GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 29, 2022

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

RE: License #: AS370011272
Investigation #: 2022A0783057
Shepherd Home

Dear Mr. Carmichael:

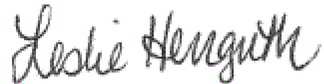
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9730.

Sincerely,



Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370011272
Investigation #:	2022A0783057
Complaint Receipt Date:	08/08/2022
Investigation Initiation Date:	08/08/2022
Report Due Date:	10/07/2022
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	Amy Spanne
Licensee Designee:	Timothy Carmichael
Name of Facility:	Shepherd Home
Facility Address:	416 N Fifth St Shepherd, MI 48883
Facility Telephone #:	(989) 828-6537
Original Issuance Date:	03/04/1986
License Status:	REGULAR
Effective Date:	03/17/2021
Expiration Date:	03/16/2023
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was not supervised according to his written plan when both staff members working went outside and Resident A drank a staff member's water.	No
Resident B was yelled at by direct care staff member Michelle Forist.	Yes

III. METHODOLOGY

08/08/2022	Special Investigation Intake - 2022A0783057
08/08/2022	Special Investigation Initiated - Telephone call with Complainant
08/08/2022	Contact - Telephone call made to Resident B
08/08/2022	Contact - Telephone call made to direct care staff member Alex Piotrowski
08/08/2022	Contact - Telephone call made to direct care staff members Vickie Davidson and Brittany Patterson
09/20/2022	Inspection Completed On-site
09/20/2022	Contact - Document Received - Resident A's resident record and *Progress Notes* for 8/6/22
09/20/2022	Contact - Face to Face interview with home manager Vickie Davis and observation of Resident A
09/28/2022	Contact - Telephone call made to direct care staff member Michelle Forist
09/28/2022	Exit Conference - Left messages for Amy Spaney and Timothy Carmichael

ALLEGATION:

Resident A was not supervised according to his written plan when both staff members working went outside and Resident A drank a staff member's water.

INVESTIGATION:

On August 8, 2022, I received a complaint via centralized intake that stated staff member Alex Piotrowski and staff member Michelle Forist were the only two staff members working at the facility when they went outside to look at Mr. Piotrowski's car. The written complaint stated while the two staff members were outside Resident A took Ms. Forist's water and drank it. The written complaint stated Resident A has a history of eating and drinking large amounts of food and water and nonfood items which has caused Resident A to choke. The written complaint stated Resident B alerted the staff members when they came inside that Resident A drank Ms. Forist's water.

On August 8, 2022, I spoke to Complainant who said Resident A is at risk for choking and should always be monitored by a staff member while in the kitchen. Complainant said she was not aware of Resident A's supervision needs outside the kitchen but both staff members working were outside the facility on August 6, 2022, at the time Resident A took and drank Ms. Forist's water.

On September 20, 2022 Bridget Vermeesch, Adult Foster Care Licensing Consultant completed an unannounced onsite investigation where she observed the facility having a half door at the entrance of the kitchen that was locked with a code pad, received the following information pertaining to Resident A: copies of his *Health Care Appraisal*, *Assessment Plan for AFC Residents*, his *Personal Centered Plan*, and an *AFC Licensing Division-Incident/Accident Report* (IR) from August 6, 2022 incident. Ms. Vermeesch interviewed home manager and direct care staff member Vickie Davidson who reported Resident A does not have any fluid restrictions, but Resident A does have a history of overdrinking in one setting and making himself vomit. Ms. Davis reported Resident A is diabetic so often is thirsty due to his diabetes. Ms. Davis reported the facility does not track Resident A's fluid intake. Ms. Davis reported she was not working on August 6, 2022, the day in which Resident A drank from direct care staff member Michelle Forist's water bottle. Ms. Davis reported a written incident report was probably completed to document Resident A drinking after another person from the same water bottle in case of illness occurring. Ms. Davis reported the kitchen is locked due to many of the residents having eating disorders in which their food intake needs to be monitored.

During the onsite investigation, Ms. Vermeesch observed Resident A eating lunch which included a sandwich, salad, fruit, and glass of water. Ms. Vermeesch attempted to interview Resident A but was unsuccessful due to Resident A's cognitive disabilities.

During Ms. Vermeesch's onsite investigation Ms. Vermeesch reviewed the staff progress notes in their computer system for August 6, 2022, which were completed by direct care staff member Michelle Forist who documented "after snack, [Resident A] came out of his room to use the bathroom when he got staff's water bottle and took a drink. Staff wrote an IR."

On August 8, 2022, I spoke to Resident B who said on August 6, 2022, he came out of his bedroom and noted that both staff members working who were Alex Piotrowski and Michelle Forist were outside in the front yard. Resident B said he next noted Resident A go to Ms. Forist's water bottle located in the living room and Resident A drank from the bottle. Resident B said Resident A is not supposed to drink others' water, so he walked out the front door and told Mr. Piotrowski and Ms. Forist that Resident A drank Ms. Forist's water from her water bottle left in the living area. Resident B stated at that time both staff members reentered the home and Ms. Forist appeared upset.

