GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 14, 2021

Andrew Davenport
Hope Network West Michigan
PO Box 890
Grand Rapids, MI 49501-0141

RE: License #: AS410088304
Investigation #: 2022A0340007
Whitney Home

Dear Mr. Davenport:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On December 1, 2021, you submitted an acceptable written corrective action plan. It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

Rebecca Piccard

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410088304
Investigation #:	2022A0340007
Complaint Receipt Date:	11/10/2021
Investigation Initiation Date:	11/12/2021
Report Due Date:	01/09/2022
Licensee Name:	Hope Network West Michigan
Licensee Address:	PO Box 890, Grand Rapids, MI 49518
Licensee Telephone #:	(616) 430-9454
Administrator:	Andrew Davenport
Licensee Designee:	Andrew Davenport
Name of Facility:	Whitney Home
Facility Address:	7780 Cascade Road, SE, Grand Rapids, MI 49546
Facility Telephone #:	(616) 977-8659
Original Issuance Date:	11/05/1999
License Status:	REGULAR
Effective Date:	08/18/2020
Expiration Date:	08/17/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was touched inappropriately by Resident B.	Yes

III. METHODOLOGY

11/10/2021	Special Investigation Intake 2022A0340007
11/12/2021	APS Referral
11/12/2021	Special Investigation Initiated - Telephone Designee Andrew Davenport
11/12/2021	Contact - Document Received Supervisor Charles Mwangi-IR
11/30/2021	Contact - Telephone call received from Andrew Davenport
12/01/2021	Inspection Completed On-site
12/01/2021	Contact – Phone call made Designee Andrew Davenport
12/01/2021	Inspection Completed-BCAL Sub. Compliance
12/01/2021	Corrective Action Plan Requested and Due on 12/10/2021
12/01/2021	Corrective Action Plan Received
12/01/2021	Corrective Action Plan Approved
12/03/2021	Exit Conference Designee Andrew Davenport

ALLEGATION: Resident A was touched inappropriately by Resident B.

INVESTIGATION: On November 10, 2021, I received a complaint from the BCAL online complaints, from Adult Protective Services (APS) regarding an assault that occurred at the Whitney AFC Home on November 9, 2021, in which Resident A was touched on his genitals, over the clothes, by Resident B, who is a registered sex offender. Adult Protective Services (APS) rejected the complaint for investigation.

On November 10, 2021, I contacted Designee Andrew Davenport. He was aware of the incident. He informed me that a safety plan is now in place to keep Resident B away from Resident A. Staff must know where Resident B is at all times and conduct 5-minute checks. Law enforcement has been called as well as the guardian. I requested a copy of both residents' Assessment Plans and Health Care Appraisals.

On November 10, 2021, I received and reviewed the documents, also including an Incident Report (IR). Resident A's Health Care Appraisal was signed by Nurse Practitioner, Margaret Vanderwater on 10/19/21. Resident A has been diagnosed bi-polar, ODD, and with Moderate Intellectual Disabilities. His Assessment Plan was signed by Resident A and Home Supervisor Charles Mwangi on 4/14/21. Under "controls sexual behavior" it states, "he has a history of sexual inappropriateness, touches without permission." There is nothing noted in Resident A's Assessment Plan regarding additional supervision required.

Resident B's Health Care Appraisal was signed by Ariel Mejia, MD on 8/24/21. Resident B has a diagnosis of Expressive Language Disorder, ADHD, Mild Intellectual Disability. His Assessment Plan was signed by his guardian at the Servants Center as well as Hope staff Michelle Kirby on 4/22/21 and 4/15/21 respectively. Under "Controls Sexual Behaviors" it states "(Resident B) has a history of criminal sexual contact. It states he is monitored for interactions with peers and has required redirection for inappropriate interactions with peers and touching himself in public.

