



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 30, 2023

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

RE: License #: AM250281878
Investigation #: 2023A0872037
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,

A handwritten signature in cursive script that reads "Susan Hutchinson".

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 #:	2023A0872037
Complaint Receipt Date:	04/12/2023
Investigation Initiation Date:	04/12/2023
Report Due Date:	06/11/2023
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?
Staff is not providing 1:1 supervision as required.	No
On 04/09/23, mouse droppings were observed on Resident A's dresser.	No
On 04/09/23, the following was observed in Resident A's room: dried fecal matter all over the bathroom and bedroom, a pile of feces on his windowsill, his mattress soiled with urine and feces, no bedding on his bed, bathroom fan hanging from the ceiling.	Yes

III. METHODOLOGY

04/12/2023	Special Investigation Intake 2023A0872037
04/12/2023	APS Referral I made an APS complaint via email
04/12/2023	Special Investigation Initiated - Letter
04/13/2023	Inspection Completed On-site Unannounced
04/14/2023	Contact - Document Sent I emailed the licensee designee, William Paige, requesting information related to this complaint
04/17/2023	Contact - Document Received I received AFC documentation from Mr. Paige
04/27/2023	Contact - Document Received I exchanged emails with APS Worker, Dan Spalthoff
05/30/2023	Contact - Telephone call made I interviewed Guardian A1
05/30/2023	Exit Conference I conducted an exit conference with the licensee designee, William Paige

ALLEGATION: Staff is not providing 1:1 supervision as required.

INVESTIGATION: On 04/13/23, I conducted an unannounced onsite inspection of New Hope Behavioral Services I Adult Foster Care facility. I interviewed the licensee designee, William Paige, staff Antonio Tedford, and observed and interacted with Resident A. I also conducted a visual inspection of Resident A's bedroom and the common areas of the facility.

While at the facility, I met with Resident A and his 1:1 staff, Antonio Tedford. Mr. Tedford said that he has worked at this facility for several years and he confirmed that Resident A requires 1:1 supervision. Mr. Tedford said that to his knowledge, Resident A does receive 1:1 supervision as required.

On 04/17/23, I received AFC documentation regarding Resident A. Resident A was admitted to New Hope Behavioral Services I AFC on 08/01/22. According to his Health Care Appraisal dated 08/18/22, he is diagnosed with cyclothymic disorder and moderate intellectual disabilities. He has "limited insight and judgement, impulsiveness, perseveration, and articulation error in speech." At the time of his examination, RN Gabrielle Shields noted that he was "appropriately dressed and groomed well."

According to Resident A's Assessment Plan, he requires 1:1 staff supervision while in the community. He has "wetting and soiling accidents periodically." He receives "1:1 staffing on 1st and 2nd shift, line of sight on 3rd shift."

I reviewed Resident A's Shiawassee County Health & Wellness Individualized Plan of Service (IPOS) dated 11/21/22. According to this document, he is self-ambulatory, can respond to yes or no questions and provides 1–4-word answers to questions. He develops a strong rapport with his 1:1 staff. While sleeping, staff is to conduct 15-minute visual checks. If Resident A is in common areas during sleeping hours, he is to remain in line-of-sight of staff. He requires moderate staff assistance with toileting, bathing, grooming, dressing, and personal hygiene. He has a history of aggressive behaviors, self-injurious behaviors, property destruction, and pica. He also has a history of hiding his soiled undergarments/briefs in his drawers, under his bed, and other hidden places. He has a tendency to tear items off the walls and tear up other items in his room.

I reviewed Resident A's staffing flow sheets for March and April 2023. According to these documents, Resident A is receiving 1:1 supervision by staff. Every 15 minutes, staff documents that Resident A is observed by staff and they document what Resident A is doing at the time of the documentation.

APPLICABLE RULE	
R 400.14303	Resident care; licensee responsibilities.
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	<p>According to Resident A's Assessment Plan, he requires 1:1 staff supervision while in the community. He has "wetting and soiling accidents periodically." He receives "1:1 staffing on 1st and 2nd shift, line of sight on 3rd shift."</p> <p>According to the licensee designee, William Paige and staff Antonio Tedford, Resident A receives 1:1 staffing as required.</p> <p>I reviewed Resident A's staffing flow sheets for March and April 2023. According to these documents, Resident A is receiving 1:1 supervision by staff. Every 15 minutes, staff documents that Resident A is observed by staff and they document what Resident A is doing at the time of the documentation.</p> <p>I conclude that there is insufficient to substantiate this rule violation at this time.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: On 04/09/23, mouse droppings were observed on Resident A's dresser.

INVESTIGATION: On 04/13/23, I conducted an unannounced onsite inspection of New Hope Behavioral Services I Adult Foster Care facility. I interviewed the licensee designee, William Paige, staff Antonio Tedford, and observed and interacted with Resident A. I also conducted a visual inspection of Resident A's bedroom and the common areas of the facility.

Mr. Paige confirmed that the facility has had a rodent problem in the past and said that they employ an exterminator service which comes out every two months to treat the facility. He said that he has not seen any evidence of rodents in several months.

I examined Resident A's room and visually inspected the common areas of the facility and did not see any evidence of rodent droppings.

I reviewed a pest control invoice from Orkin dated 03/13/23. According to the invoice, "Inspected building for signs of pest activity. Replaced interior monitor board due to it being damaged. Inspected bait station and didn't observe any activity around it. Reset empty snap trap in stairwell due to it being triggered."

