GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 21, 2022

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

RE: License #: AL700085846
Investigation #: 2022A0467050
Harbor Point Intensive West Unit

Dear Mr. Paul:

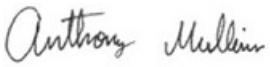
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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) 356-0183.

Sincerely,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700085846
Investigation #:	2022A0467050
Complaint Receipt Date:	07/19/2022
Investigation Initiation Date:	07/19/2022
Report Due Date:	09/17/2022
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(616) 847-4460
Administrator:	David Paul
Licensee Designee:	David Paul
Name of Facility:	Harbor Point Intensive West Unit
Facility Address:	17160 130th Avenue Nunica, MI 49448
Facility Telephone #:	(616) 847-4460
Original Issuance Date:	11/15/1999
License Status:	REGULAR
Effective Date:	06/19/2022
Expiration Date:	06/18/2024
Capacity:	15
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff member Alexis Morris maced Resident A after a verbal altercation on 7/19/22.	Yes

III. METHODOLOGY

07/19/2022	Special Investigation Intake 2022A0467050
07/19/2022	Special Investigation Initiated - Telephone
07/20/2022	APS Referral Ottawa County APS Worker, Erin Wallace sent me the complaint via email.
07/20/2022	Inspection Completed On-site
07/21/2022	Exit conference completed with licensee designee, David Paul

ALLEGATION: Staff member Alexis Morris maced Resident A after a verbal altercation on 7/19/22.

INVESTIGATION: On 7/19/22, I received a phone call from licensee designee, David Paul. Mr. Paul informed me that staff member Alexis Morris reportedly sprayed Resident A in the eye with mace during a verbal altercation. Mr. Paul stated that that Ms. Morris was escorted out of the building and is suspended pending the outcome of the investigation. EMS and Ottawa County Sheriff's Department arrived at the facility. Resident A used the eye rinse station and EMS used saline to clean his eyes. Mr. Paul stated that the incident occurred in the common area, and the area was cleaned prior to residents returning. Mr. Paul stated that the Ottawa County Sheriff's Department is sending their case to the prosecuting attorney in an attempt to have charges filed against Ms. Morris. I explained to Mr. Paul that I would be at the facility tomorrow to speak to Resident A and collect any statements he has from staff.

On 7/20/22, I received an email from Ottawa County APS worker, Erin Wallace. The email listed the same allegations I received from Mr. Paul on 7/19/22. I informed Ms. Wallace that I was aware of the allegations and going to the facility today to interview Resident A.

On 7/20/22, I made an announced onsite investigation to the facility. Upon arrival, I met with licensee designee, David Paul, Ms. Wallace from APS, and other Hope Network staff members. Mr. Paul confirmed that Ms. Morris is suspended pending the outcome of the investigation. Mr. Paul did not physically see Ms. Morris in

possession of mace. However, in the statement that Ms. Morris completed, she acknowledged that she sprayed Resident A with mace. Mr. Paul stated that Ms. Morris told Deputy Wheaton with the Ottawa County Sheriff's Department that she sprayed Resident A with Febreze. Mr. Paul confirmed that Ms. Morris and other staff members are aware that they are not allowed to have weapons on their person, and the employee manual specifically states that they are not to use mace. Staff members are trained in verbal de-escalation, and this should have been used as opposed to using mace on Resident A. Mr. Paul and his colleagues stated that there was a table in between Resident A and Ms. Morris, implying that this incident could have been avoided. The complaint number with the Ottawa County Sheriff's Department is 2207190084. Mr. Paul provided me with statements from the following staff members: Natassha Riley, Naja McGhee, and Alexis Morris.

Ms. Wallace stated that she interviewed Resident A and he told her that a staff member sprayed something in his eye. Resident A was unable to tell Ms. Wallace the name of the staff member. However, he did share that the staff member told him not to look at her. Resident A and the staff member exchanged words and Resident A told Ms. Wallace that he stood up, grabbed the resident phone and raised it at the staff member. Another staff intervened and took the phone away from Resident A prior to the main staff member spraying him in the eye.

