



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
ACTING DIRECTOR

August 28, 2023

Andrew Davenport  
Hope Network West Michigan  
PO Box 890  
Grand Rapids, MI 49501-0141

RE: License #: AS410312036  
Investigation #: 2023A0340037  
Neo Grand Rapids-Bristol

Dear Mr. Davenport:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 8/25/23, you submitted an acceptable written corrective action plan. It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

A handwritten signature in blue ink that reads "Rebecca Piccard".

Rebecca Piccard, Licensing Consultant  
Bureau of Community and Health Systems  
Unit 13, 7th Floor  
350 Ottawa, N.W.  
Grand Rapids, MI 49503  
(616) 446-5764

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF COMMUNITY AND HEALTH SYSTEMS  
SPECIAL INVESTIGATION REPORT**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS410312036
<b>Investigation #:</b>	2023A0340037
<b>Complaint Receipt Date:</b>	08/09/2023
<b>Investigation Initiation Date:</b>	08/09/2023
<b>Report Due Date:</b>	10/08/2023
<b>Licensee Name:</b>	Hope Network West Michigan
<b>Licensee Address:</b>	PO Box 890 Grand Rapids, MI 49518
<b>Licensee Telephone #:</b>	(616) 430-9454
<b>Administrator:</b>	Andrew Davenport
<b>Licensee Designee:</b>	Andrew Davenport
<b>Name of Facility:</b>	Neo Grand Rapids-Bristol
<b>Facility Address:</b>	909 Bristol Ave. NW Grand Rapids, MI 49504
<b>Facility Telephone #:</b>	(616) 791-4130
<b>Original Issuance Date:</b>	01/06/2012
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	07/16/2022
<b>Expiration Date:</b>	07/15/2024
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A eloped and was found in a neighbor's home.	Yes

**III. METHODOLOGY**

08/09/2023	Special Investigation Intake 2023A0340037
08/09/2023	APS Referral
08/09/2023	Special Investigation Initiated - Telephone Andrew Davenport
08/12/2023	Contact – telephone call made Staff Nichole Rademacher
08/15/2023	Inspection Completed On-site
08/15/2023	Exit Conference
08/15/2023	Contact - Document Received from Davenport
08/18/2023	Inspection Completed-BCAL Sub. Compliance
08/18/2023	Corrective Action Plan Requested and Due on 08/28/2023
08/25/2023	Corrective Action Plan Received
08/25/2023	Corrective Action Plan Accepted

**ALLEGATION: Resident A eloped and was found in the neighbor's house.**

**INVESTIGATION:** On August 9, 2023, a complaint was filed with BCAL Online Complaints. It stated that police were called to a home two houses down from Bristol AFC after Resident A walked into their home and entered a child's bedroom. Everyone was sleeping when the child ran to her parents' bedroom and woke them, saying there was a man in her bedroom. The homeowner looked and found Resident A in the child's room. The homeowner knew Bristol AFC was two houses down and assumed he had come from that home.

Police went to the Bristol home and spoke with staff Alex Kelley who informed them that Resident A likely snuck through a hole in the fence that surrounds the backyard.

On August 9, 2023, I contacted Designee Andrew Davenport. He was aware of the incident and agreed to send me Resident A's Assessment Plan, Health Care Appraisal and Incident Report. According to Mr. Davenport, Resident A was not arrested and will not be charged. Mr. Davenport also stated that the gap in the fence has already been fixed and Resident A's assessment plan is being updated to include the need for increased supervision when he is outside. Mr. Davenport stated Resident A has no history of elopement. Mr. Davenport stated he will send the documents as soon as the Assessment Plan is updated.

On August 12, 2023, I interviewed staff Nichole Rademacher. She confirmed that she was working the day Resident A eloped. She was outside with several residents, but within the fenced-in back yard. She was giving attention to one resident and when she looked across the yard, she did not see Resident A. Ms. Rademacher stated she first looked in the corners of the yard but did not see him. She saw the gap in the fence, but stated Resident A is a "big guy" and she did not think it would be possible for him to squeeze through it. She then went inside thinking he may have gone in to lay down. She also alerted coworker Alex Kelly who then assisted in looking for Resident A. Ms. Rademacher stated she then went outside and was looking around when she saw Resident A walking down the sidewalk with a woman. She went to meet them, and the woman asked, "are you looking for him?" Ms. Rademacher stated the woman lived two houses down. Ms. Rademacher stated the woman was understanding and knew the AFC home was nearby. Ms. Rademacher also stated that the woman made no reference to her child or that Resident A had gone into her home or her child's room. The neighbor did ask for her supervisor's number and repeatedly stated, "this can't happen again". Ms. Rademacher took Resident A inside after giving the neighbor her supervisor's number. She believed that was the end of the incident until the police showed up to the home approximately 30 minutes later. She stated that her co-worker spoke to the police and the police spoke to Resident A but she did not speak to the police. Ms. Rademacher stated the entire incident happened within an hour.

