GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 20, 2021

Debra McCovery
Hope Network, S.E.
70 Lafayette
Pontiac, MI 48342

RE: License #: AM250281878
Investigation #: 2021A0779007
New Hope Behavioral Services I

Dear Ms. McCovery:

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 (810) 787-7031.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250281878
Investigation #:	2021A0779007
Complaint Receipt Date:	12/02/2020
Investigation Initiation Date:	12/03/2020
Report Due Date:	01/31/2021
Licensee Name:	Hope Network, S.E.
Licensee Address:	70 Lafayette Pontiac, MI 48342
Licensee Telephone #:	(248) 338-7458
Administrator:	Will Paige
Licensee Designee:	Debra McCovery
Name of Facility:	New Hope Behavioral Services I
Facility Address:	Suite A 1110 Eldon Baker Dr. Flint, MI 48507
Facility Telephone #:	(810) 742-3134
Original Issuance Date:	05/06/2006
License **Status:**	REGULAR
Effective Date:	09/25/2019
Expiration Date:	09/24/2021
Capacity:	8
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 11/20/20, Michele was admitted to the hospital for acute psychosis. There are concerns that Michele is not being cared for while in the home, due to her having an extreme foul odor, severe dry/dead skin on feet, dirty and matted hair, and very long toenails.	No
ADDITIONAL FINDINGS	Yes

III. METHODOLOGY

12/02/2020	Special Investigation Intake 2021A0779007
12/02/2020	APS Referral Complaint was referred by APS.
12/03/2020	Special Investigation Initiated - Telephone Spoke to APS worker.
12/03/2020	Contact - Telephone call made. Spoke to RN at McLaren Hospital.
12/03/2020	Contact - Telephone call made. Spoke to administrator, Will Paige.
12/14/2020	Inspection Completed On-site Interviews were conducted with Resident A, Resident A's case manager, facility nurse and 1 staff person.
01/12/2021	Contact - Telephone call made. Spoke to Resident A's legal guardian.
01/14/2021	Exit Conference Conducted with administrator, Will Paige.
01/19/2021	Contact - Telephone call made. Spoke to administrator, Will Paige.

ALLEGATION:

On 11/20/20, Michele was admitted to the hospital for acute psychosis. There are concerns that Michele is not being cared for while in the home, due to her having an extreme foul odor, severe dry/dead skin on feet, dirty and matted hair, and very long toenails.

INVESTIGATION:

On 12/3/20, a phone conversation took place with McLaren hospital RN, Monica Fearnley, who confirmed that Resident A was admitted to the hospital on 11/20/20. Ms. Fearnley stated that when Resident A arrived at the hospital, she smelled horrible, had matted and dirty hair, extremely dry skin on her feet and very long toenails, which were starting to curl under her toes. Ms. Fearnley reported that Resident A is quite psychotic and delusional. She stated that Resident A has been refusing to shower, eat or get up to use the bathroom, which led to her lying in bed and soiling herself. Ms. Fearnley stated that it took several days before Resident A would allow hospital staff to bath her.

On 12/3/20, a phone interview was conducted with administrator, Will Paige. Mr. Paige stated that Resident A has a long history of refusing to bath and/or do her hygiene, even though she is physically capable of doing so. Mr. Paige reported that Resident A came to this facility from the state psych hospital, where she spent time due to this reason.

On 12/14/20, an on-site inspection was conducted. Interviews took place with Resident A's case manager, facility nurse, and one staff person. An attempt was made to interview Resident A, but she refused to participate. Resident A was viewed to be clean and well groomed.

Resident A's case manager, Tiesha Presnall, stated that Resident A came to this facility after spending time at the state psych hospital in Caro, MI., where she was admitted due to her not wanting to walk, shower, eat or take her medication due to her suffering from paranoid schizophrenia. Ms. Presnall reported that when Resident A first arrived at this facility, she would not do anything hygiene wise. She stated that staff was having to physically wash Resident A, even though Resident A could physically do it herself. Ms. Presnall stated that Resident A has declined to the point where she will not allow staff to touch her and refuses to bath or do much if any hygiene on her own. She stated that up until recently, Resident A was completing her basic hygiene and washing herself up on her own, but staff recently started noticing that Resident A's body odor was returning. Ms. Presnall reported that staff ask, prompt and encourage Resident A to bath and complete basic hygiene activities, but Resident A has been refusing. She stated that they have been trying to work with Resident A's primary care physician (PCP) and psychiatrist to get them to direct admit Resident A into the hospital, but neither of them would do it, so the facility nurse finally petitioned the hospital herself.

