

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

July 22, 2021

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

> RE: License #: AL820395614 Investigation #: 2021A0121007

> > 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,

K. Robinson, LMSW, Licensing Consultant Bureau of Community and Health Systems

K. Robinson

Cadillac Pl. Ste 9-100 3026 W. Grand Blvd Detroit, MI 48202 (313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820395614
Investigation #:	2021A0121007
Complaint Receipt Date:	06/11/2021
La carrier de la latination Data	00/45/0004
Investigation Initiation Date:	06/15/2021
Report Due Date:	08/10/2021
Report Due Date.	00/10/2021
Licensee Name:	Hope Network Behavioral Health Services
	1
Licensee Address:	PO Box 890
	3075 Orchard Vista Drive
	Grand Rapids, MI 49518-0890
	(0.10) =00.1000
Licensee Telephone #:	(616) 726-1998
Licanega Dasignas:	David Paul
Licensee Designee:	David Faul
Name of Facility:	Harbor Point Dearborn Heights
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Facility Address:	6500 N Inkster Road
-	Dearborn Heights, MI 48127
Facility Telephone #:	(313) 908-4459
Original Inguismos Dato:	00/40/0040
Original Issuance Date:	08/12/2019
License Status:	REGULAR
Lioundo Gtatao.	1120027111
Effective Date:	02/12/2020
Expiration Date:	02/11/2022
Capacity:	13
_	DEVELOPMENTALLY DISABLES
Program Type:	DEVELOPMENTALLY DISABLED
	MENTALLY ILL

II. ALLEGATION(S)

Violation Established?

III. METHODOLOGY

06/11/2021	Special Investigation Intake (APS referral denied) 2021A0121007
06/15/2021	Special Investigation Initiated - Telephone Call to licensee, David Paul
06/18/2021	Contact - Telephone call made Phone interview with Resident A
06/18/2021	Contact - Telephone call made A. Snead, Clinician/case manager
06/18/2021	Contact - Telephone call made Phone interview with Resident B
07/01/2021	Contact - Telephone call made Erica Thomas, DCW
07/09/2021	Contact - Telephone call made Deja Caldwell, DCW
07/12/2021	Contact - Telephone call made Tatiana Henderson, DCW
07/14/2021	Exit Conference David Paul, licensee

ALLEGATION: A direct care worker hit a resident with a broom on or around, 6/7/10. The same direct care worker hit the resident with a computer charger on or around, 6/10/21. A different direct care worker cursed at the resident on 6/10/21.

INVESTIGATION: Due to the Covid-19 pandemic, this special investigation was completed virtually.

The complaint was initiated with a phone call to the licensee, Mr. David Paul. Mr. Paul sent a follow up email with a list of potential witnesses. On 6/18/21, I interviewed Resident A, the victim in each incident. According to Resident A, direct care worker, Erica Thomas hit him with a broom approximately 6 times and she also hit him with a computer charger once. Although the incidents happened at separate times, Resident A reported Erica hit him on the same day (6/10/21). He indicated she hit him with the computer charger earlier in the day. The incident with the broom reportedly happened later in day, closer to evening. Resident A explained the incident involving the computer charger was unprovoked. He stated, "I was running around the house, being myself listening to music" when Erica allegedly struck him with a charger. He later learned of his sister's passing and became very upset. Resident A acknowledged he made a poor choice to act out by destroying company property. He reported Erica came outside the building to get him to stop hitting the fence, but he would not listen. He indicated that is when Erica got a broom and struck him with it multiple times.

Resident A described his relationship with Erica as playful, with physical contact between them. He even described a situation whereby Erica purposely tripped him for fun. However, he stated since the complaint was launched, Erica has been "rude and disrespectful" toward him.

On 7/1/21, I interviewed Erica Thomas by phone. Erica admits she went inside to retrieve a broom in response to seeing the resident destroy the outside of the building. She said every time Resident A punched the fence or hit the gutters, she would try to block the shots with the broom. Erica said it was never her intention to harm the resident. She also acknowledged chasing Resident A with the broom. Erica insisted her goal was to de-escalate the situation. Regarding the incident involving the charger, Erica said she may have "accidentally" hit the resident with it as she "turned around." She said the cord was dangling from the computer device, so when she turned it may have hit him mid-air. Erica indicated she is not aware if the resident was harmed as she had no knowledge he had been hit.

Direct care worker, Deja Caldwell corroborated Resident A's statement that Erica was "rude" to him. Deja reported hearing Erica curse at the resident and speak to him in a "harsh" tone. She's also witnessed Erica use profanity when addressing other residents in the home. Deja said she's even seen Erica throw things at Resident A, like a set of keys. When asked why she didn't report the incidents, Deja explained Resident A is known to horseplay with the Staff, so she did not think it was a big deal at the time. Deja had no knowledge of the broom or charger incident.

Direct care worker, Tatiana Henderson gave a similar statement as Deja. She described the Staff's relationship with Resident A as "a little unorthodox." Tatiana described Resident A as the "kid of the house." She said the workers would often

horseplay with him because the other residents were older, so he had no one else to play with. Tatiana does not believe Erica would intentionally harm the resident, but she too has seen Erica chase Resident A around the house playfully.

On 6/18/21, I interviewed the home's Clinician and Case Manager, Ms. Alissia Snead. Alissia reported overhearing Deja curse at Resident A when he self-reported punching a hole in the wall. Specifically, Alissia said Deja responded, "are you fucking kidding me!" Not only did Deja deny saying that, but Resident A also denied Deja cursed at him. The resident described his relationship with Deja as good and without incident.

I interviewed Resident B to gather more data from a resident's perspective. Resident B indicated he feels safe in the home. He has not witnessed Staff abuse residents in care. Resident B reported no one at the home has caused him harm intentionally or accidentally.

However, by her own admission, Erica acted in a manner unbecoming of a direct care worker. Regardless of her intentions, it was inappropriate for Erica to chase the resident with an object, especially something as intimidating as a broom. It is unclear if she actually hit the resident 6 times with the broom as reported since there were no witnesses outside. It is also unclear whether she deliberately hit him with the computer charger. Erica's reasoning for the abuse raises question about her character. She repeatedly displayed a lack of judgement when addressing Resident A. Therefore, Erica's conduct exposed the resident to risk of physical and emotional harm.

APPLICABLE RULE		
R 400.15308	Resident behavior interventions prohibitions.	
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.	

ANALYSIS: Resident A reported Erica hit him with a broom and computer charger on 6/10/21. Erica acknowledged she chased the resident with a broom because he was destroying the property. She also admitted she may have "accidentally" hit the resident with a computer charger earlier that day. Deja reported observing Erica use profanity and a harsh tone with residents. Deja even admitted to seeing Erica throw a set of keys at Resident A in the past. • Tatiana acknowledged she's seen Erica "chase" the resident around the house playfully. Based on these findings, the department finds Erica acted in a manner that mistreats the residents. CONCLUSION: **VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

K. Robinson	07/19/21
Kara Robinson Licensing Consultant	Date
Approved By:	07/22/21
Ardra Hunter Area Manager	Date