GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 18, 2023

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

RE: License #:	AM250281878
Investigation #:	2023A0872014
	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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AM250281878
Investigation #:	2023A0872014
Complaint Receipt Date:	12/21/2022
Investigation Initiation Date:	12/21/2022
Report Due Date:	02/19/2023
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 12/16/22, Resident A got into an altercation with staff, Keondus Miller. Resident A said that Mr. Miller punched him in the face.	Yes

III. METHODOLOGY

12/21/2022	Special Investigation Intake 2023A0872014
12/21/2022	APS Referral This complaint was referred to APS. The APS worker is Dan Spalthoff
12/21/2022	Special Investigation Initiated - Letter I emailed the licensee designee, William Paige, requesting information about this complaint
12/28/2022	Contact - Document Received AFC documentation received from Mr. Paige
01/03/2023	Contact - Telephone call received I spoke to APS Worker, Dan Spalthoff about this complaint
01/04/2023	Inspection Completed On-site Unannounced
01/13/2023	Contact - Telephone call made I interviewed staff Keondus Miller
01/17/2023	Contact - Telephone call received I received a voice mail message from Recipient Rights Officer, Matthew Potts
01/18/2023	Contact - Telephone call made I interviewed staff Devon Schofield
01/18/2023	Contact - Telephone call made I interviewed staff Terrance White

01/18/2023	Exit Conference I conducted an exit conference with the licensee designee, William Paige

ALLEGATION: On 12/16/22, Resident A got into an altercation with staff, Keondus Miller. Resident A said that Mr. Miller punched him in the face.

INVESTIGATION: On 12/22/22, I reviewed an Incident/Accident Report (IR) dated 12/16/22 completed by staff Devon Schofield, regarding Resident A. According to the IR, Mr. Schofield was in the office and heard "some commotion in the hallway." Mr. Schofield said that he saw staff Keondus Miller walking away from Resident A, "but (Resident A) was pursuing him." Mr. Miller went into the office and Mr. Schofield tried to diffuse the situation. Resident A continued trying to attack Mr. Miller, telling him he was going to fight him and telling Mr. Schofield to let him fight. Mr. Schofield told Mr. Miller to go outside which he did. Resident A then ran outside and began swinging at Mr. Miller. "For the next 15 minutes or so (Mr. Miller) was running around the yard trying to avoid (Resident A.)" Mr. Schofield wrote that Resident A picked up a tool and threatened to damage Mr. Miller's car, but Mr. Schofield was able to get the tool away from him. According to the IR, Resident A eventually calmed down after talking with Mr. Schofield. The corrective measures taken were, "Staff will continue to redirect (Resident A) when he is having aggression issues & offer coping skills. Clinical team will review by 12/30/22."

I reviewed another IR dated 12/20/22 completed by RN, Gabrielle Shields. According to the IR, during his psychiatric evaluation, Resident A said that he was punched in the face by staff Keondus Miller. RN Shields reported the allegations to all necessary parties and assessed Resident A for injuries. She determined that he did not have any bruising, lacerations, swelling, or pain. Mr. Miller was suspended pending this investigation.

On 01/03/23, I spoke to Adult Protective Services Worker, Daniel Spalthoff via telephone. Mr. Spalthoff said that he interviewed Resident A on 12/21/22. During that interview, Resident A told him that staff Keondus Miller punched him in the jaw and pushed him to the ground on 12/16/22. Mr. Spalthoff said that Resident A did not have any marks, bruises, or injuries when he interviewed him. Mr. Spalthoff said that he also interviewed Resident B, who is Resident A's roommate. According to Mr. Spalthoff, Resident B told him that Resident A "deserved it" but would not tell him anything else. Resident B would not say who hit Resident A and would not say what happened.

On 01/04/23, I conducted an unannounced onsite inspection of New Hope Behavioral Services I Adult Foster Care facility. I interviewed Resident A, Resident B, and the administrator, Tara Maynie.

Resident A told me that on 12/16/22, staff Keondus Miller came into his room to check on Resident B. Resident A said that he got out of bed and approached Mr. Miller, telling him to get out of their room. Resident A said, “I had my guard up and so did (Mr. Miller.)” Resident A said that Mr. Miller said, “What you gonna do?” and he approached Resident A. Resident A told me that he felt like this was a threat. Resident A stated that Mr. Miller then walked up to him and punched him in the left side of his face. According to Resident A, his face was slightly swollen for a couple of hours after this incident, but he did not need medical attention. Resident A said that he was angry that Mr. Miller hit him, so he followed Mr. Miller outside and “went after him.” Resident A stated that while outside, he grabbed a shovel and was going to destroy Mr. Miller’s car but said, “I didn’t end up doing that.” Resident A told me that he kept chasing Mr. Miller and kept trying to hit him. At one point, Mr. Miller “was trying to defend himself so he pushed me down, grabbed my foot and started dragging me through the snow.” According to Resident A, everything that Mr. Miller did outside was “self-defense” but said “when he hit me in my room, it wasn’t self-defense.”

Initially, Resident B told me that he did not want to talk to me. Eventually, he told me that on 12/16/22, staff Keondus Miller came into their room and Resident A “jumped out of bed and started taunting him.” He said, “(Mr. Miller) wasn’t gonna put up with that shit so he punched him.” Resident B said that Resident A “takes things too far sometimes and (Mr. Miller) got fed up and pow! He Tysoned his ass!” Resident B demonstrated a hitting motion with his fist. Resident B said that “it turned into a fist fight and then (Mr. Miller) left.” According to Resident B, none of the staff have ever put their hands on him and he said that he has never seen Mr. Miller put his hands on Resident A or any of the other residents prior to this incident. Resident B said that Resident A “deserved it” and said that Mr. Miller should not get in trouble for what he did.

