



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

January 12, 2023

Teresa Wendt  
HGA Non-Profit Homes Inc.  
917 West Norton  
Muskegon, MI 49441

RE: License #:	AS610091644
Investigation #:	2023A0356007
	Virginia's House

Dear Ms. Wendt:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in cursive script that reads "Elizabeth Elliott".

Elizabeth Elliott, Licensing Consultant  
Bureau of Community and Health Systems  
Unit 13, 7th Floor  
350 Ottawa, N.W.  
Grand Rapids, MI 49503  
(616) 901-0585

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS610091644
<b>Investigation #:</b>	2023A0356007
<b>Complaint Receipt Date:</b>	11/22/2022
<b>Investigation Initiation Date:</b>	11/22/2022
<b>Report Due Date:</b>	01/21/2023
<b>Licensee Name:</b>	HGA Non-Profit Homes Inc.
<b>Licensee Address:</b>	917 West Norton Muskegon, MI 49441
<b>Licensee Telephone #:</b>	(231) 728-3501
<b>Administrator:</b>	Channe Hicks, Administrator
<b>Licensee Designee:</b>	Teresa Wendt, Designee
<b>Name of Facility:</b>	Virginia's House
<b>Facility Address:</b>	391 Whispering Oaks Drive Muskegon, MI 49442-1853
<b>Facility Telephone #:</b>	(231) 788-5156
<b>Original Issuance Date:</b>	05/23/2000
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	11/23/2022
<b>Expiration Date:</b>	11/22/2024
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Upon discharge from the hospital, staff at the facility refused to allow Resident A to return home due to a positive COVID 19 test.	No

**III. METHODOLOGY**

11/22/2022	Special Investigation Intake 2023A0356007
11/22/2022	APS Referral Gene Gray, Muskegon Co. DHHS, APS Worker assigned.
11/22/2022	Special Investigation Initiated - Telephone Gene Gray-APS
11/22/2022	Contact - Telephone call made Relative #1
11/22/2022	Contact - Document Received Channe Hicks, Administrator.
11/29/2022	Contact - Telephone call made Spectrum Health Care Management.
12/06/2022	Contact - Telephone call made Spectrum Health Care Management, spoke to Patti Moyer.
12/08/2022	Contact - Document Sent email Angelica Ferrer at Spectrum Health Care Management.
12/12/2022	Contact - Telephone call made Darreco Scott, Program Manager.
01/10/2023	Exit Conference-Channe Hicks, administrator.

**ALLEGATION:** Upon discharge from the hospital, staff at the facility refused to allow Resident A to return home due to a positive COVID 19 test.

**INVESTIGATION:** On 11/22/2022, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported that Resident A went to the hospital and tested positive for COVID-19, the hospital attempted to discharge Resident A back to the facility but staff at the facility refused to take Resident A back because Resident A tested positive for COVID-19. The complainant reported that

because Relative #1 took Resident A out of the facility, Relative #1 had to take Resident A to quarantine for five days before he could return to the facility. The complainant cannot physically care for Resident A so the hospital will admit resident A. DHHS (Department of Health and Human Services) APS (Adult Protective Services) worker, Gene Gray is assigned to investigate this allegation.

On 11/22/2022, I interviewed Channe Hicks, Administrator. Ms. Hicks reported Relative #1, who is Resident A's legal guardian, was informed of positive Covid-19 in the facility, Relative #1 came to the facility and took Resident A reporting she was going to get him tested for COVID-19 herself and care for him. Ms. Hicks stated Relative #1 was instructed by staff at the facility to leave Resident A at the home, that he would be tested by Healthwest, and properly taken care of and closely supervised by staff at the facility. Ms. Hicks stated Relative #1 chose to remove Resident A, and Relative #1 did not allow Resident A to remain in the facility to quarantine. Ms. Hicks stated at no time did staff at the facility refuse to allow Resident A back into the facility from the hospital, but they were under the impression that Relative #1 was going to care for him herself.

On 11/22/2022, I interviewed Relative #1 via telephone. Relative #1 stated she called the facility on Saturday, 11/19/2022 and was told there was a positive case of COVID-19 in the house, but staff were watching Resident A along with other residents closely for any signs or symptoms of the virus. Relative #1 stated she was told by staff at the facility that Healthwest would be testing all residents on Monday, 11/21/2022. Relative #1 stated she did not feel comfortable with this, so she went to the facility, took Resident A to Spectrum Hospital Downtown Grand Rapids because she was worried about Resident A's health. Relative #1 stated Resident A tested positive for COVID-19 but the hospital was going to discharge Resident A back to the facility. When the discharge social worker called the facility, she was told by Darreco Scott, Program Manager, that Resident A could not return to the facility due to the positive COVID-19 test and once Resident A was removed from the facility, he needed to quarantine elsewhere for the next five days. Relative #1 stated the hospital social worker asked Relative #1 if she could care for Resident A at her home and she told them she could not. Relative #1 stated the hospital decided to send Resident A to Blodgett Hospital because his heart rate was high, and the doctor thought he might have blood clot near his heart so Resident A was admitted to the hospital and did not return to the facility until several days later.

