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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 27, 2022

Jennifer Lockhart
Hope Network, S.E.
PO Box 190179
Burton, MI 48519

RE: License #: AS090302478
Investigation #: 2022A0572024
Harbor House AFC

Dear Ms. Lockhart:

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 (906) 226-4171.

Sincerely,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS090302478
Investigation #:	2022A0572024
Complaint Receipt Date:	02/28/2022
Investigation Initiation Date:	03/04/2022
Report Due Date:	04/29/2022
Licensee Name:	Hope Network, S.E.
Licensee Address:	PO Box 190179 Burton, MI 48519
Licensee Telephone #:	(586) 206-8869
Administrator:	Theresa Plumb
Licensee Designee:	Jennifer Lockhart
Name of Facility:	Harbor House AFC
Facility Address:	5385 Kasemeyer Bay City, MI 48706
Facility Telephone #:	(989) 391-9100
Original Issuance Date:	08/03/2009
License Status:	REGULAR
Effective Date:	03/02/2022
Expiration Date:	03/01/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was being moved out of single room to a shared room, without discussing with family.	No
Facility has not taken any of the residents out for community activities, shopping, dinner, etc.	No
Staff set up an unauthorized Facebook account for Resident A.	Yes
Resident A's physician prescribed her a low carb, high protein diet. Staff call to required it not be followed.	No
Resident A's Bridge card was not returned when she moved out.	No
All the electrical outlets in northeast bedroom have faulty outlets that can cause sparks and the East Window can be easily pushed out.	No
Resident A had to supply her own furnishings.	No

III. METHODOLOGY

02/28/2022	Special Investigation Intake 2022A0572024
03/04/2022	Special Investigation Initiated - On Site Staff, Kimberly Dancy, and Melissa Bond.
04/05/2022	Contact - Face to Face Staff, Kimberly Dancy, and Melissa Bond.
04/25/2022	Contact - Telephone call made Resident A and Family Member
04/25/2022	Contact - Telephone call made Joan Schrubba
04/26/2022	Exit Conference Licensee Designee, Jennifer Lockhart.

ALLEGATION:
Resident A was being moved out of single room to a shared room, without discussing with family.

INVESTIGATION:
On 02/28/2022, the local licensing office received a complaint for investigation. There were no other investigative entities involved with this investigation, however; Recipient Rights did contact licensing regarding the investigation.

On 03/04/2022, an unannounced onsite was made at Harbor House AFC, located in Bay County, Michigan. Interviewed were Staff, Kimberly Dancy, and Melissa Bond. Resident A was not interviewed or observed at the time as she has moved out of the home.

On 03/04/2022, an interview was conducted with Staff, Kimberly Dancy regarding the above allegation. Ms. Dancy informed that they had a Town Meeting regarding some possible changes at the home because they were considering bringing in a male resident. The male resident never moved into the home and Resident A kept her private room. The family kept asking about the move, but there was nothing to discuss because they never moved her.

On 03/04/2022, an interview was conducted with Staff, Melissa Bond regarding the above allegation. She informed that Resident A never moved out of her room, and she kept her private room until she was discharged.

On 04/25/2022, an interview was conducted with Family Member #1 regarding the above allegation. Family Member #1 informed that Resident A's doctor had wrote a recommendation for her to have a private room due to being diagnosed with severe anxiety. The facility was going to move Resident A into a Room with Resident C, despite the recommendation from the doctor. Resident A did not move in with Resident C only because she was moved out of the home before this occurred.

On 04/25/2022, an interview took place with Resident A regarding the above allegation. She informed that she never moved in with Resident C because she moved out before this happened.

Issues regarding, no tv/internet for extended time, was discussed, but not investigated as tv and internet service is no part of any resident's room and board. All residents have access to the facility's internet.

Issues regarding Resident A having no money to purchase her own transportation tickets to go to community center for exercise, was not investigated, but it was discussed. The facility is not required to give the residents a stipend for transportation. They provide transportation to and from appointments and outings.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	Resident A never moved in with another resident. She remained in her private room up until she discharged from the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Facility has not taken any of the residents out for community activities, shopping, dinner, etc.

INVESTIGATION:
On 03/04/2022, an interview was conducted with Staff, Kimberly Dancy regarding the above allegation. Ms. Dancy informed that all the residents have leisure times out in the community. Resident A's issue is that she would make bad choices with her purchases, but she was able to go out into the community, as well as the other residents. Ms. Dancy indicated that going out to some places were difficult due to the covid guidelines and having to wear masks in certain areas, but the residents still were able to go out into the community. During my interview, I observed a resident in a facility van, coming from an outing.

On 03/04/2022, an interview was conducted with Staff, Melissa Bond regarding the above allegation. She insisted that this was not true and informed that a resident is just now coming home from an outing.

On 04/25/2022, an interview was conducted with Family Member #1 regarding the above allegation. Family Member #1 gave an example when the staff were supposed to take the residents out during the holidays to see the Christmas lights and then go out to Bronner's Christmas Store, but it didn't happen because one resident did not want to go. Family Member #1 believes that the staff were taking the residents on outings at first, but then it stopped.

