GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 18, 2023

William Paige
Hope Network, S.E.
PO Box 190179
Burton, MI 48519

RE: License #:	AM250281878
Investigation #:	2023A0872054
	New Hope Behavioral Services I

Dear William Paige:

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 (517) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY
THIS REPORT CONTAINS SEXUALLY EXPLICIT LANGUAGE

I. IDENTIFYING INFORMATION

License #:	AM250281878
Investigation #:	2023A0872054
Complaint Receipt Date:	06/23/2023
Investigation Initiation Date:	06/23/2023
Report Due Date:	08/22/2023
Licensee Name:	Hope Network, S.E.
Licensee Address:	PO Box 190179 Burton, MI 48519
Licensee Telephone #:	(810) 232-2766
Administrator:	Tara Maynie
Licensee Designee:	William Paige
Name of Facility:	New Hope Behavioral Services I
Facility Address:	Suite A 1110 Eldon Baker Dr. Flint, MI 48507
Facility Telephone #:	(810) 742-3134
Original Issuance Date:	05/06/2006
License Status:	REGULAR
Effective Date:	09/25/2021
Expiration Date:	09/24/2023
Capacity:	8

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 07/22/23, Resident A attacked Resident B and attempted to sexually assault her. Resident A has attacked Resident B several times in the past.	Yes
On 06/20/23, staff Antonio Tedford physically assaulted Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

06/23/2023	Special Investigation Intake 2023A0872054
06/23/2023	Referral - Recipient Rights RRO Matt Potts is investigating this complaint
06/23/2023	APS Referral I made an APS complaint via email
06/23/2023	Special Investigation Initiated - Letter
06/28/2023	Inspection Completed On-site Unannounced
06/30/2023	Contact - Document Sent I emailed the licensee designee, William Paige, requesting information related to this complaint
07/05/2023	Contact - Document Received Documentation received from Will Paige
07/25/2023	Contact - Document Received New intake received alleging that Resident A sexually assaulted Resident B
07/26/2023	Contact - Document Received Emergency discharge notice received regarding Resident A
08/01/2023	Inspection Completed On-site Unannounced

08/03/2023	Contact – Document received I received a report from Matthew Potts
08/04/2023	Contact - Telephone call made I spoke to Will Paige about this complaint
08/16/2023	Contact - Telephone call made I interviewed staff Makeda Collins
08/18/2023	Contact – Document sent I sent a FOIA request regarding the police report from 07/22/23
08/18/2023	Inspection Completed-BCAL Sub. Compliance
08/18/2023	Exit Conference I conducted an exit conference with the licensee designee, William Paige

ALLEGATION: On 07/22/23, Resident A attacked Resident B and attempted to sexually assault her. Resident A has attacked Resident B several times in the past.

INVESTIGATION: On 07/25/23, I received a complaint alleging that on 07/22/23, Resident A attacked Resident B and attempted to sexually assault her. Resident A chased Resident B into the parking lot, pulled her pants and brief down, and got on top of her. Resident B screamed at him to get off her. Staff followed them out to the parking lot and told Resident A to get off Resident B. The police were called, and Resident A was arrested.

On 07/26/23, I received an emergency discharge notice via email regarding Resident A from the Hope Network Director of Crisis and Residential Treatment Services, Kayonna Ferguson. The notice was dated 07/26/23 and was addressed to Resident A and his guardian. The notice was given due to Resident A being arrested on 07/22/23 for the sexual assault of a female peer.

On 07/26/23, Director Ferguson also emailed me a copy of the 30-day discharge notice dated 07/14/23 for Resident A. According to that discharge notice, Resident A was being discharged due to impulsiveness, aggression, sexual inappropriateness, alcohol use, being a high elopement risk, and “other behaviors isolated towards a specific female peer.”

On 08/01/23, I conducted an unannounced onsite inspection of New Hope Behavioral Services I AFC. I interviewed Resident B and Resident C and staff Cawanna Dukes and Antonio Tedford.

