STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

August 10, 2022

Marlene Burgess
Hope Network, S.E.
PO Box 190179
Burton, MI 48519

RE: License #: AS820395553
Investigation #: 2022A0121028
Kingswood Home

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

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 #:	AS820395553
Investigation #:	2022A0121028
Complaint Receipt Date:	05/31/2022
Investigation Initiation Date:	06/02/2022
Report Due Date:	07/30/2022
Licensee Name:	Hope Network, S.E.
Licensee Address:	PO Box 190179 Burton, MI 48519
Licensee Telephone #:	(586) 206-8869
Administrator:	NiKeisha Scott
Licensee Designee:	Marlene Burgess
Name of Facility:	Kingswood Home
Facility Address:	659 Beech Daly Dearborn Heights, MI 48127
Facility Telephone #:	(313) 633-9662
Original Issuance Date:	07/02/2019
License **Status:**	REGULAR
Effective Date:	01/02/2022
Expiration Date:	01/01/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 5/25/22, a resident assaulted another resident in the home causing severe injury to the victim.	Yes

III. METHODOLOGY

05/31/2022	Special Investigation Intake 2022A0121028
06/02/2022	Special Investigation Initiated - Telephone Left message for Home Manager, Nikeisha Scott
06/03/2022	Contact - Telephone call made Call to Home Manager, NiKeisha
06/03/2022	Contact - Telephone call made Call to Marlene Burgess
06/07/2022	Contact - Telephone call received Ms. Burgess called to confirm onsite for tomorrow
06/08/2022	Inspection Completed On-site Interviewed licensee designee, Marlene Burgess
06/30/2022	Contact - Telephone call made Follow up call to Ms. Burgess about requested documents
06/30/2022	Contact - Telephone call received Received Resident A's hospital discharge report
07/18/2022	APS referral made.
08/08/2022	Contact – Telephone call made Follow up call to Ms. Scott
08/08/2022	Contact – Document sent/received Email to/from Ms. Burgess regarding Resident B’s placement dates.
08/09/2022	Exit Conference

	Marlene Burgess

ALLEGATION: On 5/25/22, a resident assaulted another resident in the home causing severe injury to the victim.

INVESTIGATION: On 6/8/22, I conducted an onsite inspection at the facility. Resident A was not available because he was still recovering at a rehabilitation center. Resident B received an emergency discharge from the facility due to the incident. Per incident report authored by direct care worker, Maimuna Yongye, on 5/25/22 at approximately 5:00 p.m., Resident B came downstairs and reported Resident A had been "shocked by electric current." Ms. Yongye reported she ran upstairs to check on Resident A and noticed his nose bleeding. Ms. Yongye was instructed to call 911. Resident A was transported to Garden City Hospital by ambulance. Home Manager, NiKeisha Scott went to the hospital on 5/26/22 to visit Resident A. Ms. Scott reported she asked Resident A if Resident B caused his injury and Resident A nodded his head yes. According to Ms. Scott, Resident A is non-verbal, however, he can understand words. Ms. Scott reported Resident A can communicate well using hand gestures and head nods. Ms. Burgess informed me the hospital confirmed Resident A's injuries are not consistent with the explanation provided by Resident B. Ms. Burgess said the hospital indicated Resident A had been assaulted. Once confronted with this information, Ms. Burgess said Resident B changed his story of what happened to "I accidentally elbowed him."

Ms. Burgess completed an emergency discharge letter on 5/26/22 to have Resident B removed from the facility. A copy of the letter was sent to all applicable parties, including the licensing department. Based on the discharge letter, Ms. Burgess determined she could no longer "ensure the safety and well-being of other residents in the home" with Resident B present. Therefore, Resident B was removed from the facility on or around 5/29/22. Ms. Burgess also reported Resident B started packing his belongings before they informed him of the discharge plan which is a likely expression of guilt.

