GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2022

William Paige
Hope Network, S.E.
PO Box 190179
Burton, MI 48519

RE: License #:	AM250281878
Investigation #:	2022A0872056
	New Hope Behavioral Services I

Dear Mr. Paige:

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) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM250281878
Investigation #:	2022A0872056
Complaint Receipt Date:	09/09/2022
Investigation Initiation Date:	09/09/2022
Report Due Date:	11/08/2022
Licensee Name:	Hope Network, S.E.
Licensee Address:	PO Box 190179 Burton, MI 48519
Licensee Telephone #:	(586) 206-8869
Administrator:	Tara Maynie
Licensee Designee:	William Paige
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:	09/25/2021
Expiration Date:	09/24/2023
Capacity:	8
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was taken to the hospital on or around 01/06/22. Resident A died in the hospital on 01/21/22. Concern that staff did not seek immediate medical care.	No
Additional Findings	Yes

III. METHODOLOGY

09/09/2022	Special Investigation Intake 2022A0872056
09/09/2022	Special Investigation Initiated - Letter I emailed the licensee designee requesting information related to this complaint
09/09/2022	Contact - Telephone call made I interviewed Guardian A1
09/10/2022	Contact - Document Received I received AFC documentation regarding Resident A
09/14/2022	Inspection Completed On-site Unannounced
10/20/2022	Inspection Completed-BCAL Sub. Compliance
10/20/2022	Exit Conference I conducted an exit conference with the licensee designee, William Paige
10/23/2022	Contact – Document Sent I emailed Mr. Paige requesting additional information about this complaint
10/24/2022	Contact – Document Received I received additional documentation from Mr. Paige
10/24/2022	Contact – Telephone call made I interviewed Resident A's case manager, Tiesha Presnall
10/25/2022	Contact – Telephone call made I interviewed staff Ashley Hollins

10/25/2022	Contact – Telephone call made I interviewed former staff, LaToya Crain
10/25/2022	Contact – Telephone call made I interviewed Resident A's NP, Lisa Lyndsay
10/25/2022	Exit conference I conducted another exit conference with Mr. Paige

ALLEGATION: Resident A was taken to the hospital on or around 01/06/22. Resident A died in the hospital on 01/21/22. Concern that staff did not seek immediate medical care.

INVESTIGATION: On 09/09/22, I interviewed Guardian A1 via telephone. Guardian A1 said that Resident A was admitted to New Hope Behavioral Services I on 11/29/21. She said that Resident A had a lot of behavioral issues but no chronic medical issues. According to Guardian A1, on or around 01/06/22, at approximately 8:30pm, she called the facility and asked to speak to Resident A. Staff told her that Resident A was unable to talk because she had just gotten out of the shower. At approximately 9:30pm, staff called Guardian A1 to tell her that Resident A was being transported to McLaren Hospital, but they did not tell her why. Guardian A1 said that the next day, she went to the hospital to visit Resident A who was unresponsive. Guardian A1 was told by hospital staff that according to EMS, Resident A was found outside of the AFC facility, unresponsive, when they arrived to transport her to the hospital. According to Guardian A1, Resident A never regained consciousness and she passed away in the hospital on 01/21/22. Guardian A1 said that she feels staff must have missed signs of an underlying illness that Resident A was suffering from which resulted in her death. Guardian A1 said that according to Resident A's doctors and her death certificate, Resident A died of natural causes. Resident A was 37-years old.

On 09/14/22, I conducted an unannounced onsite inspection of New Hope Behavioral Services I Adult Foster Care facility. I interviewed staff Cawanna Dukes and the licensee designee, William Paige. Ms. Dukes said that she has worked at this facility for over two years, and she typically works 1st shift. Ms. Dukes said that when Resident A resided at this facility, she worked with her on a regular basis. According to Ms. Dukes, Resident A did not have any chronic medical issues and she was placed at this facility due to behavioral issues. Ms. Dukes told me that sometimes, Resident A would not want to get out of bed, she would act lethargic, yell at others, and say she was in pain but would never verbalize where the pain was. According to Ms. Dukes, Resident A did have a prescription for Tylenol to be taken on an as-needed basis so when she complained of pain and asked for Tylenol, staff would administer it to her.

