GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 5, 2022

Kayonna Ferguson
Hope Network, S.E.
PO Box 190179
Burton, MI 48519

RE: License #: AS250395712
Investigation #: 2022A0779029
Hegel Home

Dear Ms. Ferguson:

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 (906) 226-4171.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250395712
Investigation #:	2022A0779029
Complaint Receipt Date:	03/31/2022
Investigation Initiation Date:	04/01/2022
Report Due Date:	05/30/2022
Licensee Name:	Hope Network, S.E.
Licensee Address:	PO Box 190179 Burton, MI 48519
Licensee Telephone #:	(586) 206-8869
Administrator:	Melanie Love
Licensee Designee:	Kayonna Ferguson
Name of Facility:	Hegel Home
Facility Address:	5440 South Morrish Road Swartz Creek, MI 48473
Facility Telephone #:	(810) 701-0404
Original Issuance Date:	07/31/2019
License **Status:**	REGULAR
Effective Date:	01/31/2022
Expiration Date:	01/30/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 3/28/22, Resident A had made a threat to drink some cleaner solution and staff Eula told him to go ahead and drink it.	No
Additional Findings	Yes

III. METHODOLOGY

03/31/2022	Special Investigation Intake 2022A0779029
03/31/2022	APS Referral Complaint was referred to AFC licensing by APS centralized intake.
04/01/2022	Special Investigation Initiated - Telephone Voicemail message left for recipient rights investigator, Pat Shepard.
04/05/2022	Contact - Telephone call made Spoke to recipient right investigator, Ms. Shepard.
04/05/2022	Inspection Completed On-site
04/07/2022	Contact - Telephone call made Interview conducted with administrator, Melanie Love.
04/07/2022	Contact - Telephone call made Interview conducted with Resident A.
04/13/2022	Contact - Telephone call made Interview conducted with staff person, Kathleen Nedson.
04/13/2022	Contact - Telephone call made Interview conducted with staff person, Eula Brown.
04/28/2022	Contact - Document Received Received ORR summary report.
05/04/2022	Contact - Telephone call made Interview conducted with administrator, Melanie Love.
05/04/2022	Exit Conference Conducted with administrator, Melanie Love.

ALLEGATION:

On 3/28/22, Resident A had made a threat to drink some cleaner solution and staff Eula told him to go ahead and drink it.

INVESTIGATION:

On 4/5/22, an on-site inspection was conducted and assistant manager, Alicia Joseph, was interviewed. Ms. Joseph stated that Resident A never said anything to her about this incident and he usually tells her everything. She stated that Resident A was having a bad day that day and had several acting out behaviors/episodes. Ms. Joseph reported that she is not aware of Resident A having a history of suicidal behavior. When asked about the storage of cleaning supplies, Ms. Joseph stated that there is a locked cabinet in the garage for all cleaning supplies and that those type of supplies are supposed to be put back as soon as staff are done using it.

During the on-site inspection, Resident A was not present, but several other residents were viewed to be clean and well groomed. They appeared to be receiving adequate care and supervision.

Resident A's assessment plan was reviewed. The plan indicates that Resident A is quite independent, can physically complete all his activities of daily living on his own, but does need prompts from staff in order to do so. It states that Resident A has issues with not being able to control his aggressive behaviors and requires prompts, encouragement, and redirection to follow directions. Resident A suffers from mild intellectual disability, PTSD and delusional disorder. There was no documentation in this plan to indicate that Resident A has any history of self-harm or suicidal attempts.

On 4/7/22, a phone interview was conducted with administrator, Melanie Love. She stated that Resident A never said anything to her about an incident of this nature taking place. Ms. Love reported that Resident A was having quite a bit of acting behaviors on 3/28/22. She stated that he was being verbally aggressive, making threats toward staff and other residents, and did some minor destruction of property. Ms. Love stated that there is nothing in Resident A's GHS plan about suicidal behavior or a need for increased supervision.

On 4/7/22, a phone interview was conducted with Resident A, who confirmed that he remembers 3/28/22 and admits that he did a lot of acting out that day. He stated that there was a bottle of bleach spray on the kitchen counter that he grabbed and threatened to drink it. Resident A reported that staff person, Eula, was standing right next to him. He stated that there was another staff working, but he could not remember where she was at the time. Resident A claims that Eula said, "Go ahead and do it, it's your choice if you want to die". Resident A stated that he did not drink it and sat it back down on the counter. He reported that no other residents were around and that they were all in their rooms because of his acting out behaviors.

