GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

March 4, 2024

Amanda Ledford
Hope Network West Michigan
PO Box 890
Grand Rapids, MI 49501-0141

RE: License #: AS410318868
Investigation #: 2024A0340019
Gilead

Dear Mrs. Ledford:

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 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,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410318868
Investigation #:	2024A0340019
Complaint Receipt Date:	02/07/2024
Investigation Initiation Date:	02/07/2024
Report Due Date:	04/07/2024
Licensee Name:	Hope Network West Michigan
Licensee Address:	PO Box 890 Grand Rapids, MI 49518
Licensee Telephone #:	(616) 301-8000
Administrator:	Amanda Ledford
Licensee Designee:	Amanda Ledford
Name of Facility:	Gilead
Facility Address:	4094 Breton SE Kentwood, MI 49508
Facility Telephone #:	(616) 803-5071
Original Issuance Date:	05/22/2012
License Status:	REGULAR
Effective Date:	11/28/2022
Expiration Date:	11/27/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A injured herself with a knife that was supposed to be locked.	Yes

III. METHODOLOGY

02/07/2024	Special Investigation Intake 2024A0340019
02/07/2024	APS Referral referred from APS
02/07/2024	Special Investigation Initiated - Telephone Jessica Carter
02/20/2024	Inspection Completed On-site
02/20/2024	Contact - Telephone call made Ms. Carter
02/27/2024	Contact – Telephone call made Staff Daniel Sematungu
02/27/2024	Exit Conference Acting Designee Mega Pena
03/01/2024	Contact – Document Received From Tmnit Mogos

ALLEGATION: Resident A injured herself with a knife that was supposed to be locked.

INVESTIGATION: On February 7, 2024, I received a complaint filed by Adult Protective Services which stated that Resident A was experiencing suicidal ideations. She was found with multiple self-inflicted injuries. Resident A had retrieved an 8-inch butcher knife from a room that is supposed to be locked. She was transported to the hospital with non-life-threatening injuries.

On February 7, 2024, I contacted Manager Jessica Carter. She was aware of what had happened. She informed me staff Daniel Sematungu was working at the time of the incident. He will be disciplined, and a toolbox is being purchased to lock the sharps up inside the locked office. Ms. Carter stated Resident A does have a history of self-harm and needs to be issued a 30-day discharge notice because this home is unable to meet her needs. She is driven to obtain objects to harm herself. The cuts

have been superficial and Resident A calls 911 herself. Ms. Carter and I discussed Resident A's case management which Ms. Carter stated is from out of county and there has been significant issues getting participation from them to address the concerns.

On February 20, 2024, I conducted an unannounced home inspection. Staff Bobby Willis answered the door. I identified myself and the reason for my visit. Upon entry I noticed the office door open and a woman sitting on a bench outside the office door. I asked to see where the sharps are being kept. As we walked by the office Mr. Willis shut the door, then stated he had to get the keys to open the door. Staff Charles Lofton was also working on this day and gave Mr. Willis the keys. With both staff together I asked them to tell me what they knew about the incident regarding Resident A going to the hospital. Both staff responded, "which time". I clarified the date of the incident and specified that I believed staff Daniel Sematungu was working. Mr. Willis and Mr. Lofton stated that Resident A repeatedly attempts to cut herself and although her injuries have been superficial, she often goes to the hospital afterwards. Both denied working the day of the incident pertaining to this complaint.

Mr. Willis then took the keys from Mr. Lofton and opened the office door that he had just closed minutes before. He showed me the plastic container holding the sharps. They were in an unlocked, Rubbermaid type drawer container. I asked about a toolbox that was supposed to be purchased to double lock the sharps and keep them from Resident A. Mr. Willis did not have knowledge of this.

I informed Mr. Willis that I needed to speak with Resident A, and he identified her as the resident who was sitting outside the office on the bench when I had walked in. She was still sitting on the bench outside the office. I asked to speak with her privately, so we went outside.

I identified myself to Resident A and explained my reason for wanting to talk to her. I asked her to tell me about when she had cut herself. Resident A informed me that the last time she attempted to cut herself was two days ago, but she did not tell anyone about this. Resident A rolled up her sleeve and showed me the marks on her upper left arm. When she did this, I could see numerous other marks that had healed all the way up her arm. She said she has also cut her legs. I asked her to tell me about the incident when she recently called 911 and was taken to the hospital.

Resident A said she will obtain something to harm herself and she will "rip the doors off if I have to" in order to get ahold of the knives. She said she has broken cups and used them as well. Resident A was unable to recall the incident pertaining specifically to the complaint. She stated she does not want to harm herself, but she cannot stop. She would like therapy and 1:1 supervision so that she doesn't harm herself. Her case manager is up north, and she hasn't seen them in a long time. Resident A stated she does not feel safe living in this home and she does not feel

safe when Mr. Sematungu is working. Resident A would prefer a home with a female dominant staff.

