GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 3, 2025

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

RE: License #: AS620395569
Investigation #: 2025A0340054
The Woods North

Dear Ms. Wendt:

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 #:	AS620395569
Investigation #:	2025A0340054
Complaint Receipt Date:	08/22/2025
Investigation Initiation Date:	08/25/2025
Report Due Date:	10/21/2025
Licensee Name:	HGA Non Profit Homes Inc.
Licensee Address:	917 West Norton Muskegon, MI 49441
Licensee Telephone #:	(231) 728-3501
Administrator:	Melanie Billings
Licensee Designee:	Teresa Wendt
Name of Facility:	The Woods North
Facility Address:	355 N.North St. White Cloud, MI 49349
Facility Telephone #:	(231) 689-5023
Original Issuance Date:	12/17/2018
License Status:	REGULAR
Effective Date:	06/17/2025
Expiration Date:	06/16/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff did not supervise Resident A and she eloped from the home.	Yes

III. METHODOLOGY

08/22/2025	Special Investigation Intake 2025A0340054
08/22/2025	APS Referral Filed by APS
08/25/2025	Special Investigation Initiated - Telephone Teresa Wendt
08/26/2025	Inspection Completed On-site
08/26/2025	Exit Conference Tereas Wendt

ALLEGATION: Staff did not supervise Resident A and she eloped from the home.

INVESTIGATION: On August 22, 2025, a complaint was filed with BCHS Online Complaints by Adult Protective Services. It stated that a neighbor had caught Resident A on their Ring camera coming into their yard, up to their porch, and took packages which were on the porch. When the neighbor's dogs began barking, Resident A set the packages back down and ran off.

On August 25, 2025, I contacted Designee Teresa Wendt. I informed her of the allegation, of which she was not aware. She identified Resident A as someone who has talked to the neighbors because their dog had come over to the AFC home. Ms. Wendt also knew that Resident A likes to go to the park across the street and some people had complained about that, but added, Resident A has the right to go there. Ms. Wendt did not know the specific requirements for Resident A's supervision.

The neighbors are not new to the area and Resident A is not new to the home, but Resident A's behaviors have increased recently after she had been taken home to live by her mother (about 6 months ago), then returned shortly afterward when her mother stated she could not handle her. Newaygo CMH is in the process of updating her Behavior Plan (BSP) but Ms. Wendt did not know when that would be completed.

On August 26, 2025, I conducted an unannounced home inspection. I first spoke with Home Manager Samantha Shop and informed her of the allegation. She was aware that Resident A had gone to the neighbor's house, and they were not happy about it. She also stated that the police have been involved when Resident A has eloped and staff were unable to follow her. I asked Ms. Shop what the supervision requirements were for Resident A. She stated that due to her elopement history, it is necessary to have staff within "line of sight", unless she is in her bedroom. If staff are not able to follow Resident A when she elopes from the home, staff call the police and they return Resident A to the home. Ms. Shop stated the police are familiar with Resident A and locate her quickly. I advised Ms. Shop this is not appropriate and if this is an ongoing issue then changes to her supervision or staffing need to occur to address the situation.

Ms. Shop stated that this incident occurred when staff were outside with Resident A and she "took off". Ms. Shop had been told Resident A was only gone a few minutes before returning. Ms. Shop stated she was not working when the incident occurred. She has an Incident Report (IR) to document. I asked to see the IR.

The IR was completed by staff Amiya Pennington on 8/20/25. It stated that while she and Resident A were outside playing tag, Resident A disappeared "for a bit" and when she was calling for her, Resident A came running up the driveway. The police showed up shortly afterward, apparently called by the neighbors, and informed Ms. Pennington that Resident A had attempted to steal a package from the neighbor's porch.

I reviewed Resident A's Assessment Plan which was signed by Program Manager Leigha Arnold on 2/25/25. Under "Moves Independently in the Community" it states, "Staff will be present at all times within arm's reach".

I reviewed Resident A's Personal Centered Plan (PCP) created by Newaygo County CMH on 11/5/24. The PCP does not address supervision or require any increased monitoring.

I asked Ms. Shop about the "within arm's reach" requirement in the Assessment Plan but no supervision requirement in the PCP. Ms. Shop did not have an explanation. She stated that Resident A does not like people to be "in her space" so they usually watch her from "a distance". I informed Ms. Shop that is not consistent with what is documented in Resident A's Assessment Plan. She then clarified herself, stating staff were within arm's reach.

I interviewed Resident A privately in her bedroom. She presented herself as cognitively capable of being interviewed. I explained to Resident A who I was and the reason for my visit. I asked Resident A if she feels safe at The Woods home. She indicated that she does feel safe. I asked her if she had recently gone to the neighbor's house. Resident A said she can go places by herself. I attempted to clarify if she told anyone she was leaving or if she was supposed to leave on her

own but Resident A repeated that she can leave on her own. I attempted to discuss safety with Resident A but she stated she was safe and did not want to talk anymore.

Program Manager Leigha Arnold then arrived at the home. I discussed with Ms. Arnold my concerns regarding Resident A's safety. I pointed out the discrepancy in the PCP and the Assessment Plan. Ms. Arnold stated she had copied what had been previously written by Administrator Melanie Billings on Resident A's previous Assessment Plan. I expressed concern that it was not appropriate to "copy" something without knowledge if it was warranted or not. Ms. Arnold then mentioned that when Resident A is in her room she has pushed out the screen and eloped from there. I suggested that her PCP should be updated and that there is continued risk to her safety, especially with her reported history of eloping, that staff should be informed of and closely following her supervision requirements. I added that it was inappropriate to rely upon the police on a regular basis to return her. If this is an ongoing behavior, it needs to be addressed in her plan and possibly more staff need to be working to ensure Resident A is properly supervised without neglecting the needs of others. I discussed with Ms. Arnold that if the neighbor is calling the police instead of coming to the home to discuss their frustrations, the situation has risen to a level requiring more supervision.

I then called Ms. Wendt to conduct an exit conference and discuss with her the findings. Ms. Wendt stated she had discovered the discrepancy in documentation as well and did not have an explanation. I clarified with Ms. Wendt that neither the Designee nor the Administrator are signing the paperwork and that was concerning. I discussed with Ms. Wendt that it was also concerning that Ms. Arnold and Ms. Shop failed to recognize the discrepancy in the paperwork, which indicates they are not familiar with the paperwork. If management was not familiar then it raises concern regarding how staff are trained and how Resident A's needs are being met on a regular basis. I discussed with Ms. Wendt that Ms. Shop and Ms. Arnold seemed content to let the police handle Resident A's eloping behavior and that it was not appropriate for them to do so.

I informed Ms. Wendt that a Corrective Action Plan is required for failing to provide required supervision for Resident A.

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 staff were not supervising Resident A adequately and she eloped to the neighbor's where she proceeded to take packages off their porch. Once their

	dogs started barking, Resident A returned the packages and ran off. Resident A's Assessment Plan requires Resident A to be within arm's reach while in the community. The IR completed by Ms. Pennington stated she was playing tag with Resident A when Resident A disappeared but returned shortly thereafter. The police showed up and informed her what had happened at the neighbor's house. Resident A was not provided with the level of supervision specified in her Assessment Plan as staff did not remain within arm's reach of Resident A when she left the property.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

September 3, 2025

Rebecca Piccard — Date
Licensing Consultant

Approved By:

September 3, 2025

Jerry Hendrick — Date
Area Manager