GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 14, 2021

Debra McCovery
Hope Network, S.E.
PO Box 190179
Burton, MI 48519

RE: License #: AM250281878
Investigation #: 2021A0569038
New Hope Behavioral Services I

Dear Ms. McCovery:

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 feel free to 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 (517) 284-9730.

Sincerely,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250281878
Investigation #:	2021A0569038
Complaint Receipt Date:	09/07/2021
Investigation Initiation Date:	09/08/2021
Report Due Date:	11/06/2021
Licensee Name:	Hope Network, S.E.
Licensee Address:	PO Box 190179 Burton, MI 48519
Licensee Telephone #:	(248) 505-1987
Administrator:	William Paige
Licensee Designee:	Debra McCovery
Name of Facility:	New Hope Behavioral Services I
Facility Address:	Suite A 1110 Eldon Baker Dr. Flint, MI 48507
Facility Telephone #:	(810) 742-3134
Original Issuance Date:	05/06/2006
License Status:	REGULAR
Effective Date:	09/25/2019
Expiration Date:	09/24/2021
Capacity:	8
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A started a fire in this facility and the residents had to be evacuated.	Yes
There are rodents and inspects infesting this facility.	No
There is exposed insulation throughout this facility and there is a hole in the roof which is leaking water into the facility.	Yes
There are residents sleeping in the dining room and living room area of this facility.	Yes

III. METHODOLOGY

09/07/2021	Special Investigation Intake 2021A0569038
09/07/2021	Contact - Telephone call received received voicemail from Judy Naranjo, facility manager reporting a fire in the facility.
09/07/2021	Contact - Document Received Incident report received from Judy Naranjo.
09/08/2021	APS Referral
09/08/2021	Special Investigation Initiated - Letter email to ORR.
10/06/2021	Inspection Completed On-site
10/06/2021	Inspection Completed-BCAL Sub. Compliance
10/06/2021	Exit Conference Exit conference with Judy Naranjo, facility manager.
10/13/2021	Contact- Telephone call made. Contact with Tyeisha Presnall, case manager.
10/14/2021	Exit conference Exit conference with Judy Naranjo, facility manager.

ALLEGATION:

Resident A started a fire in this facility and the residents had to be evacuated.

INVESTIGATION:

This complaint was received via the on-line complaint portal. The complainant reported that Resident A had been arrested and was sent to the hospital from the Genesee County jail. The complainant reported that they did not know why Resident A was sent to the hospital and that Resident A had no medical needs. The complainant reported that they attempted to contact staff at the facility so that Resident A could be sent back to the facility, but staff refused to allow Resident A to return. A second complainant reported that Resident A had started a fire in one of the bedrooms at this facility and the residents had to be evacuated from the facility.

An incident report (IR) was submitted to the department on 9/6/21. The IR was completed by Judy Naranjo, clinical and operations manager. The incident report documents that Resident A did start a fire in her bedroom and that the residents were evacuated and relocated to a hotel until an evaluation of the damages could be completed. The IR also documents that Resident A was arrested by the Flint City Police at Hurley hospital in Flint, Michigan on 9/6/21 after she was discharged from the hospital and had been charged with arson. The IR documents that the corrective action was to “monitor for health and safety and follow up with Resident A’s case management team upon release from jail.

An unannounced inspection of this facility was conducted on 10/6/21. All of the rooms of this facility were observed during this inspection. Two of the resident bedrooms are currently being repaired due to water damage from the sprinkler system. There was no smoke damage or structural damage observed during this inspection. The two resident bedrooms were in the process of having the drywall replaced and there were construction workers observed working on the bedrooms during the inspection. There were no residents observed residing in the bedrooms being repaired.

