GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 31, 2023

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

RE: License #:	AS250404567
Investigation #:	2023A0872041
	New Hope Green Valley

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 #:	AS250404567
Investigation #:	2023A0872041
Complaint Receipt Date:	04/27/2023
Investigation Initiation Date:	04/27/2023
Report Due Date:	06/26/2023
Licensee Name:	Hope Network, S.E.
Licensee Address:	PO Box 190179 Burton, MI 48519
Licensee Telephone #:	(586) 206-8869
Administrator:	Kayonna Ferguson
Licensee Designee:	William Paige
Name of Facility:	New Hope Green Valley
Facility Address:	8179 Green Valley Dr Grand Blanc, MI 48439
Facility Telephone #:	(810) 600-2717
Original Issuance Date:	11/08/2021
License Status:	REGULAR
Effective Date:	05/08/2022
Expiration Date:	05/07/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 04/25/23, the residents were left home alone from 5am-7am.	Yes

III. METHODOLOGY

04/27/2023	Special Investigation Intake 2023A0872041
04/27/2023	Special Investigation Initiated - On Site Unannounced
04/28/2023	Contact - Telephone call made I spoke to the referral source
04/28/2023	Contact - Document Sent I emailed the licensee designee requesting information about this complaint
04/28/2023	APS Referral I made an APS complaint via email
04/28/2023	Contact - Document Received I received screenshots of text messages between staff Keondus Miller and Amber Horne
04/29/2023	Contact - Document Received Documentation received from Mr. Paige
05/31/2023	Contact - Telephone call made I interviewed staff Keondus Miller
05/31/2023	Contact - Telephone call made I interviewed former home manager, Amber Horne
05/31/2023	Exit Conference I conducted an exit conference with the licensee designee, William Paige
05/31/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 04/25/23, the residents were left home alone from 5am-7am.

INVESTIGATION: On 04/27/23, I conducted an unannounced onsite inspection of New Hope Green Valley Adult Foster Care facility. I interviewed Residents A-D and staff Ashley Sublet.

I interviewed all residents individually and reviewed the allegations with them. Residents A-D all stated that there is always staff present at the facility and they are never left home alone. None of the residents I interviewed said that they wake up before 7am. All residents stated that they have never woken up and found no staff present.

Ms. Sublet said that she has worked at this facility since June 2022, and she typically works from 10am-6pm. Ms. Sublet said that to her knowledge, there is always one staff at the facility at all times. She said that there has never been a time when she has come to work and found no staff present.

On 04/28/23, I interviewed the referral source (RS) via telephone. According to the RS, on 04/24/23, staff Keondus Miller was working at the facility. He asked the home manager, Amber Horne, if he could leave at 5am. Ms. Horne told him he could leave and said that she would come in at 5am. However, Ms. Horne did not get to the facility until 7am. Therefore, the residents were left home alone from 5am-7am.

On 05/31/23, I interviewed staff Keondus Miller via telephone. Mr. Miller said that on 04/24/23, he began work at 7am. He was scheduled to leave at 11pm and staff Amber Horne was supposed to be there to relieve him. At 10pm, Ms. Horne texted him and asked him if he could work for her from 11pm-7am. Mr. Miller said that he told Ms. Horne he could only work until 5am on 04/25/23 and she agreed to come in at that time. Mr. Miller said that at 5am on 04/25/23, he left the facility, believing that Ms. Horne was on her way. Mr. Miller said that when he left the facility, none of the residents were awake and no other staff were present.

On 05/31/23, I interviewed the former home manager, Amber Horne via telephone. Ms. Horne confirmed that on 04/24/23 she was scheduled to work at 11pm. She said that she texted staff Keondus Miller and asked him if he could work her shift. Mr. Miller told her that he could work until 5am on 04/25/23 so she agreed to come in at that time. According to Ms. Horne, she had been working 200+ hours at the facility and although she intended to get to work at 5am, she fell asleep and did not get to work until 7am. Ms. Horne confirmed that when she got to work, no staff was present. She said that all the residents were sleeping so she went upstairs and checked on them, noting that they were fine. According to Ms. Horne, she thought that one of the other staff was working with Mr. Miller that night and did not realize no staff was present until she got there at 7am. Ms. Horne said that her employment with this facility was terminated as a result of “mismanagement” but she feels this is unfair because of the hours she was working.

On 05/31/23, I conducted an exit conference with the licensee designee, William Paige. I discussed the results of the 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 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Staff Keondus Miller said that on 04/25/23, he left the facility at 5am, believing that staff Amber Horne would be there shortly. Mr. Miller said that no other staff was present at the facility when he left. Staff Amber Horne said that she got to work on 04/25/23 at 7am and no other staff were present. She said that all the residents were sleeping when she got to work so she checked on them and they were fine. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

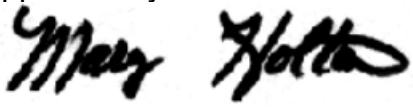
IV. RECOMMENDATION

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

May 31, 2023

Susan Hutchinson Licensing Consultant	Date

Approved By:



May 31, 2023

Mary E. Holton Area Manager	Date