GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 22, 2022

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

RE: License #: AM440380703
Investigation #: 2022A0779038
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) 284-9700.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM440380703
Investigation #:	2022A0779038
Complaint Receipt Date:	05/31/2022
Investigation Initiation Date:	06/02/2022
Report Due Date:	07/30/2022
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(161) 643-0795
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?
Resident A was physically attacked by another resident at the AFC home and staff did nothing to help.	No
Staff are verbally abusive to Resident A.	No

III. METHODOLOGY

05/31/2022	Special Investigation Intake 2022A0779038
05/31/2022	APS Referral Complaint was referred to AFC licensing by APS centralized intake.
06/02/2022	Special Investigation Initiated - On Site
06/06/2022	Contact - Telephone call made Interview conducted with staff person, Denayha Evans.
06/06/2022	Contact - Telephone call made Interview conducted with licensee designee, David Paul.
06/07/2022	Contact - Telephone call made Spoke to APS worker, Ryan DeVoe.
06/07/2022	Contact - Document Received Received police report via e-mail.
06/08/2022	Contact - Document Received Received e-mail from licensee designee, Mr. Paul.
06/09/2022	Contact - Telephone call made Interview conducted with staff person, Dorothy Harris.
06/13/2022	Contact - Telephone call made Interview conducted with staff person, Pamela Dean.
06/17/2022	Exit Conference Conducted with licensee designee, David Paul.

ALLEGATION:

Resident A was physically attacked by another resident at the AFC home and staff did nothing to help.

INVESTIGATION:

On 6/2/22, an on-site inspection was conducted. Interviews took place with Resident A, Resident B, and assistant manager, Adrianna Rukenbrod.

Resident A stated that he remembers the incident he had with Resident B well. He stated that problems with Resident B started when Resident B took his coffee. Resident A claims that Resident B started the physical altercation by jumping on his back and that he defended himself by slamming Resident B onto the ground. He stated that Resident B was hitting and kicking him and that the staff did nothing but laugh about it. When asked more about what staff were doing, Resident A could not say what staff were present to witness the incident and then admitted that one staff kept asking him to stop. Resident A stated that he stopped the fight and got off Resident B on his own.

Resident B stated that Resident A "sucker punched" him first. He claims that Resident A knocked him to the ground and he had to protect himself by hitting and kicking at Resident A in order to get Resident A off him. He stated that staff grabbed Resident A, pulled Resident A off him and took Resident A into the other room. Resident B reported that the whole thing happened very fast and only lasted a minute or two. He stated that when it was over, he went to his room and staff person, Pam Dean, kept Resident A away from him.

Assistant manager, Ms. Rukenbrod, stated that she worked on 5/3/22 and was aware of a minor issue between Resident A and Resident B but would not describe it as a fight or attack of any kind. She stated that she heard of the physical altercation that happened between them later that day, but that she was not there to witness it. Ms. Rukenbrod stated that Resident A has a history of displaying physical aggression.

Resident A's licensing assessment plan was reviewed. It confirmed that he has a history of aggressive behavior. The plan indicates that Resident A is quite independent and can physically complete all his activities of daily living (ADL's) on his own.

Resident B's licensing assessment plan was viewed. It makes no reference to Resident B not being able to control aggressive behavior. The plan indicates that Resident B is quite independent and can physically complete all his ADL's on his own.

On 6/6/22, a phone interview was conducted with licensee designee, David Paul, who confirmed that he was aware of the physical altercation between Resident A and Resident B, but that he was not present to witness it. He stated he spoke to both Resident A and Resident B by phone after the incident and stated that it is his understanding that it started as a verbal confrontation and that staff had separated the

two of them. Mr. Paul reported that staff person, Pam Dean, told him that Resident B snuck up behind her and Resident A and started the physical altercation. Mr. Paul stated that the incident happened very quickly and that staff definitely intervened.

On 6/7/22, a phone conversation took place with APS worker, Ryan DeVoe, who confirmed that he was investigating the same allegations. He stated that he has investigated multiple complaints at this home regarding Resident A and that he is very familiar with Resident A. He stated that Resident A does not like it at this home, wants to move, and has a long history of making false allegations against other residents and staff. Mr. DeVoe reported that he has spoken to Resident A's legal guardian on several occasions, who never has any concerns regarding the care that Resident A is receiving at this home. Mr. DeVoe stated that he found that staff acted appropriately in this instance and attempted to keep both Resident A and Resident B safe; therefore, he is not substantiating that any neglect took place and is closing his case.

On 6/7/22, an e-mail was received from Mr. DeVoe, which consisted of a police report regarding the physical altercation between Resident A and Resident B. The police report stated that police were at this home on 5/3/22 and interviewed both Resident A and Resident B, who accused each other of starting the fight. The report stated that, upon request from staff, the police officer requested that an ambulance come to the home and have Resident B transported to the hospital for a medication review/evaluation and then police left the home. The police report did not mention any injuries to either resident or that any charges were pressed.

On 6/9/22, a phone interview was conducted with staff person, Dorothy Harris, who confirmed that she was working on 5/3/22 and at the time of the physical altercation between Resident A and Resident B. Ms. Harris stated that she was not present at the start of the altercation and did not see how it got started. She reported that she walked up to see Resident A on top of Resident B and staff person, Pam Dean, trying to get them to stop. She stated that she was also trying to verbally redirect Resident A to get off Resident B. Ms. Harris stated that the incident did not last very long and that when Resident A got off Resident B, Ms. Dean separated them and took Resident A into another room. Ms. Harris reported that Resident A has a history of physical aggression, but Resident B does not.

