GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 3, 2019

Shelia Shang
246 Powell
Grand Rapids, MI 49506

RE: License #: AS410385361
Investigation #: 2019A0357008
Shedrice's AFC

Dear Shelia Shang:

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 (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410385361
Investigation #:	2019A0357008
Complaint Receipt Date:	02/06/2019
Investigation Initiation Date:	02/06/2019
Report Due Date:	04/07/2019
Licensee Name:	Shelia Shang
Licensee Address:	246 Powell Street, SE Grand Rapids, MI 49507
Licensee Telephone #:	(616) 375-6076
Administrator:	Shelia Shang
Name of Facility:	Shedrice's AFC
Facility Address:	246 Powell Street, SE Grand Rapids, MI 49507
Facility Telephone #:	(616) 248-1720
Original Issuance Date:	04/17/2017
License **Status:**	REGULAR
Effective Date:	10/17/2017
Expiration Date:	10/16/2019
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A wanted to cancel his ECT appointment for 01/31/2019, but the licensee would not let him use the telephone.	No
The licensee regularly yells at Resident A and other residents.	Yes
During a cold spell there was no heat in the home and the licensee gave Resident A, a space heater for his bedroom.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/06/2019	Special Investigation Intake 2019A0357008
02/06/2019	Special Investigation Initiated - Telephone with Recipient Rights, network 180, Melissa Gekeler.
02/06/2019	Contact - Telephone call made telephoned to Witness 1.
02/07/2019	Contact - Telephone call made To network 180, Recipient Rights.
02/11/2019	Inspection Completed On-site Reviewed resident and household records.
02/11/2019	Contact - Face to Face Melissa, Gekeler, Recipient Rights, from network 180 and I conducted an interview with the Licensee Shelia Shang and staff, Jackie James.
02/11/2019	Contact - Face to Face Melissa Gekeler, Recipient Rights, network 180 and I conducted an interview with Resident B in his bedroom at the AFC home.
02/12/2019	Contact - Telephone call made To Melissa, Gekeler, Recipient Rights, network 180.
02/14/2019	Inspection Completed On-site
02/14/2019	Contact - Face to Face Melissa Gekeler and I conducted an interview with Resident A and Ms. Shang.

02/20/2019	Contact - Telephone call received From Witness 1.
03/07/2019	Contact - Telephone call made To Witness 1.
03/13/2019	Contact - Document Received Email sent to Melissa Gekeler.
03/27/2019	Contact - Document Received Received a copy of Ms. Gekeler's report which I reviewed.
04/02/2019	Exit Conference by telephone with the Licensee, Shelia Shang.

ALLEGATION: Resident A wanted to cancel his ECT appointment on 01/31/2019, but the licensee would not let him use the telephone.

INVESTIGATION: On 02/06/2019, our Department received a complaint from network 180, Recipient Rights. The complaint indicated that the Office of Recipient Rights had received a verbal report from Witness 1 which had stated that Resident A had reported to Witness 1 that Ms. Shelia Shang, the Licensee, would not allow Resident A to use the telephone to cancel his ECT appointment on 01/31/2019.

On 02/06/2019, I spoke by telephone with Witness 1. Witness 1 stated that she had spoken with Resident A (no date provided) and Resident A told Witness 1 that Ms. Shang would not let him use the house telephone to cancel his ECT appointment scheduled on 01/31/2019.

On 02/11/2019, Ms. Gekeler and I conducted an interview with Ms. Shelia Shang, the licensee. She stated Resident A could use the telephone any time he wanted to and denied that she would not let him use the telephone. She stated that on 01/31/2019, the (Pine Rest staff) called Resident A to cancel his appointment for his ECT treatments because the weather was so bad and they rescheduled him for the following week. She said that Pine Rest staff calls Resident A each time to verify his appointment and his ride.

On 02/11/2019, Ms. Gekeler and I conducted an interview with Direct Care Staff, Jacqueline James. She denied that Ms. Shang had not let Resident A use the telephone. She reported that he does get to use the house telephone.

