GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 9, 2025

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

RE: License #: AS370011272
Investigation #: 2025A0622037
Shepherd Home

Dear Mr. Boyd:

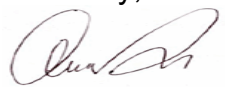
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 335-5985.

Sincerely,



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

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

I. IDENTIFYING INFORMATION

License #:	AS370011272
Investigation #:	2025A0622037
Complaint Receipt Date:	04/23/2025
Investigation Initiation Date:	04/23/2025
Report Due Date:	06/22/2025
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	James Boyd
Licensee Designee:	James Boyd
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:	03/17/2025
Expiration Date:	03/16/2027
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care worker Lisa Peterson told Resident A he was not allowed to wear his underwear outside of his bedroom and that it was disgusting.	No
Direct care workers are smoking near the AFC home and around residents.	Yes
Direct care workers are not following Resident B's diabetic diet.	Yes

III. METHODOLOGY

04/23/2025	Special Investigation Intake 2025A0622037
04/23/2025	Special Investigation Initiated – Email contact with Recipient rights officer, Sarah Watson.
05/09/2025	Inspection completed onsite
05/12/2025	Contact- Phone call to DCW Vicki Davidson and Resident A.
05/21/2025	Contact- Phone call to DCW Lisa Peterson and Maisy Urbano Camon
05/22/2025	Contact- documents requested regarding Resident B.
05/27/2025	Contact- phone call to DCW Kelly Halstead and Heather Roderick
06/02/2025	Contact- document received.
05/12/2025	Exit Conference with licensee designee, Jim Boyd.

ALLEGATION: Direct care worker, Lisa Peterson told Resident A he was not allowed to wear his underwear outside of his bedroom and that it was disgusting.

INVESTIGATION:
On 04/23/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint on 04/18/2025, an anonymous person reported a concern on behalf of Resident A. The complaint stated that on the night of 04/11/2025, Resident A came out of his bedroom to use the bathroom wearing only his underwear. According to the

complaint, in response to Resident A having only underwear on, it was reported that Lisa Peterson, Direct Support Professional (DSP) told Resident A he was not allowed to wear only his underwear out of his bedroom and Ms. Peterson told Resident A, "It's disgusting."

On 04/23/2025, I interviewed Recipient Rights Officer, Sarah Watson via email and gathered staff phone numbers and additional information regarding the allegations.

On 05/09/2025, I completed an unannounced onsite investigation to Shepard Home. During the unannounced onsite investigation, I interviewed direct care workers and viewed Resident A's bedroom. Resident A was not home during the unannounced onsite investigation.

Resident A's bedroom was viewed and is directly across from the bathroom. I attempted to interview Resident B, who has a bedroom next to Resident A. Resident B was unable to answer any of my questions due to his limited ability to communicate. I interviewed direct care worker, Heather Roderick in person. She reported that she has not worked with DCW Peterson very much and has not observed her state any negative comments to residents.

On 05/12/2025, I interviewed direct care worker, Vicki Davidson via phone. She reported that she has only observed direct care worker, Lisa Peterson during training and she has never observed any concerns. DCW Davidson reported that she has observed Resident A go up and talk to DCW Peterson and also open the door for her when she arrives. DCW Davidson stated that Resident A's bedroom is right across from the bathroom, and he normally gets up in the middle of the night and goes to the bathroom in his underwear.

On 05/12/2025, I interviewed Resident A via phone. He reported that he has lived at the home for 11 years. Resident A stated that he does not have any problems with DCW Peterson. Resident A could not recall if DCW Peterson told him not to wear his underwear out of his bedroom, nor if she said it was disgusting. Resident A reported that he walks back and forth from his bedroom to the bathroom in his underwear, as it's his house. Resident A stated that DCW Peterson has never said anything mean or disrespectful to him.

On 05/21/2025, I interviewed direct care worker, Maisy Urbano Camon via phone. She stated that she was working with DCW Peterson during this incident. DCW Camon reported that around 9 or 10pm, Resident A came out of his bedroom in his underwear, and she heard DCW Peterson ask Resident A why he didn't have clothes on and then she continued to say "it's disgusting, we don't want to see that." DCW Camon explained that DCW Peterson went on and on about how gross it was. DCW Camon reported that she told DCW Peterson that it's his home and we just need to look away.

On 05/21/2025, I interviewed direct care worker, Lisa Peterson via phone. She reported that she no longer works at Shepard Home, and she quit on 5/18/25 due to another co-worker. DCW Peterson stated that she had asked Resident A where his pants were, and he ignored her. DCW Peterson denied telling Resident A that it was disgusting to where only his underwear. DCW Peterson reported that seeing Resident A in his underwear just caught her off guard.

