STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

January 20, 2022

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

RE: License #: AS410406105
Investigation #: 2022A0340011
Neo Rockford

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 January 14, 2022, 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 #:	AS410406105
Investigation #:	2022A0340011
Complaint Receipt Date:	12/09/2021
Investigation Initiation Date:	12/09/2021
Report Due Date:	02/07/2022
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:	Neo Rockford
Facility Address:	6986 Fox Meadow NE Rockford, MI 49341
Facility Telephone #:	(676) 874-6742
Original Issuance Date:	12/11/2020
License Status:	REGULAR
Effective Date:	06/11/2021
Expiration Date:	06/10/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Isabelle Blouwe yelled at Resident A.	Yes

III. METHODOLOGY

12/09/2021	Special Investigation Intake 2022A0340011
12/09/2021	Special Investigation Initiated - Telephone ORR Bob Patterson
12/09/2021	Contact - Face to Face Bob Patterson & Resident A
12/09/2021	Contact – Telephone call made Staff Isabelle Blouwe
01/14/2022	Exit Conference Designee Andrew Davenport

ALLEGATION: Staff Isabelle Blouwe yelled at Resident A.

INVESTIGATION: On December 9, 2021, I received a complaint from the Office of Recipient Rights (ORR) stating that on 12/6/21 Ms. Blouwe was being rude and yelling at Resident A because she did not want to take him to the hospital. She stated several times that "I might as well call my boyfriend and tell him I won't make at Resident A that she was "going to die because of this".

On December 9, 2021, I contacted Bob Patterson from the Office of Recipient Rights (ORR). Mr. Patterson has already interview two staff from Neo Rockford, Jessica Fast and Aubrey Young. Ms. Fast and Young reported to Mr. Patterson the information that was included in the complaint as they witnessed the behavior by their co-worker Ms. Blouwe.

Mr. Patterson and I coordinated to interview Resident A via Teams as ORR have not returned to in person visits.

On December 9, 2021, Mr. Patterson and I interviewed Resident A via Teams. Resident A was aware that a complaint had been filed on his behalf. Resident A told us that on 12/6/21 he had a bad cough and didn't feel good. Ms. Fast and Ms. Young were worried he had Covid so Ms. Blouwe took him to the hospital. Before they left, Resident A was getting into the van and Ms. Blouwe was in the doorway

between the garage and the kitchen yelling to Ms. Fast and Ms. Young that she was going to die if she had to drive in the bad weather. Resident A also stated that Ms. Blouwe was on the phone and also texting while driving. She was also “using a mad voice” saying that they were going to “die in this van” and she’s been in an accident before.

I asked Resident A if anyone spoke to him about this incident or told him what to say. He denied being talked to or coached about the allegations.

On December 9, 2021, Mr. Patterson and I interviewed home manager Gina Merchant. Ms. Merchant was not present in the home on the day of the incident. She did not witness any of the interactions. Ms. Merchant informed us that Resident A’s guardian/father does require that the only medical office they are allowed to take Resident A is to the hospital in Greenville, even though there is a med center right around the corner from the home. I advised Ms. Merchant to address that issue with the guardian as it jeopardized his safety and the safety of the staff on the night of the 6th.

On December 9, 2021, I interviewed staff Isabelle Blouwe. I asked her to tell me about the day of 12/6. She told me that Ms. Fast and Ms. Young had concerns Resident A might be Covid positive so told her she had to take Resident A to the hospital in Greenville. They were passing medications and cooking so they were unable to take him. Ms. Blouwe stated that the roads were really bad that day and she was scared and frustrated. She admitted that she may have “come off as frustrated” but denied “yelling” at Resident A. Ms. Blouwe also admitted that she did say “I’m gonna die” but she did not think Resident A could hear her since he had already gone into the garage. I asked Ms. Blouwe if she used her phone while driving to the hospital. She first stated that she did not use her phone, but then contradicted herself that she took a call from her boyfriend.

I asked Ms. Blouwe why she didn’t take Resident A to the med center that is very close to the home. She stated that Resident A’s father does not allow him to be taken anywhere other than the Greenville hospital. I suggested that in this case she could have called the guardian and taken him to the med center. We discussed the risk of harm taking him a long distance in this situation.

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 allegation was made that Ms. Blouwe yelled at Resident A.

	Staff Fast and Young both reported hearing Ms. Blouwe make inappropriate statements in front of Resident A about not wanting to take him to the hospital and that they were going to die. Resident A recounted Ms. Blouwe being angry that she had to take him to the hospital and told him that they were going die. He also heard her saying to co-workers that she was going to die. Resident A reported additionally that Ms. Blouwe was using the phone while driving. Ms. Blouwe admitted to making the inappropriate statements about dying in she had to take Resident A to the hospital but stated she did not make them in front of Resident A. She did not realize he could hear her. Ms. Blouwe admitted to using her phone while driving.
CONCLUSION:	**VIOLATION ESTABLISHED**

On January 14, 2022, I conducted an exit conference with Designee Andrew Davenport. We discussed the issues and alternative actions which could have occurred. We also discussed Ms. Blouwe's behavior which was inappropriate. Mr. Davenport informed me that ORR also substantiated Ms. Blouwe. I requested a Corrective Action Plan for the rule violation. Mr. Davenport agreed to send it.

IV. RECOMMENDATION

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

January 19, 2022

Rebecca Piccard — Date
Licensing Consultant

Approved By:

January 20, 2022

Jerry Hendrick — Date
Area Manager