On 02/14/2019, Ms. Gekeler and I conducted an interview with Resident A in his bedroom at the AFC home. Resident A stated that he is allowed to use the home's **t**elephone, but Ms. Shang will question him about what he was going to use the telephone for and to whom he is calling.

On 02/14/2019, I asked Ms. Shang if she had questioned Resident A on why he wanted to use the house telephone if she had asked him who he was going to call. She denied that she had questioned Resident A about the use of the telephone as to why he wanted to use the telephone or to whom he was calling.

On 03/27/2019, I received and reviewed Ms. Gekeler's report. Her conclusions read that there was not sufficient evidence to indicate that Resident A was not allowed to use the telephone.

On 04/02/2019, I conducted a telephone exit conference with the Licensee Shelia Shang and she agreed with my findings.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes. (2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.
ANALYSIS:	Ms. Shang and Ms. James both denied that Resident A was not allowed to use the house telephone. Resident A acknowledged that he was allowed to use the house telephone, but Ms. Shang questioned him as to what he was make the call for and to whom was he calling. Ms. Shang denied that she had questioned Resident A for his use of the house telephone and who he was calling. Based on the investigation findings, there is insufficient evidence to indicate Ms. Shang did not allow Resident A to use the house telephone and that she did not allow Resident A privacy while using the telephone.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The licensee yells at Resident A and other residents.

INVESTIGATION: On 02/06/2019, our Department received a complaint from network 180, Recipient Rights. The complaint indicated that the Office of Recipient Rights had received a verbal report from Witness 1 which had stated that Resident A had reported that Ms. Shelia Shang, the licensee, regularly yells at Resident A and other residents.

On 02/06/2019, I spoke by telephone with Witness 1. Witness 1 stated that Resident A had told her that Ms. Shang "regularly" yells at him and other residents. No date of this conversation was provided.

On 02/11/2019, Ms. Gekeler and I conducted an interview with the licensee, Ms. Shang. Ms. Gekeler reported the allegation and asked Ms. Shang to respond. Ms. Shang said: "I don't yell. I talk loud. One of the residents has hearing difficulties and hearing aids so I have to use a loud, forceful voice so he can hear me. I have to be loud to tell the residents on the second floor to come down for dinner. I try not to do that, yell, because I don't want to be yelled at." She denied that she had yelled at Resident A or any other residents.

On 02/11/2019, Ms. Gekeler and I conducted an interview with Direct Care Staff, Jacqueline James. She denied that Ms. Shang had yelled at Resident A or any resident.

On 02/11/2019, Ms. Gekeler and I conducted an interview with Resident B. Ms. Gekeler asked him if Ms. Shang had yelled at him. Resident B said; "Ms. Shang is very strict and if I hesitate to do something, she has asked me to do, at the last minute, she yells at me what she wants me to do." He said that he has heard her yell at other residents.

On 02/14/2019, Ms. Gekeler and I conducted an interview with Resident A and I asked him if Ms. Shang had yelled at him or other residents. Resident A said; "She (Ms. Shang) yells at all of us." He said that she has yelled at him.

On 03/27/2019, I received and reviewed Ms. Gekeler's report. Her reported read that she contacted Resident A's legal guardian by telephone on 02/15/2019. The guardian reported that Resident A has reported to her that Ms. Shang is 'mean' and "she yells a lot." Ms. Gekeler's report also read that she had telephoned Resident A's Case Manager who said, "(Resident A) said Shelia wasn't nice and she yells a lot." Ms. Gekeler's report read that there was sufficient evidence to conclude that Ms. Shelia Shang yelled at Resident A.

Upon the interview with Ms. Shang, she informed us that several residents had recently moved from the home. The one female resident in the home only speaks Spanish and we would need an interrupter to conduct an interview with her. The other resident is at Hope Network every day during the day and he has severe hearing loss and wears hearing aids. Ms. Shank reported that she has to talk very loudly for him to hear her. I was at the home twice and this resident was not at home either of the times when I was there.

On 04/02/2019, I conducted a telephone exit conference with the Licensee, Shelia Shang. Ms. Shang acknowledged that her voice is loud and that she does yell upstairs for residents who live on the second floor to come to a meal. Ms. Shang denied yelling at residents in any other way.

