GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 11, 2024

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

RE: License #: AL820395614
Investigation #: 2024A0101023
Harbor Point Dearborn Heights

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 (313) 456-0380.

Sincerely,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820395614
Investigation #:	2024A0101023
Complaint Receipt Date:	03/28/2024
Investigation Initiation Date:	03/28/2024
Report Due Date:	05/27/2024
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(616) 301-8000
Administrator:	Davis Paul
Licensee Designee:	Davis Paul
Name of Facility:	Harbor Point Dearborn Heights
Facility Address:	6500 N Inkster Road Dearborn Heights, MI 48127
Facility Telephone #:	(313) 908-4459
Original Issuance Date:	08/12/2019
License **Status:**	REGULAR
Effective Date:	02/12/2024
Expiration Date:	02/11/2026
Capacity:	13
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff Taira Gee is not suitable. On 03/23/2024, Ms. Jefferson was found sleeping while on duty.	Yes

III. METHODOLOGY

03/28/2024	Special Investigation Intake 2024A0101023
03/28/2024	Referral received from Adult Protective Services (APS) and Office of Recipient Rights (ORR)
03/28/2024	Special Investigation Initiated - Telephone Crystal Delaney, Home Manager
04/01/2024	Contact - Document Received Job description regarding sleeping
05/16/2024	Contact - Document Received Resident A's treatment plan and assessment plan Hiring practices Fingerprints Verification of reference checks Experience Education Acknowledgement of Personnel policies
06/06/2024	Contact telephone call made Direct Care Staff (DCS) Taira Gee – Left Message
06/14/2024	Inspection Completed On-site Interviewed Resident A Interviewed home manger Obtain employees' phone numbers.
07/02/2024	Contact telephone call made DCS Felicia Fennel and Shara Newell
07/03/2024	Contact telephone call received Shara Newell

07/03/2024	Exit Conference David Paul Licensee designee

ALLEGATION: Direct care staff Taira Gee is not suitable. On 03/23/2024, Ms. Gee was found sleeping while on duty.

INVESTIGATION: On 03/28/2024, I spoke with the home manager, Crystal Delaney. Ms. Delaney stated on 03/23/2024, she arrived to work early and found direct care staff Taira Gee asleep. Ms. Delaney stated Ms. Gee was terminated for sleeping on the job and she was also falsifying documents. Ms. Delaney stated Ms. Gee was assigned as Resident A's one on one staff. Ms. Delany stated Resident A requires one on one staffing due to substance abuse and smoking in the facility.

On 04/01/2024, Ms. Delaney forwarded me written documentation that Ms. Gee was in receipt of the company's personnel policy regarding sleeping. Employee must "remain awake when working the third shift." On 06/06/2024, I called Ms. Gee. There was no answer. I left a voice mail message. To date, Ms. Gee has not returned my call.

I reviewed Ms. Gee's employee record on 05/16/2024. All hiring practices were in compliance with licensing regulations. According to Ms. Gee's employee record this was her second infraction for sleeping on the job. The first infraction resulted in a written reprimand. The second time Ms. Gee was found sleeping while on duty she had also been reprimanded for unsatisfactory job performance, performing personal business while on duty and falsifying documents and time sheet. Therefore on 03/29/2024, Ms. Gee was terminated.

On 05/16/2024, I reviewed Resident A's treatment plan. Resident A's treatment plan does not state he requires one on one staffing. Resident A's treatment plan states "he is to be closely monitored" due to smoking indoors and drug use.

On 06/14/2024, I interviewed Ms. Delaney. Ms. Delaney stated Resident A has one on one staffing because the responsible agency had them implement one on one staffing but never paid them or modified his treatment plan. Ms. Delaney further stated on 03/23/2024, she arrived to work at 5:00 a.m. Ms. Delaney stated she arrived to work early because a rumor was circulating that the midnight staff were sleeping while on duty. Ms. Delaney stated that on 03/23/2024, there were three staff on duty, Taira Gee, Shara Newell, and Felicia Fennel and, they were all sleeping in their makeshift beds around the dining room table. Ms. Delaney further stated the home managers are now required to monitor the midnight shift staff by routinely conducting unannounced site visits.

On 06/14/2024, I interviewed Resident A. Resident A stated that he really does not need one on one staffing but if he wants his own place he needs to comply with the

rules. Resident A stated staff were sleeping during the midnight shift, however Ms. Gee did not.

On 07/02/2024, I interviewed Ms. Fennel. Ms. Fennel stated when staff was found sleeping on duty she was working that shift. Ms. Fennel denied that she was sleeping. Ms. Fennel stated she received a written reprimand for "appearing in a resting position." Ms. Fennel acknowledged that she is aware sleeping on the job is prohibited.

I interviewed Ms. Newell on 07/03/2024. Ms. Newell stated when staff was found sleeping on duty she was working that shift. Ms. Newell denied that she was sleeping. Ms. Newell stated she received a written reprimand for "appearing in a resting position." Ms. Fennel acknowledged that she is aware sleeping on the job is prohibited.

On 07/03/2024, I conducted an exit conference with the licensee designee, David Paul. Mr. Paul stated he agrees with my findings. Mr. Paul stated disciplinary action has been taken, staff have been reprimanded and terminated for engaging in this prohibited practice. In addition, home managers are now required to conduct unannounced site visits during the midnight shift, to address staff sleeping while on duty.

APPLICABLE RULE	
R 400.15201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.
ANALYSIS:	Initially this complaint only addressed Ms. Gee's suitability to assure the welfare of residents. However, during the course of this investigation, I learned that the entire midnight staff was potentially placing residents at risk by engaging in a prohibited practice, sleeping while on duty. If the entire staff are asleep, they are not suitable to assure the welfare of residents. Even though Ms. Newell and Ms. Fennel denied they were asleep, they did not hear the home manager enter the home and finding them in a sleeping position
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

07/03/2024

Edith Richardson
Licensing Consultant

Date

Approved By:

07/11/2024

Ardra Hunter
Area Manager

Date