GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2021

Marlene Burgess
70 Lafayette
Pontiac, MI 48342

RE: License #: AS820395610
Investigation #: 2021A0121014
Cambridge

Dear Ms. Burgess:

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 (313) 456-0380.

Sincerely,

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820395610
Investigation #:	2021A0121014
Complaint Receipt Date:	08/13/2021
Investigation Initiation Date:	08/13/2021
Report Due Date:	10/12/2021
Licensee Name:	Hope Network
Licensee Address:	70 Lafayette Pontiac, MI 48342
Licensee Telephone #:	(248) 505-1987
Administrator:	Marlene Burgess, Designee
Name of Facility:	Cambridge
Facility Address:	1648 Inkster Dearborn Heights, MI 48127
Facility Telephone #:	(248) 505-1987
Original Issuance Date:	05/02/2019
License **Status:**	REGULAR
Effective Date:	11/02/2019
Expiration Date:	11/01/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The power went out at the facility on 8/11. The residents do not have AC or lights. There is no food due to being thrown out from no power. The staff have been given no way to properly care for the residents.	Yes

III. METHODOLOGY

08/13/2021	Special Investigation Intake 2021A0121014
08/13/2021	Special Investigation Initiated - Telephone Call to licensee designee, Marlene Burgess. Ms. Burgess is off today. I received a return call from Deborah McCovery, Director of Crisis and Residential Treatment. Ms. McCovery put me in contact with Program Director, Donald King who is filling in for Ms. Burgess. Per Mr. King, the residents will be relocated to a hotel until the home's power is restored.
08/13/2021	APS Referral DENIED
08/17/2021	Contact - Telephone call made Call to Facility; spoke with Emerald, direct care worker (DCW)
08/18/2021	Contact - Telephone call made Call to licensee designee, Marlene Burgess
08/18/2021	Contact - Telephone call made Scheduled onsite with Home Manager, Layunies McClain
08/19/2021	Inspection Completed On-site Resident A and Home Manager, Layunies McClain
08/27/2021	Contact - Telephone call made Call to Nikiesha Scott, home manager at sister facility. Ms. Scott is filling in for Ms. McClain in her absence.
08/31/2021	Contact - Telephone call received Direct care worker, Elizabeth Hickman

09/02/2021	Contact - Telephone call made Follow up call to Layunies McClain
09/08/2021	Contact - Telephone call made Call to Sheila Wade, DCW
09/10/2021	Exit Conference Marlene Burgess, licensee designee
10/22/2021	ORR Referral made Kimberly Little, Recipient Rights Investigator – Intake Division

ALLEGATION: The power went out at the facility on 8/11. The residents do not have AC or lights. There is no food due to being thrown out from no power. The staff have been given no way to properly care for the residents.

INVESTIGATION: On 8/13/21, I spoke with 2 Directors with Hope Network in the licensee designee's absence. Reportedly, Ms. Burgess and McCain were away on vacation for a few days They are Donald King and Deborah McCovery. Mr. King and Ms. McCovery verified there was a power outage at the facility on 8/11/21 due to heavy rain and winds. It should be noted accuweather.com reported the high temperatures on 8/11/21 and 8/12/21 were 87 degrees Fahrenheit both days. Mr. King reported they had a hard time finding an available hotel to relocate the residents, but they were able to book one today.

On 8/17/21, I called the facility to see if the power had been restored. Direct care worker, Emerald Buley, informed me the power was restored on 8/16/21 at approximately 2:00 p.m. The residents have been returned home.

On 8/19/21, I conducted an onsite inspection at the facility to verify the home had working electricity and food. I interviewed Resident A. Resident A reported the home was without power, so the Staff and residents stayed at a local hotel. Home manager, Layunies McCain reported all the food in the main refrigerator had been replaced due to spoilage. I observed an adequate supply of food in the refrigerator and freezer. Ms. McCain also reported she was off work on vacation when the power went out. She did acknowledge Staff told her about the power outage while she was vacation, the day it happened. Ms. McCain said she directed direct care worker, Sheila Wade to contact home manager, Nikeisha Scott in her absence.

On 8/27/21, I interviewed Ms. Scott by phone. Ms. Scott indicated she was filling in for Ms. McCain while she was on vacation. Ms. Scott said she became aware the Cambridge home was without power on Thursday, August 12, 2021. She could not explain why she was not notified until 24 hours later.

On 8/31/21, I interviewed direct care worker, Elizabeth Hickman. Ms. Hickman reported she was on shift when the power went out. According to Ms. Hickman, direct care worker, Sheila Hickman was on the phone with the Ms. McCain when the power turned off. Per Ms. Hickman, Ms. McCain instructed them to wait to see if the power was restored before booking a hotel room. Ms. Hickman explained this is the main reason they waited at the home overnight. Ms. Hickman indicated she also received an update from the power company (DTE) that power would be restored in their area by 8/16/21. Ms. Hickman also reported she attempted to purchase battery operated fans and lanterns at their local Target store, but the store had sold out of these items. I asked Ms. Hickman to describe the resident activity on Day 2 of the power outage. She said they sent Resident C and D to day program, and she transported Resident A and B to her private residence to cool off. Ms. Hickman was able to secure a hotel in the upcoming days with the help of Bridget Murphy who "is a manager at another home" per Ms. McCain.

On 9/2/21, I interviewed the Ms. McCain for a second time. Ms. McCain denies giving the Staff directives while she was away on vacation. Ms. McCain said Ms. Hickman was adamant the power company promised to have their power restored

the next day, so she was comfortable with Ms. Hickman's plans to purchase food and supplies to keep the placement intact. However, Ms. McCain indicated she made it very clear to Staff that the residents were to be taken to a nearby hotel on Michigan Avenue should the power stay out.

On 9/8/21, I contacted direct care worker, Sheila Wade. Ms. Wade confirmed she was on the phone with Ms. McCain when she heard "the transformer go out." According to Ms. Wade, Ms. McCain instructed the Staff to "give it a minute." Ms. Wade said they were hopeful the power would be restored soon, so they remained at home. Ms. Wade also stated they had to use the flashlights on their cell phones to move throughout the home because it was completely dark. She does not remember when Ms. Scott was notified about the problem.

On 9/10/21, I completed an exit conference with licensee designee, Marlene Burgess. Ms. Burgess reported she had 3 people backing her up while she was on vacation, so there was "no reason why things turned out the way they did." Ms. Burgess said she simply believes the direct care workers on duty thought they could handle the emergency on their own. Ms. Burgess expressed gratitude the residents remained unharmed despite the inconvenience.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**

ANALYSIS:	• There was a power outage at the home on 8/11/21. The power was not restored until 8/16/21. • Licensee designee, Marlene Burgess and home manager Layunies McCain were not available, as they were both on vacation during this time. • The residents were not relocated to a hotel until 8/13/21 due to miscommunication between the Staff and Managers. • Direct care worker, Elizabeth Hickman placed Resident A and Resident B at potential risk of harm when she took them to her personal home. • Therefore, the worker(s) failed to demonstrate they can properly handle emergency situations, like this act of nature.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

10/22/21

Kara Robinson Date

Licensing Consultant

Approved By:

10/25/21

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Ardra Hunter Date
Area Manager