Resident B said that a couple of days ago, she and Resident A were in the living room. Resident B said that Resident A "attacked me and pushed me down on the ground." He also pulled her pants down and told her, "I'm gonna have sex with you." Resident B said that she told him "No you're not!" and started screaming. Staff Cawanna Dukes came in the room and Resident A got off Resident B. Resident B said that Resident A went in his room and Staff Dukes called the police.

According to Resident B, the police arrived at the facility and interviewed her and Resident A. The police then arrested Resident A and she has not seen him since that time. Resident B told me that on one other occasion, Resident A was trying to touch her "down there" and the police were called but he was not arrested. Resident B said that she and Resident A "used to have a consensual relationship" but they have not "been together" in a long time. Resident B told me that on another occasion, Resident A physically assaulted Resident B and was taken to jail for four days. Resident B said, "The charges were dropped because he testified that I hit him too." I asked Resident B if Resident A ever touched any of the other residents inappropriately and she said that he tried to touch Resident C.

Resident C said that approximately five months ago, Resident A came into her room and said, "Let's have sex." She said that she did not want to have sex with him, "So I sucked his dick." Resident C told me that on another occasion, Resident A came into her room and "we had sex." Resident C said that she did not tell staff about either of these incidents.

According to staff Cawanna Dukes, on 07/22/23 Residents A, B, and D were in the living room watching pornography. Resident D went into his room. Staff Dukes heard Resident B screaming so she went in the living room and found Resident A on top of Resident B who was pinned to the floor. Resident A had a condom in his hand and Resident B was yelling at him, saying "Fuck you! Get off of me!" Staff Dukes told Resident A to get off Resident B and he eventually did. Staff Dukes said that when she entered the room, she saw that Resident A had unzipped his pants, he pulled Resident B's pants and brief down, under her waist. Staff Dukes then helped Resident B call 911 to report the assault.

According to Staff Dukes, Resident B went into her bedroom to wait for the police, but she came out after a while and said that she did not want to wait for the police. She then signed herself out of the facility, even though Staff Dukes encouraged her to stay in the facility until the police got there. Staff Dukes said that she went to the bathroom and by the time she came out, she noted that Resident A had also signed himself out of the facility. Immediately thereafter, another staff entered the facility and said that Resident A was chasing Resident B around the parking lot and Resident B did not have any clothes on. Staff Dukes and Staff Antonio Tedford went outside and found Resident A on top of Resident B again. Staff Tedford told Resident A to get off Resident B and he eventually did. When Resident B got up, she told Staff Tedford and Staff Dukes that in addition to trying to assault her, Resident A also took her cell phone away from her. Staff Dukes said that shortly thereafter, the police showed up and arrested Resident A.

Staff Antonio Tedford confirmed that on 07/22/23, Resident A attempted to sexually assault Resident B while in the living room of the facility. After Staff Dukes separated them, Resident B went into the staff office and said that she was going to wait for the police. Resident B then signed herself out of the facility, saying that she did not want to wait for the police anymore. Shortly thereafter, Resident A signed himself out of the facility as well. Approximately 20 minutes later, another staff entered the facility and called for staff, saying that Resident A was chasing Resident B around the parking lot.

Staff Tedford said that when he got to the parking lot, he found Resident A on top of Resident B who was screaming and saying, “Stop! Stop!” Staff Tedford said that while Resident A was on top of Resident B, he had a condom in his hand that he was trying to unwrap. Staff Tedford said that he was able to convince Resident A to get off Resident B. When the police got to the facility, they interviewed Resident A, Resident B, and staff and arrested Resident A.

Staff Dukes and Staff Tedford said that Resident A had a history of being sexually inappropriate with the other female residents, but he was not required to have 1:1 or enhanced supervision. He was also able to sign himself out of the facility whenever he chooses.

Staff Dukes and Staff Tedford said that Resident B has unsupervised community access, and she is also able to sign herself out of the facility whenever she chooses. Resident B does not have 1:1 or enhanced supervision.

