GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 12, 2025

Kathy Patterson
New Hope Group Home, LLC
3671 Senora Ave. SE
Grand Rapids, MI 49508

RE: License #: AS410418890
Investigation #: 2026A0583009
Mapleview

Dear Ms. Patterson:

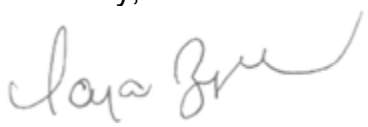
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410418890
Investigation #:	2026A0583009
Complaint Receipt Date:	11/04/2025
Investigation Initiation Date:	11/04/2025
Report Due Date:	12/04/2025
Licensee Name:	New Hope Group Home, LLC
LicenseeAddress:	3671 Senora Ave. SE Grand Rapids, MI 49508
Licensee Telephone #:	(419) 439-1218
Administrator:	Kathy Patterson
Licensee Designee:	Kathy Patterson
Name of Facility:	Mapleview
Facility Address:	1824 Mapleview St SE Grand Rapids, MI 49508
Facility Telephone #:	(419) 439-1218
Original Issuance Date:	01/15/2025
License Status:	REGULAR
Effective Date:	07/15/2025
Expiration Date:	07/14/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff left residents alone at the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/04/2025	Special Investigation Intake 2026A0583009
11/04/2025	Special Investigation Initiated - Letter Recipient Rights Michael Kuik
11/06/2025	Inspection Completed On-site
11/06/2025	APS Referral
11/12/2025	Exit Conference Licensee designee Kathy Patterson

ALLEGATION: Staff left residents alone at the facility.

INVESTIGATION: On 11/04/2025 I received the above complaint allegation via email from Network 180 Recipient Rights. The complaint alleged that, “Recently (Resident A) got home from work and there was no staff in the home” and “there were two other residents in the home without staff”.

On 11/04/2025 Michael Kuik of Network 180 Recipient Rights confirmed via email that he is investigating the complaint allegation.

On 11/05/2025 I completed an unannounced onsite investigation at the facility and interviewed licensee designee Kathy Patteron, staff Jordan Ballard, Resident A, Resident B, Resident C, and Resident D.

Ms. Patterson stated that on 11/01/2025 Ms. Ballard worked alone at the facility from approximately 2:00 PM until 6:00 PM. She stated that at 4:59 PM she received a text message from Relative 1 who stated that Resident A was at the facility without staff present. Ms. Patterson stated she text messaged Ms. Ballard, who stated that she and other residents were on their way back to the facility and Resident A had returned home early without alerting staff.

Ms. Ballard stated that at approximately 4:00 PM she transported Resident B, Resident C, and Resident D in the facility van to a local gas station. She stated that while she was at the gas station, Resident A arrived at the facility and let himself inside without her knowledge. She explained that Resident A had been in the

community but failed to text message her to let her know that he would be home at 4:00 PM. Ms. Ballard stated that she arrived back at the facility at approximately 4:20 PM and Resident C and Resident D entered the home while she stayed outside for another 10 minutes to provide verbal praise to Resident B. She stated that she parked the facility's van and her personal vehicle on the street to the left of the facility which caused Resident A to believe no staff were home.

Resident A stated that he was in his bedroom and opened his door at 4:55 PM to discover that Ms. Ballard was gone. He stated that Ms. Ballard left Resident C and Resident D at the facility with him. He stated that the residents did not know where Ms. Ballard went and observed that the facility van was gone. He stated that he used his cell phone to record a video of the inside of the facility indicating that no staff were present and photographed that no vehicles were parked in the driveway or in front of the facility on the street. He stated that he text messaged Relative 1 and informed her that Ms. Ballard had left him and other residents alone at the facility. He stated he also texted Ms. Patterson who stated that Ms. Ballard was on her way back to the facility. Resident A stated that Ms. Ballard arrived back at the facility soon afterwards.

While onsite Resident A text messaged my state issued cell phone one video and two photographs that he stated he recorded on 11/01/2025. I observed that the video is stamped 11/01/2025 4:55 PM. The video depicts Resident A searching the facility for staff and finding that he was alone with Resident C and Resident D. The first photograph depicts no vehicles in the facility driveway, and the second photograph depicts no vehicles parked on the street in front of the facility.

Resident B stated that after 4:00 PM on 11/01/2025, Ms. Ballard transported him to her home in Grand Rapids. He stated that Ms. Ballard left him unattended in the running van while she ran inside her home and brought back snacks to Resident B which consisted of items such as candy. He stated that he was unsure of how long Ms. Ballard left him inside the van. He stated that Ms. Ballard then drove him to a gas station "by her house in Grand Rapids". He stated that Ms. Ballard left him inside the running van for approximately five minutes while she went inside the gas station. He stated that Ms. Ballard then drove him back to the facility. He stated that Resident A, Resident C, and Resident D were left alone at the facility while he and Ms. Ballard were gone. Resident B estimated that the two were gone for approximately an hour. He stated that Ms. Ballard asked him not to tell anyone about the incident because she "did not want to get in trouble".

