GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 16, 2022

Stephanie Leone
Hope Network Behavioral Health Services
PO Box 890
3075 Orchard Vista Drive
Grand Rapids, MI 49518-0890

RE: License #: AS410067880
Investigation #: 2023A0467010
Breton Valley

Dear Mrs. Leone:

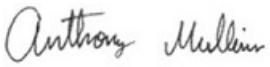
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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 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 (616) 356-0183.

Sincerely,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410067880
Investigation #:	2023A0467010
Complaint Receipt Date:	11/07/2022
Investigation Initiation Date:	11/07/2022
Report Due Date:	01/06/2023
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(616) 430-7952
Administrator:	Julie Pedraza
Licensee Designee:	Stephanie Leone
Name of Facility:	Breton Valley
Facility Address:	2451 Breton Road, SE Grand Rapids, MI 49546-5627
Facility Telephone #:	(616) 949-3813
Original Issuance Date:	09/28/1995
License Status:	REGULAR
Effective Date:	03/28/2022
Expiration Date:	03/27/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff member Gwenda Joiner pushed Resident A to prevent him from going in the laundry room. She also yelled at him.	Yes

III. METHODOLOGY

11/07/2022	Special Investigation Intake 2023A0467010
11/07/2022	Special Investigation Initiated - Telephone Lula Jackson - Program Manager
11/09/2022	Inspection Completed On-site
11/09/2022	Spoke to staff member Gwenda Joiner via phone.
11/16/2022	APS Referral – Sent to centralized intake.
11/16/2022	Exit conference completed with licensee designee, Stephanie Leone.

ALLEGATION: Staff member Gwenda Joiner pushed Resident A to prevent him from going in the laundry room. She also yelled at him.

INVESTIGATION: On 11/6/22, I received a voicemail from Program Manager, Lula Jackson. Ms. Jackson informed me that she received a report that staff member, Gwenda Joiner physically managed one of the residents in the facility and kept him from being able to do his laundry. Ms. Jackson stated that she will be completing an incident report.

On 11/7/22, I received an incident report from Ms. Jackson via email. The incident report stated that on 11/5/22, staff member Del Shawn Davidson observed his colleague, Ms. Joiner, “physically keep (Resident A) from checking his laundry by blocking the doorway and putting her hand on his arm to prevent him from entering the room. Ms. Joiner then went into the laundry room and removed the knob from the dryer to prevent Resident A from using it.”

On 11/7/22, I spoke to Ms. Jackson via phone, and she confirmed the allegations. Ms. Jackson spoke to Mr. Davidson about the incident, and he informed her that Ms. Joiner was agitated with Resident A due to checking his laundry often and this led to her stopping him from doing his laundry. Ms. Jackson confirmed that Resident A can do his own laundry. Ms. Jackson stated that Ms. Joiner has been taken off the schedule, pending the outcome of this investigation. I explained to Ms. Jackson that I would be at the facility on Wednesday, 11/9/22 to speak to Resident A. Ms.

Jackson agreed to send me Ms. Joiner and Mr. Davidson's phone numbers via text message.

On 11/7/22, I received Ms. Joiner and Mr. Davidson's phone number via text message from Ms. Jackson as requested.

On 11/9/22, I made an announced onsite investigation to the facility. Upon arrival, introductions were made with Resident A and he agreed to discuss case allegations. Resident A was adamant about discussing the case allegations with Ms. Jackson present. Resident A was asked to tell me what he recalled from the past weekend (11/5/22) regarding the incident between Ms. Joiner and him. Resident A stated that, "she raised her voice at me and forced me out of the room," referring to the laundry room. Resident A stated that Ms. Joiner, "put two hands on my arms and pushed me right out of there." Resident A stated that he was just trying to do his laundry when Ms. Joiner stated, "get out of here." Resident A stated that he broke the dryer by pulling the turning knob off. Resident A stated that Ms. Joiner was mad that he pulled the knob off. Resident A stated that he hates Ms. Joiner and described her as a "bully". Resident A was thanked for his time as this interview concluded.