Ms. Dukes said that she was working 1st shift on the day that Resident A was taken to the hospital, but she was not present when 911 was called because it happened during 2nd shift. Ms. Dukes told me that on that day (01/06/22), Resident A "was hollering a lot"

but when she asked her what was wrong, she would not say. Ms. Dukes said that Resident A was often argumentative and/or she would walk the halls, mumbling and yelling so her “hollering” was not odd behavior. Ms. Dukes said that Resident A eventually said that she was going to lay down and that is the last time Ms. Dukes saw her. Ms. Dukes stated that when she and the other staff were told that Resident A had passed away in the hospital, they were all shocked and they were not told the cause of her death.

William Paige acknowledged that Resident A resided at this facility for less than two months. He said that he was not present when Resident A was taken to the hospital, but he was told that 2nd shift staff tried to get Resident A up to take a shower, but she would not get up. Staff then called 911 and she was taken to the hospital. Mr. Paige said that they were all shocked to learn of Resident A’s death and said that he did not receive a copy of the death certificate. Mr. Paige said that he feels staff acted appropriately because they contacted 911 immediately when they discovered there was an issue.

On 09/10/22, I received AFC documentation from the licensee designee, William Paige. Resident A was admitted to New Hope Behavioral Services I AFC on 11/29/21. Her Assessment Plan was completed on 12/02/21 by Aaron Hynes, LPC. It states that she has a history of threatening to harm others and aggression. There is no documentation of any medical conditions.

According to her Nursing Assessment dated 11/29/21, Resident A has an extensive mental health history and has been psychiatrically hospitalized approximately 25 times since 2010. She has a history of hydrocephalus and had a VP shunt inserted in 1996. She has a history of headaches associate with her shunt and has a history of shunt malfunction and hypochondria. She has not been vaccinated for Covid-19 or the flu.

I reviewed two Health Care Appraisals regarding Resident A. The first one dated 11/29/21 was completed by New Hope I’s RN, Cheryl Steve. According to that appraisal, Resident A (37-years old) was diagnosed with schizoaffective disorder, bipolar type, nicotine dependence, and generalized anxiety disorder. No allergies were noted. The second appraisal dated 12/27/21 was completed by NP, Lisa Lindsay. According to that appraisal, Resident A was diagnosed with schizophrenia, anxiety, and insomnia. “A mild” allergy to the medication Prolixin (an antipsychotic used to treat schizophrenia) was noted.

Under the physical examination section of both appraisals, no abnormalities were noted other than neurological, which was listed as “abnormal.” She was fully ambulatory and not on a special diet.

Resident A’s mental health treatment plan is dated 12/15/22. It states that Resident A has a history of physical and sexual abuse as a child and young adult. Resident A was prescribed the following medications at the time of that assessment: Ativan 1mg 3x’s per day; Benztropine 1mg 2x’s per day; Depakote 500mg tablet each morning and 2

tablets at night; Lithium Carbonate 300mg 3x's per day; Remeron 45mg 1x per day and Risperdal 3mg 2x's per day.

I reviewed Resident A's Specialized & Subjective Units of Distress (SUDs) Residential Progress Notes from 12/31/21 through her hospitalization on 01/06/22. Staff documented the following notes on Resident A's SUDs:

