GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 15, 2024

Amanda Ledford
Hope Network West Michigan
PO Box 890
Grand Rapids, MI 49501-0141

RE: License #: AS410417907
Investigation #: 2024A0340042
Neo Willard

Dear Mrs. Ledford:

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 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 (616) 356-0183.

Sincerely,

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

License #:	AS410417907
Investigation #:	2024A0340042
Complaint Receipt Date:	06/25/2024
Investigation Initiation Date:	06/25/2024
Report Due Date:	08/24/2024
Licensee Name:	Hope Network West Michigan
Licensee Address:	PO Box 890, Grand Rapids, MI 49518
Licensee Telephone #:	(616) 490-3684
Administrator:	Amanda Ledford
Licensee Designee:	Amanda Ledford
Name of Facility:	Neo Willard
Facility Address:	7126 Willard Ave SE, Grand Rapids, MI 49548
Facility Telephone #:	(616) 301-8000
Original Issuance Date:	02/12/2024
License Status:	TEMPORARY
Effective Date:	02/12/2024
Expiration Date:	08/11/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Kent County Sheriff's Dept responded to a call that Resident A was wandering outside without clothes on. It was reported that there are children who live next door to the home.	Yes

III. METHODOLOGY

06/25/2024	Special Investigation Intake 2024A0340042
06/25/2024	APS Referral from APS
06/25/2024	Special Investigation Initiated - Telephone Designee Amanda Ledford
06/28/2024	Contact - Document Received IR received.
07/01/2024	Inspection Completed On-site
07/12/2024	Exit Conference Designee Amanda Ledford

ALLEGATION: Kent County Sheriff's Dept responded to a call that Resident A was wandering outside without clothes on. It was reported that there are children who live next door to the home.

INVESTIGATION: On June 25, 2024, I received a complaint from Adult Protective Services through the BCAL Online Complaints which stated Kent County Sheriff's Department responded to a call that Resident A was wandering the neighborhood unsupervised without clothes on and there are children who live next door. By the time law enforcement arrived, Resident A was back home.

On June 25, 2024, I contacted Designee Amanda Ledford. She knew the police had been called regarding Resident A being outside. Ms. Ledford stated he was not naked. She will send the Incident Report (IR).

On June 28, 2024, I reviewed and received the IR from Ms. Ledford. It was written by staff Shanel Taylor, who was working in the home on her own. At approximately 1:10 PM, Ms. Taylor reportedly went downstairs to the medication room to obtain resident medications to pass. While down there she heard the next-door neighbor

call into the home asking if anyone was home. She responded “yes”, and the neighbor said that Resident A was next door in their garage. Ms. Taylor immediately went upstairs and took Resident B with her, and they went next door to retrieve Resident A. Ms. Taylor found Resident A in the neighbor’s garage, fully clothed, walking around playing with his ribbon. Resident A is known to always have ribbons to play with. As Ms. Taylor was verbally redirecting Resident A back to the home, she could hear the neighbor calling the police. All three of them returned to the home within a few minutes. Ms. Taylor gave Resident A some food and 15 minutes later the police arrived at the home. They asked if Resident A had clothes on to which Ms. Taylor told them he did. They confirmed this was Resident A’s home and then left without action or incident.

On July 1, 2024, I conducted an unannounced home inspection. When I arrived at the home, I saw Resident A wandering around in front of the home, fully clothed, and staff were standing on the front porch watching him as he went from the garage to the van to the grass and back. As I walked up the driveway Resident A went into the garage where I witnessed him lay on the cement. Resident A is non-verbal. He had his ribbon in his hand as I have witnessed him to always have when I have previously been to the home.

I spoke first with staff Danika Williams who was outside watching Resident A. I asked her how Resident A has been and if he has attempted to leave the property. She stated he has been fine. He has been walking around on the grass, to the garage and the van and around again. He has not attempted to leave the property or go to the neighbor’s house. I asked if she was aware of what had happened, and she said she had heard. I asked Ms. Williams if she has had any previous issues with Resident A eloping. She said, in her opinion, Ms. Taylor is a newer staff and she thought it was her first time working alone. She speculated that Ms. Taylor didn’t know that when you go downstairs to get medications, you have to give Resident A some food. If he has food, he will not leave the table until it is gone. That gives staff enough time to get whatever they need from downstairs. Ms. Williams also stated that you have to listen to the footsteps if either of the residents head for the door, or go out the door, then she knows to run upstairs. Ms. Williams did not feel that additional staffing is required for Resident A, but staff have to be aware of his whereabouts at all times.

I then spoke with staff Gequila Rowe. Ms. Rowe had also heard about the incident of the police being called by the neighbor. Ms. Rowe said she has not had any interactions with the neighbors, but she knows that they “are watched” especially by the woman kitty corner from the home. The people next door whom Resident A had gone to their house have never expressed any concern about Resident A. He likes to go outside and does so often. No one has complained in the past. Ms. Rowe agreed with Ms. Williams in that you have to “be smart” about working in this home with Resident A. He likes to go outside and will do so when he thinks he has the opportunity. I asked Ms. Rowe if staff could bring Resident A downstairs when they need to get medication. Ms. Rowe stated that Resident A is afraid of the flight of

stairs like those going to the basement. He is okay with a couple steps, but not a whole flight. Ms. Rowe has never had any issues with Resident A eloping.

I asked to see Resident A's Assessment Plan which Ms. Rowe provided. It was signed by Tmnit Mogos on 4/17/24. There is no increased supervision required on the assessment plan. Under "Moves Independently in the Community" it states that Resident A is ambulatory but does "require supervision in the community as he does not have a sense of safety skills".

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:	The allegation was made that Resident A was wandering the neighborhood unsupervised and without clothes on. The IR written by staff Shanel Taylor stated she went downstairs to retrieve medication for a med pass when she heard the next door neighbor inform her that Resident A had gone outside and was in their garage. Ms. Taylor went next door and found Resident A, fully clothed, and verbally redirected Resident A back to the home without incident. She heard the neighbor calling the police as she was walking back to the Willard home. Kent County Sheriff's Dept arrived at the home approximately 15 minutes later. They inquired about Resident A being outside without clothing. They left without further action. Resident A is non-verbal and was not interviewed. I did witness him walking around outside while supervised by staff. Staff Danika Williams stated Resident A does not require increased supervision, but it is necessary to know where he is at all times and he will leave the home if he is not occupied. Her opinion was that Ms. Taylor had never worked on her own before and was not aware of the things to be aware of with Resident A Staff Gequila Rowe stated she has not had any issues with the neighbors. She did concur with Ms. Williams that staff need to be "smart" when working with Resident A. She has not had an issue with Resident A eloping.

	There is a preponderance of evidence that while Ms. Taylor was working, Resident A eloped from the home without her knowledge and did go to the neighbors without supervision.
CONCLUSION:	**VIOLATION ESTABLISHED**

On July 12, 2024, I conducted an exit conference with Designee Amanda Ledford. I informed her I did find a preponderance of evidence to support a rule violation and requested a Corrective Action Plan. She understood the violation and had no further questions.

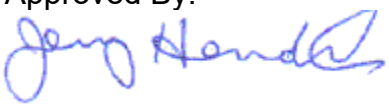
IV. RECOMMENDATION

Upon receipt of an approved Corrective Action Plan, I recommend no change to the current license status.

July 15, 2024

Rebecca Piccard — Date
Licensing Consultant

Approved By:



July 15, 2024

Jerry Hendrick — Date
Area Manager