Judy Naranjo, facility manager, stated that Resident A had found a cigarette lighter on 9/5/21 and was using it in her bedroom when she caught the window curtains on fire. Ms. Naranjo stated that the curtains then started the window air conditioning unit on fire and the facility sprinkler system turned on. Ms. Naranjo stated that all of the residents were immediately evacuated from the facility, and the fire was extinguished by the sprinkler system before any further damage was done. Ms. Naranjo stated that the bedroom where the fire started, and the adjacent bedroom did sustain water damage and that the rooms were in the process of having the drywall replaced and all other repairs completed. Ms. Naranjo stated that all of the residents were relocated to a hotel until the condition of the facility could be evaluated. Ms. Naranjo stated that Hammer

Construction LLC is the company hired to repair the facility and that an inspector from the company gave her the clearance to move the residents back into the facility as there was no structural damage and the water damage was contained to just two bedrooms. Ms. Naranjo stated that Resident A did not require 1:1 staffing or any additional monitoring beyond the bedroom checks conducted by staff throughout each shift. Ms. Naranjo stated that when all of the residents had been evacuated, the Flint City Police arrived at the facility. Ms. Naranjo stated that Resident A then ran from the facility but later returned and was arrested by the police. Ms. Naranjo stated that Resident A was then taken to the hospital for a psychiatric evaluation and treatment of a burned hand that Resident A stated she had sustained. Ms. Naranjo stated that when Resident A was at the hospital, it was determined that she did not have a burn injury and the hospital staff decided that Resident A did not need psychiatric evaluation. Ms. Naranjo stated that the hospital social worker has alleged that she refused to allow Resident A to return to the facility, but in fact, the police took Resident A to the County jail when she was released from the hospital. Ms. Naranjo stated that Resident A is still in the jail and a discharge notice was issued for Resident A.

Tyeisha Presnall, Resident A's case manager, stated on 10/13/2021 that Resident A did not have any specific supervision requirement while residing in this facility. Ms. Presnall stated that Resident A's plan of service does not require a 1:1 staffing or a "line of sight" supervision pattern. Ms. Presnall stated that the residents in this facility are observed by staff every 15 minutes to ensure their safety. Ms. Presnall stated that Resident A had found the lighter the same day that she started the fire in her bedroom, and that Resident A did not have any history of starting fires. Ms. Presnall stated that she did not have any concerns regarding the level of supervision for Resident A while she resided at this facility.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Resident A started a fire in her bedroom on 9/5/21 using a cigarette lighter she had found. Ms. Presnall and Resident A's plan of service indicate that Resident A did not require any additional supervision beyond the normal bedroom checks conducted by staff. Ms. Presnall also stated that Resident A had no history of staring fires and found the cigarette lighter the same day she started the fire. All of the residents were safely evacuated and relocated to a hotel until the damages to the facility could be assessed. Resident A was taken to the hospital for an assessment the arrested when she was discharged from

	the hospital. The facility was observed to have no structural damaged when inspected and the two resident bedrooms
	damaged by water from the sprinkler system were observed to have no residents residing in them. The damaged bedrooms were also observed to be in the process of repair during the inspection. Based on the fact that the residents had to be evacuated from this facility and subsequently be housed in a hotel due to the damage making this facility uninhabitable, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There are rodents and inspects infesting this facility.

INVESTIGATION:

The complainant reported that there are rodents and insects infesting this facility. The complainant did not report any specific information regarding what rooms of the facility were infested or any other specific information.

All of the rooms in this facility were inspected on 10/6/21. There was no indication of the presence of rodents or insects in any of the resident bedrooms, bathrooms, kitchen area, living room, or staff offices.

Ms. Naranjo stated that the facility is treated monthly by a pest control company as preventative maintenance. Ms. Naranjo stated that there is no rident or insect infestation currently in this facility.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.

ANALYSIS:	The complainant reported that this facility is infested with rodents and insects. Every room of this facility was inspected on 10/6/21 and there was no indication of rodents or insects observed. Ms. Naranjo stated that the facility is treated monthly by a pest control company as preventative maintenance and that there is no rodent or insect infestation at this facility. Based on the observation made during the inspection, it is determined that there has been no violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There is exposed insulation throughout this facility and there is a hole in the roof which is leaking water into the facility.

INVESTIGATION:

The complainant reported that there is exposed insulation throughout the facility and that there is a hole in the roof which is leaking water into the facility. All of the rooms of this facility were inspected on 10/6/21. There was no exposed insulation observed except in the two resident bedrooms being repaired due to the water damage. The two resident bedrooms were having drywall replaced and the areas that had not yet been drywalled had exposed insulation. The two bedrooms were observed to be unoccupied and there were construction workers observed working in the bedrooms. There was a ceiling tile in the hallway observed to have some water damage indicating that there is a leak in the roof. There was no water observed pooling on the floor of the hallway.