- 12/31/21 from 7:00am-3:00pm; Resident A was sleeping in bed. She was 100% compliant with lunch. Staff prompted her with self-care. She was "having an outburst and was yelling at staff for no apparent reason, stated to staff that she was having a baby.
- 12/31/21 from 3:00pm-11:00pm; Resident A did not complete any self-care tasks, but she did take all her medications and meals. She walked up and down the hallway and sat in the kitchen with staff and peers.
- 12/31/21 from 11:00pm-7:00am; Resident A was in her bedroom yelling and screaming. She roamed up and down the hallway, "yelling for no reason." She said she was in pain. so staff assisted her to get up and gave her a PRN for pain. Resident A eventually went to her bedroom and went to sleep.
- 01/01/22 from 7:00am-3:00pm; Resident A completed self-care, took all medications and ate all meals. She was non-compliant with household chores.
- 01/01/22 from 3:00pm-11:00pm; Resident A accepted all meals and medications. She kept "picking on her roommate" and calling her names. Her roommate said she was scared of her.
- 01/01/22 from 11:00pm-7:00am; Resident A said she needed a new mattress because she could feel all the springs. She continued yelling at staff throughout the shift. Staff put in a request for a new mattress.
- 01/02/22 from 7:00am-3:00pm; Resident A was social with staff and peers. She did not complete any self-care but ate all meals and took her medications. Resident A "appeared agitated today and she was moaning really loud." She said she wanted to talk to her mom but did not have the phone number. She took a nap in the tv room.
- 01/02/22 from 3:00pm-11:00pm; Resident A ate all meals and took all medications. She refused to complete any self-care. She spent the majority of the shift in the living room, sleeping.
- 01/02/22 from 11:00pm-7:00am; Resident A came out of her room without pants on. She went back to her room and was yelling continuously, saying her mattress is "terrible."
- 01/03/22 from 7:00am-3:00pm; Resident A was not compliant with her morning medications. She did not complete any self-care and had "a couple of loud outbursts during the shift."
- 01/03/22 from 3:00pm-11:00pm; Resident A accepted all meals and medications. She interacted with staff and peers but would not complete any self-care.
- 01/03/22 from 11:00pm-7:00am; Resident A "was up and down most of the shift yelling and cussing at staff."
- 01/04/22 from 7:00am-3:00pm; Resident A refused morning medications and slept through breakfast. She ate lunch and took her afternoon medications but

threw one pill in the trash. She was yelling and cussing at staff and peers because she could not put her shoes on. “(She) was walking through the hall moaning really loud today.”

- 01/04/22 from 3:00pm-11:00pm; Resident A spent most of the shift pacing the hallways, smoking outside, and talking on her cell phone. She accepted all meals and medications. She was rude and instigated arguments with staff and peers. “(She) would also scream and moan in her bedroom or when walking down the hallways.”
- 01/04/22 from 11:00pm-7:00am; Resident A was sleeping at the beginning of shift but got up at approximately 4:15am asking staff for something but staff was not able to understand her. She continued yelling and going in and out of her bedroom for the next two hours before returning to her bedroom and going to sleep.
- 01/05/22 from 7:00am-3:00pm; Resident A accepted all medications and meals. She spent most of the morning walking the hallway and going outside. She chose not to attend group therapy. She washed up and put on clean clothing.
- 01/05/22 from 3:00pm-11:00pm; Resident A was laying down at the beginning of shift. She got up and started walking around, asking her peers for pop, and yelling loudly. Staff prompted her to speak clearly. She accepted all meals and medications.
- 01/05/22 from 11:00pm-7:00am; Resident A slept throughout the shift.
- 01/06/22 from 7:00am-3:00pm; “(Resident A) spent her day in bed sleeping. She took all her meds. Kitchen staff prepared meals for individual. Staff was monitored all shift.”
- 01/06/22 from 3:00pm-8:00pm; Resident A took her 5pm medications but refused dinner. She stayed in bed most of the shift and complained of back pain. Staff offered her a PRN, but she refused. Staff assisted her with a shower. Staff LaToya Crain reported the following: “They heard her yell for assistance, staff found her laying on floor by her bedroom door in the hallway. Staff assisted with getting her up off the floor and getting her dressed. She wasn’t responding to conversation, so the nurse instructed to call 911. She was transported McLaren hospital emergency department. Staff stayed with her until she was admitted.”
- 01/06/22 from 8:30pm-11:00pm; Resident A called for assistance at about 9:30pm. Staff observed her laying in the hallway, naked and only mildly responsive to her name. Staff dressed her, took her vitals, and called 911. Resident A was transported to the hospital and staff remained with her in the waiting room until 3rd shift staff came to relieve 2nd shift. Resident A was eventually admitted to McLaren Hospital.

