GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 14, 2024

Deshra Vines-Leak
Precious Places, LLC
PO Box 310332
Flint, MI 48531

RE: License #: AS250415731
Investigation #: 2024A0572062
Victoria's House Of Hope

Dear Deborah Vines-Leak:

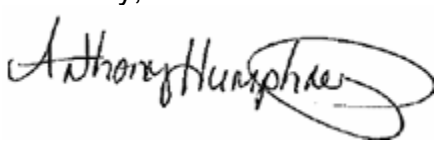
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250415731
Investigation #:	2024A0572062
Complaint Receipt Date:	09/16/2024
Investigation Initiation Date:	09/20/2024
Report Due Date:	11/15/2024
Licensee Name:	Precious Places, LLC
Licensee Address:	PO Box 310332 Flint, MI 48531
Licensee Telephone #:	(810) 233-6696
Administrator:	Deshra Vines-Leak
Licensee Designee:	Deshra Vines-Leak
Name of Facility:	Victoria's House Of Hope
Facility Address:	1219 North Dye Rd. Flint, MI 48532
Facility Telephone #:	(810) 233-6696
Original Issuance Date:	04/10/2024
License Status:	TEMPORARY
Effective Date:	04/10/2024
Expiration Date:	10/09/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was sent to the hospital by EMS and had the wrong information about the facility. The home was called over 20 times and no one answered the phone until 3 hours later. Staff Erika, said it was not her responsibility to transport as she is the only staff working.	No
Resident A was found wandering out in the community. Resident A had not informed the facility she was leaving or where she was going on 09/22/2024.	Yes

Was APS notified of this allegation?

III. METHODOLOGY

09/16/2024	Special Investigation Intake 2024A0572062
09/20/2024	Special Investigation Initiated - On Site Resident A and Staff, Erika Jenkins.
09/30/2024	Contact - Face to Face Licensee Designee, Deshra Vines-Leak.
11/04/2024	Contact - Telephone call made Resident A's Guardian.
11/04/2024	Contact - Telephone call made Resident A's Guardian.
11/04/2024	Contact - Telephone call made Attempt phone contact with Case Manager.
11/07/2024	Contact - Telephone call made Attempt phone contact with Case Manager.
11/08/2024	Contact - Telephone call made
11/12/2024	Contact - Document Sent Complainant.

11/12/2024	Contact - Telephone call made Attempt phone contact with Case Manager.
11/12/2024	Contact - Telephone call made Resident A's Guardian.
11/12/2024	Contact - Face to Face Staff, Erika Jenkins
11/12/2024	Contact - Document Received Complainant.
11/13/2024	Contact - Telephone call made Guardian.
11/13/2024	Contact – Face to Face Staff, Erika Jenkins
11/13/2024	Contact - Document Received Licensee Designee, Deshra Vines-Leak.
11/14/2024	Exit Conference Licensee Designee, Deshra Vines-Leak.

ALLEGATION:

- Resident A was sent to the hospital by EMS and had the wrong information about the facility. The home was called over 20 times and no one answered phone until 3 hours later. Staff Ericka, said it was not her responsibility to transport as she is the only staff working.

- Resident A was found wandering out in the community. Resident A had not informed the facility she was leaving or where she was going on 09/22/2024.

INVESTIGATION:

On 09/16/2024, the local licensing office received a complaint for investigation. Recipient Rights also conducted their own investigation.

On 09/20/2024, I made an unannounced onsite to Victoria’s House of Hope, located in Genesee County Michigan. Present for an interview were Resident A and Staff, Erika Jenkins. Licensee Designee, Deshra Vines-Leak was informed that I was there due to a complaint.

On 09/20/2024, I reviewed Resident A's Face Sheet as it was alleged that the facility had an incorrect phone number. The phone numbers on the Face Sheet appeared to be correct. It had Resident A's phone number and the home's phone number.

On 09/20/2024, I interviewed Resident A regarding the allegation. Resident A was very difficult to interview as Resident A was rambling off topic. Resident A appeared to be hallucinating. When a question would be asked, Resident A would answer the questions with answers that had nothing to do with the questions being asked and would get upset when I look down at my sheet to write down the statements. Resident A became angry when I ended the interview, got up and kicked a chair towards me.

On 09/20/2024, I spoke with Staff, Erika Jenkins regarding the allegation. Erika Jenkins informed that Resident A has gone to the hospital on multiple occasions and always gets sent back home. The night of September 13th, 2024, the police came to because they were called by Resident A who was yelling and screaming, and then the police called EMS. Erika Jenkins informed EMS and law enforcement that if they transport Resident A to the hospital, she would be unable to follow them to the hospital because it's 3rd shift and she is the only staff working. Hurley Hospital called later that night and she spoke with a social worker. Someone was in the background screaming that Resident A needed to be picked up now and that it was the home's obligation to pick Resident A up upon discharge. Erika Jenkins denied that anyone called the home 20 times and indicated that she did spoke with hospital personnel.

