GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 14, 2025

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

RE: License #: AS410412351
Investigation #: 2025A0340048
Neo Grand Rapids

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) 356-0100.

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 #:	AS410412351
Investigation #:	2025A0340048
Complaint Receipt Date:	07/07/2025
Investigation Initiation Date:	07/07/2025
Report Due Date:	09/05/2025
Licensee Name:	Hope Network West Michigan
Licensee Address:	PO Box 890 Grand Rapids, MI 49518
LicenseeTelephone #:	(616) 490-3684
Administrator:	Amanda Ledford
Licensee Designee:	Amanda Ledford
Name of Facility:	Neo Grand Rapids
Facility Address:	456 Baltimore St NE Grand Rapids, MI 49503
Facility Telephone #:	(616) 490-3684
Original Issuance Date:	06/13/2022
License Status:	REGULAR
Effective Date:	12/13/2024
Expiration Date:	12/12/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was punched by staff Sheena Frye.	Yes

III. METHODOLOGY

07/07/2025	Special Investigation Intake 2025A0340048
07/07/2025	APS Referral Received from APS
07/07/2025	Special Investigation Initiated - Telephone Amanda Ledford
07/09/2025	Inspection Completed On-site
07/09/2025	Contact - Telephone call made Amanda Ledford-requested staff contact info
07/09/2025	Inspection Completed On-site
07/09/2025	Contact - Telephone call made staff Sheena Frye
07/09/2025	Contact - Telephone call made Amanda-requested Jean Francois's number
07/09/2025	Contact - Telephone call made staff Jean Francois
07/11/2025	Inspection Completed On-site
07/11/2025	Contact - Telephone call made staff Sheena Frye
07/11/2025	Contact - Telephone call made HR Sabrina Jones - left message
07/11/2025	Contact - Telephone call made HR Director Tiffany Speerbrecker
07/11/2025	Exit Conference Amanda Ledford

ALLEGATION: Resident A was punched by staff Sheena Frye.

INVESTIGATION: On July 7, 2025, a complaint was filed with the BCHS Online Complaints by Adult Protective Services who denied their referral. It stated that staff Sheena Frye punched Connor in the cheek on 7/1/2025. Resident A did not have any visible marks on the day of the complaint being filed, however, after the incident took place Resident A was observed with a swollen cheek and he complained of pain. Ms. Frye has been removed from working in the home pending the investigation.

On July 7, 2025, I contacted Designee Amanda Ledford and informed her of the allegation. Ms. Ledford knew that the complaint was filed. I requested the contact information for the staff involved as well as any Incident Report (IR) completed.

The IR Ms. Ledford sent was completed by staff Yordanos Tesfahanes on 7/1/25. It stated: *'(Resident A) was on his way to get his incentive with staff Yorda when he told me and staff Simona that his cheek hurt and he held his hand up to his right cheek. I asked why his cheek hurts. (Resident A) then said that his cheek hurts because Sheena punched him.*

Staff Yorda inspected his right cheek and it appeared swollen. I had staff Simona look at it as well and she stated that it appeared swollen. I called Lindsay McBride at 9:10 pm and informed her. All reporting was completed.'

On July 9, 2025, I conducted an unannounced home inspection. Resident A was in the common area of the home playing on his tablet. I attempted to interview him but there were many people in the home and Resident A was very preoccupied with his tablet and I was unable to redirect his attention.

I then spoke with staff Danica Williams who stated she was present the day of the incident. She stated she went with staff Sheena Frye as well as Resident A and Resident B for a van ride. Resident A was seated in the third row, Resident B was in the 2nd row and Ms. Frye was driving while Ms. Williams was in the passenger seat. Resident A wanted some skittles so they stopped at a nearby convenience store. Ms. Williams had gotten out of the van to throw some things away and then get the skittles. Ms. Williams did not get far from the van when she turned back because she heard a commotion. She saw Resident A was sitting in the passenger seat, crying loudly and holding his face. Ms. Frye was standing outside the van. Resident B was still in her seat and her eyes were closed, which is normal for her to either be sleeping or ignoring everyone. Ms. Williams did not ask what happened, but got back in the van and they returned home because Resident A was upset. It was only later she heard that Resident A had told 3rd shift staff that he was hit by Ms. Frye. I asked Ms. Williams if Ms. Frye said anything to her about why Resident A was crying and she said that Ms. Frye did not say anything.