I spoke to the administrator, Tara Maynie about the incident. She said that she is aware of the allegations, and she removed Keondus Miller from the schedule pending this investigation.

On 01/13/23, I interviewed staff Keondus Miller via telephone. Mr. Miller said that on 12/16/22, he was working with staff Terrance White, and Devon Schofield. According to Mr. Miller, Resident B was upset about something, and he kept yelling and slamming his bedroom door. Mr. Miller said that he eventually went down to Resident A and B’s bedroom and opened the door. He said that he began talking to Resident B when Resident A got up out of bed and approached him with his fists clenched. Mr. Miller said that Resident A said, “get the fuck out of our room” and put his fists up. According to Mr. Miller, he said “okay, I’ll leave” at which time Resident A “took a swing at me.” Mr. Miller said that Resident A did not actually make contact with him, and he left the room. According to Mr. Miller, he never put his hands on Resident A and Resident A never hit him. Mr. Miller said that when he walked out of the bedroom, staff Terrance White was standing in the hallway “and he saw the whole thing.” I asked Mr. Miller if Resident B was in the bedroom when this all took place and he said, “yes.” Mr. Miller said that Resident B saw Resident A try to hit him and also saw that Mr. Miller did not put his hands on Resident A. I asked Mr. Miller why Resident B would say that he did hit

Resident A and he said, “maybe he’s just saying what (Resident A) told him to say.” Mr. Miller told me, “I’m a big guy. If I did hit Resident A, it wouldn’t be good.” Mr. Miller said that he knows he is not supposed to put his hands on the residents and said that he would never harm any of them.

According to Mr. Miller, after walking out of the resident’s bedroom, he went into the staff office. He said that Resident A kept “coming after me” and eventually followed him outside, trying to hit him. Mr. Miller said that Resident A picked up a shovel and said he was going to destroy his car, but he did not end up doing that. Mr. Miller said that Resident A kept coming after him, trying to hit him, until eventually he calmed down. Mr. Miller again told me that at no time did he put his hands on Resident A or harm him in any way.

On 01/17/23, I received a voice mail message from Recipient Rights Officer, Matthew Potts. Mr. Potts said that he did substantiate the allegations regarding staff Keondus Miller hitting Resident A.

On 01/18/23, I interviewed staff Devon Schofield via telephone. Mr. Schofield confirmed that he worked with staff Keondus Miller and Terrance White on 12/16/22. According to Mr. Schofield, he “heard a commotion” in the hallway. He looked in the hallway and saw Resident A chasing staff, Keondus Miller. Mr. Schofield said that Resident A was “going ballistic” and was yelling and cussing at Mr. Miller. Mr. Schofield stated that Mr. Miller went into the office to separate himself from Resident A but Resident A “came barreling in” and continued going after Mr. Miller, trying to hit him with the fire extinguisher. Mr. Schofield told me that Resident A continued going after Mr. Miller and even followed him outside. I asked Mr. Schofield if Resident A ever stated that Mr. Miller had hit him and he said, “no.” Mr. Schofield said that Resident A kept saying, “Let me fight him! Let me fight him like a man!” Mr. Schofield told me that he never saw Mr. Miller hit Resident A.

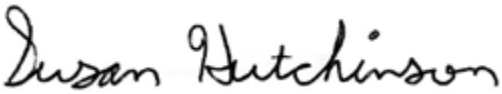
On 01/18/23, I interviewed staff Terrance White via telephone. Mr. White confirmed that he worked with staff Devon Schofield and Keondus Miller on 12/16/22. According to Mr. White, he was in the hallway when he saw the door to Resident A’s room “swinging open and (Mr. Miller) was backing out, protecting his face.” Mr. White said that Resident A was following Mr. Miller, saying “Get the fuck out of my room!” Mr. White stated that Resident A continued chasing after Mr. Miller, trying to hit him. He said that Resident A was yelling at Mr. Schofield saying, “Fire him! Fire him!” referring to Mr. Miller. I asked Mr. White if Resident A ever said that Mr. Miller hit him and he said, “no.” Mr. White said that he never saw Mr. Miller hit Resident A. I asked him if Resident A had any marks, bruises, or injuries on that date and he said, “no.”

On 01/18/23, I conducted an exit conference with the licensee designee, William Paige. I told him that I have concluded my investigation and told him which rule violation I am substantiating. Mr. Paige agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Resident A and Resident B said that on 12/16/22, staff Keondus Miller hit Resident A in the face while they were all in Resident A and B's bedroom. Staff Keondus Miller said that he did not hit Resident A. Staff Devon Schofield and Terrance White said that they did not see Mr. Miller hit Resident A and Resident A did not tell them that Mr. Miller hit him. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

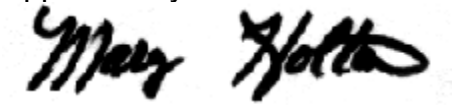
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



January 18, 2023

Susan Hutchinson Licensing Consultant	Date

Approved By:



January 18, 2023

Mary E. Holton Area Manager	Date