
11/18/2024	Contact - Face to Face interview was conducted with DCS Jennifer Iso.
11/18/2024	Contact - Document Received from Administrator Sherry Kidd.
11/20/2024	Inspection Completed-BCAL Sub. Compliance
11/20/2024	Exit Conference with LD Jim Boyd.

ALLEGATION:

Staff were not following Resident A's plan of service.

INVESTIGATION:

On 11/6/24, I conducted an interview with the complainant via telephone, who verified the information.

On 11/14/24, I conducted an investigation at the facility, with recipients rights officer (RRO) Sara Watson, administrator Sherry Kidd and licensee Jim Boyd were present for the interviews.

I interviewed direct care staff (DCS) Lillian Mcgurie. Ms. Mcgurie stated Resident A is a two person assist when transporting. Ms. Mcgurie stated DCS Jennifer Ison refused to use a second person or a Hoyer lift when moving Resident A.

I interviewed DCS Amelia Abraham whose statement was consistent with those made by Ms. Mcgurie.

I interviewed DCS Keli Comer who provided a statement consistent with those made by Ms. Mcgurie and Ms. Abraham. Ms. Comer added she was only told about the situation but had not witnessed anything.

I interviewed DCS Jennifer Morrison who stated she has never worked with DCS Ison, so she does not have anything to provide regarding the complaint.

I interviewed home manager Billie Thomas who stated she has not witnessed Ms. Ison not following Resident A's plan. Ms. Thomas stated she has only been told about the concerns of the incident.

I was unable to interview Resident A as he was non-verbal.

On 11/18/24, I interviewed DCS Jennifer Ison at the facility. Again, RRO Watson, administrator Kidd and licensee Boyd were present for the interview. Ms. Ison verified she does move Resident A by herself. Ms. Ison stated majority of the staff at the facility move Resident A by themselves with no help. Ms. Ison stated there is no Hoyer lift or any other assistance device used to transfer him. Ms. Ison stated she has not been trained on the proper way to transfer Resident B or using the Hoyer lift.

On 11/20/24, I reviewed Resident A's *Health Care Appraisal*, *Assessment Plan* and his *Individual Plan of Service* (IPOS). In summary the documents read it would be best to use the mechanical lift when getting Resident A in and out of bed due to his difficulty with pivoting. It would continue to take two staff members to perform the lift to ensure safety for Resident A and caregivers. Resident A weighed 259 pounds and

it was important that staff ensure safety with moving him from one surface to another.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.
ANALYSIS:	Based on my interview with staff and the review of documents, there was enough corroborating evidence of staff not following Resident A's plan of service.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

An employee has been physically violent with Resident B.

INVESTIGATION:

Ms. Mcgurie stated Ms. Ison picks Resident A up and places him into his chair roughly. Ms. Mcgurie stated on 10/29/24 she witnessed Ms. Ison enter into Resident B's room and without warning picked Resident B up out of bed then throw Resident B into her shower chair. Resident B was heard saying "ouch" out loud.

DCS Abraham provided a statement that was consistent with those made by DCS Mcgurie. DCS Abraham added she was unsure if DCS Ison was ~~being~~ rough with Resident A or just having difficulty moving him due to his size. DCS Abraham added DCS Ison is more rough with Resident B when transporting her.

DCS Morris stated she has not worked with DCS Ison so she could not comment on the allegation.

Ms. Thomas stated she has not witnessed DCS Ison rough with the residents. Ms. Thomas stated she has no concerns with Ms. Ison and her interaction with the residents.

DCS Ison stated she is not rough with the residents DCS Ison stated she has never thrown any resident into a chair and denied transferring residents roughly.

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 there was not enough corroborating evidence of the staff being physically violent with the staff.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

Staff are not properly trained to care for Resident B

INVESTIGATION:

DCS Ison stated she was not trained to properly transfer Resident B with the Hoyer lift (Maxi move).

I reviewed of the training documents provided by the facility. It listed home manager Billie Thomas, DCS Courtney Cooper, DCS Lisa Adair, DCS Keli Comer and DCS Tina Kincaid were trained on the Hoyer (Maxi move) on 6/14/24, which is the proper assistance device to use to move residents from their beds to any type of sitting device. The documentation verifies DCS Jennifer Ison did not sign the documents verifying she attended the training.

APPLICABLE RULE	
R 400.14204	**Direct Care Staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on my interview and the review of documents. There is enough evidence corroborating DCS Ison was not properly trained to transfer Resident B safely.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

11/25/24

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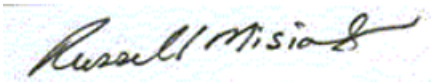
Johnnie Daniels Date
Licensing Consultant

Approved By:



11/27/24

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Russell B. Misiak Date
Area Manager