Resident C stated that on the afternoon of 11/01/2025, Ms. Ballard told Resident C that she "would be back in minute" because she needed to "get stuff from her house". He stated that she took Resident B with her and left Resident A, Resident C, and Resident D without staff at the facility. He stated that she was gone approximately one hour.

Resident D stated that on 11/01/2025, Ms. Ballard left him at the facility and “said she’d be right back”. He stated that Ms. Ballard took Resident B “downtown” with her and was gone “a long time”.

On 11/06/2025 I emailed complaint the allegation to Adult Protective Services via the online portal.

On 11/06/2025 I interviewed Relative 1 via telephone. She stated that she is Resident A’s mother. She stated that on the afternoon of 11/01/2025 she was contacted by Resident A and he reported that he was at the facility without staff present. She stated that she “messaged” Ms. Patterson right away and informed her that Resident A was at the facility without staff supervision. Ms. Patterson said Ms. Ballard had all residents with Ms. Ballard in the community and Ms. Ballard was on her way back to the facility. Ms. Patterson reported that Ms. Ballard did not know that Resident A was at the facility alone because he had returned to the facility from an outing without alerting staff. Relative 1 stated that she spoke to Ms. Ballard later in the evening on 11/01/2025 and Ms. Ballard stated that she did not leave any residents alone at the facility. Ms. Ballard said that she was in her personal car in the driveway making a personal call when Resident A could not locate her.

On 11/12/2025 I completed an exit conference via telephone with licensee designee Kathy Patterson. Ms. Patterson agreed that a violation had occurred and stated that Ms. Ballard was terminated from her employment at the facility effective 11/05/2025. She stated that she would submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.** **(b) 12 residents for small group and family homes.**
ANALYSIS:	Resident A, C, and D each stated that on 11/01/2025 staff Jordan Ballard left them at home without any staff present. Resident B confirmed that on 11/01/2025 Ms. Ballard left Resident A, C, and D without staff at the facility while he and Ms. Ballard were out in the community.

	Resident A text messaged my state issued cell phone one video and two photographs that he stated he recorded on 11/01/2025. The video is stamped 11/01/2025 4:55 PM. The video depicts Resident A searching the facility for staff and finding that he was alone with Resident C and D. The first photograph depicts no vehicles in the facility driveway and the second photograph depicts no vehicles parked on the street in front of the facility. Based upon my investigation it has been established that on the afternoon of 11/01/2025 Ms. Ballard left Resident A, C, and D alone and unsupervised at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's gold necklace is missing.

INVESTIGATION: On 11/04/2025 I received complaint allegation via email from Network 180 Recipient Rights. The complaint alleged that Resident A's "gold necklace is gone".

While onsite on 11/05/2025 I interviewed licensee designee Kathy Patterson, staff Jordan Ballard, staff Martellus Ballard, Resident A, Resident B, Resident C, and Resident D.

Ms. Patterson stated that Resident A recently stated that he is missing his necklace, which is an inexpensive gold colored chain. She stated that Resident A has a lock and key on his private bedroom door which allows him to lock it when he chooses. She stated that she has asked all residents and staff where Resident A's chain could be, but no one has observed the missing chain. She stated that she would continue to look for the chain.

Ms. Ballard and Mr. Ballard both stated that they do not know where Resident A's chain is and they will continue to look for it.

Resident A stated that his chain recently went missing. He stated that he left the chain hanging on the wall in his private bedroom and did not know who would have taken it. He acknowledged that he has a key to lock his bedroom door but often forgets to do so.

Resident B, C, and D each stated that the do not know who may have taken Resident A's chain. They each denied taking the chain.

On 11/06/2025 I interviewed staff Janet Dollman via telephone. Ms. Dallman confirmed that Resident A is missing a chain. She stated that she has no knowledge of who may have taken the chain.

On 11/12/2025 I completed an exit conference via telephone with licensee designee Kathy Patterson. Ms. Patterson agreed with the findings.

APPLICABLE RULE	
R 400.637	**Handling of resident funds and valuables.**
	(11) A licensee, staff, volunteers, members of the household, and their family members cannot accept, take, or borrow money, resident funds, or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Licensee designee Kathy Patterson, staff Jordan Ballard, staff Marcellus Ballard, staff Janet Dallman each reported that they do not know who may have taken Resident A's chain. Resident B, C, and D each stated that they do not know who may have taken Resident A's chain. Resident A stated that he left the chain hanging on the wall in his private bedroom and did not know who would have taken it. Based upon my investigation it has not been established that staff or residents took Resident A's chain.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff did not provide Resident A with his medications while out of the facility.

