GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 5, 2023

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

RE: License #:	AS250404568
Investigation #:	2023A0872062
	New Hope Fenton Hills

Dear William 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 #:	AS250404568
Investigation #:	2023A0872062
Complaint Receipt Date:	07/28/2023
Investigation Initiation Date:	07/28/2023
Report Due Date:	09/26/2023
Licensee Name:	Hope Network, S.E.
Licensee Address:	PO Box 190179 Burton, MI 48519
Licensee Telephone #:	(810) 232-2766
Administrator:	Trina Wicks
Licensee Designee:	William Paige
Name of Facility:	New Hope Fenton Hills
Facility Address:	1253 Woodnoll Dr Flint, MI 48507
Facility Telephone #:	(810) 243-0986
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?
Since October 2022, police have responded to this facility 54+ times, mostly regarding Resident A. Calls are regarding domestic disturbances, disorderly conduct, EMS, missing, runaway, unknown trouble, and welfare checks. Staff tells the police that they cannot restrict Resident A's rights from leaving the property and calling the police.	Yes

III. METHODOLOGY

07/28/2023	Special Investigation Intake 2023A0872062
07/28/2023	Special Investigation Initiated - Telephone
07/28/2023	Contact - Telephone call made I spoke to Det. Lutz from the Metro Police Department about this complaint
07/28/2023	APS Referral I made an APS complaint via email
07/28/2023	Contact - Document Received Documentation received
09/01/2023	Contact - Document Sent I emailed Resident A's case manager requesting a call back
09/05/2023	Contact - Telephone call made I interviewed staff Tessa Dudley
09/05/2023	Contact - Telephone call made I interviewed Guardian A1
09/05/2023	Exit Conference I conducted an exit conference with the licensee designee, William Paige
09/05/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Since October 2022, police have responded to this facility 54+ times, mostly regarding Resident A. Calls are regarding domestic disturbances, disorderly conduct, EMS, missing, runaway, unknown trouble, and welfare checks. Staff tells the police that they cannot restrict Resident A's rights from leaving the property and calling the police.

INVESTIGATION: On 07/28/23, I received a copy of a 30-day discharge notice dated 07/14/23 regarding Resident A. According to the document, Resident A was served the notice due to the following reasons: she is unable to be redirected, she does not respond to de-escalation techniques, situations are only diffused when law enforcement becomes involved, she is physically aggressive toward peers, she is verbally aggressive toward peers and staff, she has a pending court case for Assault & Battery, she has stolen a peers' debit card, she leaves the facility without notifying staff, she exhibits self-harming behaviors, she engages in property destruction, and law enforcement has been out to the facility on 52 occasions since her admission and they are requesting/recommending relocation.

On 07/28/23, I received a copy of an emergency discharge notice dated 07/28/23 regarding Resident A. According to this document, Resident A was given the notice due to the following reasons: she engaged in self-harming behaviors on 3 occasions with the last occasion resulting in a fractured lower back/tailbone and she engaged in property destruction on 07/27/23.

On 08/01/23, I conducted an unannounced onsite inspection of New Hope Fenton Hills. I interviewed the administrator (AD), Trina Wicks and obtained copies of Resident A's Adult Foster Care paperwork. I reviewed the allegations with AD Wicks, and she confirmed that the police are called to this facility on a frequent basis. She said that most of the residents in this home have cell phones, and they will often call 911 without staff knowledge. AD Wicks also said that staff has called the police due to one resident assaulting another and the police have arrested residents in some of these situations.

AD Wicks said that Resident A was admitted to this facility on 12/12/22 and she was given a 30-day discharge notice on 07/14/23. AD Wicks said that due to Resident A's increased behavioral problems, she was issued an emergency discharge notice on 07/27/23 and she will not be returning to this facility.

According to AD Wicks, Resident A has a history of property destruction, suicidal ideations, self-harming behaviors, and elopements. AD Wicks acknowledged that staff contacted the police on multiple occasions due to Resident A's behaviors.

AD Wicks told me that while a resident of New Hope Fenton Hills, Resident A had community access and she did not require enhanced or 1:1 supervision. AD Wicks said that she and staff consistently talked with Resident A's case manager about her behaviors and asked for enhanced supervision and limited community access. AD Wicks said that she and staff reached out to Resident A's case manager early on in her placement, asking for assistance but Resident A's case manager would not restrict her

community access, they would not assign 1:1 or enhanced supervision, and they would not revoke Resident A's phone privileges.

Resident A often eloped from the facility and every time she did, staff followed her. Staff typically followed her in the facility van and would continually encourage Resident A to get in the van and return to the facility. If Resident A began making self-harm threats or if she refused to get in the van, staff would then contact 911 for assistance. AD Wicks said that on one occasion, Resident A had 2 strangers pick her up and staff was not able to physically stop her from leaving the residence. Her Individualized Plan of Service (IPOS) states that if she elopes and staff cannot find her after 30-minutes, they are supposed to call the police.

AD Wicks said that on 07/26/23, Resident A eloped from the home and threatened to jump off a highway overpass. Police transported her to Hurley Medical Center. She returned on 07/27/23 and her hospital discharge instructions stated that she needed 1:1 supervision. Therefore, the facility assigned 1:1 staff to her. AD Wicks stated that shortly after Resident A returned to the facility, she walked up the stairs to her bedroom and staff followed her. Resident A opened her window and crawled out onto the roof. Staff is not allowed to physically restrain Resident A, so staff kept telling Resident A that it was unsafe for her to be on the roof, and she needs to come back inside. Resident A apparently slipped or lost her footing and she fell off the roof, while staff was present. Staff contacted 911 and Resident A was taken to McLaren Hospital. As of this date, she is still there, awaiting surgery for a broken tailbone. Due to the seriousness of this incident, management issued her an emergency discharge notice.