I then attempted to interview Resident B. She stated she did not want to talk to me

so I was not able to complete an interview.

On July 9, 2025, I called Ms. Ledford again to clarify that they were in the van when the incident occurred and that Ms. Williams was present which had been unknown. Ms. Ledford also informed me that when Hope Network HR Sabrina Jones called Ms. Frye to inform her that she was being suspended, Ms. Frye admitted to Ms. Jones and she, “probably hit him but didn’t mean to” and that “everything happened so fast” and that she was trying to keep him from “hurting himself”.

On July 9, 2025, I called staff Sheena Frye. After I identified myself, I informed her of the allegation. Ms. Frye indicated she was aware someone would be asking about what had happened because she was suspended from work. I asked her to recall the events which occurred on the date of the incident with Resident A. She first stated Resident A was having a difficult time earlier in the day, wanting skittles and Checkers (the restaurant). Once he had settled down and after he took a nap, staff took Resident A and B on a van ride. Ms. Frye clarified that the staff were herself, Ms. Williams and staff Jean Francois. She stated she drove. Ms. Williams was in the passenger seat. Mr. Francois was sitting behind the drivers seat and the two residents were in the third row. They stopped at a store nearby so that Resident A could get the skittles he wanted. Ms. Williams got out and went into the store. Ms. Williams stated Resident A began to exhibit behaviors again which were alarming to Ms. Frye so she got out of the van, leaving it running, and went around to the passenger side since Mr. Francois was seated behind the driver’s seat. Resident A moved from the third row to the front of the van and was attempting to grab the steering wheel. Ms. Frye stated she “dove” through the passenger door, laying over the passenger seat to grab the wheel, yelling for assistance from Mr. Francois, attempting to keep Resident A from sitting in the drivers seat, taking the wheel, or jumping out the door. She added that Mr. Francois came through the center aisle of the van and the two of them successfully got Resident A seated in the passenger seat where he sat with his knees to his chest in a “squatted” style position and began to cry. At this time Ms. Williams returned and asked Resident A what was wrong. He told Ms. Williams “you hit my cheek” as he pointed to Ms. Frye. Ms. Frye stated at this time she apologized to Resident A. She stated she did not realize she hit him, but she may have during the incident in trying to keep him safe. I asked her what happened next. She said because Resident A was crying, they returned home.

I asked Ms. Frye where Resident B was during the incident. She said she remained in the back seat and did not engage, which would be normal behavior for her.

I asked Ms. Frye why she did not complete an Incident Report (IR). She informed me that it was near the end of the shift and so she was going to come in the next day to complete one. She did return the next day but was told she was not allowed to be there as she was being suspended. She assumed someone else had filed the IR.

On July 9, 2025, I contacted Ms. Ledford and informed her that Mr. Francois was also involved in the alleged incident and requested his phone number which she provided. I asked about Mr. Francois as an employee. Ms. Ledford stated Mr. Francois is a very hard worker. He is always busy doing something to make the house better. I also discussed with Ms. Ledford that my visit with Residents A and B may not have been productive because they do not know me or were not comfortable with me. I asked if there was a staff person whom they were especially close to and would feel comfortable speaking with me if that staff was present. She suggested Manager of Operations Lindsey McBride who has known the two Residents since they resided at Dart, the children's program at Hope Network. She stated she would contact Ms. McBride and set up a meeting for us at the home. Ms. Ledford also noted that staff did not note in the home daily log any behaviors for Resident A on July 1, 2025. She again confirmed there were no IR's for anything during 1st shift when this allegedly occurred.

On July 9, 2025, I left a message for Mr. Francois.