On 09/20/2024, I attempted to review the phone records for 09/13/2024 and 09/14/2024 to see if there were repeated calls missed from Hurley Hospital, however; the Caller ID stopped at 09/15/2024.

On 09/30/2024, I made another onsite at the home due to allegations that Resident A was found wandering in the community. I spoke with Licensee Designee, Deshra Vines-Leak about both complaints. Deshra Vines-Leak informed that Resident A is currently in the hospital due to a crisis. Resident A's Face Sheet is sent with whoever transports Resident A to the hospital and it has the home's phone number on it as well. Deshra Vines-Leak is not certain if the hospital called the home over 20 times to reach them so that Resident A could be picked up and believe that it seems to be quite excessive to be true. Deshra Vines-Leak did inform that they schedule one staff on 3rd shift so they are unable to pick up a resident from the hospital until 1st shift when there are more than one staff on schedule. Deshra Vines-Leak informed that Resident A is able to go out into the community on their own.

On 11/04/2024, I spoke with Resident A's Public Guardian regarding the allegation. Resident A's guardian is aware that Resident A went to the hospital on multiple occasions. The guardian informed that she was told that part of the home's contract is that they have sufficient staffing so that someone can go with Resident A to the hospital. Also, based on their contract, Resident A should not have been allowed to elope from the home, as there should be a staff with Resident A due to Resident A's

behaviors. The guardian informed that there may have been some issues with the wording of the service plan.

On 11/04/2024, I attempted to contact Resident A's Case Manager, Kelly Banks regarding the allegation. I called and left voicemail messages on 11/04/2024, 11/07/2024, 11/08/2024 and 11/12/2024.

On 11/12/2024, the Complainant explained that the home is required to have enough staff on shift to carry out the plans of services of the residents being served. The home had 6 residents in the home at the time of these issues, and Resident A was presenting some challenges. The home requirements for when the Residents goes to the hospital, they must send a staff to accompany the resident and remain with them until discharged or admitted.

On 11/12/2024, I reviewed Resident A's Assessment Plan. It indicates that Resident A is able to go out into the community unsupervised. A history of elopement was not mentioned in Resident A's Assessment Plan.

On 11/12/2024, I reviewed Resident A's Treatment Plan. Under the Elopement section, it states, "[Resident A] was previously living independently before stepping down to a general AFC, and then stepping down again to a specialized residential home. [Resident A] was previously accustomed to coming and going independently as [Resident A] pleased. [Resident A] may need reminders about using the group home sign out and sign in procedures and letting staff know when [Resident A] is going on a community outing." It also indicates that Staff should make sure [Resident A] has the group home's phone number saved in [Resident A's] cell phone so that [Resident A] can contact staff if going to be late returning home, or if [Resident A] has questions/concerns or needs staff assistance while [Resident A] is out the community. If [Resident A] fails to return from an unsupervised outing on time (within 30 minutes) and has not notified staff of the reason for the delay in return, staff should attempt to call [Resident A] on [Resident A'] cell phone to make sure [Resident A] is okay. If [Resident A] does not return home prior to her 8:00PM medication passing and staff cannot reach [Resident A] on cell phone, staff should follow the group home's emergency procedures and call 911 to assist in locating/returning [Resident A].

On 11/12/2024, I reviewed Resident A's Safety Plan. It indicates that [Resident A] will utilize the sign in/sign out form provided by the home when leaving to engage in the community. Prior to leaving, [Resident A] will notify staff of where [Resident A] will be going, the length of time [Resident A] plans to be gone and who [Resident A] will be with. Should [Resident A's] plans change while in the community, [Resident A] will notify AFC staff immediately of any changes in order to monitor [Resident A's] safety when [Resident A] engages in the community independently.

On 11/13/2024, I spoke with the Public Guardian regarding Resident A signing out when out in the community. The guardian informed that to their knowledge, Resident

A was not signing out during elopement. When asked what constitutes elopement, the guardian informed that Resident A would be outside on the property and then just leave without telling anyone where Resident A was going. The guardian does not believe that the home did anything to bring Resident A back home and was informed that there was nothing that they could do if Resident A left without notice. With Resident A's mental state, they are not sure why the staff would allow Resident A to go out into the community without signing out and letting staff know where Resident A was going and when Resident A would be expected to come back.

On 11/13/2024, I spoke with Staff, Erika Jenkins regarding the sign out sheet. Erika Jenkins informed that the expectation was for Resident A to sign out when leaving to go out into the community, but there were times when Resident A did not follow that plan and would go out into the community and not let anyone know where Resident A was going or when Resident A would be coming back.