I reviewed a Macomb County CMH Consumer Incident, Accident, Illness, Death or Arrest Report dated 01/06/22 at 9:30pm completed by staff LaToya Crain regarding Resident A. According to the report, “(Resident A) complained of body aches at that time staff assisted (her) with a shower and offered her a PRN for pain. (She) refused and stated she wanted to lay down. Staff notified the nurse, and she checked her vitals and instructed staff to keep an eye on any changes. (Resident A) awoke from her nap

yelling for staff in the hallway staff immediately ran to (her) and found (her) laying on the hallway floor." The action taken by staff was, "Staff immediately checked to make sure (she) was conscious and coherent while yelling for other staff on shift to call 911. While staff B was calling 911 myself was checking (her) B/P and talking to her to make sure she was still conscious and aware of her surrounding(s). Staff A and B then dressed (her) and made her as comfortable as possible until the paramedics arrived."

I reviewed a Macomb County CMH Consumer Incident, Accident, Illness, Death or Arrest Report dated 01/07/22 regarding Resident A. According to the report, "(Resident A) was admitted to McLaren Hospital after she was diagnosed with metabolic encephalopathy and pneumonia."

I reviewed another Macomb County CMH Consumer Incident, Accident, Illness, Death or Arrest Report IR dated 01/21/22 regarding Resident A. According to the report, "(Resident A) passed away on 01/21/22 while a patient at McLaren Hospital. Death certificate indicates cause of death – natural. The chain of events, diseases, injuries or complications directly related to the cause of death: Acute Hypoxic resp. failure, COVID PNA, Acute Encephalopathy."

On 09/15/22 and 10/05/22, I emailed Guardian A1 requesting additional information related to this complaint. As of 10/23/22, she has failed to respond to my requests.

On 10/24/22, I received a copy of Resident A's death certificate completed by Emad Alkhankon, MD. According to the report, Resident A died on 01/21/22 at 4:04pm. Her cause of death was listed as Acute Hypoxic Respiratory Failure, COVID PNA, and Acute Encephalopathy. The "approximate interval between onset and death" is five days. Her manner of death was "natural", and no autopsy was performed.

On 10/24/22, I interviewed Resident A's case manager, Tiesha Presnall via telephone. Ms. Presnall confirmed that she was working on 01/06/22 and was present when Resident A was taken to the hospital. According to Ms. Presnall, earlier in the day, Guardian A1 called to talk to Resident A. Resident A came out of her bedroom, naked, so Ms. Presnall guided her back to her room to get dressed. Resident A laid down in bed and immediately started snoring, so Ms. Presnall told staff to let Guardian A1 know that Resident A was not going to come to the phone.

Later that night, staff LaToya Crain called out, so Ms. Presnall came out of her office and saw Resident A laying on the hallway floor, on her back, naked. Ms. Presnall contacted 911 while staff checked Resident A's vitals. While waiting for the paramedics to arrive, Ms. Presnall and staff helped Resident A get some clothes on. Resident A was not communicating with staff, but she did lift one of her legs up to help staff get her pants on. Paramedics arrived and took Resident A to McLaren Hospital where she was admitted. Ms. Presnall said that she and the rest of the staff were shocked by this incident. She said that Resident A did not appear to have any injuries, and the way she was laying on the floor did not indicate that she had fallen. Ms. Presnall said that

leading up to this incident, Resident A was not complaining of any pain or problems and Ms. Presnall has no idea what happened to cause this incident.

On 10/25/22, I interviewed staff Ashley Hollins via telephone. Ms. Hollins confirmed that she was working on 01/06/22 and she was very familiar with Resident A. According to Ms. Hollins, Resident A was not acting unusual, but she did seem a bit weak. She did ask Ms. Hollins to help her with her shower and when Ms. Hollins asked her if anything was wrong, she said, “I just need help.” Ms. Hollins said that Resident A was able to stand during her shower and she only required minimal assistance. After her shower, Ms. Hollins helped Resident A get dressed and Resident A asked to lay down again, so Ms. Hollins helped her to bed. Ms. Hollins said that she saw Resident A a few more times before leaving at 5:00pm and did not notice anything out of the ordinary.

