GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 7, 2021

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

RE: License #:	AM440380703
Investigation #:	2021A0872037
	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 (906) 226-4171.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM440380703
Investigation #:	2021A0872037
Complaint Receipt Date:	08/18/2021
Investigation Initiation Date:	08/19/2021
Report Due Date:	10/17/2021
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?
Staff Autumn Granlund accepted gifts from Resident A.	Yes

III. METHODOLOGY

08/18/2021	Special Investigation Intake 2021A0872037
08/19/2021	Special Investigation Initiated - On Site Unannounced
09/22/2021	Inspection Completed On-site Unannounced
09/23/2021	APS Referral I made an APS complaint
09/23/2021	Contact - Document Sent I emailed the program manager, Katie Walquist, requesting information about this complaint
10/05/2021	Contact - Document Received I received documentation from Ms. Walquist and the licensee designee, David Paul
10/06/2021	Contact - Telephone call made I interviewed staff Autumn Granlund
10/07/2021	Contact - Telephone call made I interviewed staff Dorothy Harris
10/07/2021	Contact - Telephone call made I interviewed Resident A
10/07/2021	Exit Conference I conducted an exit conference with the licensee designee, David Paul, via telephone
10/07/2021	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Staff Autumn Granlund accepted gifts from Resident A.

INVESTIGATION: I reviewed an Incident/Accident Report dated 8/17/21 regarding Resident A. According to the report, Resident A told another staff that he "got in trouble" for "smacking Autumn (staff) on her behind." Resident A told staff that he thought Autumn liked him and that they were boyfriend and girlfriend. He said that a week and a half ago, he bought Autumn a necklace and a box of cookies and she said, "that's right up my alley." Resident A said that he is upset because he thought Autumn liked him, but she did not like it when he slapped her behind and said that he knows she has a boyfriend. Staff reported this situation to management and the corrective actions taken were "training and discussions with staff will be held to make sure staff understand how to set boundaries with consumers, and how to redirect when behaviors such as this take place. (Resident A's) clinician has been made aware of this situation so it can be addressed and worked on and prevented from occurring again."

On 8/19/21, I conducted an unannounced onsite inspection of Harbor Point Lapeer Adult Foster Care facility. I spoke to the manager of program operations, Katie Walquist. Ms. Walquist said that management is in the process of conducting an internal investigation into this situation and will take appropriate measures if needed. I was unable to interview Resident A because he was on an outing.

On 9/22/21, I conducted another unannounced onsite inspection of Harbor Point Lapeer AFC. Staff said that Resident A is no longer a resident of this facility. However, I did interview Residents B and C. Resident B said that that he likes staff Autumn Granlund and Resident A never told him he had any problems with her. I asked Resident B if he ever gave gifts to Ms. Granlund, and he said that he tried to give her a picture once, but she would not take it because she told him she cannot accept gifts because she is staff. I asked him if he knows whether Resident A ever gave Ms. Granlund gifts and he said he does not know.

Resident C said that he gets along well with Ms. Granlund, and she is "nice." I asked him if he ever gave her gifts and he said no. He said "(Resident A) told me that he tried to give Autumn a box of chocolates and a necklace, but she told him she can't accept gifts because it's policy." Resident C confirmed that Resident A no longer lives at this facility and said that he never noticed anything inappropriate between Resident A and Ms. Granlund.

On 10/05/21, I reviewed AFC paperwork related to Resident A. Resident A was admitted to Harbor Point Lapeer on 9/18/19 and was discharged on 9/07/21. According to his Health Care Appraisal dated 9/02/21, he is diagnosed with schizoaffective disorder, bipolar type; neuroleptic induced parkinsonism, and psychophysiologic insomnia. Resident A is his own guardian.

On 10/06/21, I interviewed staff Autumn Granlund via telephone. Ms. Granlund said that she has worked at Harbor Point-Lapeer since 6/01/21 but she has been suspended pending this investigation. She said that on a few occasions, Resident A tried to give

her gifts including a necklace and chocolates, but she always refused. Ms. Granlund said that she is aware that she is not allowed to accept gifts from residents and said that she never accepted any gifts from Resident A or any other residents. According to Ms. Granlund, she was told that Resident A thought she liked him but said that she never insinuated to Resident A that she was interested in him. She said that she tries to keep her personal life private but made it clear to the residents that she was in a relationship and also made it clear that she was not romantically interested in any of the residents.

On 10/07/21, I interviewed Resident A's former case manager, Alexi "Lexi" Brown via telephone. Ms. Brown said that she was Resident A's case manager while he resided at Harbor Point Lapeer but confirmed that he was discharged to a different AFC facility. According to Ms. Brown, on one occasion Resident A told her that he was upset because he got in trouble for "smacking" staff Autumn Granlund on the butt. Ms. Brown said that Resident A told her that he gave Ms. Granlund a necklace and some cookies and he thought they were boyfriend/girlfriend. Resident A told Ms. Brown that he and Ms. Granlund spent a lot of time together and he thought she liked him. Ms. Brown said that Resident A stated that he knows a lot of personal information about Ms. Granlund's life because she told him.

On 10/07/21, I interviewed staff Dorothy Harris via telephone. Ms. Harris said that on one occasion, she was working with staff Autumn Granlund and she heard her yell out. Ms. Harris asked what happened and Ms. Granlund told her that Resident A had smacked her on the butt. Ms. Harris said she asked Resident A about it, and he said that he did it because he thought Ms. Granlund liked him. Resident A told Ms. Harris that he had given Ms. Granlund a necklace and a box of cookies and she acted like she liked him. Ms. Harris said that Ms. Granlund does not set appropriate boundaries with the residents, and she has had to talk to her about this in the past. She has seen Ms. Granlund hugging Resident A which is not appropriate contact to have with the residents. Residents also told Ms. Harris that they know Ms. Granlund was hospitalized in the past due to mental health issues because she told them.

On 10/07/21, I interviewed Resident A via telephone. Resident A confirmed that he "got in trouble" because he smacked staff Autumn Granlund on the butt. Resident A said that Ms. Granlund "was coming on to me" and he thought they were boyfriend and girlfriend. According to Resident A, on one occasion he gave Ms. Granlund a chain with a pentagram on it and some cookies and she accepted them. He later asked her where the chain was, and she said it was on her dresser at home.

On 10/07/21, I conducted an exit conference with the licensee designee, David Paul, via telephone. I discussed the results of my investigation and explained which rule violation I am substantiating. Mr. Paul agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Staff Autumn Granlund said that she never accepted any gifts or other items from Resident A or any of the other residents. Resident A's case manager, Alexi Brown and staff Dorothy Harris said that Resident A told them he gave Ms. Granlund a necklace and a box of chocolates and/or a bag of cookies. Resident A told me that he gave Ms. Granlund a chain with a pentagram on it and a bag of cookies. He asked her about the necklace later and she told him it was on her dresser at home. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

Susan Hutchinson October 7, 2021

Susan Hutchinson Licensing Consultant	Date

Approved By:

Mary Holton October 7, 2021

Mary E Holton Area Manager	Date