On 4/13/22, a phone interview was conducted with staff person, Eula Brown, who denied that she told Resident A to drink the cleaning solution and stated that she would never do a thing like that. Ms. Brown stated that Resident A was acting out a lot that day and appeared to be doing things to seek attention. She stated that the more attention she gave him, the worse he got, so she was continuing to cook in the kitchen, while staying close to Resident A and keeping an eye on him. Ms. Brown stated that she had just got done using the cleaner to clean the kitchen before starting dinner. She reported that Resident A grabbed the cleaner bottle, held it up near his mouth and threatened to drink it. She claims that she repeatedly asked Resident A to put the bottle down on the counter and Resident A kept saying "No". Ms. Brown stated that Resident A eventually put the bottle down and left the room without drinking any of the solution. Ms. Brown reported that she had all the residents go to their room to be safe, so they were not there to witness the incident and that staff person, Kathleen Nedson, was in the laundry room at the time.

On 4/13/22, a phone interview was conducted with staff person, Kathleen Nedson. She confirmed that she worked with Ms. Brown on 3/28/22 and that Resident A was acting out on and off that day for several hours. She stated that she was in the laundry room at the time of this incident and that she did not see or hear anything related to Resident A threatening to drink cleaning solution. Ms. Nedson reported that she came out of the laundry room because she heard Resident A yelling and throwing things, but never observed him with a bottle of cleaning solution.

On 4/28/22, a copy of recipient rights investigator, Pat Shepard's, ORR summary report was received via e-mail. Ms. Shepard's report documented that she had completed her investigation into the same allegations and did not find a preponderance of evidence to substantiate that Resident A was neglected by staff.

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:	There was no evidence found to prove that Resident A was not provided adequate supervision and safety by staff person, Eula Brown. Resident A confirmed that he grabbed a bottle of beach spray and threatened to drink it but did not do it. Staff person, Ms. Brown, denies that she told Resident A to drink the cleaning solution. She stated that she stayed close to Resident A and repeatedly asked him to put the bottle on the counter, until Resident A actually did put it down without drinking any of it. There were no known witnesses to the incident. The other staff working that day, Kathleen Nedson, was in another room and all the other residents were in their rooms at the time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 4/7/22, a phone interview was conducted with Resident A, who confirmed that he remembers 3/28/22 and admits that he did a lot of acting out that day. He stated that there was a bottle of bleach spray on the kitchen counter that he grabbed and threatened to drink it.

On 4/13/22, a phone interview was conducted with staff person, Eula Brown, who denied that she told Resident A to drink the cleaning solution and stated that she would never do a thing like that. Ms. Brown stated that Resident A was acting out a lot that day and appeared to be doing things to seek attention. She stated that the more attention she gave him, the worse he got, so she was continuing to cook in the kitchen, while staying close to Resident A and keeping an eye on him. Ms. Brown stated that she had just got done using the cleaner to clean the kitchen before starting dinner. She reported that Resident A grabbed the cleaner bottle, held it up near his mouth and threatened to drink it. She claims that she repeatedly asked Resident A to put the bottle down on the counter and Resident A kept saying “No”. Ms. Brown stated that Resident A eventually put the bottle down and left the room without drinking any of the solution. Ms. Brown reported that she had all the residents go to their room to be safe, so they were not there to witness the incident and that staff person, Kathleen Nedson, was in the laundry room at the time.

On 5/4/22, a phone conversation took place with administrator, Ms. Love. She confirmed that staff are trained to utilize the locked cabinet in the garage for all cleaning supplies and that all cleaning supplies should be placed back in the cabinet as soon as they are no longer being used.

APPLICABLE RULE	
R 400.14401	**Environmental health**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.
ANALYSIS:	Although this home has an appropriate storage area for cleaning supplies, staff person, Eula Brown, failed to utilize it on 3/28/22. A bottle of cleaning solution was not properly safeguarded and was left out on the counter unsupervised, allowing Resident A to grab the bottle and threaten to drink it.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 5/4/22, a phone conversation took place with administrator, Ms. Love. She confirmed that staff failed to complete a written incident report, documenting the events on 3/28/22, involving Resident A grabbing a bottle of cleaning solution and threatening to drink it.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of 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: **(c) Incidents that involve any of the following:** **(iii) Attempts at self-inflicted harm or harm to others.**

ANALYSIS:	On 3/28/22, Resident A was able to obtain a bottle of cleaning solution and threatened to drink it. Licensee failed to ensure that a written incident report documenting these events was completed by staff. Resident A's threat and/or attempt at self-inflicted harm was not documented in written form or provided to Resident A's designated representative, responsible agency, or the adult foster care licensing division within the required 48 hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/4/22, an exit conference was conducted with administrator, Melanie Love. She was informed that a written corrective action plan is required to address the two licensing rule violations stated above.

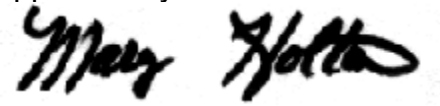
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the status of this license.

5/5/2022

Christopher Holvey Date
Licensing Consultant

Approved By:



5/5/2022

Mary E Holton Date
Area Manager