On November 30, 2021, I received a call from Mr. Davenport. He reported that Resident B was arrested for the incident on November 22, 2021 and has been in jail since this time. There was an arraignment hearing on November 29, 2021, and the Judge ordered no contact between Resident B and Resident A. We discussed an emergency discharge which I agreed was appropriate for this situation. It is unknown how long Resident B will be in jail, but he will not be allowed to return to his residence at the Whitney Home.

On December 1, 2021, I conducted an unannounced home inspection. I interviewed Resident A, who stated he was 40 years old and would be 41 in February, although he presented with the cognitive level of an adolescent. I asked Resident A to tell me what happened when Resident B was living at the home. He stated that Resident B harassed him and his "housemates" but Resident A felt "targeted" by Resident B. He said he was always staring at him and talking about him, saying he stinks, or he doesn't wear deodorant. Resident A stated he felt that Resident B was always trying to get his housemates to "talk about me behind my back" and Resident A did not like

any of that. Then he said one day while he was sitting on the couch in the common area, Resident B came up behind him and put his hand on his “private area” and, as Resident A demonstrated, grabbed and fondled his genitals. Resident A stated he “squeezed” his “privates six times”, saying to Resident A “I know you like this, I know it feels good”. Resident A stated that he yelled at Resident B and yelled for help from staff who were in the kitchen. Resident A stated he thinks at first staff must not have heard him because they did not respond right away. The kitchen is adjacent to the living room area of the home. Before staff came into the room, Resident B told Resident A that he “better not tell staff”, but Resident A said that he “will tell” and Resident B said to him “what do you think is gonna happen? You think I’ll get arrested?”.

On December 2, 22021, I interviewed staff Shayla Rigsbee. I asked her about the events regarding Resident A and B which had been documented in an IR sent to me. She stated she had gone downstairs to do “med passes”. When she came back upstairs Resident A asked to talk to her. He told her Resident B had been rubbing his groin and told Resident B to stop but he didn’t. Ms. Rigsbee talked to Resident B who told her they were just talking and he talks with his hands and must have “fallen” into his lap and when he realized where it was he removed his hand.

On December 2, 2021, I interviewed staff James Gunnoe. Mr. Gunnoe stated he has no memory of the events between Resident A and B. He did not know of the IR that had been filed which included his name. He stated he did not hear anything from Resident A when he was allegedly calling for help. Mr. Gunnoe was also not aware of Resident B’s Assessment Plan requiring him needing monitoring if he’s with other residents. Mr. Gunnoe stated that he knows that Resident A doesn’t like Resident B. He stated there had been previous interactions between the two residents which Resident A complained about Resident B.

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:	A complaint was filed regarding Resident A being sexually assaulted by Resident B. Resident A stated Resident B came up from behind him and grabbed and fondled his genitals six times while he yelled for Resident B to stop and for staff to help him. Resident B is a registered sex offender. His Assessment plan states he is to have “monitored interactions with peers”. This

	did not happen. Resident B assaulted Resident A and staff did not immediately respond when Resident A called out for help. Staff Rigsbee and Gunnoe did not witness the incident between Residents A and B. Mr. Davenport stated Resident B was arrested and during his arraignment hearing the Judge ordered no contact between Resident A and Resident B. An emergency discharge notice was sent to all appropriate parties on December 1, 2021. Resident B is still in jail. There is a preponderance of evidence that Resident B was not properly supervised and did perpetrate on Resident A leading Resident B to be arrested and charged and a no contact order being put in place by a Judge.
CONCLUSION:	**VIOLATION ESTABLISHED**

On December 3, 2021, I conducted an exit conference with Designee Andrew Davenport. We discussed the rule violation. He understood and sent a Corrective Action Plan. He had no further questions.

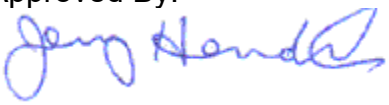
IV. RECOMMENDATION

After receiving an acceptable Corrective Action Plan, I recommend no change to the current license status.

December 14, 2021

Rebecca Piccard — Date
Licensing Consultant

Approved By:



December 14, 2021

Jerry Hendrick — Date
Area Manager