GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 15, 2022

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

RE: License #:	AM250281878
Investigation #:	2023A0872006
	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 #:	2023A0872006
Complaint Receipt Date:	10/31/2022
Investigation Initiation Date:	10/31/2022
Report Due Date:	12/30/2022
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?
On 10/29/22, a mattress in one of the resident bedrooms caught fire. No one was hurt and all residents were relocated to a hotel. The cause of the fire is unknown at this time.	Yes

III. METHODOLOGY

10/31/2022	Special Investigation Intake 2023A0872006
10/31/2022	Special Investigation Initiated - Telephone I spoke to Kayonna Ferguson, Director of Crisis & Residential Treatment
11/01/2022	Inspection Completed On-site Unannounced
11/01/2022	Contact - Face to Face I interviewed staff and residents at their temporary location of Holiday Inn Express
11/04/2022	Contact - Document Received I received documentation related to this complaint
11/28/2022	APS Referral I made an APS complaint
12/13/2022	Contact - Telephone call made I interviewed staff Devon Schofield
12/13/2022	Contact - Telephone call made I interviewed staff Kellie Hoey
12/14/2022	Contact - Document Sent I exchanged emails with the licensee designee, William Paige
12/14/2022	Exit Conference I conducted an exit conference with the licensee designee, William Paige
12/14/2022	Exit Conference I conducted another exit conference with the licensee designee, William Paige

ALLEGATION: On 10/29/22, a mattress in one of the resident bedrooms caught fire. No one was hurt and all residents were relocated to a hotel. The cause of the fire is unknown at this time.

INVESTIGATION: On 10/29/22, I received a voicemail message, an email, and several Incident/Accident Reports (IR) regarding a fire that happened at New Hope Behavioral Services I Adult Foster Care facility earlier that day. I reviewed these IRs, voicemail, and email on 10/31/22.

According to the IRs completed by Devon Schofield on 10/29/22 at approximately 2:50pm, "After returning from taking the trash out with two residents, the fire alarms began going off. There were 3 residents already outside. Staff immediately began evacuating the remaining residents in the building to the designated fire area. Staff conducted a head count. Staff then grabbed emergency bags and keys and met the clients at the designated fire area. Staff called 911 to report a fire. Staff then notified supervisors of the ongoing fire." Staff took the residents to a hotel due to the situation. The corrective measures taken were, "All staff will be in-serviced on the Program description – Residential Treatment Criteria focusing on the section Admission/ Readmission in which persons served must agree to have the program safeguard lighters and matches for their own safety. Lighters/matches will be given to persons served when they request them."

On 10/31/22, I spoke to the director of Crisis and Residential Treatment Services, Kayonna Ferguson via telephone. Ms. Ferguson said that on 10/29/22, a mattress in one of the resident's bedrooms caught fire. Staff evacuated the residents and relocated them to the Holiday Inn Express hotel in Flint, Michigan. She said that there was minimal damage, and no one was hurt but the sprinkler system was unable to be reset because they were unable to find a technician. As a result, there was water damage to the facility. Ms. Ferguson said that the cause of the fire is unknown.

On 11/01/22, I conducted an unannounced onsite inspection of New Hope Behavioral Services I AFC. None of the residents or staff were present. I visually inspected the facility and noted workers from Hammer Restoration in the facility. The Hammer Restoration employee told me that he saw staff earlier this morning but no residents. He was in room #6 which was where the fire was. I observed the room which was in poor condition. The carpet was pulled up and the Hammer Restoration employees were working on the room.

On 11/01/22, I conducted an onsite inspection at the Holiday Inn Express on Robert T. Longway Blvd. in Flint, Michigan. I interviewed staff Cawanna Dukes, Ashley Hollins, Gabrielle Shields, Makeda Collins, and Aaron Hynes, and the licensee designee, William Paige. I also interviewed Residents A, B, C, and D. Residents E and F were at the Crisis Intervention Unit, so I was not able to interview them.

Ms. Dukes said that on 10/19/22, she, Devon Schofield, and Kelly Hoey were working. Ms. Dukes told me that she went to her car briefly and when she went back in the facility, Mr. Schofield was right behind her, and Ms. Hoey was in the bathroom. Shortly thereafter, she and Mr. Schofield heard the fire alarms go off. Ms. Dukes and Mr. Schofield began checking all the resident bedrooms. Ms. Dukes opened the door to Resident A and G's bedroom and found them both in their room. Ms. Dukes said that she ushered them out of the building. According to Ms. Dukes, Mr. Schofield continued clearing the rest of the bedrooms. When he opened the door to Room #6, "it was blazing." Ms. Dukes said that the remaining residents were already outside so staff called 911 and made sure all residents were safe.