On August 15, 2023, I received Resident A's documentation that I had requested from Mr. Davenport. The Incident Report (IR) was reviewed. It was completed by staff Nicole Rademacher and dated 7/29/2023 and indicated Ms. Rademacher was outside with three residents. While engaging with one resident she then realized that Resident A was no longer in the fenced-in backyard. She searched the immediate area and while outside a neighbor came over and informed her Resident A had come to their house. A gap in the fence was known but it was not believed that Resident A would be able to squeeze through the gap. Police arrived at the home regarding this incident.

I reviewed Resident A's Assessment Plan dated 8/15/2023 and signed by Andrew Davenport. Under "Moves Independently In the Community" it states Resident A "is ambulatory and requires supervision while out in the community. With a recent episode of elopement, staff are doing frequent checks to know of his whereabouts to ensure safety and well-being." Prior to this Assessment, the plan for Resident A was signed 10/27/22 by Andrew Davenport and under "Moves Independently in the Community" it states Resident A "requires supervision in the community for safety purposes".

Resident A's Health Care Appraisal was dated 1/25/23 and signed by Dr. Kimberly Harper, NP. Resident A is diagnosed with autism. He is 6'0 and 256 pounds. He has limited cognition and speech.

On August 15, 2023, I conducted an unannounced home inspection. Resident A was in his room and agreed to talk with me. It was evident that Resident A had limited cognition as he was delayed in his speech pattern. I asked Resident A if he remembered going to the neighbor's house. He smiled and said "yeah". We then went outside to the fenced-in backyard for Resident A to show me what happened.

I asked Resident A if Ms. Rademacher was outside and he said "yeah" and pointed to one of the patio chairs. I asked if she was sitting there, and he said "yeah". He then led me to the corner of the fence which surrounded the backyard, behind a large tree, to an area of the fence that previously had a gap, but the gap was now fixed and solid. Resident A showed me that he went through the gap and then went around the outside of the fence, around the house and to the neighbors. Resident A stated he "snuck out". He was able to articulate that he went inside the neighbor's house through the garage.

I asked Resident A to tell me what happened while he was in the house. He said "the man" found him and didn't let him leave. I asked what room he was in and Resident A said it was a kid's room but he was not able to articulate any additional information. I asked him how he got back to Bristol and he stated, "Nicole got me". Resident A then stated he got a "big punishment" and he can no longer be outside by himself. I assured Resident A it was not a punishment but just to make sure he was safe.

I was able to then interview staff Alex Kelly. He was also working in the home at the time of the incident. Mr. Kelly stated he was inside while his coworker was outside with some residents. He did not see what happened, but when Ms. Rademacher called for assistance, he began to look for Resident A. Mr. Kelly stated he knew that Ms. Rademacher went outside to look beyond the home property but Mr. Kelly remained at the home with the residents. He did go outside when Mr. Rademacher returned with Resident A and the neighbor. He stated the neighbor appeared very understanding and there was no indication from her that the police had been called until they arrived approximately 30 minutes later.

Mr. Kelly explained to the officers what had happened. They spoke to Resident A and Resident A showed them where he eloped through the fence. They did not arrest him or indicate he was being charged. Mr. Kelly stated Resident A did not have an elopement history.

<b>APPLICABLE RULE</b>	
<b>R 400.14303</b>	<b>Resident Care; licensee responsibilities.</b>
	(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.
<b>ANALYSIS:</b>	<p>The allegation was made that Resident A eloped from the home and entered the neighbor's home two doors down and was found in the neighbor child's bedroom.</p> <p>Mr. Davenport reported Resident A does not have a history of elopement but as a result of this incident the fence has been fixed and Resident A will receive increased supervision while outside.</p> <p>Staff Rademacher stated she was outside with several residents when she realized Resident A was missing. She called for assistance from staff Kelly. She looked around the outside and walked down the sidewalk when she saw the woman two houses down was walking with Resident A and they returned to the AFC home.</p> <p>Resident A admitted to having sneaked out of the yard through a gap in the fence. He stated he went to the neighbors and entered the home through the garage. He went into a child's bedroom and was found by "the man". He walked home with the female neighbor and Ms. Rademacher returned home with him.</p> <p>Staff Kelly stated he was informed of Resident A's elopement by Ms. Rademacher. He assisted in looking but remained at the home. Resident A returned with Ms. Rademacher and the police showed up 30 minutes later.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On August 15, 2023, I conducted an exit conference with Designee Andrew Davenport. I informed him of my findings and requested a Corrective Action Plan. He understood and agreed to send one. He had no further questions.

**IV. RECOMMENDATION**

On 8/25/2023 I received an acceptable Corrective Action Plan. I recommend no change to the license status.

 August 28, 2023

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Rebecca Piccard Date  
Licensing Consultant

Approved By:

 August 28, 2023

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Jerry Hendrick Date  
Area Manager