After speaking to Resident A, I spoke to staff member Del Shawn Davidson. Mr. Davidson confirmed that Ms. Joiner pushed Resident A away from the laundry room with her hand while he was trying to enter the room. Mr. Davidson stated that when Resident A does laundry, he becomes fixated on checking the status of the washer/dryer. Despite this, Mr. Davidson stated that the situation between Resident A and Ms. Joiner shouldn't have resorted to Resident A being pushed.

Mr. Davidson stated that prior to Ms. Joiner letting Resident A in the laundry room, she took the knob off the dryer to prevent him from using it. Mr. Davidson stated that Resident A broke the cap that the knob was connected to, which prevented it from working. Mr. Davidson stated that Ms. Joiner raised her voice at Resident A by stating something along the lines of him not being able to enter the laundry room and that, "I don't give a shit" about Resident A wanting to be in the laundry room.

Mr. Davidson stated that he started employment at the home on 9/1/22. Mr. Davidson stated that not only has he seen Ms. Joiner being disrespectful to Resident A, he has also seen Ms. Joiner being disrespectful to other residents. Mr. Davidson stated that he has been at the facility just over 60 days and he estimated that Ms. Joiner has been rude or disrespectful to residents, "at least 40 of those days." Mr. Davidson was thanked for his time as this interview concluded.

On 11/9/22, I spoke to Ms. Joiner via phone and asked her to share what occurred between Resident A and her on Saturday (11/5/22). Ms. Joiner stated that there is a house rule posted on the door in the home that states that residents are not allowed to be in the laundry area without staff. Ms. Joiner stated that Resident A kept trying to go in the laundry room to check on his clothes after she told him to wait. Ms. Joiner stated that Resident A pushed passed her to get to the dryer. Ms. Joiner

stated that she asked him to stop but he wouldn't. Ms. Joiner stated that she asked her colleague, Mr. Davidson to take the knob off the dryer to prevent Resident A from breaking it "but it was already broken."

Ms. Joiner adamantly denied pushing Resident A or putting her hands on him to stop him from entering the laundry room. Ms. Joiner stated that she put her hand on the doorknob and on the dryer knob. Ms. Joiner stated that her colleague Mr. Davidson was in the kitchen area and based on how the house is designed, he couldn't have seen the incident. Ms. Joiner stated that Mr. Davidson eventually stepped closer to the laundry area and saw her and Resident A, "pushing through the door" of the laundry room. Ms. Joiner stated that her hand and Resident A's hand were both on the door and they pushed through the door at the same time. Ms. Joiner stated that Mr. Davidson had to take two steps over from where he was standing to see the incident. Ms. Joiner stated, "the rest he did because I asked him to," referring to Mr. Davidson. Mr. Joiner stated that Mr. Davidson put the doorknob and the broken piece from it in a bag for maintenance to fix. Ms. Joiner was adamant that she did not raise her voice at Resident A and she did not tell him that she, "doesn't give a shit" about him wanting to go in the laundry room.

During this onsite investigation, I spoke to Resident B. Resident B stated he observed Ms. Joiner attack Resident A approximately one month ago by, "grabbing the back of his arms and shaking him." Resident B stated that he told Ms. Joiner to "knock it off." He did not have any knowledge of an incident between Resident A and Ms. Joiner this past weekend (11/5/22).

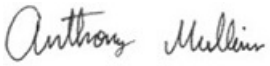
On 11/16/22, I spoke to licensee designee, Stephanie Leone. She was informed of the investigative findings and I explained that this type of behavior by staff is inappropriate towards residents. Mrs. Leone agreed to complete a corrective action plan.

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.
A**NALYSIS:**	Resident A and Mr. Davidson both confirmed that Ms. Joiner prevented him from doing his laundry by pushing him out of the laundry room. Resident A and Mr. Davidson also confirmed that Ms. Joiner raised her voice at Resident A. Ms. Joiner denied touching or pushing Resident A out of the laundry room. She also denied raising her voice at him.

	Due to Resident A and Mr. Davidson confirming the incident occurred, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

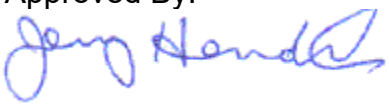
Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



11/16/2022

Anthony Mullins Date
Licensing Consultant

Approved By:



11/16/2022

Jerry Hendrick Date
Area Manager