Ms. Dukes stated that the fire was in Resident E and F's room. Leading up to the incident, Resident E was outside. She came in the facility, asked for an ice pack, and immediately went back outside again. Ms. Dukes did not see Resident E in or near her room prior to going outside. The rest of the residents, except for Resident A and G, were outside.

All staff said that they do not know who started the fire or how it was started. Staff said that all the residents who smoke cigarettes, do have access to a lighter. However, Resident A was in his bedroom, and he had his C-pap machine on when Ms. Dukes opened his door. Although Resident E was also in the building, all staff stated that he would not be able to strike a lighter due to his disability and he was also in his room when the fire started.

Resident A confirmed that there was a fire at his AFC home a few days ago. He said that he and his roommate (Resident G) were in their room and Resident A was lying in bed. He said that he does not know who started the fire and he does not know how the fire started. He told me that Resident G did not leave their bedroom until Ms. Dukes opened their bedroom door and told them they needed to evacuate. I asked Resident A if any of the staff or residents have talked about the fire and what may have caused it, and he said that he has not heard anything. Resident A said that if he finds out who started the fire, he will report it to management.

Resident B said that he has lived at this facility for six years and said that he has "no clue" how the fire started. He said that he was outside when the fire broke out and did not know about it until staff came outside and told everyone that there was a fire and they needed to call the fire department. Resident B said, "Someone started it, but I have no clue who. I have no idea what happened." I asked Resident B if he has heard any of the staff or residents talking about the fire and he said that everyone is talking about it, but nobody said what happened.

Resident C confirmed that there was a fire at his AFC home a few days ago. He said that he was taking the trash out and when he was walking back to the building, he heard someone say, "There's a fire." He said that the fire department came, and they were all evacuated to the Holiday Inn Express in Flint. I asked Resident C if he knows who started the fire or how it started and he said, "No, but I didn't do it!" Resident C told me

that he has heard people talking about the fire, but he has not heard anyone say who started it or how it started.

Initially, Resident D would not speak to me, and he would not answer any of my questions. Eventually, he did acknowledge that there was a fire at his AFC facility. I asked him if he knew what happened and he told me that Resident C and E started the fire. Resident D said, “They were smoking in (Resident E’s) room and they lit the mattress on fire!” Resident D said, “I had nothing to do with it.” Resident D then began talking about nonsensical things so I do not know how credible his statements are.

William Paige confirmed that the fire was in Room #6, and it appeared that Resident E’s mattress was set on fire. He said that none of the staff or residents have admitted to starting the fire and they still do not know what happened.

On 11/10/22, I conducted an onsite inspection at the Genesee Regional Crisis Residential Unit at 304 W. Tobias in Flint, Michigan and interviewed Residents E and F. Resident E confirmed that a couple of weeks ago, there was a fire in her bedroom at her AFC facility. She said that she and Resident C went outside to take the trash out. When they went back inside, staff began yelling, saying there was a fire. Resident E said that staff called 911 and the fire department came.

I asked Resident E what she was doing prior to taking the trash out. Resident E told me a couple different stories. First, she said that she and Resident C were in the television room, listening to music. Then, she said that she and Resident C were in her bedroom, sitting on her bed, listening to music. I asked her if either of them was smoking or using fire, and she said, “no.” Resident E told me, “My window was cracked, and my mattress wasn’t near the heat vent. We didn’t smell smoke either.” Then Resident E told me that her mattress was not near the heat vent. I asked Resident E if she knows how the fire started and she said, “I think (Resident D) did it. He hates me.” I asked her if Resident D told her he started the fire or threatened her in any way and she said, “no.”

Resident E told me that she and Resident C spend a lot of time together. She said that Resident C carries a lighter, but she does not. I asked her if she ever saw Resident C start his lighter in the building and she became upset. Resident E said that she never asked Resident C if he started the fire and said that he would not tell her the truth anyway because, “He lies about everything!” Several times throughout this interview, Resident E said, “I didn’t do anything!” She told me that she has not heard staff, or the other residents talking about the fire and said that she wants her room to get finished so she can return to her AFC facility.

Resident F confirmed that a few weeks ago, there was a fire at her AFC facility. She also confirmed that she and Resident E share a bedroom and the fire started in their room. According to Resident F, she was outside smoking when staff came outside and told everyone they had to go outside of the gate because there was a fire. Resident F said that she smokes cigarettes, but she does not carry a lighter. Resident F told me

that she does not know how the fire started and she does not know who started the fire. I asked her if she has heard staff or residents talk about the fire and she said, “no.”

On 11/04/22, I received documentation related to this complaint. On 12/13/22, I reviewed the AFC documentation received on 11/04/22. I reviewed all the resident’s Individualized Plans of Service and noted that none of them have a history of fire-starting behaviors. In addition, none of the residents are restricted from carrying lighters on their person. None of the IPOS’s state that staff needs to search their person or their rooms for any reasons.

