GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 1, 2022

Robert and Laura Hopkins
P O Box 728
Evart, MI 496310728

RE: License #: AS670012822
Investigation #: 2023A0360001
Hopkins Whispering Pines

Dear Robert and Laura Hopkins:

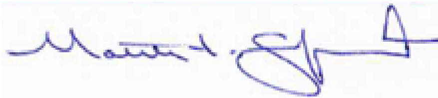
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (866) 865-0006.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS670012822
Investigation #:	2023A0360001
Complaint Receipt Date:	10/11/2022
Investigation Initiation Date:	10/11/2022
Report Due Date:	11/10/2022
Licensee Name:	Robert and Laura Hopkins
Licensee Address:	1375 Chaput Sears, MI 49679
Licensee Telephone #:	(231) 734-5936
Administrator:	Laura Hopkins
Licensee Designee:	N/A
Name of Facility:	Hopkins Whispering Pines
Facility Address:	7401 65th Avenue Evart, MI 49631
Facility Telephone #:	(231) 734-3628
Original Issuance Date:	10/14/1985
License Status:	REGULAR
Effective Date:	07/19/2022
Expiration Date:	07/18/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff Kim Wilson told Resident A to "drop dead".	Yes
Direct care staff Kayzie Wilson refuses to help Resident A, B and C with their personal needs.	No

III. METHODOLOGY

10/11/2022	Special Investigation Intake 2023A0360001
10/11/2022	Special Investigation Initiated - Letter APS complaint
10/11/2022	APS Referral online complaint
10/12/2022	Inspection Completed On-site DCS Kim Wilson
10/12/2022	Contact - Telephone call made Katie Hohner, Recipient Rights CMHCM
10/13/2022	Inspection Completed On-site Home manager Sally Hopkins, DCS Kim Wilson, Resident's A, B, C.
10/31/2022	Contact - Telephone call made Guardian 1-A
10/31/2022	Contact - Telephone call made Guardian 1-B
10/31/2022	Contact - Telephone call made Guardian 1-C
11/01/2022	Exit Conference With licensee Laura Hopkins

ALLEGATION: Direct care staff Kim Wilson told Resident A to "drop dead."

INVESTIGATION: On 10/11/2022 I was assigned a complaint from the LARA online complaint system.

On 10/11/2022 I completed an adult protective services complaint referral.
On 10/12/2022 I conducted an unannounced onsite inspection at the facility. Direct care staff Kim Wilson stated Resident A was sleeping and Resident B was on an outing. She stated she was contacted by the recipient rights officer Katie Hohner who scheduled interviews with staff and residents for tomorrow morning. I informed her I would return the next day to conduct interviews with recipient rights.

On 10/12/2022 I contacted Katie Hohner from Community Mental Health of Central Michigan Office of Recipient Rights. Ms. Hohner confirmed she will be at the facility tomorrow to conduct interviews of residents and staff.

On 10/13/2022 I conducted an onsite inspection at the facility. Rights officer Katie Hohner and I interviewed the home manager Sally Hopkins. Ms. Hopkins stated about a week ago on 10/5/2022 or 10/06/2022 another direct care staff Scott Hopkins reported to her that he had overheard direct care staff Kim Wilson tell Resident A to "drop dead" and then slammed his door shut. She stated Resident A had been "pushing her buttons." She stated Resident A can be very demanding and rude to staff. She stated she talked with Ms. Wilson about the incident, and she admitted she lost her cool and told him to drop dead.

While at the facility on 10/13/2022 I interviewed Resident A. Resident A stated he has had the cops called on him for arguing with the staff and other residents. He stated that direct care staff Kim Wilson did tell him to "go ahead and die" but that she is a good staff, and they typically get along very well. He stated she helps him with all of his needs, and she must've gotten frustrated when she said that and slammed his door. I then interviewed Resident B. Resident B stated Ms. Wilson treats her very well and she is not aware of any yelling at residents. I then attempted an interview with Resident C however she is non-verbal and was unable to be interviewed.

While at the facility on 10/13/2022 I interviewed direct care staff Kim Wilson. Ms. Wilson stated she did get frustrated with Resident A about a week ago and said something inappropriate to him. She stated she could not remember exactly what she said, but it was basically something along the lines of "I'm sick of him and hope he suffocates." She stated she does not remember telling him that she hopes he "drops dead." She stated she was working with Scott Hopkins that evening. She stated she feels bad about losing her temper and has apologized.

On 10/13/2022 I contacted direct care staff Scott Hopkins. Mr. Hopkins stated he has not heard Ms. Wilson say anything about her wanting Resident A to die. He stated Resident A will argue with her a lot. I then contacted direct care staff Kayzie Wilson. Ms. Wilson stated she has heard Kim Wilson yell at Resident A and say she wishes he would "keel over and die." She stated Resident A does not get along with her so Kim Wilson provides most of Resident A's care while she is in the home. I then contacted direct care staff Barb Lepord. Ms. Lepord stated that Kim Wilson sometimes looses her temper when Resident A starts arguing and yelling at staff.

