GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 14, 2025

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

RE: License #: AS370084055
Investigation #: 2025A0577028
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 (517) 284-9727.

Sincerely,

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370084055
Investigation #:	2025A0577028
Complaint Receipt Date:	03/17/2025
Investigation Initiation Date:	03/18/2025
Report Due Date:	05/16/2025
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:	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?
On March 03, 2025, Resident A missed a doctor's appointment due to lack of direct care staff.	Yes

III. METHODOLOGY

03/17/2025	Special Investigation Intake 2025A0577028
03/18/2025	Special Investigation Initiated - Face to Face- Interviews with staff and resident.
03/18/2025	APS Referral- Complainant made APS referral, denied for investigation.
03/18/2025	Referral - Recipient Rights
03/18/2025	Inspection Completed On-site
03/21/2025	Contact - Telephone call made to Guardian A1
03/21/2025	Contact - Telephone call made- Dr. Vashista-PCP.
04/02/2025	Contact - Document Received- Interview with Guardian A1.
04/02/2025	Contact - Document Sent- Email correspondence with Jim Boyd, Administrator.
04/05/2025	Contact - Telephone call made- Interview with Katie Hohner and Andrea Cotter. CMHCM.
04/09/2025	Inspection Completed-BCAL Sub. Compliance
04/09/2025	Exit Conference with licensee designee Jim Boyd.

ALLEGATION: On March 03, 2025, Resident A missed a doctor's appointment due to lack of direct care staff.

INVESTIGATION:

On March 17, 2025, a complaint was received reporting on March 03, 2025, Resident A missed a doctor's appointment due to the facility being short staffed. The complaint reported Resident A was then hospitalized on March 04, 2025, until March 12, 2025,

with pneumonia and pleural effusion which possibly could have been prevented had the appointment on March 03, 2025, not been missed.

On March 18, 2025, I completed an unannounced onsite investigation and attempted to interview Resident A but was unsuccessful due to Resident A not wanting to be interviewed. During the onsite investigation I interviewed Direct Care Staff (DCS) Lexus Bushong and Morgan Montey. DCS Bushong reported on February 27, 2025, Resident A was seen by her primary care physician Dr. Vashista for a urinary tract infection (UTI) and was prescribed an antibiotic. DCS Bushong and DCS Montey reported they both were working on March 03, 2025, and noticed in the morning that Resident A was still not having much energy, eating small meals, and just seemed to not be feeling well. DCS Bushong reported Resident A's vitals were taken and recorded Resident A's temperature was 97.7 degrees, all other vitals were normal, and Resident A did not have a cough, runny nose, or other signs of illness. DCS Bushong reported she contacted PCP Vashista's office and explained their concerns and an appointment was scheduled for 3:00pm for a recheck of Resident A's UTI. DCS Montey reported another resident in the home had an appointment in Midland at 3:00pm and DCS Montey was already scheduled to transport. DCS Montey and DCS Bushong reported they called and left messages with all direct care staff requesting for one to take Resident A to her appointment at 3:00pm with no success. DCS Montey reported they contacted licensee designee Jim Boyd who advised they continue to attempt to contact other staff. DCS Bushong and DCS Montey reported they were unsuccessful in finding another direct care staff to transport Resident A to her appointment. DCS Bushon reported there were other residents at the facility so she could not transport Resident A to her appointment. DCS Bushon and DCS Montey reported they did not contact Guardian A1 to see of Guardian A1 would be able to transport Resident A to her appointment. DCS Bushon and DCS Montey reported Resident A was not showing any signs or symptoms of having pneumonia on the day of March 03, 2025.

During the onsite investigation I reviewed and received a copy of Resident A's *AFC-Resident Care Agreement,* completed on January 09, 2025, documenting Licensee will assure the availability of transportation. Resident A's *AFC-Resident Care Agreement,* documents if transportation alternatives are not available, licensee will assure the resident is transported for routine medical and dental appointments within the community.

On March 21, 2025, I called and left a message for Guardian A1 and received a return call on April 02, 2025. Guardian A1 reported on February 27, 2025, Resident A was taken to Dr. Vashista's office for a urine analysis, where Resident A was diagnosed with a UTI. Guardian A1 reported he then received a phone call from the facility on March 03, 2025, that Resident A was still not feeling well and had a stomachache and back pain so the facility was taking Resident A to see Dr. Vashista. Guardian A1 reported he received a phone call about 4:00pm from DCS Morgan Montey reporting Resident A missed her appointment because DCS Montey was in Midland with another resident, and no other direct care staff was able to transport Resident A. Guardian A1 reported he inquired why he was not called to transport Resident A and was told by DCS Montey

that the conversation in the morning sounded like Guardian A1 was busy and would not be able to transport Resident A if needed.

On March 21, 2025, I interviewed Tia Marcott, Medical Assistant with Dr. Vashista's Office who reported they received a phone call on the morning of March 03, 2025, regarding concerns of Resident A not feeling well and a possibility of the antibiotic not working for Resident A's UTI. MA Marcott reported an appointment to see Dr. Vashista was scheduled for 3:00pm on March 03, 2025. MA Marcott reported Resident A was not brought in for the appointment and the notes in their system documents Resident A was a no call no show for the appointment.

On April 02, 2025, I spoke with Katie Hohner, Office of Recipient Rights Community Mental Health Central Michigan. Ms. Hohner reported per her interview with Jim Boyd, Licensee Designee and DCS Morgan Montey both reported Resident A's appointment scheduled on March 03, 2025, was not an emergent appointment and should have been cancelled and rescheduled when they could not find transportation. Ms. Hohner reported DCS Montey reported she got busy with trying to contact other direct care staff to transport Resident A, get the other resident ready for their appointment and take them and forgot to call to reschedule. Ms. Hohner reported both DCS Montey and Mr. Boyd acknowledged that the appointment should have been rescheduled and was overlooked, but again the appointment was not an emergency, and Resident A was not showing any signs of pneumonia or even having a cold rather the appointment was to determine if Resident A still had a UTI.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall always have sufficient direct care staff on duty 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:	Per Resident A's *AFC-Resident Care Agreement,* if transportation alternatives are not available, the licensee will assure the resident is transported for routine medical and dental appointments within the community. Based on the information gathered during the investigation, it has been determined the facility had insufficient direct care staff on duty on March 03, 2025, to meet the transportation needs of Resident A as documented in Resident A's *AFC-Resident Care Agreement* causing Resident A to miss a medical appointment with her primary care physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an approved correction action plan, I recommend continuation of the current status of the license of this AFC adult small group home capacity 4.

Bridget Vermeesch

04/14/2025

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 04/11/2025

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Dawn N. Timm Date
Area Manager