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 interviews with Resident A and direct care workers, no evidence was found that Resident A was being treated with disrespect. DCW Lisa Peterson denied saying disrespectful statements to Resident A and Resident A could not recall DCW Peterson saying anything disrespectful to him.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care workers are smoking near the AFC home and around residents.

INVESTIGATION:
On 05/22/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint staff members are smoking around residents and close to the AFC home.

On 05/21/2025, during my phone interview with DCW Maisy Urbano Camon she reported that she has observed direct care worker, Kelly Halstead smoke right next to the residents and near the home. DCW Camon reported that none of the resident’s smoke in the home.

On 05/21/2025, during my phone interview with DCW Lisa Peterson she reported that she observed direct care worker, Kelly Halstead smoking right outside the back door next to Resident B. DCW Peterson was able to take a picture and provide this

documentation to me. According to the picture received, DCW Kelly Halstead was observed to be sitting on the step right outside of the back door with a cigarette in her mouth. A resident was observed in the picture to be sitting in a chair outside within 10 feet from DCW Halstead. DCW Peterson reported that she has tried to explain to DCW Halstead that she can't smoke there, but she is not acceptive of feedback.

On 05/22/2025, I interviewed direct care worker, Thor Pittman and he reported that he has only worked one shift with DCW Kelly Halstead. He stated that he has heard about her smoking near residents but has not observed it. DCW Pittman stated that it's his understanding that if someone smokes, they need to smoke father away from the back deck.

On 5/27/2025, I interviewed direct care worker, Heather Roderick via phone. She reported that she has not worked with DCW Kelly Halstead, but today when all staff were present for a Recipient Rights meeting, she observed DCW Halstead smoking outside. DCW Roderick reported that a resident was outside pacing and talking to himself and DCW Halstead when outside to the yard and started smoking with the resident near her. DCW Roderick reported that she observed DCW Vicki Davidson ask the resident to go to the front of the home, so he would not be near DCW Halstead while she was smoking. DCW Roderick reported that she does not smoke, and she believes that the policy states that staff need to be fifty feet from residents and the home to smoke.

On 05/29/2025, I interviewed DCW Kelly Halstead via phone. She reported that she has worked at Shepard Home for about a month. She stated that she believes the policy states that she must be fifty feet from the house and away from residents to smoke. DCW Halstead reported that she takes a smoke break every hour to two hours. DCW Halstead stated that none of the resident's smoke. DCW Halstead denied smoking near residents or near the home.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	Based upon my interviews with direct care workers, Heather Roderick, Maisy Urbano Camon and Lisa Peterson all three reported that they have observed DCW Kelly Halstead smoking near residents. Picture documentation was also received, confirming that DCW Kelly Halstead is not adequately providing for the health and safety of residents of the home by smoking within less than 25 feet of the home and residents. Based on the information above the home was not constructed adequately for the health safety, and well-being of the residents and therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care workers are not following Resident B's diabetic diet.

INVESTIGATION:
On 05/22/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint staff are not following Resident B's diabetic diet. The complaint stated that Resident B is getting into staff's drinks that are left unattended.

On 05/21/2025, during my phone interview with DCW Maisy Urbano Camon she reported that she has observed direct care worker, Kelly Halstead giving Resident B juice and candy. DCW Camon stated DCW Halstead brings in candy and shares with Resident B and gives him regular juice at mealtimes. DCW Camon reported Resident B receives a special sugar free dessert, but she observed DCW Halstead give Resident B the sugar filled dessert at a mealtime. DCW Camon stated that she was able to scrap off the wrong dessert and replace it with the sugar free dessert before Resident B ate it. DCW Camon stated that DCW Kelly Halstead brings pop with her to work and leaves it unattended often. DCW Camon explained that Resident B will run towards any unattended drink and drink it as fast as possible. She stated that they are supposed to have their drink right next to them or leave them in the office. DCW Camon explained that she has tried reminding DCW Halstead about her drinks, but it continues to happen. DCW Camon reported that she started writing up incident reports after each occurrence, as it was causing Resident B's sugar to spike and was happening more frequently. DCW Camon reported that she heard that if his sugar does not go down, new medication will be needed.