The facility nurse, Cheryl Steve, confirmed that Resident A had been hospitalized in the past for not wanting to eat, drink, shower or take her medications. Ms. Steve stated that

Resident A had made some progress here and for quite a while was able to complete enough hygiene activities to appear adequately clean and stay odor free, but her body odor has recently returned and she started not changing her clothes. Ms. Steve reported that staff prompt and encourage Resident A multiple times daily, but Resident A will not bath herself and she refuses to allow staff to help her. Ms. Steve stated that they thought Resident A may need an adjustment to her medications and took Resident A to her PCP's office for bloodwork on 11/17/20, but Resident A refused to cooperate with giving blood or seeing the physician. Ms. Steve stated that she spoke to Resident A's psychiatrist on 11/17/20 and her PCP on 11/18/20 and that they both refused to direct admit Resident A into the hospital. She stated that they told her that there is no direct harm by Resident A refusing to do self-care and therefore, no reason to admit her into the hospital. Ms. Steve reported that on 11/20/20, she finally decided to write the petition herself to have Resident A placed on a psych hold. She reported that the hospital accepted the petition and that Resident A remained in the hospital until today, 12/15/20.

Staff person, Ashley Hollins, stated that staff have been trying hard to get Resident A to change her clothes and wash herself up, but that it has come to the point where Resident A has refused to do anything. Ms. Hollins stated that all the staff have tried several different techniques to get Resident A to help herself, but nothing was working and Resident A would not allow staff to touch her. She stated that all staff could get Resident A to do was wash her face, brush her teeth and take her medications. Ms. Hollins stated that staff cannot physically force Resident A to bath or complete hygiene activities. Ms. Hollins reported that when it got to the point where Resident A started having body odor and was refusing to change her clothes, the nurse, Ms. Steve, had Resident A admitted to the hospital.

Resident A's medication log and written assessment plan were reviewed. The medication logs indicate that Resident A was taking all her medications daily and as prescribed. Resident A's assessment plan stated that when stable, Resident A is able to complete all her activities of daily living (ADL's) on her own, with prompting from staff; however, during periods of increased psychiatric instability, Resident A requires assistance from staff. Resident A's assessment plan indicates that Resident A is able to communicate her needs and follow directions but chooses not to do so at times.

On 1/7/21, a phone conversation took place with Resident A's legal guardian, who confirmed that this is part of Resident A's psychosis not to bath or do her ADL's. Guardian stated that Resident A will do the bare minimum to avoid going back to the state psych hospital, where she was for quite some time due to this issue. Guardian reported that this facility has done well considering Resident A's difficult mental illness and that Resident A was doing better until only recently. She stated that the facility acted appropriately by having Resident A petitioned to the hospital for a psych hold. Guardian believes that this facility staff has a plan in place that they are frequently tweaking to try and get Resident A to bath. Guardian stated that she has no concerns regarding the care that Resident A is receiving at this facility.

On 1/14/21, an exit conference was conducted with administrator, Will Paige. Mr. Paige stated that Resident A seems to be doing better, since returning from the hospital.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathe at least weekly and more often if necessary.
ANALYSIS:	There was insufficient evidence found to prove that Resident A was being neglected at this facility. It is well documented that Resident A suffers from paranoid schizophrenia and that part of her psychosis is to refuse to bath. Staff were prompting and encouraging Resident A daily to bath and/or complete her ADL's, but Resident A was refusing to do so. When it got to the point where Resident A started to develop body odor and refused to change her clothing, facility staff reached out to Resident A's psychiatrist and PCP and received no help. On 11/20/20, facility nurse, Cheryl Steve, took it upon herself to petition to have Resident A admitted to the hospital on a psych hold. Resident A has returned to this facility on 12/15/20 and appears to be doing better.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 1/19/201, a phone conversation took place with administrator, Will Paige, who confirmed that the facility did not have available a copy of the Incident Report (IR), which documented the illness/reason behind Resident A having to be hospitalized. Mr. Paige stated that an IR was completed, but that the staff who completed it is no longer employed at this facility and may have taken it and/or not officially turned it in.

R 400.14311	**Investigation and reporting 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:	This licensee/facility staff did not have available a copy of the incident report (IR), which documented the illness/reason behind Resident A having to be hospitalized. As of 1/19/2021, the adult foster care licensing division had not received an IR regarding Resident A's hospitalization on 11/20/2020.
CONCLUSION:	**VIOLATION ESTABLISHED**

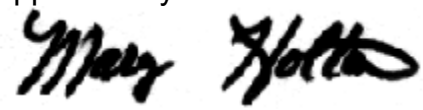
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, I recommend that the status of this facility's license remain unchanged.

1/20/2021

Christopher Holvey Date
Licensing Consultant

Approved By:



1/20/2021

Mary E Holton Date
Area Manager