After speaking to Mr. Paul and Ms. Wallace, staff assisted me to the activity room to meet with Resident A. Minutes later, Resident A arrived in the activity room and introductions were made. Resident A confirmed that yesterday, he was sprayed in the eye with "something you put on your couch to make it smell good." Resident A stated that his eyes were hurting, and he could not see for nearly an hour. Resident A stated that an ambulance came and put a water solution in his eyes to help. Resident A stated that Ms. Morris was the staff member that sprayed him. When asked how this incident started, Resident A stated that Ms. Morris accused him of looking at her. Resident A stated that he was looking at the board by the desk and not Ms. Morris. Ms. Morris reportedly told him not to look at her and he told her he can look at her if he chooses. Resident A stated that Ms. Morris said he called her a "bitch." Resident A stated that, "I didn't call her a bitch until she called me one." Resident A stated that Ms. Morris is pregnant, and she accused him of saying he was going to hit the baby out of her stomach. Resident A then acknowledged that he made the statement but was adamant that he would not follow through with it to avoid being placed in prison.

After exchanging words with Ms. Morris, Resident A stated that he picked up the resident phone, walked towards Ms. Morris and lifted his hand to prepare to throw the phone at her. Prior to throwing the phone, Resident A stated that another staff member grabbed his hand and made him put the phone down. After the unknown staff member made him put the phone down, Resident A stated that Ms. Morris sprayed him in his face/eyes. After Ms. Morris sprayed him, the unknown staff member reportedly told Ms. Morris that she's never coming back here. Resident A stated that he's aware that Mr. Paul has suspended Ms. Morris. Resident A stated

that this is the only time that something like this has occurred to him while at Harbor Point. Resident A is happy that Ms. Morris has been suspended. However, he is concerned that staff may try to poison him by “putting something in my food.” Resident A stated that all other staff members have been nice and respectful to him. Despite this, he does not feel safe at the facility.

On 7/20/22, licensee designee, David Paul sent me an email with a copy of Hope Network’s employee manual, which clearly states: “Hope Network prohibits the possession of weapons (firearms, knives, etc.), explosives, and other dangerous or hazardous devices or substances (mace or pepper spray) on company property.” Despite this, Ms. Morris had mace on her on person while working.

On 7/21/22, Rights and Compliance Manager, Lynn TenBrock provided me with Ms. Morris’ training transcript. The transcript confirmed that Ms. Morris signed off on acknowledging the employee manual.

On 7/21/22, I reviewed written statements made by staff members that were present during the incident. Staff member Natassha Riley and Naja McGhee confirmed that they witnessed Ms. Morris mace Resident A after a verbal altercation. Ms. Morris also confirmed that she sprayed Resident A after he “charged” towards her quickly.

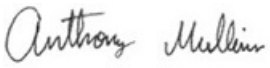
On 07/21/22, I conducted an exit conference with licensee designee, David Paul. He was informed of the investigative findings and agreed to complete a corrective action plan within 15 days.

APPLICABLE RULE	
R 400.15308	**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: (a) Use any form of punishment. (b) Use any form of physical force other than physical restraint as defined in these rules. (c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident. (d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner. (e) Withhold food, water, clothing, rest, or toilet use. (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse.

	(iii) Derogatory remarks about the resident or members of his or her family. (iv) Threats. (g) Refuse the resident entrance to the home. (h) Isolation of a resident as defined in R400.15102(1)(m). (i) Any electrical shock device.
ANALYSIS:	Resident A stated that Ms. Morris maced him during a verbal altercation. Ms. Morris acknowledged that she maced Resident A. Ms. McGhee and Ms. Riley also acknowledged that Ms. Morris maced Resident A. Therefore, a preponderance of evidence exists to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

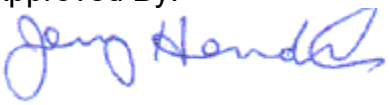
I recommend no changes to the current license status.



07/21/2022

Anthony Mullins Date
Licensing Consultant

Approved By:



07/21/2022

Jerry Hendrick Date
Area Manager