On July 11, 2025, I met Ms. McBride at the Neo GR home. I gave her a brief summary of the allegation and what happened during my previous visit. I explained Resident B was present, but did not want to speak with me. I am familiar with Resident B and her history, her behaviors, and her que's for becoming agitated or upset. I thanked Ms. McBride for assisting in another attempt to speak with both residents. When we entered the home, Resident A was at the door and remembered me and said hello to me by name. Ms. McBride and I explained we were here for another visit. Ms. McBride then spoke to Resident B and asked her if she would speak with me if she were present and Resident B agreed to do so. We went to Resident B's room to speak privately.

I introduced myself to Resident B and the reason for my visit. I was aware of her cognitive limitations, but knew she was capable of being interviewed. I asked Resident B if she remembered going on a van ride last week with Resident A and Ms. Frye, Ms. Williams, and Mr. Francois. She said "yes". I asked Resident B if she remembered stopping at the store during the van ride. She said "yes". I asked Resident B if she remembered anything happening during the stop at the store. Resident B stated that Ms. Frye got out of the van and walked around. Resident A went to the front of the van and sat in the passenger seat. Ms. Frye opened the passenger door and was leaning in on Resident A. Resident A began to cry. When I asked Resident B why Resident A began to cry, she stated, "I don't know". Ms. McBride offered encouragement that she was not in trouble and that we want to make sure that she and Resident A were safe. I asked Resident B if Ms. Frye put her hands on Resident A. Resident B responded "I don't know". I asked Resident B if Ms. Frye hit Resident A. Resident B responded "I don't know". At this point the interview was concluded.

After Resident B had left the room, Ms. McBride informed me that her drooling was a signal of her feeling very uncomfortable. We discussed the abrupt change in

demeanor when asked about details after Resident A went to the front of the van.

Mr. Francois happened to be working during my home inspection, so I was able to interview him while I was there. I informed him of the allegation of which he was aware. I asked him to recall the events of that day and the van ride they took with Residents A and B. He stated Mr. Francois stated Ms. Frye was driving. Ms. Williams was in the passenger seat. He was seated behind the driver. Resident B was seated next to him-the second row are two captain chairs so there is an aisle all the way to the third row where Resident A always sits. Mr. Francois stated that Residents A and B cannot sit next to each other because they are like siblings and will pick at each other. Ms. Williams got out to get the skittles, but she did not leave the van area. She threw something away and was only gone for “maybe a minute” before she was back near the van because everything happened very fast. Mr. Francois stated Ms. Frye also got out of the van at the same time as Ms. Williams. Ms. Frye went around to the other side of the van and Resident A immediately went to the passenger seat. Mr. Francois stated Resident A is a “tall guy” so it is only a step or so and he is in the front. He sat down and Ms. Frye opened the passenger door. Mr. Francois stated all three staff attempted to redirect Resident A to his original seat in the back of the van. It did not work, so they buckled him in, Ms. Williams got in the back and they went back home because Resident A was crying.

I asked Mr. Francois why Resident A was crying. He stated he assumed because he wanted his skittles. I asked if he saw Ms. Frye strike Resident A and he said he did not. I asked if Resident A had gotten in the driver’s seat or attempted to get in the driver’s seat or grab the steering wheel and he stated he did not. I asked if Ms. Frye had gotten in the van through the passenger side, laying on the passenger seat, and Mr. Francois stated she did not. Mr. Francois clarified that he did not have to put hands on Resident A because all they did was talk to him in an attempt to redirect. He did not view it as an “incident” and therefore did not file an IR. Mr. Francois stated if he witnessed someone behave inappropriately he would not hesitate to report. He added that if something happened between Resident A and Ms. Frye, he did not witness it.