Upon review of Resident B's record, I requested to see a copy of his pre-screening assessment before entering the home. Ms. Burgess acknowledged she did not complete a written assessment before accepting Resident B into the home. Ms. Burgess explained Resident B transferred to the Kingswood Home from another placement (called Milestones) within the corporation. Ms. Burgess indicated Milestones is considered a crisis program to offer residents an "alternative to a hospital." Resident B was placed at Milestones from 4/15/22 to 5/9/22; he was placed at Kingswood Home on 5/9/22. Ms. Burgess stated she conducted a tele-conference meeting via Zoom with Resident B, Resident B's guardian, and Donald King (who is another licensee designee within the corporation) in lieu of a pre-placement visit. Ms. Burgess could not recall why the pre-placement visit was not conducted in-person. However, Ms. Burgess did admit "we didn't discuss too much of his history because it might be triggering," referring to the zoom call with Resident A and his guardian.

It should also be noted Resident B resided at the licensee's Rosewood home from 3/8/21-12/7/21. According to Ms. Burgess, Resident B was discharged from Rosewood after physically assaulting another resident in the home. Resident B has a known history of aggression "towards staff and other residents in the group home" per his most recent Individual Plan of Service (IPOS) dated 4/4/22. Resident B's psychiatric evaluation dated 3/17/21 reports "when he did not get his way he would beat up on people." Resident B was diagnosed with "impulse control disorder; bipolar disorder; ADHD; intermittent explosive disorder by Don Smith". In addition, Resident B's AFC Assessment Plan completed by Hope Network staff, Bridget Murphy states, "he has an extensive history of agitated mood and aggressive behavior." This plan was completed on 3/8/21. No other plan was made available for department review although a new plan was required once Resident B was admitted to Kingswood Home. Resident B was assigned to share a room with Resident A. When asked to describe both residents, Ms. Burgess indicated Resident A is 63 years old, 5 feet, 2 inches tall, and 130 pounds; Resident B is 27 years old, 6 feet, 2 inches tall, and weighs over 200 pounds.

Ms. Scott described Resident A as "very mild-mannered … quiet, stays to himself." Ms. Burgess said based on Resident A's history, the attack was likely unprovoked. Ms. Burgess explained "he wouldn't hurt a fly." Staff suspect the attack happened while Resident A was lying in bed because he was not wearing his glasses. Staff later found the glasses on his nightstand. Per Ms. Burgess, the treating physician told them, Resident A's eye would have been cut if he had been wearing glasses during the attack. Resident A was admitted to Garden City Hospital for traumatic brain injury; he was diagnosed with a subdural hematoma (brain bleed). Once released from intensive care, Resident A continued his recovery in a rehabilitation unit. Resident A was away from the home recovering from his injuries 5/25/22-6/13/22.

On 8/9/22, I completed an exit conference with Ms. Burgess. Ms. Burgess emphasized, "I would never place a resident in danger." Ms. Burgess said she felt comfortable accepting Resident B for placement at Kingswood Home after conferencing the case with the Program Manager at Rosewood, Bridget Murphy. Ms. Burgess also indicated she is surprised I did not receive a current copy of Resident B's AFC assessment plan; she is rather certain a new plan was completed upon his admission to the home. Ms. Burgess said although Resident B had assaulted a resident in the past, the attack was instigated by the victim. Therefore, the incident was deemed isolated.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	• Resident B is known to be aggressive and has an explosive temper resulting in violence towards others. • By his own admission, according to the latest Psychiatric Evaluation, Resident B said he beats people up whenever he doesn't get his way. • There is a 36-year age difference between Resident A and B. They also have significant differences in physical stature and personalities. Resident A has a small stature and mild personality; whereas, Resident B is tall, overweight and has aggressive tendencies. • Resident B physically attacked Resident A, likely unprovoked. • Resident A was severely injured during the attack causing him to suffer a brain bleed. • The licensee failed to demonstrate how she determined Resident B was suitable for placement. Ms. Burgess did not provide the department proof of a written assessment completed before and after Resident B's admission to the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

K. Robinson 08/09/22

Kara Robinson Date
Licensing Consultant

Approved By:

A. Hunter 08/10/22

Ardra Hunter Date
Area Manager