INVESTIGATION: On 11/04/2025 I received the above complaint allegation via email from Network 180 Recipient Rights. The complaint stated that a couple weeks after moving into the home Relative 1 brought Resident A to her home, but the staff forgot to pack two of his medications which were controlled substances.

While onsite on 11/05/2025 I interviewed licensee designee Kathy Patterson. She stated that on 10/20/2025 Resident A spent the night at Relative 1's home and on 10/20/2025 staff Janet Dollman packed and sent Resident A's medications with Relative 1. Ms. Patterson stated that on 10/21/2025 Relative 1 brought Resident A back to the facility and stated that Resident A's Ativan and Concerta were not sent with Resident A. Ms. Patterson stated that she later spoke with Ms. Dollman who acknowledged that she had forgotten to pack Resident A's Concerta and Ativan because they are stored in a locked box.

On 11/06/2025 I received and reviewed an email from Ms. Patterson that contained Resident A's Medication Administration Record (MAR). Resident A is prescribed

Lorazepam (Ativan) .5 MG take 1 tablet at bedtime and Concerta 36 MG take 1 tablet in the morning. The MAR indicates that the two medications were provided to Relative 1 on 10/20/2025 by Ms. Dollman.

On 11/06/2025 I interviewed Ms. Dollman via telephone. Ms. Dollman confirmed that on 10/20/2025 she had forgotten to pack and send Resident A's Concerta and Ativan with Relative 1.

On 11/06/2025 I interviewed Relative 1 via telephone. She stated that on 10/20/2025 she picked up Resident A for an overnight visit and Ms. Dollman provided her with Resident A's medications. Relative 1 stated that later 10/20/2025 she observed that Resident A's Concerta and Ativan medications were not provided by Ms. Dollman.

On 11/12/2025 I completed an exit conference via telephone with licensee designee Kathy Patterson. Ms. Patterson agreed that a violation had occurred and stated that she would submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(5) A licensee, administrator, or direct care staff shall ensure that the resident or the individual who assumes responsibility for the resident has the appropriate information, medication, and instructions when the resident is out of the facility but still requires medication during that period.
ANALYSIS:	Staff Janet Dollman confirmed that on 10/20/2025 she had forgotten to pack and send Resident A's Concerta and Ativan with Relative 1. Relative 1 stated that on 10/20/2025 she picked up Resident A for an overnight visit and Ms. Dollman provided her with Resident A's medications. Relative 1 stated that later on 10/20/2025 she observed that Resident A's Concerta and Ativan medications were not provided by Ms. Dollman. Based upon my investigation it has been established that on 10/20/2025 Ms. Dollman failed to pack and send Resident A's Ativan and Concerta.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: Staff left Resident B alone in a running van.

INVESTIGATION: While onsite on 11/05/2025 Resident B stated that after 4:00 PM on 11/01/2025, Ms. Ballard transported him to her home in Grand Rapids. He stated that Ms. Ballard left him unattended in the running van while she "ran inside" her home and brought back "snacks" to Resident B. He stated that he was unsure of how long Ms. Ballard left him inside the van. He stated that Ms. Ballard then drove him to a gas station "by her house in Grand Rapids". He stated that Ms. Ballard left him inside the running van for approximately five minutes while she went inside the gas station. He stated that Ms. Ballard then drove him back to the facility. He stated that Resident A, C, and D were left alone at the facility while he and Ms. Ballard were gone. Resident A estimated that the two were gone for approximately an hour. He stated that Ms. Ballard asked him not to tell anyone about the incident because she "did not want to get in trouble".

On 11/06/2025 I observed Special Investigation 2025A0583052 dated 08/13/2025. This report indicated that staff Jordan Ballard left four residents unsupervised in the facility van on 08/02/2025 and 08/03/2025. A Corrective Action was received and approved 08/14/2025.

On 11/12/2025 I completed an exit conference via telephone with licensee designee Kathy Patterson. Ms. Patterson agreed that a violation had occurred and stated that she would submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Resident B stated that on 11/01/2025 staff Jordan Ballard left him alone inside of the running facility van while she went inside of her home and later inside of a gas station. Based upon my investigation it has been established that on the afternoon of 11/01/2025 Ms. Ballard left Resident B unsupervised in the facility van while she went inside of her home and while she went inside of a gas station.
CONCLUSION:	**VIOLATION ESTABLISHED** **(Repeat Violation from Special Investigation 2025A0583052 dated 08/13/2025)**

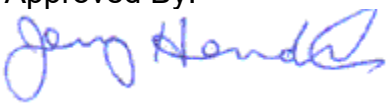
IV. RECOMMENDATION

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

11/12/2025

Toya Zylstra — Date
Licensing Consultant

Approved By:



11/12/2025

Jerry Hendrick — Date
Area Manager