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: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.**
ANALYSIS:	Ms. Shang denied yelling at Resident A or any other resident but acknowledged that her voice was loud. Ms. James denied that Ms. Shang had yelled at Resident A or any other resident. Resident A and Resident B both stated that Ms. Shang had yelled at both of them. Based on the investigative findings, there is sufficient evidence to support the rule violation that Ms. Shang, has yelled at Resident A and Resident B which is verbal abuse.

CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: During a cold spell there was not heat in the home and the licensee gave Resident A, a space heater for his bedroom.

INVESTIGATION: On 02/06/2019, our Department received a complaint from network 180, Recipient Rights. The complaint indicated that the Office of Recipient Rights had received a verbal report from Witness 1 which had stated that Resident A had reported to that during cold weather last week there was no heat in the home and Sheila Shang gave Resident A, a space heater for his bedroom. The call was received by Recipient Rights, from Witness 1 was on 02/04/2019.

On 02/06/2019, I telephoned Witness 1 and she reported that Resident A had told her that the home was without heat last week and the Home Owner, Shelia Shang gave him a space heater for his bedroom.

On 02/11/2019, Ms. Gekeler and I conducted an interview with Ms. Shang at the AFC home. When Ms. Gekeler explained the allegation Ms. Shang immediately responded by saying; “We did have heat. The furnace was not blowing like it should. It would come on and then turn off. It blew about five minutes. When I woke in the morning I thought it was chilly. Through the night I noticed my room was cold and the guy’s room was chilly. The upstairs was totally warm. It felt like it was 65 degrees. I keep the house at 72 to 73 degrees. The thermostat stayed at 70 degrees. I called the maintenance man and he suggested I change the furnace filter. I did that but it did not help. I noticed that the thermostat was staying on the same number, so I went out and bought a new one, but it did not fit correctly. I had to go buy another thermostat and that one fit. I know it was more cold, at the front of the house and (Resident A’s) bedroom. His room was really cold.” Ms. Shang showed us the furnace and the filter. There was a filter in the trash can. She reported that after she changed the furnace filter it still was not feeling warm. She said she called her son and he brought over a space heater. She said that she put the space heater in Resident A’s bedroom; “just in there for this room to warm up overnight.” She said that they turned the stove on in the kitchen to keep the house warm and then she left to buy a new thermostat. Ms. Shang was unable to provide the exact dates for this event but narrowed it down between 01/28/2019 and 02/01/2019. Ms. Shang took us to Resident A’s bedroom to show us the space heater. It was a small black space heater and it was covered with dust. Ms. Shang stated that since she put the new thermostat in, she has not used the space heater in Resident A’s bedroom.

On 02/11/2019 Ms. Gekeler and I conducted an interview with Ms. James, the Direct Care Staff. She stated that the home was not as warm. She confirmed that she turned the stove on for heat for a few hours while Ms. Shang went to get a new thermostat.

On 02/14/2019, Ms. Gekeler and I conducted an interview with Resident A. Resident A stated; “Sheila put a heater in my room. The room got warm and then it turned off. It was very cold in here. I don’t remember how long it was in here. A few days maybe. It wasn’t her fault that the heat went out.”

On 04/02/2019, I conducted a telephone exit conference with the Licensee, Shelia Shang and she stated that she fixed the thermostat right away and it was not her

fault that the furnace did not work correctly. Ms. Shang stated she does not agree that any licensing rules were violated and stated she didn't know what else she could have done to warm the home other than use an electric space heater. I provided alternative suggestions to Ms. Shang as a part of this discussion.

