GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 14, 2026

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

RE: License #: AS410415106
Investigation #: 2026A0340045
Neo Wyoming

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) 356-0100.

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 #:	AS410415106
Investigation #:	2026A0340045
Complaint Receipt Date:	06/12/2026
Investigation Initiation Date:	06/12/2026
Report Due Date:	08/11/2026
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 Wyoming
Facility Address:	3280 Michael Ave. SW Wyoming, MI 49509
Facility Telephone #:	(616) 248-5100
Original Issuance Date:	03/15/2023
License Status:	REGULAR
Effective Date:	09/15/2025
Expiration Date:	09/14/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A has scratches on his chin and arms after staff Jordyn Wollman forced him out of another resident's bedroom.	Yes

III. METHODOLOGY

06/12/2026	Special Investigation Intake 2026A0340045
06/12/2026	APS Referral Complaint filed by Adult Protective Services (APS)
06/12/2026	Special Investigation Initiated – Telephone call made APS worker Sheena McBride
06/12/2026	Contact - Face to Face Amanda Ledford
06/24/2026	Inspection Completed On-site
06/26/2026	Contact - Telephone call made Message left for Home Manager Candy McCain
06/26/2026	Contact - Telephone call made staff Jordyn Wollman
07/13/2026	Contact – Telephone call made Staff David N'Dele
07/13/2026	Exit Conference Designee Amanda Ledford

ALLEGATION: Resident A has scratches on his chin and arms after staff Jordyn Wollman forced him out of another resident's bedroom.

INVESTIGATION: On June 12, 2026, a complaint was sent to me from APS worker Sheena McBride. It stated, *'On 06/10/26, (Resident A) went into the bedroom of one of his peers. There was no one else in that room. A staff member named Jordyn Wollman ran down to the bedroom and (Resident A) could be heard screaming. Another staff member, David Ndaniele, went to see what was going on and Jordyn was observed pushing (Resident A) to get him out of the bedroom. Jordyn had one of her arms behind (Resident A) and her other arm on (Resident A's) arm pushing him. (Resident A) has a scratch on his chin and a few marks on both arms.*

(Resident A) bit Jordyn and Jordyn has a bite mark on each arm. This morning it was noticed that (Resident A) also has a cut on his lower lip and his lip is swollen. Jordyn has been suspended until further investigation.'

On June 12, 2026, I spoke with Ms. McBride (APS). She will be investigating the complaint.

On June 12, 2026, I met with Ms. Ledford and inquired about the allegation. She stated she had been told Resident A went into another resident's room and Ms. Wollman ran in to get him out after home manager Candy McCain told her not to because he wasn't doing anything harmful. Ms. Ledford has the Incident Report (IR). She confirmed Ms. Wollman was suspended pending the investigation. She also stated Resident A was seen by nursing staff, but it was superficial scratches which only required Neosporin. She will send me the nursing report.

I requested and received the IR and Nursing notes for Resident A.

On June 15, 2026, I reviewed the documents Ms. Leford sent. Nurse Sarah Boulerice documented that she saw Resident A on 6/11/2026. She observed three superficial scratches, one on the left side of his chin, and one on each arm above the elbow.

The IR was written by Ms. Wollman on 6/10/26. It stated, *'(Resident A) had gone into peer 1 room when Staff (Jordyn) had followed him to redirect him out of peer's room. (Resident A) then attacked by attempting to bite Jordyn where then she attempted the elbow to hip containment, but it was unsuccessful due to him dropping to the floor. Jordyn then released the containment and backed up. He then got up to bite her again. Staff (David) then came to help verbally redirect telling him to stop which was also unsuccessful. David then also tried the elbow to hip containment which failed, due to him dropping, David released him and backed up. (Resident A) then got up again and bit David where Jordyn then did the cheek release before David then once more attempted the elbow the hip containment which was unsuccessful, once again due to him dropping immediately released and reattempted and was unsuccessful. David then tried the elbow to hip containment again which was also unsuccessful when (Resident A) bit David again and Jordyn did the cheek release. David then again attempted the elbow to hip containment which was unsuccessful again due to him dropping where David immediately released the containment. (Resident A) then bit down on Jordyn's arm twice one of which broke skin. David did the Jaw release and Jordyn removed herself while David did one last final attempt of the elbow to hip containment which was successful at 3:00PM. (Resident A) then was in his room where he was able to calm.'*

On June 24, 2026, I conducted an unannounced home inspection. Resident A was home at the time. I was able to observe him in his room. Resident A is primarily non-verbal. I viewed his face and arms. The scratches were already healing and barely noticeable.