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:	<p>According to the licensee designee, William Paige, the facility has had a rodent problem in the past. Therefore, the facility is inspected by a pest control company every two months.</p> <p>While at the facility on 04/13/23, I did not see any evidence of rodent droppings. Mr. Paige said that he has not seen any evidence of rodent droppings for several months.</p> <p>I reviewed a pest control invoice from Orkin dated 03/13/23. According to the invoice, "Inspected building for signs of pest activity. Replaced interior monitor board due to it being damaged. Inspected bait station and didn't observe any activity around it. Reset empty snap trap in stairwell due to it being triggered."</p> <p>I conclude that there is insufficient evidence to substantiate this rule violation.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: On 04/09/23, the following was observed in Resident A's room: dried fecal matter all over the bathroom and bedroom, a pile of feces on his windowsill, his mattress soiled with urine and feces, no bedding on his bed, bathroom fan hanging from the ceiling.

INVESTIGATION: On 04/13/23, I conducted an unannounced onsite inspection of New Hope Behavioral Services I Adult Foster Care facility. I interviewed the licensee designee, William Paige, staff Antonio Tedford, and observed and interacted with Resident A. I also conducted a visual inspection of Resident A's bedroom.

According to Mr. Paige, Resident A wears pull ups, but he pulls them off all the time. Resident A will urinate all over his bedroom and in other places in the facility. He will also take feces out of his pull up and smear it all over his bedroom, and the walls and floors in the rest of the facility. Mr. Paige said that staff attempts to prevent Resident A's behaviors, but Resident A persists. Mr. Paige told me that staff attempts to promptly clean up after Resident A, but they are not always able to do so.

I visually inspected Resident A's room and detected a strong odor of urine in the hallway before entering his bedroom. While in his bedroom, the smell of urine persisted, and I noted that the room did not appear clean. I did not observe any evidence of feces

on the floors, walls, or in his bathroom. I observed his mattress which had a vinyl protected mattress but no sheets or blanket. Mr. Paige explained that Resident A soiled his sheets, and they are currently being laundered. He said that once the sheets are clean and dry, he will have them placed back on Resident A's bed. Mr. Paige told me that Resident A soils his sheets and blanket regularly, so staff is washing his bedding on an almost daily basis.

Mr. Paige stated that due to Resident A's incontinence problem, he has a work order in for a professional cleaning company to come in and clean and disinfect the entire facility. The appointment is scheduled for 04/15/23.

While in Resident A's room, I saw several holes in the walls and the exhaust fan in the bathroom was hanging from the ceiling. In addition, Resident A did not have a doorknob on his bedroom door. There was a handy man in the room repairing the walls while I was at the facility. Mr. Paige said that he will have the handy man install a doorknob, repair the bathroom exhaust fan, and make any other necessary repairs to Resident A's room. Mr. Paige told me that Resident A has a history of physically destructive behaviors.

While at the facility, I met with Resident A and his 1:1 staff, Antonio Tedford. Due to Resident A's intellectual disability, he only provided short answers to my questions. I asked him if he wears briefs, and he said yes because his "stomach hurts sometimes." I asked him what happens when his brief is soiled, and he did not answer. I asked him if staff changes his briefs, and he said that he does it himself. I asked him where he puts his soiled brief and he said, "in my bed."

Mr. Tedford said that he has worked at this facility for several years and he is often assigned as Resident A's 1:1 staff. Mr. Tedford confirmed that Resident A wears briefs and he will constantly take his briefs off, smear feces throughout the facility, and urinate on the floors and everywhere in his bedroom.

On 04/17/23, I received documentation from Mr. Paige regarding this complaint. I reviewed an invoice from Stanley Steemer dated 04/14/23. According to the invoice, the following rooms had hard surfaces which were cleaned: Four bathrooms, hallway, four rooms, day room, laundry room, entry, and the kitchen/dining room area. The invoice also stated that four carpeted rooms were cleaned.

I reviewed an invoice from A Woman's Touch (AWT) cleaning service dated 04/16/23. According to the invoice, on 04/15/23 the following services were completed: "Deep cleaning, trash removal, furniture moved for cleaning, personal property moved for cleaning in bathrooms, bedrooms, and closets." The following rooms were cleaned: Four bedrooms, five bathrooms, kitchen, office, living room, and stairs.

APPLICABLE RULE	
R 400.14403	Maintenance of premises.
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	<p>On 04/13/23, I conducted an unannounced onsite inspection of New Hope Behavioral Services I Adult Foster Care facility.</p> <p>I visually inspected Resident A's room and detected a strong odor of urine in the hallway before entering his bedroom. While in his bedroom, the smell of urine persisted, and I noted that the room was not clean. I did not observe any evidence of feces on the floors, walls, or in his bathroom. I saw several holes in the walls and the exhaust fan in the bathroom was hanging from the ceiling. In addition, Resident A did not have a doorknob on his bedroom door.</p> <p>According to Mr. Paige, Resident A wears pull ups, but he pulls them off all the time. Resident A will urinate all over his bedroom and in other places in the facility. He will also take feces out of his pull up and smear it all over his bedroom, and the walls and floors in the rest of the facility. Mr. Paige said that staff attempts to prevent Resident A's behaviors, but Resident A persists. Mr. Paige told me that staff attempts to promptly clean up after Resident A, but they are not always able to do so.</p> <p>I conclude that there is sufficient evidence to substantiate this rule violation.</p>
CONCLUSION:	VIOLATION ESTABLISHED

On 05/30/23, I conducted an exit conference with the licensee designee, William Paige. I discussed the results of my investigation and explained which rule violation 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.

Susan Hutchinson

May 30, 2023

Susan Hutchinson Licensing Consultant	Date
--	------

Approved By:

Mary Holton

May 30, 2023

Mary E. Holton Area Manager	Date
--------------------------------	------