On 6/13/22, a phone interview was conducted with staff person, Pamela Dean, who confirmed that she was working on 5/3/22 and at the time of the physical altercation between Resident A and Resident B. Ms. Dean started that it started with a verbal confrontation over coffee and that she separated Resident A and was guiding him into another room. She stated that before she knew it, Resident B had come up behind them and Resident A and Resident B started fighting. Ms. Dean reported that she was not sure if Resident B touched Resident A first or simply said something to Resident A before the fight started. Ms. Dean stated that she kept trying to verbally redirect them to stop . She stated that it happened so fast that she didn't even get a chance to verbally work with them to calm them down and that they stopped on their own after only a

minute or two. Ms. Dean reported that she separated them again and called her supervisor, Mr. Paul, who spoke to both residents over the phone.

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:	It was confirmed that a physical altercation took place between Resident A and Resident B on 5/3/22, and that the incident happened very fast and only lasted a few minutes. It appears that staff was appropriately attempting to separate Resident A and Resident B during a verbal confrontation between the two, when the physical altercation took place. Both staff working at the time, Dorothy Harris and Pamela Dean, stated that they were verbally redirecting both residents to stop and that Ms. Dean quickly separated them again after the altercation ended. Resident B stated that staff grabbed Resident A, pulled Resident A off him and took Resident A into the other room. It appears that staff acted appropriately in this instance and attempted to keep both Resident A and Resident B safe. There was insufficient evidence found to prove that Resident A was not provided adequate protection and/or safety.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff are verbally abusive to Resident A.

INVESTIGATION:

On 6/2/22, Resident A claimed that staff are always cussing at him when they get mad at him. When asked for examples of what staff say, Resident A could not come up with any. He only said, “They say all kinds of stuff”. When asked if there were any specific staff that cuss at him, Resident A said, “They all do”.

On 6/2/22, Resident B stated that staff do not cuss at the residents and that he has never witnessed staff cuss at Resident A. He stated that staff are good to him here.

On 6/2/22, assistant manager, Ms. Rukenbrod stated that she has never witnessed any staff cuss at Resident A or any other resident. She stated that no residents have come to her to report staff cussing or being inappropriate toward them. Ms. Rukenbrod reported that it is common for Resident A to say that staff are mistreating him when he gets upset and he will lie about things to try and get his way.

During the on-site inspection on 6/2/22, a brief conversation took place with a few residents sitting in the living room area. They all stated that staff are okay and do not cuss at them. They stated that they like it there.

On 6/6/22, licensee designee, Mr. Paul, stated that he is not aware of staff cussing at Resident A , or any other resident, as being an issue. He reported that no residents have come to him to complain about that happening and that there are several residents in this home that would say something if staff were cussing at them. Mr. Paul stated that Resident A has a long history of making false allegations against staff when he is upset and/or when he is trying to get his way about something.

On 6/6/22, a phone interview was conducted with staff person, Denayha Evans, who stated that she has never witnessed any staff cuss at Resident A. She stated that there are some staff who may cuss in general around the residents, but do not cuss directly at residents or verbally abuse them in any way. Ms. Evans reported that Resident A is usually good at being redirected, so there is no need to get upset with him.

On 6/7/22, APS worker, Mr. DeVoe, stated that he has investigated several complaints involving Resident A and that he knows him well. He stated that it is typical behavior for Resident A to make false allegations against staff when he gets mad about something. Mr. DeVoe reported that Resident A wants to move out of this home and will say things that are not true about staff as his attempt to try and move. Mr. DeVoe stated that he has spoken to Resident A's legal guardian on several occasions, who never has any concerns regarding the care that Resident A is receiving at this home.

On 6/9/22, staff person, Ms. Harris, denied that she has ever cussed at Resident A or that she has ever witnessed any other staff do that. She stated that it is common for Resident A to make false allegations when he gets upset or doesn't get his way about something.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.**
ANALYSIS:	There was no evidence found to prove that staff are cussing at or verbally abusing Resident A. Multiple residents stated that staff do not cuss at the residents of this home. Multiple staff deny that Resident A is being cussed at by staff and state that it is common behavior for Resident A to make false allegations against staff when he gets upset.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During an on-site inspection on 6/2/22, assistant manager, Ms. Rukenbrod, stated that there should have been an incident report (IR) completed regarding the physical altercation that took place between Resident A and Resident B. She took several minutes searching their computer system and could not find an IR documenting this incident. Ms. Rukenbrod called her supervisor for assistance in finding an IR, but could still not locate one.

On 6/8/22, emails were exchanged with licensee designee, Mr. Paul. In that email, Mr. Paul confirmed that he had searched for an IR documenting Resident A and Resident B's physical altercation, but he could not locate one.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative,

	responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.**
ANALYSIS:	On 5/3/22, Resident A and Resident B displayed serious hostility as they engaged in a physical altercation with one another. This home was unable to provide an IR documenting this event and licensee designee, David Paul, confirmed that one was not written by the staff involved. The licensee failed to ensure that staff completed a written report/IR documenting this event and that an IR was sent to the resident's designated representative, responsible agency, and the adult foster care licensing division
CONCLUSION:	VIOLATION ESTABLISHED

On 6/17/22, an exit conference was conducted with licensee designee, Davis Paul. He was informed that a written corrective action plan was required to address the above licensing rule violation.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

6/22/2022

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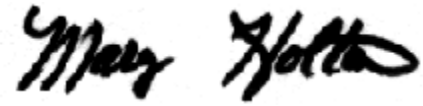
Christopher Holvey Date
Licensing Consultant

Approved By:



6/22/2022

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Mary E Holton Date
Area Manager