GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 3, 2024

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

RE: License #: AS410363929
Investigation #: 2024A0340055
Grace

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 #:	AS410363929
Investigation #:	2024A0340055
Complaint Receipt Date:	08/12/2024
Investigation Initiation Date:	08/13/2024
Report Due Date:	10/11/2024
Licensee Name:	Hope Network West Michigan
Licensee Address:	PO Box 890, Grand Rapids, MI 49518
Licensee Telephone #:	(616) 301-8000
Administrator:	Amanda Ledford
Licensee Designee:	Amanda Ledford
Name of Facility:	Grace
Facility Address:	2260 Peerpoint SE, Caledonia, MI 49316
Facility Telephone #:	(616) 803-5631
Original Issuance Date:	08/04/2014
License Status:	REGULAR
Effective Date:	02/01/2023
Expiration Date:	01/31/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 8/9/24 staff Daniqua "Nikki" Payne, pushed Resident A out of a chair and sprayed him with Lysol.	Yes

III. METHODOLOGY

08/12/2024	Special Investigation Intake 2024A0340055
08/12/2024	Contact - Telephone call made
08/13/2024	APS Referral From APS
08/13/2024	Special Investigation Initiated - Telephone Mareeta Bracken-APS
08/22/2024	Inspection Completed On-site
08/26/2024	Exit Conference Designee Amanda Ledford

ALLEGATION: On 8/9/24 staff Daniqua "Nikki" Payne, pushed Resident A out of a chair and sprayed him with Lysol.

INVESTIGATION: On 8/12/24, I received a complaint from the BCHS Online Complaints from Adult Protective Services (APS). It stated that Resident A had tested positive for Covid. He had been isolating in his room but around approximately 6:00 am on 8/9/24 he came out of his room with a mask on when no other residents were around. Ms. Payne arrived for her shift and when she saw him she said, "Oh hell no you're not gonna be in the living room". Ms. Payne then proceeded to tip the chair over where Resident A was sitting, causing him to fall out. Ms. Payne then sprayed Resident A with Lysol.

On 8/12/24 I spoke with APS worker Mareeta Bracken. She stated that she had interviewed Ms. Payne who admitted to spraying Lysol on herself near Resident A, but denied spraying him or pushing him down. There was another staff in the home at the time, but Ms. Payne told Ms. Bracken that her cowroker was not close enough to see anything.

On 8/22/24, I conducted an unannounced home inspection. I first spoke with Home Manager Healther Vanderstelt. I asked her what she knew about the incident

involving Ms. Payne and Resident A. Ms. Vanderstelt stated that Ms. Payne was immediately suspended when she had been informed of what happened. The other staff present in the home at the time was Shariqua Mathis. She was the one who called Ms. Vanderstelt as soon as the incident occurred and said what was reported in the allegations. Ms. Vanderstelt went to the home immediately, while calling Hope Network Admin on the way who instructed her to inform Ms. Payne she was being suspended. When she arrived at the home she immediately told Ms. Payne she was suspended without pay. Ms. Vanderstelt assessed Resident A who appeared to be okay since he was wearing a mask. She monitored him for the rest of the day without incident.

Resident A was home and agreed to be interviewed. His cognitive level is limited. Ms. Vanderstelt was present to provide support. I asked Resident A if he remembered what happened with Ms. Payne. He said, “she dumped me out of my chair”. I asked him if anything else happened and he stated he did not remember.

On August 26, 2024, I interviewed staff Shareka Mathis. I asked her to recall the incident involving Ms. Payne and Resident A. She stated that Resident A had tested positive for Covid. He had to quarantine in his room for 5 days and then wear a mask for 5 days per policy. Resident A had voluntarily stayed in his room for a week in quarantine, came out when no one was around, wore a mask, sanitized his hands, and wore gloves on the day of the incident.

It was very early in the morning. Ms. Payne was late and came into work and saw Resident A watching TV in the common area and said, “Oh hell no, you gotta get up outta here. You’re not gonna be out here while I’m working. I got kids and I’m not bringing that home to my kids”.

She told Resident A to get back to his room but he did not want to. Ms. Payne went to where Resident A was sitting and lifted up the back of the chair, causing Resident A to fall out of the chair. She then sprayed him with Lysol and said that she would continue to spray him until he would go back to his room. At this time, Ms. Mathis had called Manager Vanderstelt and asked to speak with Ms. Payne. Ms. Payne stopped spraying Resident A to take the call. She went outside to speak with Ms. Vanderstelt and when she came back inside the home she was angry and speaking inappropriately toward Ms. Mathis. She then went in the office and shut the door. Ms. Mathis took care of Resident A until Ms. Vanderstelt arrived a few minutes later. At that time Ms. Mathis left and she is unaware of what happened afterward. She has not seen or spoken with Ms. Payne since this incident.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be

	attended to at all times in accordance with the provisions of the act.
ANALYSIS:	The allegation was made that Resident A had tested positive for Covid, had been in quarantine in his room but came out early in the morning and was sitting in a chair in the common area, wearing a mask, and no other residents were around. Ms. Payne came in for her shift and said, “Oh hell no you’re not sitting in the living room”. She then proceeded to tip over the chair Resident A was sitting in and sprayed him with Lysol. Ms. Bracken interviewed Ms. Payne who denied the allegations. Ms. Vanderstelt was informed of the incident by a staff who was present at the time. Ms. Vanderstelt went to the home and Ms. Payne was immediately suspended without pay. Resident A stated he was okay, but was monitored afterward. Resident A was able to recall that Ms. Payne dumped him out of the chair he was sitting in. Ms. Mathis witnessed Ms. Payne yell at Resident A, tip him out of his chair and spray him with Lysol. This continued until Ms. Mathis informed Ms. Payne that Ms. Vanderstelt wanted to speak with her on the phone. Ms. Vanderstelt informed Ms. Payne she was suspended without pay and Ms. Payne left the home. There is a preponderance of evidence that Ms. Payne did not treat Resident A with dignity or respect. A violation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

On August 26, 2024, I conducted an exit conference with Designee Amanda Ledford. We discussed the incident and the rule violation found. I requested a Corrective Action Plan which she agreed to send. She had no further questions.

IV. RECOMMENDATION

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

 September 3, 2024

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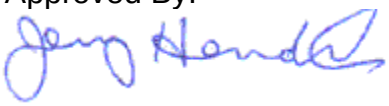
Rebecca Piccard Date
Licensing Consultant

Approved By:



September 3, 2024

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Jerry Hendrick Date
Area Manager