AD Wicks stated that finally, in July 2023 Resident A's case manager took her community access away and took her phone privileges away. They authorized 1:1 staffing on 07/27/23 when Resident A was released from the hospital. However, this is the date she fell off the roof and had to be hospitalized once again.

While at the facility, I obtained a copy of Resident A's IPOS dated 06/20/23. Resident A is diagnosed with PTSD, ADHD, unspecified trauma and stress related disorder, childhood sexual abuse, and conduct disorder. Resident A resided with her grandparents from age 2-years and was eventually placed in a specialized AFC facility. Resident A has a history of stealing and eloping with strangers and on a few occasions, when she returned, she reported that she had been sexually assaulted.

On 06/28/23, Resident A was picked up by a man in a red pickup truck and staff did not know who he was or where they went. She was gone overnight and eventually contacted a relative to pick her up and take her back to the AFC facility. According to this document, "These behaviors have led to police involvement on multiple occasions and are causing distress in the home as well as concern for (her) wellbeing."

According to this report, Resident A has a history of "engaging in inappropriate or unsafe social behaviors while in the community. Historically, (she) has had inappropriate sexual behavior toward peers while in the community, unsafe behavior

needing redirection from staff while in the community." She uses her phone and the internet to communicate with strangers who then come to her AFC home to pick her up. On several occasions, Resident A stole a housemate's debit card and used it take money out of the account and make internet purchases.

Despite her history, the IPOS does not state that Resident A requires 1:1 or enhanced supervision nor does it state that she is not allowed community access, or access to the internet. She is required to have staff supervision while in the community. According to the IPOS, if Resident A leaves the facility, staff will follow her and give her prompts to return to the AFC facility. If she is not directed back to the home in 30-minutes or if she becomes unsafe, staff are supposed to contact the police and ask their assistance with getting her back to the facility.

On 09/05/23, I interviewed staff Tessa Dudley via telephone. Staff Dudley said that she has worked at this facility for approximately one year. She said that she worked closely with Resident A while she resided at New Hope Fenton Hills AFC facility. According to Staff Dudley, Resident A eloped from the facility on multiple occasions and staff was not allowed to physically restrain her from leaving. Staff followed her IPOS which stated that if Resident A left the facility without permission, staff is supposed to follow her and encourage her to return. If she refused to return, or if staff was unable to locate her after 30-minutes, they were supposed to call the police.

Staff Dudley told me that on one occasion, she had to call the police because Resident A had eloped. When the police brought Resident A back to the facility, the officer was "mad" at Resident A and obviously frustrated by the number of times that police have had to respond to the facility. Staff Dudley said that she tried to explain to the officer that she and the other staff are not allowed to restrict Resident A from leaving. She said that she told Resident A, "I can't keep you here. You know that. But every time you leave, I have to do what I have to do." Staff Dudley said that the police officer seemed angry that Staff Dudley did not tell Resident A that she cannot leave the property. According to Staff Dudley, since Resident A left this facility, things have been "quiet", and they have not had to call the police for assistance.

On 09/05/23, I interviewed Guardian A1 via telephone. Guardian A1 confirmed that Resident A resided at New Hope Fenton Hills for several months and she eloped on multiple occasions. According to Guardian A1, several months ago, she spoke to Resident A's case manager about moving Resident A to a more restrictive setting and the case manager said, "If they issue her a 30-day notice, we will talk about it then."

Guardian A1 told me that on 07/27/23, Resident A was hospitalized due to falling/jumping off the roof. She was on the medical floor for several days and her case manager tried looking for a new placement for her. She was eventually transferred to the psychiatric unit on 08/14/23. Shortly thereafter, she was sent to an AFC crisis residential center but she only lasted 2 hours before she eloped. She was eventually brought back to the hospital, and she is now on the psychiatric unit at McLaren Medical Center awaiting an outpatient placement. Guardian A1 confirmed that Resident A did

not seem to be a good fit for the New Hope Fenton Hills AFC because she would not adhere to the rules, and she needed a more restrictive setting.

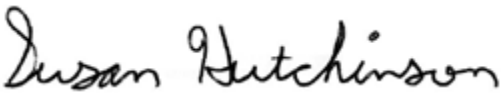
On 09/05/23, I conducted an exit conference with the licensee designee (LD), William Paige. I discussed the results of my investigation and explained which rule violation I am substantiating. I spoke with LD Paige about the importance of making sure residents are appropriate for his AFC setting and if they are not, and he cannot get assistance from the resident's case manager, he needs to issue a 30-day notice. LD Paige agreed and agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
ANALYSIS:	**(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions:** **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.** **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.** **(c) The resident appears to be compatible with other residents and members of the household.**
	Resident A was admitted to New Hope Fenton Hills AFC facility on 12/22/22. Since that time, the police have responded to the facility on multiple occasions due to her behaviors and/or her elopements. Resident A's IPOS states that Resident A is allowed community access. It states that if Resident A is gone for more than 30 minutes without staff being able to locate her and/or convince her to return to the facility, they are supposed to call the police. The AFC facility was aware of Resident A's history of elopements and self-harm when she was admitted. They continually called the police due to her behaviors and/or elopements. The facility did not issue a 30-day discharge notice to Resident A until 07/14/23 despite their inability to meet her needs.

	I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

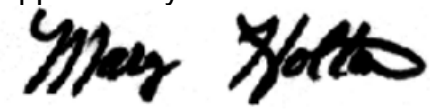
Upon the receipt of an acceptable action plan, I recommend no change in the license status.



September 5, 2023

Susan Hutchinson Licensing Consultant	Date

Approved By:



September 5, 2023

Mary E. Holton Area Manager	Date