On 10/31/2022 I contacted Guardian 1-A. Guardian 1-A stated Resident A can be very challenging and has had the police called on him because of threats and yelling at other residents and staff. She stated he has thrown urine at the staff when they try to help him change his catheter. She stated the staff have a lot of patience to be able to meet Resident A's needs.

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:	The complaint alleged direct care staff Kim Wilson told Resident A to "drop dead." Home manager Sally Hopkins stated Ms. Wilson admitted she told Resident A to drop dead after getting frustrated with Resident A. Resident A stated Ms. Wilson told him to "go ahead and die" but that she is a good staff, and they typically get along well. Ms. Wilson stated she did get frustrated and told Resident A something along the lines that she is sick of him and hopes he suffocates. She stated she knew it was not right to say and she has apologized to him. Guardian 1-A stated Resident A can be very challenging to work with. She stated the police have been called to the home numerous times because of Resident A hitting or yelling at other residents and staff. She stated she gives the staff a lot of credit for having patience with him. There is a preponderance of evidence that Resident A was not treated with dignity.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff Kayzie Wilson refuses to help Resident A, B and C with their personal needs.

INVESTIGATION: On 10/11/2022 I completed an adult protective services complaint.

On 10/12/2022 I conducted an unannounced onsite inspection at the facility. Direct care staff Kim Wilson stated Resident A was sleeping and Resident B was on an outing. She stated she was contacted by the recipient rights officer Katie Hohner who scheduled interviews with staff and residents for tomorrow morning. I informed her I would return the next day to conduct interviews with recipient rights.

On 10/12/2022 I contacted Katie Hohner from Community Mental Health of Central Michigan Office of Recipient Rights. Ms. Hohner confirmed she will be at the facility tomorrow to conduct interviews of residents and staff.

On 10/13/2022 I conducted an onsite inspection at the facility. Rights officer Katie Hohner and I interviewed the home manager Sally Hopkins. Ms. Hopkins stated direct care staff Kayzie Wilson has reported numerous times that Resident A has made sexually inappropriate comments to her and looks at her inappropriately. She stated while Ms. Wilson is working, she will provide most of the personal care for Resident B and C and have the other staff that is working provide the personal care for Resident A. Ms. Hopkins stated there is always two staff working and no residents ever go without getting their personal care needs met.

While at the facility on 10/13/2022 I interviewed Resident A. Resident A stated Kayzie Wilson does not help him with his personal care needs. He stated Sally Hopkins or Kim Wilson help him with his personal care. He denied that he ever goes without his personal care needs being met. He stated Kayzie Wilson never works at the home alone.

While at the facility on 10/13/2022 I interviewed direct care staff Kim Wilson. Ms. Wilson stated Resident A does not allow Kayzie Wilson to help him. She stated Ms. Wilson provides all the personal care for Residents B and C while she is working. She stated several months ago Ms. Wilson had to call the police on Resident A because he assaulted her. She denied that any of the residents do not receive the personal care they need.

On 10/13/2022 I contacted direct care staff Kayzie Wilson. Ms. Wilson stated Resident A has a problem with her, so she typically has the other staff on duty provide the personal care for Resident A. She stated Resident A has attacked her in the past and she has had to contact the police. She stated she provides the personal care for Resident B and C while she is working.

On 10/31/2022 I contacted Guardian 1-A. Guardian 1-A stated Resident A can be very challenging and has had the police called on him because of threats and yelling at other residents and staff. She stated he has thrown urine at the staff when they try to help him change his catheter. She stated the staff have a lot of patience to be able to meet Resident A's needs. She stated she has no concerns that his personal care needs are not being met in the home.

On 10/31/2022 I contacted Guardian 1-B. Guardian 1-B stated she has no concerns with the home. She stated she is regularly in the home during the day and the personal care needs of the residents are met. She stated staff have been “wonderful” with Resident B.

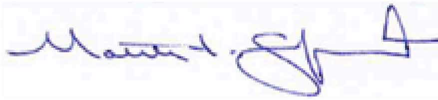
On 10/31/2022 I contacted Guardian 1-C. Guardian 1-C stated the staff take very good care of Resident C and he had no concerns.

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:	The complaint alleged direct care staff Kayzie Wilson refuses to help Resident A, B and C with personal care. Resident A has a history of assaulting and throwing urine on direct care staff. Ms. Wilson provided personal care to Residents B and C while she is working. There are always two direct care staff on duty and the other direct care staff provide the personal care for Resident A while Ms. Wilson is working. Residents A, B and C all reported their personal care needs are met by staff. Guardian 1-A, 1-B and 1-C reported no concerns regarding the personal care needs of residents being met. There is not a preponderance of evidence that the personal needs of Residents A, B and C are not being met.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 11/01/2022 I conducted an exit conference with the licensee Laura Hopkins. Ms. Hopkins concurred with the findings and agreed to submit a corrective action plan for approval.

IV. RECOMMENDATION

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



11/01/2022

Matthew Soderquist Date
Licensing Consultant

Approved By:

11/01/2022

Jerry Hendrick Date
Area Manager