I also reviewed all resident’s Health Care Appraisals. All residents are diagnosed with mental illness, intellectual disabilities, and/or developmental disabilities. They all are listed as having limited insight, poor decision-making skills and/or impulsiveness.

I reviewed the Fire Report dated 10/29/22. The report stated that the fire department reported to the location at 2:43pm and the last unit cleared the scene at 4:03pm. The actions taken by the fire department were investigate, ventilate, and shut down the system. There were zero deaths or injuries and the estimated financial loss of the fire totaled $3,000. According to the report, “Engine 81 was dispatched for an alarm and upgraded to a commercial structure while en route. Engine 81 arrived to find light smoke showing from the New Hope recovery center. Workers on scene stated that there was a mattress on fire in room 6. Engine 81 officer located the room and found water pouring from under the door. The room was checked, and the fire had been extinguished by the sprinkler system.” The cause of the fire was listed as “undetermined after investigation.” The heat source and type of material were also listed as “undetermined.” The area of origin of the fire was confined to a bedroom, and the items first ignited were listed as bedding, blanket, and/or sheet.

On 12/13/22, I interviewed staff Devon Schofield via telephone. Mr. Schofield confirmed that he was working with Cawanna Dukes and Kellie Hoey on 10/29/22. He said that he and Residents C and E took the trash out and were gone for approximately five minutes. When they got back in the facility, the fire alarms went off. Mr. Schofield said that he and his coworkers began evacuating the residents. He opened the door to Room #6 and said that it was completely black with smoke and the mattress was on fire. Mr. Schofield said that he immediately closed the door and went outside with the rest of the staff and residents. I asked Mr. Schofield what he remembers about the events leading up to the incident. He said that all day, Resident D and E were arguing. Resident E was upset and was outside crying, and Resident C was often with her. Mr. Schofield said that he does not know who started the fire or how it started. He also said that none of the residents have confessed to anything as of this date. Mr. Schofield told me that although several of the residents were allowed to carry lighters prior to this incident, they are now required to lock them up and not carry them on their person.

On 12/13/22, I interviewed staff Kellie Hoey via telephone. Ms. Hoey confirmed that she was working with Cawanna Dukes and Devon Schofield on 10/29/22. According to Ms. Hoey, she and Ms. Dukes were in the office. Ms. Hoey went to the bathroom and while

in the bathroom, she heard yelling. Someone knocked on the door and when she came out, she heard the fire alarm, and her coworkers told her that there was a fire. Ms. Hoey said that she and her coworkers evacuated and once everyone was outside, they counted all the residents to make sure everyone was safe. According to Ms. Hoey, she does not know who started the fire or how it started.

On 12/14/22, I exchanged emails with the licensee designee, William Paige. Mr. Paige said that he has not received any additional documentation about the fire from any involved parties. He also confirmed that all resident lighters are now kept locked up and residents are not allowed to carry lighters on their person. The majority of the residents were able to return to New Hope Behavioral Services a few days after the fire. The residents in Room #6 returned to New Hope Behavioral Services less than two weeks after the fire.

On 12/14/22, I conducted an exit conference with the licensee designee, William Paige. I told him that I have concluded my investigation and explained which rule violation I am substantiating. I asked him to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14303	**Maintenance of premises.**
ANALYSIS:	**(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.**
	On 10/29/22, a mattress in Room #6 caught on fire and all the residents were evacuated to a hotel. Most of the residents were able to relocate to the facility a few days after the fire. The residents in Room #6 returned to the home in less than two weeks. Residents A, B, C, D, E, and F said that they do not know how the fire started and they do not know who started the fire. Staff Kayonna Ferguson, Cawanna Dukes, Devon Schofield, Kellie Hoey, and William Paige said that they do not know how the fire started and they do not know who started the fire. According to the Fire Report dated 10/29/22, Engine 81 from the Fire Department responded to the scene and found a mattress on fire in Room #6. The Fire Report stated that the cause of fire was listed as “undetermined after investigation.” According to the Resident Health Care Appraisals, all the residents at this facility are diagnosed with mental illness,

	intellectual disabilities, and/or developmental disabilities. They all are listed as having limited insight, poor decision-making skills and/or impulsiveness. I reviewed all the resident's Individualized Plans of Service and noted that none of them have a history of fire-starting behaviors. In addition, none of the residents are restricted from carrying lighters on their person. None of the IPOS's state that staff needs to search their person or their rooms for any reasons. The licensee designee, William Paige said that as a result of this incident, all lighters are now kept in a locked box and no residents are allowed to have lighters on their person. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Susan Hutchinson December 15, 2022

Susan Hutchinson Licensing Consultant	Date

Approved By:

Mary Holton December 15, 2022

Mary E. Holton Area Manager	Date