On 08/04/23, I spoke to the licensee designee (LD), William Paige via telephone. He said that Resident A went to court last week and was remanded to jail with a $25,000 bond. LD Paige confirmed that Resident A was given an emergency discharge notice and he will not be able to return to New Hope Behavioral Services I AFC.

On 08/16/23, I reviewed AFC paperwork related to Resident A, Resident B, and Resident C. According to Resident A’s Health Care Appraisal, he is diagnosed with schizoaffective disorder, bipolar type. According to Resident A’s Genesee Health System’s Individualized Plan of Service (IPOS) dated 11/30/22, he has a history of impulsivity, and he engages in situations that put himself and others at risk. He “continues to have challenges with maintaining healthy physical boundaries with others and has a history of inappropriate contact of sexual nature with others.” His IPOS does not specify that he has 1:1 or enhanced supervision. According to Resident A’s Assessment Plan dated 10/19/22, he “is physically able to move independently within the community, however, needs staff support and supervision to maintain safety.” As far as his ability to control his sexual behavior, “(He) has a history of inappropriate boundaries related to sexual behavior and has engaged in inappropriate sexual contact with peers. Staff will encourage abstinence, safe sex practices and reinforce through gentle teaching appropriate boundaries. In the last year (he) has been accused by multiple female peers of unwanted sexual advances including charges of sexual assault that were later dropped.”

According to Resident B's Health Care Appraisal, she is diagnosed with bipolar disorder with psychotic features and generalized anxiety disorder. She also has a mild neurocognitive disorder due to known physiological condition with behavioral disturbance. According to Resident B's Macomb County Community Mental Health Crisis Treatment Plan (CTP) dated 11/16/22, she does not require 1:1 or enhanced supervision. Resident B has a public guardian. According to her Assessment Plan, she does not have a history of inappropriate sexual behaviors but does have a history of aggressive behaviors. Resident B wears briefs due to incontinence. She is allowed to move independently in the community, however she "does have a history of signing herself out from the program and going on unauthorized leaves of absences."

According to Resident C's Health Care Appraisal, she is diagnosed with disorganized schizophrenia. She does not require 1:1 or enhanced supervision. Resident C has a public guardian. She requires staff supervision while in the community. She does not have a history of sexually or physically inappropriate behaviors.

On 08/16/23, I checked Michigan Vinelink and confirmed that Resident A is still in custody in the Genesee County jail, and he has an open court case with the Genesee County Prosecuting Attorney's Office. On 08/18/23, I submitted a FOIA request to the Flint City Police Department, requesting a copy of the police report from the incident that occurred on 07/22/23.

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:	According to Resident B, on 07/22/23 Resident A attacked her and tried to sexually assault her. Resident B told me that on one other occasion, Resident A was trying to touch her "down there" and the police were called but he was not arrested. Resident B told me that on another occasion, Resident A physically assaulted her and was taken to jail for four days. Resident C said that approximately five months ago, Resident A came into her room and said, "Let's have sex." She said that she did not want to have sex with him, "So I sucked his dick." Resident C told me that on another occasion, Resident A came into her room and "we had sex." Resident C said that she did not tell staff about either of these incidents.

	Staff Cawanna Dukes and Antonio Tedford confirmed that on 07/22/23, Resident A attacked Resident B and attempted to sexually assault her. The police were called, and Resident A was arrested. As of 08/16/23, Resident A is charged with assault and is being held at the Genesee County jail on a $25,000 bond. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 06/20/23, staff Antonio Tedford physically assaulted Resident A.

INVESTIGATION: I reviewed an Incident/Accident Report (IR) dated 06/20/23 regarding Resident A. According to the IR, Resident A went to the cabinet and took several loafs of bread. Staff attempted to redirect him, but he got angry and hit at the male staff and verbally threatened the female staff. The corrective measures taken were, “Staff will continue to redirect as needed. The clinical team will review and have psych provider to assist for possible medication change if needed.”

