



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 15, 2025

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

RE: License #: AS410311897
Investigation #: 2026A0340009
Kinney Home

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 #:	AS410311897
Investigation #:	2026A0340009
Complaint Receipt Date:	11/10/2025
Investigation Initiation Date:	11/10/2025
Report Due Date:	01/09/2026
Licensee Name:	Hope Network West Michigan
Licensee Address:	PO Box 890 Grand Rapids, MI 49518
Licensee Telephone #:	(616) 490-3684
Administrator:	Amanda Ledford
Licensee Designee:	Amanda Ledford
Name of Facility:	Kinney Home
Facility Address:	2210 Kinney Street N.W. Walker, MI 49504
Facility Telephone #:	(616) 805-5137
Original Issuance Date:	04/04/2011
License Status:	REGULAR
Effective Date:	09/07/2025
Expiration Date:	09/06/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Staff Kelli Ferris flipped a couch over while Resident A was sitting on it and then dragged him out of the room.	Yes

III. METHODOLOGY

11/10/2025	Special Investigation Intake 2026A0340009
11/10/2025	Special Investigation Initiated - Telephone Amanda Ledford
11/12/2025	Inspection Completed On-site
11/14/2025	Contact - Document Sent ORR Brandy Marvin
11/14/2025	Contact - Telephone call made staff Kelli Ferris-left message
11/14/2025	Contact - Telephone call made Amanda Ledford-had HR contacted Kelli for suspension
12/12/2025	Exit Conference Designee Amanda Ledford

ALLEGATION: Staff Kelli Ferris flipped a couch over while Resident A was sitting on it and then dragged him out of the room.

INVESTIGATION: On November 10, 2025, a complaint was sent to me by the Office of Recipient Rights in North Country CMH, Brandy Marvin. It stated that on 11/7/25, Resident A was sitting on the couch in the living room. Staff Kelli Ferris was asking him to get up and dust his room. Resident A told Ms. Ferris that his mother would help him at another time. Ms. Ferris became upset and flipped the couch over and Resident A fell off the couch onto the floor. Ms. Ferris told Resident A to get up but he wouldn't, so she grabbed him by his feet and dragged him across the floor into the hallway and then shut the hallway door.

On November 10, 2025, I received a call from Ms. Marvin. She provided me the contact information for the staff. She asked for a summary of my interviews of the residents.

On November 12, 2025, I contacted Designee Amanda Ledford. I informed her of

the allegation, which she was already aware. Ms. Ledford stated there is no history of disciplinary action against Ms. Ferris. She stated that Ms. Ferris was working by herself but the residents in the home would be able to provide an account of what they witnessed. Resident A is somewhat limited but able to communicate. All the residents go to day programs so she advised I go later in the day.

On November 12, 2025, I conducted an unannounced home inspection. All the residents of the home were present during my visit. I first spoke with Tamarisk Harris, home manager. She informed me that Ms. Ferris has been suspended pending this investigation. Ms. Harris was not present on the day of the incident, but heard about it. She has not had any problems with Ms. Ferris in the past and the allegations reportedly surprised her.

I first interviewed Resident A who agreed to meet with me privately in his room. Resident A had some verbal limitations. He agreed to answer questions for me but due to the verbal limitations we did a re-enactment and walked step by step so he would only have to provide simple words or phrases to explain what happened. Resident A stated he was on the couch and Ms. Ferris was behind the couch. He stated that Ms. Ferris tipped the couch over by pushing it forward and he fell to the floor, in a "sliding off" manner. He stated Ms. Ferris then dragged him by the legs to the hallway and shut the emergency fire door behind him. He said it hurt his back but his back doesn't hurt anymore. Resident A then began to cry so the interview ended.

Resident B was interviewed next in her room. She stated she was in her room when it happened but heard Resident A crying so she went out and saw him on the floor in the hallway. She said she saw Ms. Ferris shut the fire door on Resident A and tell him to quit crying and not come out until lunch. Ms. Ferris also reportedly told Resident B to go back to her room. Resident B stated she does not like Ms. Ferris because she yells and curses at residents. Resident B stated she would be happy if Ms. Ferris did not return to work at the home.

Next, I interviewed Resident C. She stated she witnessed Ms. Ferris tip the couch over causing Resident A to fall to the floor because he wouldn't dust his room. Resident C said Resident A's mother dusts his room so he does not do this chore. Resident C stated that Resident A began to cry after he fell off the couch. Ms. Ferris told him to get up but he did not and continued to cry so Ms. Ferris dragged him to the hallway where the bedrooms are, left him in the hallway, laying on the floor, and shut the emergency door on him. Resident C did hear Ms. Ferris tell Resident B to get back in her room. All of this happened in the morning.

Resident C said the rest of the day was "okay", but everyone "was scared" of Ms. Ferris. She stated Ms. Ferris "yells a lot" and frequently raises her voice at residents before, "but never like this".

Resident D was sleeping at the time of this incident, so he was not interviewed.

I then interviewed staff Leslie Singleton. She stated she worked the shift after Ms. Ferris. No one said anything to her during that shift.

I reviewed the Assessment Plan for Resident A. It was signed by Designee Amanda Ledford on 7/30/25. Under "Follows Instructions" it states: "(Resident A) can follow instructions however, he may be very slow in completing a specific task. It is important that staff avoid giving instructions with not enough time for (Resident A) to process his request. (Resident A) does not respond well to "orders", staff must be mindful of their tone of voice, body language when asking (Resident A) to complete something."

Under "Participates in household chores" it states; "(Resident A) is reluctant on completing any household chores."

On November 14, 2025, I left a message for Ms. Ferris to call me. As of this date I have not heard back from her.

On November 14, 2025, I contacted Ms. Ledford to discuss my findings. She informed me that HR has informed Ms. Ferris of her suspension.

On December 12, 2025, I again spoke with Ms. Ledford who informed me that Ms. Ferris has been terminated.

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:	<p>The allegation was made that Ms. Ferris turned over a couch that Resident A was sitting on and dragged him by his legs to the hallway and shut the emergency door on him. Resident A and C both stated the allegation is true. Resident B witnessed Resident A on the floor in the hallway and Ms. Ferris shut the door on him.</p> <p>Ms. Ferris failed to return my call. She has been terminated from employment with Hope Network.</p> <p>Ms. Ferris disregard the details in the Assessment Plan regarding how to speak with Resident A. In addition, she reacted to him in a manner which was not dignified nor respectful. She was not protective and did not keep him safe from harm. There is a preponderance of evidence to support the allegation.</p>