The staff working on this day were not present on the day of the incident and had no information regarding the incident.

On June 26, 2026, I called and left a message for Home Manager Candy McCain.

On June 26, 2026, I called and left a message for staff David N'Dele

On June 26, 2026, I interviewed staff Jordyn Wellman. I introduced myself and explained the reason for my call. I asked her to tell me what happened with Resident A. She said Resident A was going into someone else's bedroom so she tried to redirect him. He would not exit the room and tried to grab and bite her so Ms. Wollman stated she did an "elbow to hip" (intervention technique) and Resident A "dropped". Staff David N'Dele came into the room and "took over". He was able to get Resident A back to his room.

I asked Ms. Wollman why the urgency to get Resident A out of the other bedroom if no one else was in there and he was not harming himself or anyone else. Ms. Wollman stated he was not supposed to go into other resident's bedrooms.

I asked Ms. Wollman about the scratches, but Ms. Wollman did not know about any scratches. Ms. Wollman stated they could have occurred when he bit her. She stated she had bite marks on both her arms. Ms. Wollman stated she was upset that she was let go recently because her manager, Ms. McCain "lied on me".

On July 13, 2026, I called Mr. N'Dele. After I identified myself and the reason for my call, I asked him to tell me what he had witnessed regarding the incident involving Resident A and Ms. Wollman. Mr. N'Dele stated Resident A had gone into another resident's room. No one was in that room, but Resident A began "messing with" the other resident's DVD's. Ms. Wollman ran down the hall to that bedroom to get Resident A out of the room. Mr. N'Dele stated it was likely that the resident whose room Resident A was in, would become upset that his DVD's were messed up and there would be an issue between the two. Mr. N'Dele assumed Ms. Wollman wanted to avoid that by redirecting Resident A out of the bedroom.

Mr. N'Dele observed Ms. Wollman attempt to physically manage Resident A out of the room but Resident A wouldn't leave. Mr. N'Dele could see Resident A was becoming agitated and he bit Ms. Wollman. Mr. N'Dele stated he verbally redirected Resident A out of the room, back to his bedroom to play with his iPad until dinner was ready. Mr. N'Dele stated Resident A was "fine" with him and cooperated. Mr. N'Dele went back to making dinner and the incident was over. I asked Mr. N'Dele if he utilized physical management on Resident A. He said "absolutely not, I never put my hands on him".

On July 13, 2026, I conducted an exit conference with Designee Amanda Ledford. We discussed the incident and the choice Ms. Wollman made to utilize physical

management when Resident A was not harming himself or others. This choice actually caused harm to Resident A and Ms. Wollman. Using physical management was not warranted in this incident and was therefore a rule violation. Ms. Ledford understood and had no further questions. She confirmed that Ms. Wollman's employment has been terminated from Hope Network. Ms. McCain's employment was also terminated from Hope Network for reasons unrelated to this incident, but likely why she did not return my call. I requested a Corrective Action Plan from Ms. Ledford which she agreed to send.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(1) A licensee shall ensure methods of behavior intervention are appropriate to the needs of the resident.
ANALYSIS:	Allegations were made that Resident A has scratches on his chin and arms after staff Jordyn Wollman forced him out of another resident's bedroom. Nurse Boulerice documented that she saw Resident A on 6/11/2026. She observed three superficial scratches, one on the left side of his chin, and one on each arm above the elbow. Ms. Wollman completed an IR and acknowledged she attempted to redirect Resident A out of another resident's bedroom of which no one was in. When he did not comply, she utilized physical management which escalated Resident A to react toward her and she was bit by him. Ms. Wollman stated her co-worker, Ms. N'Dele then intervened and utilized physical management and was successful in getting Resident A out of the bedroom. Mr. N'Dele stated he witnessed Resident A go to the other resident's bedroom. No one else was in the room. He was not hurting himself or anyone else. Ms. Wollman tried to get him out and attempted to utilize physical management but was unsuccessful. Mr. N'Dele was able to verbally redirect Resident A out of the other resident's bedroom and back to his own bedroom without issue. Due to the fact that Resident A was not harming himself or others and Ms. Wollman chose to utilize physical intervention which resulted in harm to Resident A, there is a preponderance of evidence of a rule violation.

CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

July 14, 2026

Rebecca Piccard — Date
Licensing Consultant

Approved By:

July 14, 2026

Jerry Hendrick — Date
Area Manager