APPLICABLE RULE	
R 400.14406	**Room temperature.**
	All resident-occupied rooms of a home shall be heated at a temperature range between 68 and 72 degrees Fahrenheit during non-sleeping hours. Precautions shall be taken to prevent prolonged resident exposure to stale, noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations from the requirements of this rule shall be based upon a resident's health care appraisal and shall be addressed in the resident's written assessment plan. The resident care agreement shall address the resident's preferences for variations from the temperatures and requirements specified in this rule.
ANALYSIS:	The Licensee, Ms. Sheila Shang acknowledged that the furnace in the home was not heating the home properly and she thought it was 65 degrees in the home. Based on the investigative findings, there is sufficient evidence to support the rule violation that the temperature was below the required 68 to 72 degrees Fahrenheit in the AFC home for a period of time.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14510	**Heating equipment generally.**
	(5) Portable heating units shall not be permitted.
ANALYSIS:	Resident A stated that Ms. Shang had used a space heater to heat his cold bedroom. Ms. Shang showed me the space heater in Resident A's bedroom and acknowledged she used this appliance to heat his bedroom when the furnace was not producing the required heat.

	Based on the investigative findings, there is sufficient evidence to support the rule violation that the licensee, Ms. Shang used a portable space heater to heat Resident A's bedroom.
CONCLUSION:	**VIOLATION ESTABLIHSED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 02/11/2018, Ms. Gekeler and I were in the AFC home. I observed Direct Care Staff, Ms. James, starting to prepare lunch. I asked what she was fixing for lunch and she said it depended on what was in the freezer and she found some chicken nuggets. She served Resident B the chicken nuggets, chips and Capri Sun to drink. I looked in the kitchen and on the bulletin board for the menus and I did not see any, so I asked to see them. Ms. Shang acknowledged that she did not have menus. She reported that she did not know she had to have menus. I explained that menus were required and that the are to be posted a week in advance. She stated that she liked to use menus from other places because they would provide her more ideas on what to serve.

On 02/14/2019, I was in the AFC home and Ms. Shang provided me with a sheet that she reported was her menu. Printed on the sheet was the following: "The Ferguson Café Menu. Hours of Operation. Food Service provided by Hospitality Food Service, a learning environment of Goodwill Industries." Hand written in was "Feb 2019." The days of the week were recorded, Monday through Sunday with the food items recorded for each meal, breakfast, lunch and dinner. Under Breakfast the typed food items had been blotted out and hand written in new food items. The same was completed for lunch. I explained that if she served other foods that were not on the menu, she would have to complete a substitute list. She produced a Substitute Menu dated Feb 2019 and written on 02/11/2019 was "Lasagna, green beans." Written on the line for 02/12/2019, was the following: "Leftovers 2/11/19."

On 04/02/2019, I conducted a telephone exit conference with the Licensee, Shelia Shang and she said she had a menu that she showed me. Ms. Shang stated that she felt the menu she had was sufficient and did not agree with my findings.

APPLICABLE RULE	
R400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any changes or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	The home did not have the required menus posted a week in advance.

	Ms. Shang acknowledged that she did not know she had to have menus prepared and that they were to be posted a week in advanced. Based on the investigative findings, there is sufficient evidence to support the rule violation that the Licensee, Ms. Shang did not have written menus and therefore could not be posted a week in advance.
CONCLUSION:	**VIOLATION ESTABLIHSED**

INVESTIGATION: On 02/14/2019, Ms. Gekeler and I were in the AFC home to conduct an interview of Resident A. During the interview with Resident A he stated that he is on a "Gluten Free Diet." He said: "I'm allergic to gluten. I lost some weight from not having access to snacks. Sheila put a stop to me walking to the party store a few weeks ago. I can use the Go Bus to go to any store. For breakfast I have Chex cereal and fruit cocktail or juice. I'm at Sheldon House for lunch. Shelia called me a liar and said I was eating my lunch for breakfast. She offers to give me a lunch to take with me, but I told her I don't want it. I rode the exercise bike for 11 miles today. For dinner we have casseroles and that sort of stuff. She's offered me popcorn and cookies for snacks."

On 02/14/2019, Ms. Gekeler and I interviewed Ms. Shang. She said; "(Resident A) is on a gluten free diet. We don't have a special menu. I just buy what he can eat like tuna, baked beans, and Chex cereal. Visiting Physicians said he lost 17 pounds. I give him more than the rest of the residents because he can't have bread. His insurance won't pay for Ensure or Boost. His guardian said she was going to work on it. I make his lunch every night. He's been refusing to eat. He doesn't take it with him. I buy a lot of fruit, popcorn, fruit snacks, and pudding." She said he lost weight because he exercises so much.