On September 28, 2022, I spoke to direct care staff member Michelle Forist who said on August 6, 2022 at approximately 8:00 pm direct care staff member Alex Piotrowski told her he hit a deer with his car and she did not believe him so she went outside where he followed her and the two looked at Mr. Piotrowski's car for approximately 30 seconds before Resident B came outside and told her Resident A took a drink from the water bottle she left in the living room. Ms. Forist said she typically leaves her water in the locked kitchen where Resident A does not have access but that day, she "forgot" and left her water bottle in the living room. Ms. Forist stated Resident A does not have any fluid restrictions nor is the fluid Resident A intakes tracked in any way. Ms. Forist said Resident A only requires enhanced (arm's reach) supervision when he is in the kitchen but not in the rest of the home. Ms. Forist said when she stepped outside to look at Mr. Piotrowski's vehicle, Resident A was in his bedroom.

On August 8, 2022, I spoke to direct care staff member Alex Piotrowski who said at approximately 8:00 pm on August 6, 2022, he was working with direct care staff member Michelle Forist when he told Ms. Forist he hit a deer with his car the night before and she and Resident C walked outside to look at his car and he followed, leaving the remaining residents inside alone. Mr. Piotrowski said after the two staff members and Resident C were outside for approximately two minutes, Resident B came outside and said that Resident A drank Ms. Forist's water. Mr. Piotrowski said he then "bolted" indoors and redirected Resident A away from Ms. Forist's water bottle. Mr. Piotrowski said Resident A is supposed to be visually monitored while he is in the kitchen, but Ms. Forist's water bottle was left in the living room when Resident A drank from the water bottle. Mr. Piotrowski denied that Resident A has any fluid restrictions and said that Resident A's fluid intake is not tracked in any way. Mr. Piotrowski denied that Resident A appeared to suffer any negative consequences from the water he drank from Ms. Forist's water bottle.

On August 8, 2022, I spoke to direct care staff member and home manager Vickie Davidson who said she was not working on August 6, 2022, when Resident A drank from Ms. Forist's water bottle in the living room. Ms. Davidson said Resident A requires line – of – sight supervision in the kitchen but not throughout the rest of the home. Ms. Davidson said her understanding was that on August 6, 2022, Resident A drank from staff member Michelle Forist's water bottle which was left in the living room when Ms. Forist briefly went outside. Ms. Davidson was not aware of any other instances where Ms. Forist allowed Resident A to access her water. Ms. Davidson denied that Resident A has any fluid restrictions, nor that he choked nor had any other negative outcomes from drinking from Ms. Forist's water bottle.

On August 8, 2022, I spoke to direct care staff member Brittany Patterson who stated she was not working on August 6, 2022, when Resident A gained access to Ms. Forist's water bottle and drank from it. Ms. Patterson said Resident A requires line-of-sight supervision in the kitchen to monitor him for choking but that he does not require line of sight supervision throughout the rest of the facility. Ms. Patterson denied that Resident A has any specific fluid restrictions nor that she was aware of any specific negative outcomes from Resident A gaining access to and drinking from Ms. Forist's water bottle.

On September 20, 2022, I received and reviewed a written incident report dated August 6, 2022, concerning Resident A, and completed by direct care staff member Michelle Forist. The written report stated, "I left my water unattended and [Resident A] got it and took a drink." In the "action taken by staff" section of the written incident report Ms. Forist wrote, "Moved the water." In the "corrective measures" section of the written report Ms. Forist wrote, "Remember to keep drinks in office area or kitchen with door locked to prevent this from happening again."

On September 20, 2022, I received and reviewed Resident A's current written *Health Care Appraisal* dated December 21, 2021. The only dietary restrictions or recommendations noted was an 1,800-calorie diabetic diet.

On September 20, 2022, I received and reviewed Resident A's current written *Assessment Plan for AFC Residents* dated March 1, 2022. The assessment plan indicated staff members should monitor Resident A during meals and should provide a diabetic diet low in cholesterol, carbohydrates, and sugar. There were no fluid restrictions nor instructions related to fluid on Resident A's written assessment plan.

On September 20, 2022, I received and reviewed Resident A's written *Person Centered Plan* (PCP) dated December 10, 2021. The written PCP indicated that Resident A needs a diabetic diet consisting of whole grains, vegetables, fruits, nonfat dairy, lean meats, poultry, fish and beans. The PCP indicated Resident A should not be restricted from sugar, starches, nor carbohydrates but encouraged to make healthy choices. The PCP specifically stated that Resident A should not be denied any foods nor beverages and that drinking water can help regulate Resident A's blood sugar. The PCP documented that Resident A can become obsessive

about food and/or drinks and will “steal” food and drinks from others. The PCP indicated a half door with a lock was installed to prevent Resident A from going into the kitchen unattended and that Resident A should receive “arm’s reach supervision” when he is in the kitchen. The PCP did not indicate that there were any fluid restrictions as part of Resident A’s special diet and did not indicate that Resident A required additional supervision except for when in the kitchen.

