GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 13, 2025

Kathy Patterson
New Hope Group Home, LLC
3671 Senora Ave. SE
Grand Rapids, MI 49508

RE: License #: AS410418890
Investigation #: 2025A0583052
Mapleview

Dear Ms. Patterson:

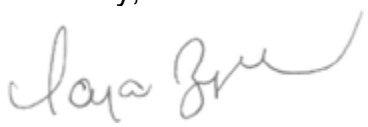
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0100.

Sincerely,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410418890
Investigation #:	2025A0583052
Complaint Receipt Date:	08/06/2025
Investigation Initiation Date:	08/07/2025
Report Due Date:	09/05/2025
Licensee Name:	New Hope Group Home, LLC
Licensee Address:	3671 Senora Ave. SE Grand Rapids, MI 49508
Licensee Telephone #:	(419) 439-1218
Administrator:	Kathy Patterson
Licensee Designee:	Kathy Patterson
Name of Facility:	Mapleview
Facility Address:	1824 Mapleview St SE Grand Rapids, MI 49508
Facility Telephone #:	(419) 439-1218
Original Issuance Date:	01/15/2025
License Status:	REGULAR
Effective Date:	07/15/2025
Expiration Date:	07/14/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Facility staff left residents unattended in a van and verbally threatened them.	Yes

III. METHODOLOGY

08/06/2025	Special Investigation Intake 2025A0583052
08/06/2025	APS Referral
08/07/2025	Special Investigation Initiated - On Site
08/12/2025	Exit Conference Licensee Designee Kathy Patterson

ALLEGATION: Facility staff left residents unattended in a van and verbally threatened them.

INVESTIGATION: On 08/04/2025 the above complaint allegation was received from LARA-BCHS-Complaints forum. The allegation was assigned for investigation on 08/06/2025 and stated the following: “all of the other residents/consumers of Mapleview AFC were left unattended in the facility vehicle for over an hour in the driveway of staff member "Jordan's" personal home on 8/3/25” and “when Resident A and the other residents complained/asked to go home, staff Jordan stated that she would call the police on them/send them to jail”.

On 08/05/2025 Adult Protective Services Staff Marquest Mc Lemore referred the complaint allegation to LARA-BCHS-Complaints and stated the following “APS made contact with the client Resident A and another resident Resident D who confirmed that they were left in the van by Jordan for some time but the van was running with the AC on. They did not know how long they were in the van. APS talked with supervisor Kathy Patterson who stated that they were in the van for about 8 minutes. APS will talk with the perp Jordan Ballard at noon as she is working at her other job. The AFC home was clean with all working utilities and food. APS did not see any concerns. Resident A and the other resident Resident D was not harmed and did not disclose any threats by Jordan to take them to jail”.

On 08/07/2025 I completed an unannounced onsite investigation at the facility and privately interviewed licensee designee Kathy Patterson, Resident A, Resident C, and Resident D. I observed the wellbeing of Resident B who appeared appropriately dressed and groomed. Resident D was unable to complete an interview given his developmental delay and communication limitations. Resident E was not home during the inspection.

Ms. Patterson stated that on 08/03/2025 she did not work at the facility and only recently became aware of the allegation. Ms. Patterson stated that staff Jordan Ballard admitted to transporting Resident A, B, C, D and E to Meijer on 08/03/2025 and leaving only Resident A in the facility van for approximately 15 minutes because Resident A refused to go inside. Ms. Patterson stated that Ms. Ballard's actions were not acceptable, and Ms. Ballard was formally verbally reprimanded.

Resident A stated that on 08/02/2025 Ms. Ballard transported himself and other residents to her personal home using the facility van. Resident A stated that Ms. Ballard left the van running with air conditioning on while she went inside her house. Resident A stated that Ms. Ballard told the residents that she "would be right back" but left the residents unattended in the van for "an hour". Resident A stated that on 08/03/2025 Ms. Ballard transported Resident A and other residents to Meijer using the facility van. Resident A stated that Ms. Ballard left the van running with air conditioning on while she was inside Meijer. Resident A stated that he could not recall how long he was left in the van while Ms. Ballard was inside.