I then interviewed Ms. Williams again as she was also working during my inspection. I explained to Ms. Williams I needed clarification regarding details which she stated she was happy to assist. Ms. Williams clarified that she did not go into the store. She did not leave the van area and only left the van to throw something away and then knew something happened so she returned “after a minute or two.” I asked Ms. Williams to clarify the time of day that the van ride occurred. She stated it was morning because when they returned she passed Resident A’s noon medication. She then clarified that Ms. Frye got out at the same time that she did when they arrived at the store. Ms. Williams still did not know why she got out of the van. She stated whatever happened in the van happened very quickly and when she got back to the passenger side, Resident A was squatting in the passenger seat, crying, and covering his face. I read the statement Ms. Frye made regarding what Ms. Williams said upon her return to the van. Ms. Williams denied asking Resident A about what

happened. She denied that Ms. Frye “apologized”. Ms. Frye stated firmly that “Ms. Frye is lying”. She stated when Resident A was crying and Ms. Frye and Mr. Francois were attempting to get him back in his seat she assumed he was upset about that and wanting his skittles. She attempted to assist in redirecting him. That did not happen so she got in the back and they returned to the home.

When they returned, staff got Resident A calmed and Ms. Williams passed his medications. She did not notice a mark or redness on his face, but she was also not looking. Later they got Checkers for dinner and then it was the end of shift. Ms. Williams did not experience anything which would warrant the completion of an IR for any behaviors for either resident. Ms. Williams stated if something happened between Resident A and Ms. Frye, she did not see it.

Ms. McBride and I then interviewed Resident A in his room. He seemed much more comfortable and did not have his tablet distracting him. I asked him if he remembered taking a van ride last week with Resident B, Ms. Williams, Mr. Francois, and Ms. Frye. He said “yeah”. I asked if he remembered stopping at the store. He said “Yeah, to get skittles” and a drink. I asked who was going into the store to get his skittles and drink and he named Ms. Williams. I asked if anyone else got out of the van. He stated Ms. Frye got out and walked around the van. I asked Resident A why she did that but he did not know. I asked if he got his skittles and drink. He said “no, I went to the front of the van”. I asked if he was supposed to go to the front of the van. Resident A said “no”. I asked Resident A what happened when he went to the front of the van. Resident A stated that Ms. Frye punched him in the face. Ms. McBride asked Resident A if he could show us how she punched him. Resident A made a closed fist and demonstrated a punch to the right side of his face. I asked Resident A if he was afraid of Ms. Frye when she worked in the home and Resident A stated “yes”. Ms. McBride and I assured Resident A that we will make sure that he is safe and not afraid of anyone in his own home.

I spoke with Ms. McBride privately afterward. She shared that she has known Resident A for many years and while he can exhibit behaviors of physically acting out, it is not normal for him to cry unless something happened. Ms. McBride was very concerned that he was crying and staff were not attempting to find the cause of what was upsetting him during first shift. She did not believe he would “cry” over skittles to the point staff would end an outing.

I asked Ms. McBride about any concerns of disciplinary action or behavior in the past by Ms. Frye. She stated there were no physical abuse allegations in the past. There have been situations brought to her attention in which it seemed Ms. Frye may have been intimidating other staff members. I asked her if she thought Mr. Francois or Ms. Williams could be intimidated by Ms. Frye. Ms. McBride did not believe Ms. Williams would be, but there have been previous situations in which Ms. McBride had concerns that Ms. Frye had intimidated Mr. Francois.

On July 11, 2025, I contacted Ms. Frye for a second interview. I informed her that I

needed clarification with some details and asked her to tell me approximately what time it was that they went out for the van ride. At first she stated she could not remember. I then asked if it was morning or afternoon. She then stated it was in the afternoon. I asked Ms. Frye to clarify why she had gotten out of the van. She repeatedly stated that Resident A was “having behaviors”. I asked her to clarify what she meant by “behaviors”. Ms. Frye was unable to articulate what she meant other than to say “he kept asking for skittles”. I asked again why she got out of the van, leaving it running. She stated that Ms. Williams had gone into the store and she “had a feeling” that Resident A was “going to have behaviors” such as jumping out of the van and she was “preparing for that”. She further stated that he had had behaviors earlier that day and they had to calm him down and he took a nap before they could go on the van ride.