On 05/21/2025, I interviewed direct care worker, Lisa Peterson via phone. DCW Peterson reported that she has observed DCW Kelly Halstead state that she does not understand why Resident B has his own bread and does not take redirection well

when it comes to following Resident B's diabetic diet. DCW Peterson stated that she heard that if his sugar does not level out, Resident B will need more medication.

On 05/22/2025, I received documentation for Resident B. Resident B's *Assessment Plan for AFC Residents* was reviewed.

Special Diet: Low cholesterol, carbs, sugar, diabetic diet, sugar free, caffeine soda.

Eating/feeding: staff to monitor for diet compliance and to remind him to not to put too much food in his mouth. See mealtime protocol.

On 05/22/2025, I requested *AFC Licensing Division- Incident/Accident Reports* for May and April for Resident B. According to the incident reports, I viewed four incident reports regarding staff leaving their soda unattended and Resident B being able to grab the soda and drink it. Two of the incidents occurred on 5/11/2025, one at 5:23pm and another one at 5:35pm. The other two incidents of Resident B grabbing a staff members soda occurred on 4/17/2025 and 4/30/2025.

On 05/22/2025, I viewed documentation of Resident B's glucometer tests. According to the test, his sugar is checked each morning before breakfast. Resident B's tests average between 100-130 for his morning test. For the four incidents that occurred where, Resident B grabbed a staff members soda, his blood sugar was checked afterwards and recorded. The following numbers were documented:

4/4/25: 182
4/17/25: 174
4/30/25:193
4/11/25: 244 and 261

On 05/22/2025, I interviewed Thor Pittman via phone. He reported that he has not worked with DCW Kelly Halstead very often, but he has observed her to leave pop laying around the home. DCW Pittman reported that he always has his drink next to his side or he leaves it in the office. DCW Pittman stated that Resident B has never grabbed his drink as he tries to be very aware. DCW Pittman reported that he has not observed DCW Halstead to not follow Resident B's diabetic diet, but he has noticed a few times when Resident B's blood sugar will be higher in the morning, or his sugar free dessert will be untouched in the fridge.

On 05/27/2025, I interviewed direct care worker, Heather Roderick via phone. She stated that she does not work with DCW Halstead very often, but she has noticed that Resident B's sugar levels have been higher over the last month, and she feels that it's due to new staff not following his diabetic diet. She stated that she is not sure if staff are measuring his food or its from Resident B getting into staff drinks. DCW Roderick reported that staff are supposed to keep their sugar drinks in the office, or hide it in the microwave, as Resident B will go for any drink or even take it right out of your hand. DCW Roderick reported that she has worked at Shepard Home for the last five years and Resident B's sugar has been mostly stable for the

last year. DCW Roderick reported that she was told that the doctor stated that his sugar needs to be under control, otherwise he will need additional medication.

On 05/27/2025, I interviewed direct care worker, Kelly Halstead via phone. She reported that she has worked at Shepard Home for one month and previously worked at another AFC in the past. DCW Halstead stated that she mainly works second shift. DCW Halstead was able to describe that Resident B was a diabetic and needs low sugar and low carbohydrate foods. She reported that she has not given him any candy that she brought into the house, nor given him any food that he was not supposed to have. DCW Halstead reported that she has only given Resident B water or milk and does not recall giving him juice. DCW Halstead reported that Resident B has grabbed her soda at least three times and she usually brings in a Styrofoam cup with Coke Zero. DCW Halstead stated that she is now keeping her drinks in the office. DCW Halstead reported that Resident B is grabbing staff members drinks almost daily and it's not just her drinks. DCW Halstead described the process of having to encourage Resident B to drink water afterwards or exercise and then checking his blood sugar an hour after he has grabbed a staff members drink. DCW Halstead reported that he blood sugar will usually be in the 200 afterwards. DCW Halstead stated that most of Resident B's desserts are premade ahead of time and on second shift an evening snack is already scheduled and labeled. DCW Halstead explained that staff are assigned certain residents, and she has been assigned to care for Resident B over the last month.

On 06/02/2025, I requested to view the menu for Shepard Home. The menu was reviewed and no concerns regarding a diabetic diet were noted.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	Based on documentation received through *AFC Licensing Division- Incident/Accident Reports, Resident B's* glucometer tests and interviews with direct care workers it was determined that direct care workers are not following Resident B's diabetic diet. All direct care workers interviewed were able to confirm that Resident B will grab any drink left out, but direct care workers continued to leave sugar filled drinks unsupervised which cause Resident B's blood sugar to raise to over 200.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/06/2025

Amanda Blasius Date
Licensing Consultant

Approved By:

06/09/2025

Dawn N. Timm Date
Area Manager