Resident C stated that on 08/02/2025 Ms. Ballard transported himself and Resident A, B, D and E to Ms. Ballard's home. Resident C stated that Ms. Ballard left the residents unattended inside of the van with air conditioning while Ms. Ballard went inside of her home. Resident C stated that the residents were left unattended for "a short time". Resident C stated that on 08/03/2025 Ms. Ballard transported the same residents to Meijer. Resident C stated that Ms. Ballard went inside Meijer by herself and left the residents inside of the van with the air conditioning on. Resident C stated that Resident E "was upset" that Ms. Ballard left the residents in the running van. Resident C stated that Ms. Ballard was inside Meijer for a short time.

Resident D stated that on 08/02/2025 Ms. Ballard transported Resident A, B, C, D and E to her home and left the residents in the running air-conditioned van while she went inside of her home. Resident D stated that the residents were left in the van unattended for "a couple minutes". Resident D stated that on 08/03/2025 Ms. Ballard transported the same residents to Meijer and left all the residents in the running air-conditioned van for approximately "ten minutes".

On 08/07/2025 I interviewed staff Jordan Ballard via telephone. Ms. Ballard stated that on 08/02/2025 and 08/03/2025 she worked independently at the facility. She stated that on 08/02/2025 at approximately 2:00 PM she stopped at her personal residence for "five to six minutes". She stated that that she drove the facility's van with Resident A, B, C, D and E to her apartment and left the residents in the air conditioned, running van, while she unloaded her laundry into her second story dwelling. She stated that she took the van's key fob with her while she left the residents in the van and was gone "five to six minutes". Ms. Ballard stated that on 08/03/2025 at approximately 3:00 PM she transported the same residents to Meijer. She stated that while at Meijer, she left Resident A, B and Resident E in the running air-conditioned van while Resident C and Resident D accompanied her into the store to purchase "lettuce and cheese". She stated that she was inside of the store for

approximately “seven to eight minutes”. She stated that during the two incidents the residents did not express anxiety or stress regarding being left unattended inside the van.

On 08/08/2025 I received an email from license designee Kathy Patterson which contained Resident A, B, C, D and E’s Assessment Plans. Resident A’s Assessment Plan, signed 01/31/2025 indicates that Resident A can move independently in the community “but only on his bicycle to a few stores or fast food”. Resident B’s Assessment Plan, signed 03/05/2025, indicates Resident B cannot move independently within the community. Resident C’s Assessment Plan, signed 05/27/2025, indicates that Resident C cannot move independently in the community. Resident D’s Assessment Plan, signed 02/03/2025, indicates that Resident D cannot move independently in the community. Resident E’s Assessment Plan, signed 04/01/2025, indicates that Resident E can move independently within the community.

On 08/11/2025 I completed an unannounced onsite investigation at the facility and privately interviewed Resident C and D. Both residents stated that Ms. Ballard did not verbally threaten them while they were in the van and both residents stated that Ms. Ballard has never verbally mistreated them in the past.

On 08/11/2025 I interviewed staff Jordan Ballard via telephone. Ms. Ballard stated that on 08/02/2025 and 08/03/2025 at no time did any resident voice an unwillingness to stay in the van while Ms. Ballard was gone and Ms. Ballard denied threatening any residents during the incidents.

On 08/12/2025 I completed an exit conference via telephone with licensee designee Kathy Patterson. Ms. Patterson agreed that a violation had occurred and stated that Ms. Ballard was formally verbally reprimanded. She stated that she would submit an acceptable corrective action plan.

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:	Residents A-E each reported that they were left unsupervised in the facility’s van on 08/02/2025 and 08/03/2025 by staff Jordan Ballard. Resident C and Resident D deny that Ms. Ballard verbally mistreated them. Ms. Ballard acknowledged leaving Residents A-E unsupervised in the facility’s van on 08/02/2025. She acknowledged leaving

	Resident A, Resident B, and Resident E unsupervised in the facility's van on 08/03/2025. She denied that she verbally mistreated residents during the incidents. Based upon my investigation it has been established that facility staff Jordan Ballard left Resident A, B, C, D and E unsupervised in the facility van on 08/02/2025 and 08/03/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

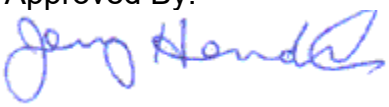
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the licensing status.

08/12/2025

Toya Zylstra Date
Licensing Consultant

Approved By:



08/13/2025

Jerry Hendrick Date
Area Manager