On 12/06/2022, I interviewed Patti Moyer, care manager at Spectrum Hospital. Ms. Moyer stated Resident A was discharged on 11/23/2022 to the facility but notes indicate on 11/20/2022 care manager, Angelica Ferrer spoke to staff Tamia (Williams) who referred her to home supervisor "Recco" (Darreco Scott). Ms. Moyer stated Mr. Scott informed Ms. Ferrer that Resident A was unable to return to the facility until the quarantine time was over.

On 12/12/2022, I interviewed Darreco Scott, Program Manager via telephone. Mr. Scott stated Relative #1 came to the facility late in the evening on 11/19/2022 after

being notified that there was a positive COVID-19 case in the facility. Mr. Scott stated Relative #1 came in, tested Resident A's vitals, and told staff that they were not caring for Resident A properly and took him (Resident A) out of the facility. Mr. Scott stated at that time he had tried to get Relative #1 to leave Resident A in the facility where there were around the clock staff to supervise and care for Resident A. Mr. Scott stated Relative #1 took Resident A home with her and Relative #1 is Resident A's legal guardian, so she was allowed to do so. Mr. Scott stated he did not know that Relative #1 took Resident A from the facility in Muskegon, to a hospital in Grand Rapids. Mr. Scott stated when he got a telephone call from the hospital, he was surprised to hear Resident A was in a hospital in Grand Rapids. Mr. Scott stated he informed staff at the hospital that from what he knew, Resident A was going to be going to Relative #1's home as he was in her care as she had come to the facility and took him out. Mr. Scott stated he never said Resident A could not come back to the facility but rather told hospital staff that Resident A was going to go home with Relative #1 from the hospital. Mr. Scott stated he did not even know if there was a quarantine period for COVID-19 positive cases and follows what Healthwest guidelines are at the time of positive testing. Mr. Scott stated all the residents were scheduled to get COVID-19 tests through Healthwest on 11/21/2022. Mr. Scott stated staff at the hospital requested that he (Mr. Scott) come to Grand Rapids and pick Resident A up, that is when he told hospital staff that Resident A left the facility in the care of Relative #1, that Relative #1 was currently at the hospital with him and Relative #1 would be taking Resident A home to care for him. Mr. Scott stated hospital staff told him Relative #1 reported she could not care for Resident A. Mr. Scott stated this was the first he had heard about her inability to care for Resident A as she had removed him from the facility stating she was going to care for him. Mr. Scott stated he informed hospital staff that facility staff would not come to Grand Rapids to pick Resident A up. Mr. Scott stated had Relative #1 brought Resident A back to the facility after the hospital, they would not have turned him away.

On 01/10/2023, I conducted an Exit Conference with Channe Hicks, Administrator. Ms. Hicks stated

<b>APPLICABLE RULE</b>	
<b>R 400.14305</b>	<b>Resident protection.</b>
	(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.
<b>ANALYSIS:</b>	The complainant reported Resident A was not allowed to return to the facility from the hospital for a period because he had Covid-19.

	<p>Ms. Hicks stated staff at the facility did not refuse to allow Resident A back into the facility but were under the impression that Relative #1 was going to care for him herself.</p> <p>Relative #1 stated when the hospital discharge social worker called the facility, she was told Resident A could not return to the facility.</p> <p>Mr. Scott stated he told staff at the hospital that Relative #1 was taking Resident A home. Mr. Scott stated he told hospital staff that staff from the facility would not go to Grand Rapids and pick Resident A up but did not refuse to take Resident A back into the facility.</p> <p>Based on investigative findings, there is not a preponderance of evidence to show that on 11/20/2022, staff at the facility refused to take Resident A back into their care. Therefore, a violation of this applicable rule is not established.</p>
<b>CONCLUSION:</b>	VIOLATION NOT ESTABLISHED

**IV. RECOMMENDATION**

I recommend the status of the license remain unchanged.



01/12/2023

Elizabeth Elliott  
Licensing Consultant

Date

Approved By:



01/12/2023

Jerry Hendrick  
Area Manager

Date