I then asked Ms. Frye why she opened the passenger door if she was concerned Resident A was going to elope from the van? Ms. Frye stated when Resident A “leaped forward” in the van she thought he was going to grab the steering wheel and she tried to grab it and was screaming for Mr. Francois to help her but he was on his phone. I asked Ms. Frye again why she did not complete an IR and she again stated she was going to, but she went home instead and planned to fill it out the next day but was then informed she was suspended. I asked her why she did not call someone or tell someone that day that she needed to file it. Ms. Frye did not have an answer. I explained that if the events happened the way that she explained then Ms. Frye failed to report the incident. Ms. Frye then attempted to blame her co-workers for not filing an IR for her. I explained that their account of what happened did not coincide with her events and it is not their responsibility to file an IR for her. Ms. Frye then accused her co-workers of lying and covering up what happened. I then addressed the fact that Ms. Frye admitted to me earlier and to Hope Network HR that she could have struck Resident A. She again admitted that it was possible. I suggested to Ms. Frye that she should have documented the incident and her actions and let her manager or anyone else know what happened.

On July 11, 2025, I left a message for Ms. Jones.

On July 11, 2025, I spoke with Hope Network HR Director Tiffany Speerbrecker. She interviewed Resident A after he told 3rd shift staff what happened, and they filed the IR. Resident A had made the same statement to her as he had made to me and Ms. McBride. He made a closed fist and demonstrated a punch to the right side of his face and stated that Ms. Frye punched him. HR staff Sabrina Jones was the one who called Ms. Frye to inform her of her suspension. Ms. Frye had asked Ms. Jones if it was because she has “knicked him”. Ms. Speerbrecker provided me with the contact information for Ms. Jones but Ms. Jone is out of the office until Tuesday.

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:	The allegation was made that staff Sheena Frye punched Resident A. An IR was filed after Resident A told 3rd shift staff that he was punched by Ms. Frye and he was observed to have a swollen right cheek. When HR called Ms. Frye to suspend her pending the investigation, Ms. Frye reportedly made the comment that she "probably hit him but didn't mean to". Ms. Frye stated during a van ride she got out when Resident A was exhibiting behaviors, and he attempted to grab the steering wheel. Ms. Frye opened the passenger door and attempted to keep Resident A from the driver's seat and taking the wheel as she lay across the passenger seat. She admitted that she could have struck him during this incident but did not mean to. Ms. Williams stated she got out of the van to get skittles for Resident A. Ms. Frye got out at the same time for unknown reasons. Ms. Williams first threw stuff in the garbage and then noticed commotion so she returned to the van. She observed Resident A in the passenger seat crying. She did not see what happened. They returned to the home. Resident B stated "I don't know" when asked details about what happened after Resident A moved to the front of the van. Mr. Francois stated Resident A did move to the passenger seat of the van. There were no behaviors. It was not an incident. They tried to redirect him back to his seat but he did not want to go so they let him stay there and they returned home. Resident A was crying but Mr. Francois assumed it was because of wanting skittles. He did not see Ms. Frye hit Resident A. He did not know why Ms. Frye got out of the van but she got out at the same time as Ms. Williams. Resident A stated Ms. Frye punched him in the face with a closed fist.

	Ms. Speerbrecker stated Resident A told her Ms. Frye punched him in the face with a closed fist. Ms. Speerbrecker confirmed that Ms. Frye stated to Ms. Jones when Ms. Jones called to inform Ms. Frye of her suspension from employment, that she may have "knicked" Resident A. There is a preponderance of evidence to support a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On July 11, 2025, I conducted an exit conference with Designee Amanda Ledford. I shared with her the details of my interviews. We discussed the fact that Resident A made the same statement multiple times on multiple occasions. Ms. Ledford stated she will inform HR of the substantiation of physical abuse. She will get a Corrective Action Plan for this violation to me as soon as possible.

IV. RECOMMENDATION

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

Rebecca Piccard July 14, 2025

Rebecca Piccard Date
Licensing Consultant

Approved By:

Jerry Hendrick July 14, 2025

Jerry Hendrick Date
Area Manager