On 10/25/22, I interviewed former staff, LaToya Crain via telephone. I spoke with Ms. Crain about my investigation, and she told me that she has not worked at New Hope for almost a year, and she cannot tell me anything about the incident other than what she wrote in the Incident/Accident Report. I attempted to ask Ms. Crain some further questions and she told me that she is not comfortable talking to me unless her attorney is present.

On 10/25/22, I interviewed Resident A’s Nurse Practioner (NP) Lisa Lyndsay, via telephone. I reviewed the allegations with NP Lyndsay and told her what Resident A’s death certificate said. NP Lyndsay said that while working with Resident A, she noted that Resident A’s lungs were poor, and she had a lot of respiratory issues. She had a shunt, diabetes, anemia, and obesity. NP Lyndsay said that based on Resident A’s death certificate, it sounds like she contracted Covid-19 which turned into pneumonia which she was unable to overcome. NP Lyndsay said that she is saddened by Resident A's death but considering her medical and mental health issues, and her co-morbidities her death from pneumonia resulting from Covid-19 is not shocking. NP Lyndsay said that to her knowledge, there was nothing staff did or did not do that would have contributed to her death.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Resident A was admitted to New Hope Behavioral Services I on 11/29/21. She had a history of hydrocephalus and had a VP shunt inserted in 1996. She had a history of headaches associate with her shunt and has a history of shunt malfunction and hypochondria. According to Resident A's progress notes from 12/31/21 through 01/06/22, Resident A only had one medical complaint which was on 12/31/21. On that date, she complained of generalized pain, so staff administered her a PRN. She walked the hallways and later went to sleep. On 01/06/22, Resident A complained of body aches, so staff offered her a PRN which she refused. Staff assisted her with a shower, and she went and laid down. Staff notified the nurse who checked Resident A's vitals and advised staff to keep an eye on her. At approximately 9:30pm, Resident A yelled for staff. Staff found her laying on the floor in the hallway. Staff assessed her condition, checked her vitals, and called 911. Staff dressed her while waiting for the ambulance and stayed with her, checking her consciousness. Paramedics arrived and transported Resident A to the hospital. Resident A passed away at McLaren Hospital on 01/21/22. Her death certificate listed her cause of death as "natural" and said that the contributing factors were Acute Hypoxic respiratory failure, COVID PNA, and Acute Encephalopathy. According to Resident A's NP, Lisa Lyndsay, Resident A suffered from numerous mental health and respiratory issues. She had a lot of co-morbidities which NP Lyndsay said contributed to her death. I conclude that there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: Resident A was admitted to New Hope Behavioral Services I on 11/29/21. Her Assessment Plan was not completed until 12/02/21 and it was not signed

by the licensee designee until 1/26/22. Neither Resident A nor Guardian A1 signed the Assessment Plan.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A was admitted to New Hope Behavioral Services I on 11/29/21. Her Assessment Plan was not completed until 12/02/21 and it was not signed by the licensee designee until 1/26/22. Neither Resident A nor Guardian A1 signed the Assessment Plan. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: Resident A was admitted to the hospital on 01/06/22. The licensee designee failed to send me an Incident/Accident Report (IR) regarding this hospitalization. Resident A died on 01/21/22 while at McLaren Hospital. The licensee designee failed to send me an IR regarding this death.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.**

	(iii) Attempts at self-inflicted harm or harm to others. **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	Resident A was admitted to the hospital on 01/06/22. The licensee designee failed to send me an Incident/Accident Report (IR) regarding this hospitalization. Resident A died on 01/21/22 while at McLaren Hospital. The licensee designee failed to send me an IR regarding this death. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/20/22, and again on 10/25/22, I conducted an exit conference with the licensee designee, William Paige. I discussed the findings of my investigation and explained which rule violations I am substantiating. Mr. Paige agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

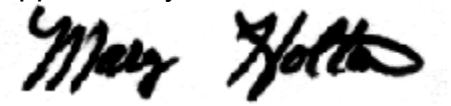
IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

October 25, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:



October 25, 2022

Mary E. Holton Area Manager	Date