



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

January 15, 2025

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

RE: License #: AS410363929  
**Grace**  
**2260 Peerpoint SE**  
**Caledonia, MI 49316**

Dear Mrs. Ledford:

Attached is the Licensing Study Report for the above referenced facility. The study has determined substantial compliance with applicable licensing statutes and rules. Your license and special certification is renewed. It is valid only at your present address and is nontransferable.

Please contact me with any questions. In the event that I am not available and you need to speak to someone immediately, you may contact the local office at (616) 356-0183.

Sincerely,

A handwritten signature in blue ink that reads "Rebecca Piccard".

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

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF COMMUNITY AND HEALTH SYSTEMS  
RENEWAL INSPECTION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS410363929
<b>Licensee Name:</b>	Hope Network West Michigan
<b>Licensee Address:</b>	PO Box 890 Grand Rapids, MI 49518
<b>Licensee Telephone #:</b>	(616) 490-3684
<b>Licensee/Licensee Designee:</b>	Amanda Ledford
<b>Administrator:</b>	Amanda Ledford
<b>Name of Facility:</b>	Grace
<b>Facility Address:</b>	2260 Peerpoint SE Caledonia, MI 49316
<b>Facility Telephone #:</b>	(616) 490-3684
<b>Original Issuance Date:</b>	08/04/2014
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL
<b>Certified Programs:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL

## II. METHODS OF INSPECTION

Date of On-site Inspection(s): 01/14/2025

Date of Bureau of Fire Services Inspection if applicable: 01/15/2025

Date of Health Authority Inspection if applicable: 01/15/2025

No. of staff interviewed and/or observed 4

No. of residents interviewed and/or observed 3

No. of others interviewed Role:

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.
- Medication(s) and medication record(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☒ No ☐ If no, explain.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.
- Fire drills reviewed? Yes ☒ No ☐ If no, explain.
- Fire safety equipment and practices observed? Yes ☒ No ☐ If no, explain.
- E-scores reviewed? (Special Certification Only) Yes ☒ No ☐ N/A ☐ If no, explain.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.
- Incident report follow-up? Yes ☒ No ☐ If no, explain.
- Corrective action plan compliance verified? Yes ☐ CAP date/s and rule/s: N/A ☒
- Number of excluded employees followed-up? N/A ☒
- Variances? Yes ☐ (please explain) No ☐ N/A ☒

## III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was determined to be in substantial compliance with rules and requirements.

#### IV. RECOMMENDATION

I recommend issuance of a 2 year regular adult foster care license.

 January 15, 2025

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Rebecca Piccard  
Licensing Consultant

Date