On February 20, 2024, I spoke with Ms. Carter again. I informed her of what I had seen at the home with the office door open and the sharps not locked and Resident A sitting outside the doorway. She informed me a toolbox will be purchased today and the sharps will be locked in the medication room. I asked Ms. Carter to send me Resident A's Assessment Plan, Treatment Plan and Health Care Appraisal which she said she would.

On February 26, 2024, I reviewed the Assessment Plan, Health Care Appraisal and Treatment Plan for Resident A. Resident A's Assessment Plan was signed by Janessa Kelly on 10/5/23. Under "Exhibits Self Injurious Behavior" it states Resident A, "will engage in SIB's-she does want to go to the hospital as often as she can. She will find ways to cut herself when upset."

Resident A's Health Care Appraisal was signed by Sam Woods, RNA on 9/22/23. Resident A's diagnosis is listed as: Bipolar disorder, current episode manic severe with psychotic features; PTSD, unspecified.

Resident A's Treatment Plan was dated 6/29/23 and created by Kristen Stillwell from Northern Lakes CMH. The Treatment Plan did not address self-injurious behavior.

On February 27, 2024, I interviewed staff Daniel Sematungu. When I asked Mr. Sematungu to recall for me the events that occurred regarding this incident, Mr. Semtaungu was unable to provide a reliable account of the details. His statements changed numerous times throughout our conversation. He eventually denied any knowledge of where sharps are kept in the home, how sharps are kept secure or that Resident A had even harmed herself.

On March 1, 2024, I received a copy of the Incident Report written by Tmnit Mogos. Staff working this date that are mentioned in the IR are the staff previously interviewed who denied working or having knowledge of the incident when I had interviewed them; Bobby Willis and Daniel Sematungu. The IR stated: *'Per report from staff Bobby who was there in the beginning of this incident, he stated "(Resident A) helped staff Bobby prepare for dinner in the kitchen area, as staff Bobby was preparing dinner (Resident A) took house keys from staff Bobby then sat in common area. Staff Bobby asked for keys when dinner was served (Resident A) stated that she didn't have the keys then went to room. Staff Bobby knocked on (Resident A) door to get keys back but never received them. (Resident A) came back into common area and was targeting staff Bobby by using vulgar language such as "little d****", told staff Daniel "go back to your country", "N****". (Resident A) stated that she was refusing her meds then changed her mind and was threatening Staff Bobby if she doesn't receive her meds. Staff Bobby administered meds (Resident A) put meds in her pocket and continued to talk down on staff Bobby till the end of shift. The following medications were not taken were Atorvastatin tab*

20mg, belsomra tab10mg, eszopiclone tab 2mg, hydroxyzine 50mg, lithium 150mg, lorazepam 1mg, Advair inhaler (1 puff) and desatin cream. Per report from staff Daniel "(Resident A) took the phone into the bathroom that's where she phoned 911. I knew she had the phone but did not know she called 911 until the ambulance arrived. (Resident A) was not physically hurt. She took the office key and the laundry room key off the set she took earlier that day and handed it to staff Daniel before going to the hospital around 830pm." (Resident A) was experiencing suicidal ideation'.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	The allegation was made that Resident A was able to access knives that were supposed to be locked up, and she cut herself. Ms. Carter confirmed the sharps were kept in a container in the office which is supposed to be kept locked. Resident A obtained a knife from the office. The sharps will now be kept in a toolbox with a lock within the locked office. Ms. Carter stated Resident A has a known history of seeking ways to cut herself. I witnessed the office door open, sharps unlocked and Resident A sitting outside the office door. She confirmed she cuts herself and will continue to do so. Staff Bobby Willis and Charles Lofton denied working the day of the incident. Staff Daniel Sematungu denied knowledge of the incident, a toolbox for sharps or even that Resident A had cut herself. Resident A's Assessment Plan reports that she will "engage in SIB's-she does want to go to the hospital as often as she can. She will find ways to cut herself when upset." The IR written from statements from Mr. Willis confirms he and Mr. Sematungu were both working the day of the incident. The sharps were not locked when they were supposed to be. Resident A admitted to cutting herself and stated she will continue to do so. There is a preponderance of evidence to support the rule violations.

CONCLUSION:	**VIOLATION ESTABLISHED**

On February 27, 2024, I conducted an exit conference with interim Designee Megan Pena. We discussed the allegations and steps that had already been taken to address the concerns. I requested a Corrective Action Plan which Ms. Pena agreed to send. She had no further questions.

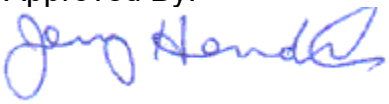
IV. RECOMMENDATION

Upon receipt of an approved Corrective Action Plan, I recommend no change to the current license status.

March 4, 2024

Rebecca Piccard — Date
Licensing Consultant

Approved By:



March 4, 2024

Jerry Hendrick — Date
Area Manager