On 11/13/2024, I spoke with Licensee Designee, Deshra Vines-Leak regarding the allegations. She informed that she was unaware that Resident A had a history of eloping or continuously going to the hospital. Deshra Vines-Leak does not understand how Resident A can be able to go out into the community with no restrictions, but also expect the home to have a staff follow Resident A into the community. Had she known Resident A had this history, she would not have accepted Resident A because they are not equipped to provide line-of-sight and believes that is what the Case Manager was attempting to amend the plan to reflect this without an agreement with the team. Deshra Vines-Leak indicated that Resident A would go out into the community without restrictions and without their knowledge, would use Resident A's cell phone to call 911. One of the responding officers remembered Resident A from living in Burton and said that "this is what [Resident A] does", which is call 911 requesting to go to the hospital. Deshra Vines-Leak insisted that this was not in Resident A's plan of service that they received when Resident A moved in and the case manager wanted to modify the plan without the team members agreeing which would have required Resident A to have either a 1:1 staff and or be placed on restrictions (line-of-sight).

On 11/13/2024, I received Resident A's Care Agreement, which indicates that basic fees include room and board, transportation to local medical/dental appointments, treatment team, store shopping, errands and errands when scheduled by the home. The basic transportation fees states, "Transportation within 10-mile radius to appointments or community planned events scheduled by the home."

On 11/13/2024, I received staff hospital notes that they kept for each time Resident A went to the hospital. On 09/13/2024, [Resident A] called 911 from cellphone at 9:31pm requesting EMS to get help. When EMS arrived, I (Erika) let them know that I was the only staff here at the home and I think it would be best for [Resident A] to stay. The Paramedics said they could not deny [Resident A] service. I then attempted to find coverage. On 09/22/2024, [Resident A] walked away from home. Staff received a call from McClaren saying that [Resident A] was being discharged

and needed to be picked up. The Assistant Manager picked [Resident A] up and it was a repeated struggle to get [Resident A] in the car.

On 11/13/2024, I received ABC Charts that documents progress for the day. On 09/13/2024 at 9:31pm, Resident A was in Living Room with housemates. Resident A called 911 to go to the hospital. Resident A was yelling and cursing at staff. EMS came to pick Resident A up. On 09/22/2024 at 2:38pm, [Resident A] was sitting outside talking loudly. Resident A said she wanted to smoke weed. Resident A came inside the house and continued to talk loudly, started to argue with housemates and then eloped. Resident A was asked to calm down and tried to redirect but Resident A refused. Resident A continued to elope and went to the hospital. On 09/23/2024 at 8pm to 2am, Resident A eloped from home. Resident A walked off from home, was redirected back home but refused to come inside. Resident A spoke with someone from crisis. The lady left and Resident A stayed up yelling until 2am, calling staff, explicit names and using sexually explicit language.

On 11/14/2024, I spoke with Licensee Designee, Deshra Vines-Leak regarding Resident A's current placement. Deshra Vines-Leak informed that Resident A went to another AFC Home. The guardian decided that the home was not equipped to care for Resident A, so the home was given a notice and Resident A was moved on 10/04/2024.

On 11/14/2024, I held an exit conference with Licensee Designee, Deshra Vines-Leak regarding the results of the Special Investigation. Deshra Vines-Leak informed that she agrees with the results of the special investigation and understand that the home will have to take measures in making sure that residents are signing out when going out into the community.

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:	Based on the interviews of Staff, Licensee Designee, Resident A, Guardian, Complainant and review of Resident A files, there is not enough evidence to establish a rules violation. According to Resident A's Plan, Resident A is able to go out into the community without assistance. The plan also does not indicate that Resident A needs to be accompanied by staff when in the hospital.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
MCL 400.707	**Definitions; R to T.**
	(7) "Supervision" means guidance of a resident in the activities of daily living, including 1 or more of the following: **(d) Being aware of a resident's general whereabouts even though the resident may travel independently about the community.**
ANALYSIS:	Based on the interviews of Staff, Licensee Designee, Resident A, Guardian, Complainant and review of Resident A files, there is enough evidence to establish a rules violation. On 09/22/2024, Resident A became upset and eloped from the home. Staff did not know Resident A's general whereabouts until the hospital called to inform that Resident A is ready to be discharged.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

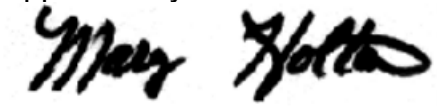
I recommend that no changes be made to the licensing status of this small adult foster care group home, pending the receipt of an appropriate corrective action plan (capacity 3-6).

11/14/2024

_____

Anthony Humphrey Date
Licensing Consultant

Approved By:



11/14/2024

_____

Mary E. Holton Date
Area Manager