On 02/14/2019, we reviewed Resident A's Health Care Appraisal dated 08/11/2018. One of the diagnosis recorded was Celiac Disease but the form did not have a special diet ordered.

On 02/14/2019, I reviewed Resident A's Person-Centered Plan of Care dated 11/01/2018. This plan stated: "(Resident A) has Celiac Disease which requires him to follow a strict gluten-free diet. AFC will provide a gluten-free diet daily and monitor his compliance."

On 04/02/2019, I conducted a telephone interview with Licensee, Sheila Shang. Ms. Shang stated that because there was not a special diet written on Resident A's Health Care Appraisal, she does not believe one was required and does not agree that a licensing rule was violated. I explained that it was documented in Resident A's PCP that she would provide the special diet. She did not agree with my findings.

APPLICABLE RULE	
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: (b) Special diets.
ANALYSIS:	Resident A's Person-Centered Plan stated he has Celiac Disease which requires him to follow a strict gluten-free diet. AFC will provide a gluten-free daily and monitor his compliance. Ms. Shang acknowledged that Resident A was on a gluten free diet. She acknowledged she did not have a special menu for this diet. Based on the investigative findings, there is sufficient evidence to support the rule violation that the Licensee, Ms. Shang did not follow the instructions in Resident A's Person-Centered Plan that the AFC will provide a strict gluten free diet, daily and monitor his compliance.
CONCLUSION:	**VIOLATION ESTABLIHSED**

INVESTIGATION: On 02/06/2019, our Department received a complaint from network 180, Recipient Rights.

On 02/14/2019, Ms. Gekeler and I conducted an interview with Resident A. He stated; "I'm getting out of here. I was given a 30-day notice. She said that it was a bad fit. She's selling her business. She's burned out. Shelia accused me of calling you people; filing a complaint. I just want out of here. I just don't want anything to do with her. I don't want any more commotion."

On 02/14/2019, Ms. Gekeler and I conducted an interview with Ms. Shelia Shang. She confirmed that she gave Resident A, a 30-day notice of discharge because she believed he filed the recipient rights complaint against her. Ms. Shang stated; "I gave him a 30-day notice because he put these allegations on me. I believe he called in the compliant." She also stated that Resident A was not getting along with a "respite" resident. I asked how often the respite resident was in her home and she said not very often and only for a few weekends. She said that Resident A complained to her that the respite resident got into his belongings.

On 03/27/2019, I received and reviewed Ms. Gekeler's report. Her report read that she interviewed Resident A's legal guardian by telephone on 02/15/2019. Her report read; "Sheila faxed over a 30-day notice on Monday 02/11/2019. I called her on Tuesday to ask about it. She said she gave (Resident A) a 30-day notice because

someone called recipient rights. (Resident A) had some concerns. He's not excited about being there. He said she's 'mean' and yells a lot.'"

On 04/02/2019 I conducted a telephone exit conference with the Licensee, Shelia Shang. She maintained her position that Resident A along with his Case Manager had made the complaint to Recipient Rights concerning her. Ms. Shank did not deny that the discharge notice to Resident A was issued in retaliation for making the complaint. She did not agree with my findings.

APPLICABLE RULE	
R400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the designated representative, and provide to the resident or the designated representative, a copy of all of the following resident rights: (f) The right to voice grievances and present recommendations pertaining to the policies, services, and house rules of the home without fear of retaliation. (2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.
ANALYSIS:	Based on the investigative findings, there is sufficient evidence to support the rule violation that the Licensee, Ms. Shang issued a 30-day discharge notice to Resident A at least in part because she believed that Resident A made a compliant about her to Recipient Rights. She failed to safeguard Resident A's rights.
CONCLUSION:	**VIOLATION ESTABLIHSED**

IV. RECOMMENDATION

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

Arlene B. Smith 04/03/2019

Arlene B. Smith Date
Licensing Consultant

Approved By:

Jerry Hendrick 04/03/2019

Jerry Hendrick Date
Area Manager