



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 14, 2026

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

RE: License #:	AM440380703
Investigation #:	2026A0872026
	Harbor Point-Lapeer

Dear David 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) 643-7960.

Sincerely,

A handwritten signature in cursive script that reads "Susan Hutchinson".

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
THIS REPORT CONTAINS QUOTED PROFANITY**

I. IDENTIFYING INFORMATION

License #:	AM440380703
Investigation #:	2026A0872026
Complaint Receipt Date:	03/16/2026
Investigation Initiation Date:	03/18/2026
Report Due Date:	05/15/2026
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(616) 430-7952
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:	10/08/2024
Expiration Date:	10/07/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 03/25/2026, staff Kayela Ritch administered the wrong medications to Resident B.	Yes
On 03/05/2026, staff Marcell Jones spoke to Resident A aggressively and said, "Why are you sitting in my fucking chair?" causing him to cry.	No
Additional Findings	Yes

III. METHODOLOGY

03/16/2026	Special Investigation Intake 2026A0872026
03/16/2026	APS Referral This complaint was referred by APS but was not assigned for investigation
03/18/2026	Special Investigation Initiated - On Site Unannounced
04/09/2026	Inspection Completed On-site Unannounced
04/13/2026	Contact - Document Sent I emailed the LD requesting information related to this complaint
04/13/2026	Contact - Document Received Documentation received
04/14/2026	Contact - Telephone call made I interviewed staff Marcell Jones
04/14/2026	Exit Conference I conducted an exit conference with the licensee designee, David Paul
04/14/2026	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 03/25/2026, staff Kayela Ritch administered the wrong medications to Resident B.

INVESTIGATION: On 04/09/2026, I conducted an unannounced onsite inspection of Harbor Point Lapeer AFC and I interviewed Resident B. I reviewed the allegations with Resident B, and he confirmed that one day last month, he was given the wrong medications. Resident B said that he was taken to the hospital and said he was “scared.” Resident B stated that to his knowledge, this is the first time he has ever been given the incorrect medications.

On 04/14/2026, I reviewed an Incident/Accident Report (IR) dated 03/25/2026 at 8:15am completed by staff Kayela Ritch. According to the IR, “During med passes, I passed the wrong medications with (Resident B’s) medication pass. Once I noticed I had (him) spit out the medications. The medications were Quetiapine 300mg, Vitamin D3, Benztropine 1mg that were ingested.”

The action taken by staff was, “Immediately self-reported, contacted supervisor, I called nurse, poison control and EMS to check out resident.” The corrective measures taken were, “The program nurse was contacted, and he instructed staff to call emergency services. EMS came out and checked his vitals. EMS stated that (he) was fine and that it was up to the guardian if he wanted (him) to go to the ER. The guardian wanted (him) to go to the ER, so he was transported by EMS. (Resident B) was discharged from the hospital and he was cleared to take all other medications at prescribed times. Staff was prompted to pay close attention to (him) for the next 48 hours.” In addition, ORR was contacted, an IR was completed, and Staff Ritch was instructed to retake medication administering and monitoring training.

I reviewed Resident B’s medication list dated 4/13/2026. The medications prescribed by Resident B’s physician are Clozapine 100mg, Clozaril 200mg, Fluoxetine 20mg, Melatonin 10mg, and Risperdal 2mg. Resident B is not prescribed Quetiapine 300mg, Vitamin D3, or Benztropine 1mg which he was administered on 03/25/2026.

APPLICABLE RULE	
R 400.675	Resident medications.
	(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	On 03/25/2026, staff Kayela Ritch administered the wrong medications to Resident B. Staff Ritch contacted the appropriate parties, and Resident B was taken to the hospital, evaluated, and returned to the facility. Resident B also confirmed that he was administered in correct medication and was taken to the hospital.

	I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: On 03/05/2026, staff Marcell Jones spoke to Resident A aggressively and said, “Why are you sitting in my fucking chair?” causing him to cry.

INVESTIGATION: On 03/18/2026, I conducted an unannounced onsite inspection of Harbor Point Lapeer Adult Foster Care facility and I interviewed Resident A. I reviewed the allegations with Resident A, and he said that the allegations are not true. Resident A stated that on one occasion after group therapy, he was upset because he wanted to do push-ups instead of pull-ups. When he went to sit down, staff Marcell Jones told him, “This is my chair” so Resident A had to sit in another chair. Resident A told me that Staff Jones did not cuss at him, call him names, or talk to him disrespectfully. Resident A stated that staff “treats me good” and said that none of the staff has ever treated him disrespectfully.

On 04/14/2026, I interviewed staff Marcell Jones via telephone. I reviewed the allegations with Staff Jones which he denied. Staff Jones stated that on one occasion, he, Resident A, and some of the other residents went outside to the “man cave” to watch a movie. Resident A sat in a chair that was close to the door so Staff Jones asked him if he could move so he could sit there but Resident A said no. Staff Jones said that Resident A sat in the chair and no other conversation took place about it. Staff Jones said that he never cussed at Resident A and he never spoke to him disrespectfully. Staff Jones told me that Resident A has a history of making false allegations against staff if he gets upset with them about anything.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Resident A said that on one occasion, Staff Jones said, “This is my chair.” Resident A told me that Staff Jones nor any of the other staff ever cussed at him, called him names, or treated him disrespectfully. Staff Jones said that on one occasion, he asked Resident A to move so Staff Jones could sit closer to the door, but Resident A refused. Staff Jones denied cussing at Resident A or treating him disrespectfully.

	I conclude that there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: During my onsite inspection on 04/09/26, I noted that Resident B's bed did not have a fitted sheet, a top sheet, or pillowcases. I also noted that Resident B's pillows were excessively dirty, stained and worn.

APPLICABLE RULE	
R 400.669	Linens.
	<p>(1) A licensee shall provide all of the following:</p> <p>(a) Clean bedding in good condition that includes a minimum of a fitted sheet, top sheet, pillowcase, and blanket or comforter for each bed.</p> <p>(b) At least 1 standard bed pillow that is comfortable, clean, and in good condition for each resident.</p> <p>(c) Bath towels and washcloths.</p>
ANALYSIS:	<p>During my onsite inspection on 04/09/26, I noted that Resident B's bed did not have a fitted sheet, a top sheet, or pillowcases. I also noted that Resident B's pillows were excessively dirty, stained and worn.</p> <p>I conclude that there is sufficient evidence to substantiate this rule violation at this time.</p>
CONCLUSION:	VIOLATION ESTABLISHED

On 04/14/26, I conducted an exit conference with the licensee designee (LD), David Paul. I told him that I have concluded my investigation and explained which rule violations I am substantiating. I told LD Paul that I would send him a copy of my investigation report once it is approved, requesting a corrective action plan.

IV. RECOMMENDATION

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

Susan Hutchinson

April 14, 2026

Susan Hutchinson Licensing Consultant	Date
--	------

Approved By:

Mary Holton

April 14, 2026

Mary E. Holton Area Manager	Date
--------------------------------	------