GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 29, 2021

David Paul
Hope Network Behavioral Health Services
PO Box 890
3075 Orchard Vista Drive
Grand Rapids, MI 49518-0890

RE: License #: AM440380703
Investigation #: 2021A0569031
Harbor Point-Lapeer

Dear Mr. Paul:

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) 284-9730.

Sincerely,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM440380703
Investigation #:	2021A0569031
Complaint Receipt Date:	07/07/2021
Investigation Initiation Date:	07/07/2021
Report Due Date:	09/05/2021
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(616) 726-1998
Administrator:	David Paul
Licensee Designee:	David Paul
Name of Facility:	Harbor Point-Lapeer
Facility Address:	5699 Genesee Road Lapeer, MI 48446
Facility Telephone #:	(810) 969-4561
Original Issuance Date:	04/08/2016
License Status:	REGULAR
Effective Date:	10/08/2020
Expiration Date:	10/07/2022
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 7/3/2021, Katelyn Brown, staff person, operated the facility van in a dangerous manner placing the residents at risk of harm.	Yes

III. METHODOLOGY

07/07/2021	Special Investigation Intake 2021A0569031
07/07/2021	APS Referral complaint received from APS.
07/07/2021	Special Investigation Initiated - Telephone Contact with ORR.
07/28/2021	Contact - Telephone call made Attempted contact with Kim Nguyen-Forbes, RRO. Requested return phone call.
07/28/2021	Contact - Telephone call made Attempted contact with Katelyn Brown, staff person.
07/28/2021	Contact - Telephone call made Contact with Dorothy Harris, staff person.
07/28/2021	Inspection Completed On-site
07/28/2021	Inspection Completed-BCAL Sub. Compliance
07/28/2021	Exit Conference Exit conference with David Paul, licensee designee.
07/29/2021	Contact- Telephone call made Attempted contact with Katelyn Brown.

ALLEGATION:

On 7/3/2021 Katelyn Brown, staff person, operated the facility van in a dangerous manner placing the residents at risk of harm.

INVESTIGATION:

This complaint was received from the adult protective services central intake department. The complainant reported that; “On 7/3/2021 staff Dorothy Harris and residents residing in this facility were riding in a company van driven by staff member, Katelyn Brown. Katelyn was yelling, screaming, and cursing at Dorothy in front of the residents before entering the expressway. When she got on the expressway, she pushed accelerator to ground and began driving recklessly for an unknown amount of time and was weaving in/out of traffic, cutting off other drivers. Residents were all terrified.”

An unannounced inspection of this facility was conducted on 7/28/21. Resident A was alert and oriented to person, place, and time. Resident A was appropriately dressed and groomed with no visible injuries. Resident A stated that he was present for the outing on 7/3/21. Resident A stated that Ms. Harris and Ms. Brown took several of the residents, including himself, on an outing to several stores on 7/3/21. Resident A stated that Ms. Brown was driving the facility van. Resident A stated that they had gone to a couple of stores and were making a third stop. Resident A stated that he went into the store with Ms. Harris, while Ms. Brown and other residents were waiting in the van. Resident A stated that when they returned to the van, Ms. Brown was upset that they had taken too long in the store. Resident A stated that Ms. Brown started “yelling and swearing” at Ms. Harris while Ms. Harris was trying to “calm Kate down”. Resident A stated that Ms. Brown then started yelling and “speeding”. Resident A stated that Ms. Brown then pulled onto the expressway and was “going way too fast, cutting other cars off, weaving in and out of traffic, and just driving reckless.” Resident A stated that he and the other residents felt scared and were asking Ms. Brown to slow down, but she kept yelling and swearing at Ms. Harris. Resident A stated that Ms. Brown continued to drive “reckless” all the way back to the facility. Resident A stated that Ms. Brown then left because it was the end of the shift. Resident A stated that no one was injured, but that they were scared that Ms. Brown was going to get into a crash.

Resident B was alert and oriented to person, place, and time. Resident B was appropriately dressed and groomed with no visible injuries. Resident B stated that he was one of the residents who stayed in the van with Ms. Brown at the last stop during the outing on 7/3/21. Resident B stated that Ms. Brown was getting upset that Ms. Harris and the other residents were taking too long in the store and started saying things about Ms. Harris. Resident B stated that when Ms. Harris and the other residents returned to the van, Ms. Brown started “yelling and swearing” at Ms. Harris. Resident B stated that Ms. Harris was trying to calm Ms. Brown down, but Ms. Brown continued to swear and yell at Ms. Harris. Resident B stated that once the van got back onto the

road, Ms. Brown started driving “very fast” and was cutting other cars off. Resident B stated that he and the other residents kept asking Ms. Brown to slow down, but she did not. Resident B stated that Ms. Brown continued to “drive wild and reckless” until they got back to the facility. Resident B stated that Ms. Brown then got out of the van once they had returned to the facility, threw the keys at Ms. Harris, then left the facility. Resident B stated that no one was hurt, but the residents were afraid that they would be in a wreck.

Dorothy Harris, staff person, stated on 7/28/21, that she and Ms. Brown took some of the residents on an outing to a few stores on 7/3/21. Ms. Harris stated that at the last stop Ms. Brown became upset that she was taking too long in the store with one of the residents. Ms. Harris stated that it was getting close to the end of their shift, and Ms. Brown wanted to get back to the facility. Ms. Harris stated that Ms. Brown started yelling and swearing at her in front of the residents. Ms. Harris stated that she was trying to calm Ms. Brown, but Ms. Brown kept yelling and swearing at her. Ms. Harris stated that Ms. Brown was driving the van back to the facility and was speeding and weaving in traffic being very reckless. Ms. Harris stated that the residents kept asking Ms. Brown to slow down but she would not. Ms. Harris stated that once they returned to the facility Ms. Brown left because it was the end of their shift.

Katie Walquist, program manager, stated on 7/28/21, that Ms. Brown was going to be terminated from employment due to this incident. Ms. Walquist stated that Ms. Brown then quit on 7/9/21 and is no longer employed at this facility. Ms. Brown did not return to work at this facility following the incident on 7/3/21. An incident report was submitted to the department on 7/6/21 reporting this incident. The IR was completed by David Paul, licensee designee, and documents that Resident B reported this incident to Mr. Paul on 7/6/21. The IR documents that Mr. Paul then notified the RRO of Resident B’s statement as well as this department. The IR documents that the corrective actions taken were to comply fully with any investigation conducted regarding this incident.

Attempted contact with Ms. Brown was made on 7/28/21 and 7/29/21. The call did not go to voicemail, so no message was left requesting a return phone call.

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 complainant reported that Ms. Brown operated the facility van in a dangerous manner on 7/3/21 with residents present in the vehicle. Resident A, Resident B, and Ms. Harris all stated that Ms. Brown operated the facility van in a “reckless” manner by driving too fast, cutting other motorists off and weaving in traffic while “yelling and swearing” at Ms. Harris in front of the residents. Resident A and Resident B both stated that they were asking Ms. Brown to slow down because they felt unsafe and were afraid that they would be in an accident. Based on the statements made, it is determined that there was a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with David Paul, licensee designee, on 7/28/21. The findings in this report were reviewed.

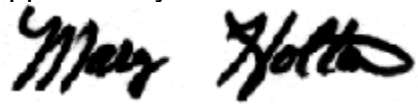
IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

7/29/21

Kent W Gieselman Date
Licensing Consultant

Approved By:



7/29/2021

Mary E Holton Date
Area Manager