GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 22, 2022

Paula Ott
Central State Community Services, Inc.
Suite 201
2603 W Wackerly Rd
Midland, MI 48640

RE: License #: AS250010882
Investigation #: 2022A0871017
Herrington House

Dear Ms. Ott:

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 (989) 732-8062.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250010882
Investigation #:	2022A0871017
Complaint Receipt Date:	12/29/2021
Investigation Initiation Date:	12/29/2021
Report Due Date:	02/27/2022
Licensee Name:	Central State Community Services, Inc.
Licensee Address:	Suite 201 2603 W Wackerly Rd Midland, MI 48640
Licensee Telephone #:	(989) 631-6691
Administrator:	Jamilla Cheatom
Licensee Designee:	Paula Ott
Name of Facility:	Herrington House
Facility Address:	12168 Lake Road Montrose, MI 48457
Facility Telephone #:	(810) 639-3388
Original Issuance Date:	08/14/1989
License **Status:**	REGULAR
Effective Date:	05/24/2020
Expiration Date:	05/23/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Sharnisha Green hit another vehicle while driving the facility van on 12/22/2021 at 10:44 am. There was one resident passenger in the van, and he was seemingly uninjured.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/29/2021	Special Investigation Intake 2022A0871017
12/29/2021	Special Investigation Initiated - Telephone Telephone call to Recipient Rights Officer Pat Shepherd
02/01/2022	Contact - Document Received Received a copy of the Montrose Township Police Report
02/11/2022	Inspection Completed On-site Interviewed Home Manager Shantell Player
02/15/2022	Contact - Document Received Received information from Recipient Rights Officer Pat Shepherd
02/15/2022	Contact - Telephone call made Telephone call to Staff Sharnisha Green, telephone number no longer in service
02/17/2022	Exit Conference Telephone exit conference with Licensee Paula Ott
02/17/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Staff Sharnisha Green hit another vehicle while driving the facility van on 12/22/2021 at 10:44 am. There was one resident passenger in the van, and he was seemingly uninjured.

INVESTIGATION:

On December 29, 2021, I telephoned Recipient Rights Officer Pat Shepherd. Ms. Shepherd indicated she will be opening a complaint as the accident occurred @ 10:44 am and the car Staff Sharnisha Green hit was right in front of her. Ms. Shepherd said Ms. Green "was either going too fast or just not paying attention."

On January 11, 2022, I conducted an onsite investigation and interviewed Home Manager Shantell Player. Manager Player indicated that Resident A was not injured but it is corporate policy that Resident A went to the hospital for any possible injuries. Manager Player said she believes the van was totaled and it was not drivable. Manager Player stated Ms. Green was not ticketed.

On January 11, 2022, I observed Resident A. He appeared healthy and well taken care of. Resident A is severely cognitively impaired and unable to be interviewed.

On February 1, 2022, Recipient Rights Officer Pat Shepherd forwarded me a copy of the police report that was written by Officer Eric Hundshamer. Officer Hundshamer indicated the time of the crash on 12/23/2021 was 10:45 am. Officer Hundshamer's narrative indicates "Unit #1 (Ms. Green's van) was traveling eastbound on W. Vienna Rd. at N. Morrish Rd. and was unable to stop within assured, clear distance and struck Unit #2. Unit #2 was traveling eastbound on W. Vienna Rd. and turning left. Unit #2 was attempted to travel northbound on N. Morrish Rd. Unit #1 driver stated she didn't know what happened and thought she was following a black vehicle. Unit #1 driver stated she wasn't texting while driving or doing anything else in the vehicle to distract her driving. Unit #1 vehicle driver and rear passenger were transported to Hurley by MMR to be evaluated per their company policy. Unit #1 driver was stating her wrist was hurting. Unit #1 was towed by M-57 Towing to the same. Unit #2 driver stated she recently broke her back, but she wasn't complaining of any pain. Unit #2 driver refused further treatment by MMR Ambulance, but later advised when the scene was almost cleared that she was going to get checked out at the after-hour clinic due to some tightness in her stomach. Unit #2 was towed by M-57 to the same."

On February 15, 2022, I telephoned the phone number for Staff Sharnisha Green that was given to me by Manager Player. When I telephoned the number, the message indicated the number was no longer in service.

On February 15, 2022, I conducted an onsite investigation and Manager Player advised me that Ms. Green is no longer employed and her last day of work was 01/11/2022. Ms. Player did not have a different phone number for Ms. Green.

On February 15, 2022, I emailed Recipient Rights Officer Pat Shepherd. Ms. Shepherd indicated she did speak with Ms. Green and was told "the same thing that was in the police narrative." Ms. Shepherd indicated Ms. Green was not given a ticket, but Officer Hundshamer indicated on his report "Unable to Stop in Assured Clear Distance." Ms. Shepherd said, "there are no extenuating circumstances or explanation for the accident." She also indicated she substantiated Neglect Class 3 – failing to stop and hitting another vehicle placing Resident A at risk of physical harm.

On February 16, 2022, I telephoned Resident A's Guardian A1. Guardian A1 said she has no concerns about the care Resident A receives and "he likes it there and is happy."

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Even though there are no extenuating circumstances that caused this accident, Staff Sharnisha Green put Resident A at risk of

	physical harm causing a car crash. Officer Eric Hundshamer reported that Ms. Green was "Unable to Stop in Assured Clear Distance." I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On February 1, 2022, Recipient Rights Officer Pat Shepherd emailed me a copy of the *AFC Licensing Division – Incident/Accident Report* that was written regarding the car accident. What happened indicates "Staff and resident was in a car accident. Client and staff are both in stable condition." Action taken says "Staff made sure [Resident A] was okay and then called manager." Corrective measures indicate "follow driving '? illegible." This report was written on 12/23/2021 and was not signed by the Licensee nor Administrator. I also looked on SharePoint for the incident report and it was not there.

On February 16, 2022, I told Guardian A1 that I was conducting an investigation regarding the car accident that Resident A was in. Guardian A1 said "I never heard of a car crash" and was totally unaware that Resident A was involved and taken to the hospital. Guardian A1 said she will be visiting this weekend and inquire about the accident.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**

ANALYSIS:	Guardian A1 was unaware that Resident A was in a car accident and transported to the hospital. On February 17, 2022, I looked for the *AFC Licensing Division – Incident/Accident Report* in the file and there are no incident reports in the file. Licensee Paula Ott did not sign and date the incident report nor was one provided to the Licensing Division. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On February 17, 2022, I conducted a telephone exit conference with Licensee Paula Ott. I advised Licensee Ott there were two rule violations cited in this complaint.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care small group home remain unchanged (capacity 1-6).

02/17/2022

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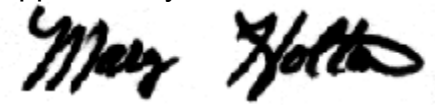
Kathryn A. Huber Date
Licensing Consultant

Approved By:



02/22/2022

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Mary E Holton Date
Area Manager