On 06/28/23, I conducted an unannounced onsite inspection of New Hope Behavioral Services I Adult Foster Care facility. I interviewed Resident A and staff, Antonio Tedford.

I reviewed the allegations with Resident A, and he said, “He (Antonio Tedford) did physically assault me, but I want to close this case.” According to Resident A, “I took a loaf of bread with his (Staff Tedford) permission. He changed his mind and started screaming in my face. Resident A said that he swung at Staff Tedford, so Staff Tedford pushed him. Resident A reported that he “slid along the dining room floor” and hurt his back. I asked Resident A if anyone else was present during this incident and he said no. I asked him if he received any marks or bruises from the incident and he said, “I’m fine now. I already told you I’m fine and I want to close this case.” Resident A then got up and walked out of the interview room.

Staff Tedford said that he has worked at this facility for over 11 years, and he typically works 1st shift. According to Staff Tedford, on 06/20/23 he and Resident A were in the hallway. Resident A took a loaf of bread and began running down the hallway. One of the other staff, Makeda Collins asked him to give the bread back. Resident A got angry, so he swung at Staff Tedford. Staff Tedford said that Resident A did not actually hit him and said that he never put his hands on Resident A.

On 08/03/23, I received an investigation report from Genesee Health System Recipient Rights Officer (RRO), Matthew Potts. According to the report, RRO Potts concluded his

investigation regarding Resident A alleging that Staff Tedford physically assaulted him. RRO Potts did not substantiate the allegation.

On 08/16/23, I interviewed staff Makeda Collins via telephone. Staff Collins acknowledged that in June 2023 there was an incident involving Resident A. She said that Resident A took a loaf of bread and began running down the hallway. She asked Resident A to give the bread back and “he went crazy and started swinging wildly.” Staff Collins said that Resident A was angry and swinging at Staff Tedford so she and Staff Tedford “just let him have it and left him alone.” Staff Collins said that Resident A did not end up hitting anyone and said that at no time did Staff Tedford put his hands on Resident A.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	According to an IR dated 06/20/23, Resident A went in the cabinet and took several loafs of bread. Staff attempted to redirect him, but he got angry and hit at the male staff and verbally threatened the female staff. Resident A told me that on 06/20/23, he took a loaf of bread and staff Antonio Tedford began screaming in his face. Resident A said he swung at Staff Tedford and Staff Tedford pushed him. Resident A said he fell and slid along the dining room floor, hurting his back. Staff Tedford said that on 06/20/23, Resident A took a loaf of bread and began running down the hallway. Resident A got angry at staff Makeda Collins, so he swung at Staff Tedford but did not actually hit him. Staff Tedford denies hitting Resident A or putting his hands on him.

	Staff Makeda Collins said that during an incident in June 2023, Resident A took a loaf of bread and began running down the hallway. Staff Collins asked him to give the bread back and "he went crazy and started swinging wildly." Staff Collins said that Resident A did not end up hitting anyone and said that at no time did Staff Tedford put his hands on Resident A. GHS RRO Matthew Potts conducted an investigation regarding these allegations and did not substantiate abuse or neglect. I conclude that there is insufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: Resident A was admitted to New Hope Behavioral Services I on 07/03/18 and Resident B was admitted to New Hope Behavioral Services I on 07/10/18. During the course of my investigation, I determined that Resident A has a history of inappropriate and unsafe behaviors, putting other residents, specifically females, at risk of harm. He also has a history of elopements, drinking alcohol while encouraging other residents to drink alcohol and for the past few months he has been watching pornography in the common areas of the facility, regardless of who else is around.

I reviewed numerous Incident/Accident Reports (IRs) Regarding Resident A from January 2023 to July 2023.

Staff completed an IR dated 01/18/23 stating that during medication time, Resident A told staff he was going to the store to purchase alcohol. Resident A went into one of his peer's rooms and the two of them went to the store. "After eloping to the store, they stated to staff they was going to drink in the gazebo." The action taken by staff was, "Staff was observing him throughout the shift, staff also notified the assistant program manager."