Ms. Naranjo stated that a leak in the roof has developed but that it was not the result of the bedroom fire started by Resident A. Ms. Naranjo stated that Hammer Construction, LLC has also been hired to repair the roof and that they have ordered the materials needed to repair but that the materials have not arrived yet. Ms. Naranjo stated that the roof leak was addressed as soon as it was noticed, but delivery of the building materials has not occurred yet.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(4) A roof, exterior walls, doors, skylights, and windows shall be weathertight and watertight and shall be kept in sound condition and good repair.

ANALYSIS:	The complainant reported that there is exposed insulation throughout the facility. The only exposed insulation observed on 10/6/21 was in the bedrooms being repaired from the fire. The two resident rooms being repaired are having new drywall hung and the areas not yet covered by the new drywall did have exposed insulation, but the rooms are not currently occupied by any residents. There was no exposed insulation observed in any of the other rooms of this facility. A ceiling tile was observed to have some water damage in the hallway of this facility when inspected on 10/6/21, however, a construction company has been hired to repair the leak in the ceiling and the materials have been ordered but not yet delivered. Repairs to the two resident bedrooms were being completed by workers during the inspection on 10/6/21 and the needed repairs to the facility were being addressed. Based on the observation made that there is currently a leak in the roof of this facility, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There are residents sleeping in the dining room and living room area of this facility.

INVESTIGATION:

The complainant reported that Resident B was sleeping on an air mattress in the dining room area of this facility. The complainant also reported that there are two residents sleeping on beds in the living room area of this facility.

The living room area of this facility was observed during the inspection on 10/6/21. There were two resident beds observed in the living room and there was a resident lying in one of the beds during the inspection. The dining room was inspected, and there were no resident beds observed in the dining room area.

Resident A was alert and oriented to person, place, and time. Resident A was appropriately groomed and dressed with no visible injuries. Resident A stated that he did sleep in the dining room for about three nights. Resident A stated that he slept in the dining room because his roommate had COVID-19 and Resident A couldn't "be around that". Resident A stated that after about three nights, his bed was moved back into his bedroom and he "is fine". Resident A did not have any other complaints and stated that he feels that he is treated well in this facility.

Ms. Naranjo stated that Resident A did sleep in the dining room for a few nights because he requested to. Ms. Naranjo stated that Resident A's roommate had been tested for COVID-19, but that the test was negative for COVID-19. Ms. Naranjo stated that Resident A wanted to sleep in the dining room to be safe and was then moved back to his bedroom when he wanted to. Ms. Naranjo stated that the two residents sleeping in the living room were displaced due to their bedroom being one of the rooms being repaired from the water damage. Ms. Naranjo stated that the two residents were being moved to a bedroom on the first floor on 10/7/21.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(2) A living room, dining room, hallway, or other room that is not ordinarily used for sleeping or a room that contains a required means of egress shall not be used for sleeping purposes by anyone.
ANALYSIS:	The complainant reported that Resident A was sleeping in the dining room and two additional residents were sleeping in the living room of this facility. There were two resident beds observed in the living room during the inspection on 10/6/21 with a resident lying in one of the beds. Resident A also stated that he did sleep in the dining room for about three nights because his roommate had COVID-19 and he couldn't "be around" his roommate. Ms. Naranjo stated that the two residents in the living
	room were displaced from their bedroom because of the water damage and were being moved to a bedroom on the first floor on 10/7/21. Ms. Naranjo stated that Resident A did sleep in the dining room for a few nights by his own request because he was afraid that his roommate had COVID-19. Ms. Naranjo stated that Resident A's roommate tested negative for COVID-19, but Resident A requested to sleep in another room anyway, then returned to his bedroom when he wanted to. Based on the statements given, and observations made, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with Judy Naranjo, facility manager, on 10/14/21. The findings in this report were reviewed.

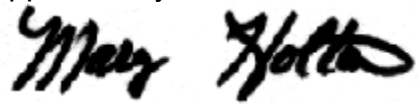
IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

10/14/2021

Kent W Gieselman Date
Licensing Consultant

Approved By:



10/14/2021

Mary E Holton Date
Area Manager