GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 23, 2021

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

RE: License #: AM490392115
Investigation #: 2022A0360003
Bay Haven Integrated Care

Dear Ms. Frazier:

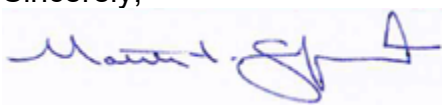
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (989) 732-8062.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
Ste 3
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM490392115
Investigation #:	2022A0360003
Complaint Receipt Date:	10/27/2021
Investigation Initiation Date:	10/27/2021
Report Due Date:	11/26/2021
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/Licensee Designee	Katherine Frazier
Name of Facility:	Bay Haven Integrated Care
Facility Address:	799 Hombach Street St. Ignace, MI 49781
Facility Telephone #:	(906) 298-8000
Original Issuance Date:	10/08/2019
License **Status:**	REGULAR
Effective Date:	04/08/2020
Expiration Date:	04/07/2022
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff Jennifer Huff refused to answer Resident A's request for help and blasted music ignoring his request for assistance.	Yes

III. METHODOLOGY

10/27/2021	Special Investigation Intake 2022A0360003
10/27/2021	Special Investigation Initiated - On Site
10/27/2021	Inspection Completed On-site Resident A, licensee designee Katherine Frazier
11/17/2021	Contact - Telephone call made DCS Jennifer Huff
11/17/2021	Contact - Telephone call made DCS Austin Chamberlain
11/22/2021	Contact – Telephone call made DCS Jennifer Huff
11/23/2021	Exit Conference With licensee designee Katherine Frazier

ALLEGATION: Direct care staff Jennifer Huff refused to answer Resident A's request for help and blasted music ignoring his request for assistance.

INVESTIGATION: On 10/27/2021 I was assigned a complaint from the LARA online complaint system.

On 10/27/2021 I received a copy of Resident A's recipient rights complaint filed on 10/22/2021 as part of the complaint information. The complaint stated "Jennifer shut off my call bell and blasted music on the radio near my door. She wouldn't answer when I called. She seems like she is schizophrenic when she talks. She put me in bed with assistance and she came in and took my mask. Jennifer wouldn't let me go in the chair out front. Wednesday night she did the same thing. Another worker heard me yelling and came in my room to check on me. The worker brought me to the common area, and Jennifer yelled at me. She acted very bizarre both nights, like she was high. With my walker she pushed on one side while I tried to stand up, and I couldn't get up that way because all my weight was forced to one side.

On 10/27/2021 I conducted an unannounced onsite inspection at the facility. The licensee designee Katherine Frazier stated direct care staff Austin Chamberlain reported to her that he witnessed direct care staff Jennifer Huff leave Resident A in his room and blast music in the early morning of 10/22/2021. She stated when Mr. Chamberlain noticed what was going on he went and checked on Resident A. She stated Mr. Chamberlain turned the music off and brought Resident A to the living room which he was requesting. Ms. Frazier stated that Ms. Huff was terminated on 10/25/2021 and will not be returning.

While at the facility on 10/27/2021 I interviewed Resident A. Resident A stated everything he documented in the recipient rights complaint was accurate and true. He stated he wanted to come into the living room at about 4:00 a.m. on 10/22/2021 and direct care staff Jennifer Huff refused to help him into his wheelchair to come into the living room, turned on loud music and yelled at him. He stated direct care staff Austin Chamberlain came down after hearing the radio blaring and turned the radio off and brought him down to the living room.

On 11/17/2021 I contacted former direct care staff Jennifer Huff and left her a voicemail message.

On 11/17/2021 I contacted direct care staff Austin Chamberlain. Mr. Chamberlain stated at about 4:00 a.m. on 10/22/2021 he heard loud music playing down the hallway and went to see what was going on. He stated he turned the music down and heard Resident A calling from his room. He stated Resident A wanted to go down to the living room and stated Ms. Huff told him he was not allowed to because she was cleaning and turned up music, so she didn't have to listen to him call for help. Mr. Chamberlain stated he brought Resident A down to the living room on the other side of the facility. He stated Ms. Huff was not happy about him getting Resident A up and was doing a lot of cussing and swearing about it.

On 11/22/2021 I contacted former direct care staff Jennifer Huff and left her a voicemail message.

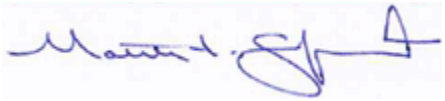
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A and direct care staff Austin Chamberlain both reported that on 10/22/2021 at about 4:00 a.m. Resident A requested assistance into his wheelchair to go into the living room. Direct care staff Jennifer Huff refused to assist Resident A and turned on loud music to avoid hearing his calls for

	assistance. Direct care staff Austin Chamberlain then assisted Resident A into his wheelchair and brought him to the living room. The licensee designee Katherine Frazier stated Ms. Huff was terminated on 10/25/2021. There is a preponderance of evidence that Resident A was not treated with dignity and that his personal needs, including protection and safety, were not attended to at all times when Jennifer Huff refused to answer Resident A's request for help and blasted music ignoring his request for assistance. .
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/23/2021 I conducted an exit conference with licensee designee Katherine Frazier. Ms. Frazier concurred with the findings of the investigation.

IV. RECOMMENDATION

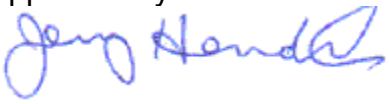
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



11/23/2021

Matthew Soderquist Date
Licensing Consultant

Approved By:



11/23/2021

Jerry Hendrick Date
Area Manager