Staff completed an IR dated 01/25/23 stating that during 15-minute checks, staff noticed that Resident A was not in his room. Staff went outside and saw Resident A walking towards his window with a bag in his hand. Resident A eventually showed staff what he had in the bag. He had a 6-pack of beer and a bottle of wine. He refused to give it to staff and instead, he stayed outside and drank all the alcohol until it was all gone. The corrective measures taken by staff were, "Staff will continue to monitor (him) for safety & health document and follow protocol for elopement. (He) was also placed on a flow sheet for precaution until further notice. Clinical team will review during meeting on 02/09/23."

Staff completed an IR dated 02/09/23 stating that Resident A took a naked picture of one of his peers and posted it on Tik Tok. Staff tried to get him to take it down, but he was banned from Tik Tok who took it down. The corrective measures taken by staff were to “continue to educate (him) on inappropriate sexual behavior” and to review the behavior with his clinical team. On 02/10/23, the police showed up at the AFC facility to arrest Resident A due to his peer stating he posted nude photos of her on social media.

Staff completed an IR dated 02/25/23 stating that, “As (Resident B) was walking in the hallway, her peer (Resident A) began cursing at her and told her to shut up. She responded to him that she didn’t have to shut up. Her peer then went to his dresser and grabbed a clock and threw it at her hitting her in the face which caused some swelling and bruising. (She) proceeded to call 911 to file a complaint against her peer.” The corrective measures taken were, “(Resident B) was educated on staying away from her peer. Staff will continue to monitor for swelling.”

Staff completed an IR dated 03/22/23 stating that Resident A eloped to the store and was panhandling. The corrective measures taken were, “Staff will continue to follow elopement protocol and document.”

Staff completed an IR dated 03/24/23 stating that Resident A eloped to the corner store and was asking people for money. He was kicked off the store property by the store owner, so he went to another store, asking people for money. The corrective measures taken by staff were, “Staff will continue to follow elopement protocol. Also, staff will continue to educate (him) on the dangers of eloping.”

Staff completed an IR dated 04/17/23 stating that Resident A was in the living room with a female peer (Resident B.) “He kiss(ed) female peer without permission. Police was called but no arrest was made.” The corrective measures taken were, “Persons served was educated on touching, kissing someone else without permission is illegal.”

Staff completed an IR dated 05/20/23 stating that Resident A and Resident B had a disagreement. Resident A came out of his room later, grabbed Resident B and threw her to the ground. He then began kicking Resident B in the head and punching her in the face. He also took her phone and threw it at her face. Staff called the police who came and arrested Resident A for assault. According to the IR, staff tried to redirect Resident A and get between the two of them. The corrective measures taken were, “(He) was arrested when he returns back to the program, he will be placed on a precaution flow sheet until further notice. Clinical team will review when he is released.”

On 08/18/23, I conducted an exit conference with the licensee designee, William Paige. I discussed the results of my investigation and explained which rule violations I am substantiating.

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 A has a history of inappropriate and unsafe behaviors, putting other residents, specifically females, at risk of harm. He also has a history of elopements, drinking alcohol while encouraging other residents to drink alcohol and for the past few months he has been watching pornography in the common areas of the facility, regardless of who else is around. Resident A has resided at New Hope Behavioral Services I AFC since 07/03/18. In spite of his dangerous behaviors putting others at risk and in spite of his history of sexually and physically inappropriate behaviors, the facility did not issue him with a 30-day and/or emergency discharge notice until 07/14/23. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

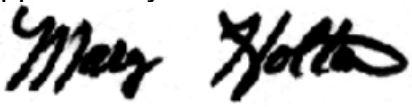
IV. RECOMMENDATION

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

August 18, 2023

Susan Hutchinson Licensing Consultant	Date

Approved By:



August 18, 2023

Mary E. Holton Area Manager	Date