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:	Based on statements from Complainant, Ms. Davidson, Ms. Forist, Mr. Piotrowski, Ms. Davidson, Ms. Patterson, written documentation at the facility and Ms. Vermeesch’s observations at the onsite inspection I determined that unless in the kitchen Resident A requires baseline supervision (staff members being aware of his general whereabouts). The investigation revealed Resident A was in the living room when he briefly gained access to Ms. Forist’s water. Based on the investigation completed Resident A has no fluid restrictions nor instructions provided by any of his healthcare providers that indicated Resident A cannot consume water. The investigation did not indicate a negative outcome from Resident A drinking Ms. Forist’s water and an appropriate corrective measure was implemented to ensure staff members keep their beverages away from Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B was yelled at by direct care staff member Michelle Forist.

INVESTIGATION:

On August 8, 2022, I received a complaint via centralized intake that stated Resident B made a comment to direct care staff member Michelle Forist that she "messed up," which caused her to become upset and she said, "I can't lose my job. I might as well go home and slit my throat." The written complaint stated Ms. Forist asked Resident B, "How can you call yourself a Christian?"

On August 8, 2022, I spoke to Complainant who said Resident B told her that staff member Michelle Forist screamed at him on August 6, 2022 and made him feel very uncomfortable.

On August 8, 2022, I spoke to Resident B who said after he alerted Ms. Forist that Resident A drank her water she became upset and said, “I’m going to get fired,” and asked Resident B, “how can you call yourself a Christian?” Resident B denied Ms. Forist said anything about harming herself. Resident B said Ms. Forist raised her voice at him and made him feel uncomfortable.

On August 8, 2022, I spoke to direct care staff member Alex Piotrowski who said on August 6, 2022, direct care staff member Michelle Forist left her personal water bottle in the living room area and then went outside and left Resident A with access to the water bottle. Mr. Piotrowski said when Resident B expressed to Ms. Forist she allowed Resident A to get her water bottle Ms. Forist became angry with Resident B and “started [verbally] laying into” Resident B. Mr. Piotrowski said Ms. Forist asked Resident B how he could call himself a Christian and treat her this way and that Ms. Forist was “yelling” at Resident B. Mr. Piotrowski said Ms. Forist yelled at Resident B for “30 -45” minutes while Mr. Piotrowski continuously asked her to stop. Mr. Piotrowski said Resident B eventually went into his bedroom while Ms. Forist continued to yell. Mr. Piotrowski said Ms. Forist stated she was going to lose her job and “might as well slit her throat” while she was in the living room where Residents B and C could hear her.

On September 28, 2022, I spoke to direct care staff member Michelle Forist who said on August 6, 2022, she was working with direct care staff member Alex Piotrowski when Resident B “began cussing” at Ms. Forist because she left her water bottle in the living room and Resident A drank from the bottle. Ms. Forist said Resident B kept saying, “You f’ed up, you f’ed up.” Ms. Forist said she attempted to verbally deescalate Resident B because he “was causing a scene,” but Resident B was angry with her and “trying to turn [Ms. Forist] in” to the office of recipient rights or facility management. Ms. Forist said she was “not being mean” to Resident B but “just trying to get [Resident B] to talk to [Ms. Forist.]” Ms. Forist said she was speaking to Resident B in an “irritated tone” and that she was likely “snappy,” because he was ignoring her, but she denied she yelled at Resident B. Ms. Forist said her co-worker Mr. Piotrowski was “egging on” Resident B by telling her she should stop talking to Resident B and that she was going to get in trouble. Ms. Forist denied she asked Resident B how he could call himself a Christian but acknowledged she told him as Christians, they should forgive one another. Ms. Forist acknowledged making statements about being fired and losing her job in front of Resident B but could not recall if she made any comments about harming herself. I noted that during the interview Ms. Forist spoke to me in an aggressive tone and seemed very agitated about answering my questions.

On August 8, 2022, I spoke to direct care staff members Vickie Davidson and Brittany Patterson and each stated they worked with direct care staff member

Michelle Forist in the past but both denied that they worked with her regularly. Both staff members denied that they ever heard her yell at a resident nor threaten to harm herself in front of a resident.

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: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on a statement from Ms. Forist she acknowledged she was persistent with trying to get Resident A to talk to her even though he was not responding, she spoke to him in an "irritated" and "snappy" tone, and that her co-worker Mr. Piotrowski continuously tried to redirect her from interacting with Resident B at that time. Mr. Piotrowski said that Ms. Forist "yelled" at Resident B and Resident B confirmed it. Finally, Ms. Forist's reaction to me asking questions weeks after the incident was aggressive and angry and consistent with what witnesses reported seeing on August 6, 2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in the status of the license.

Leslie Herrguth 09/28/2022

Leslie Herrguth — Date
Licensing Consultant

Approved By:

Dawn Timm 09/29/2022

Dawn N. Timm — Date
Area Manager