On 04/25/2022, an interview took place with Resident A regarding the allegation. Resident A indicated that the facility only took her out to eat once. They never got to do anything at the facility.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(h) The right to participate in the activities of social, religious, and community groups at his or her own discretion.**
ANALYSIS:	Staff indicated that they take the residents on outings, and they had a period where it was difficult due to Covid Restrictions. Family Member #1 indicated that the facility was taking them on outings and then it stopped. Resident A indicated that she only went on one outing.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Staff set up an unauthorized Facebook account for Resident A.

INVESTIGATION:
On 03/04/2022, an interview was conducted with Staff, Kimberly Dancy regarding the above allegation. She informed that she really didn't know anything about the Facebook page until recently and thought that because Resident A had a Job Coach and she overheard them talking about it, that was something that they created together for employment.

On 03/04/2022, an interview was conducted with Staff, Melissa Bond regarding the above allegation. Ms. Bond informed that she was the staff who helped her create a Facebook page, because Resident A asked her to help her with it. There's no pictures or any type of information on there, other than her name. Resident A does not know how to work the Facebook app, so there's nothing on it.

On 03/04/2022, I went on Facebook and typed Resident A's name in the search bar. Several profiles came up, however; those with profile pictures were not of Resident A. I also looked at the ones without a profile picture and there was no information on these pages.

On 04/25/2022, an interview was conducted with Administrator, Theresa Plumb regarding the above allegation. Ms. Plumb informed that she was not aware of the Facebook page until the investigation. She logged into Facebook during our interview and informed none of the profile pics belong to Resident A, so it has to be one of the profiles with nothing on it.

On 04/25/2022, an interview was conducted with Family Member #1 who is also Resident A's Guardian ~~r~~egarding the above allegation. Family Member #1 informed that a staff member created a Facebook Account with Resident A's first name, last name, middle initial, phone number and date of birth. There is no profile picture or any posts on the page. Family Member #1 wasn't certain if it was a HIPPA Violation, but still is upset that they were not contacted first to approve of her having a Facebook Page. Resident A has been receiving several phone messages from people who are contacting her through Facebook.

On 04/25/2022, an interview was conducted with Resident A regarding the above allegation. Resident A informed that someone put her on Facebook, and she don't know why as she doesn't even know what Facebook is. Her and the staff were talking about tattoos and then she made her a Facebook page. Resident A denied asking anyone to create a Facebook page for her.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.
ANALYSIS:	Staff, Family Member #1, and Resident A all indicated that a Facebook Page was created for Resident A. Family Member #1 informed that they did not approve of this social media account and was not asked if it could be done.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
Resident A's physician prescribed her a low carb, high protein diet. Staff call to required it not be followed.

INVESTIGATION:
On 03/04/2022, an interview was conducted with Staff, Kimberly Dancy regarding the above allegation. Ms. Dancy informed that the facility followed the doctor's order of her special diet, however; Resident A would make poor choices and eat things she does not supposed to eat and when they stop her, she will get upset and call her family. Resident A always ask can she eat something that she knows she is not supposed to eat.

On 03/04/2022, an interview was conducted with Staff, Melissa Bond regarding the above allegation. Pasta was on the menu one day and Resident A kept asking can she have some and she was informed that she could not because that was against her dietary plan. Resident A kept asking multiple times if she can have some pasta, so Ms. Bond informed her to ask her guardian if she can have some pasta, because she thought that Resident A would accept the answer better from the guardian than from her. But when Resident A called the guardian, she indicated that she was only given Slim Fast to eat and nothing else but will tell her family that is all she had to eat. Resident A had an option, but she chose to drink the Slim Fast and wanted to eat some pasta.

On 04/25/2022, an interview was conducted with Family Member #1 regarding the above allegation. Family Member #1 informed that the special diet was not followed. He knows this because staff always had Resident A call them to see if she can have something that she is not allowed to eat, and he questioned why else they would have her ask them. He has not witnessed this but said that Resident A eats whatever the other residents eat. He informed that Resident A also said that she has eaten pasta, but staff with less sauce.

On 04/25/2022, an interview was conducted with Resident A regarding the above allegation. She informed that she has eaten pasta, pizza, and other carbs at the facility. She said that she told staff that she is supposed to be on a diet, but there was nothing else to eat.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	Resident A is on a special diet plan. Staff informed that they have been going through issues with Resident A wanting to eat things that are not part of her dietary plan and then she will get upset and tell her family that they only fed her Slim Fast, so they staff started telling her to ask her parents if she can eat pasta and see what they say. Family Member #1 believes that staff were feeding her pasta and believes that staff were asking her to ask them if it was okay because they didn't want to make her anything else. Resident A informed that she has had pasta with less sauce.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Resident A's Bridge card was not returned she when moved out.

INVESTIGATION:
On 03/04/2022, an interview was conducted with Staff, Kimberly Dancy regarding the above allegation. Ms. Dancy informed that the Bridge Card was sent to Corporate and Corporate handles everything because the home is no longer involved.

On 04/25/2022, an interview was conducted with Administrator, Theresa Plumb regarding the above allegation. She informed that the Bridge Card was sent to Corporate after the family moved Resident A. The home received no notice that they were moving her, and they moved her on a Saturday, so the Bridge Card was sent to Corporate. The family was told to contact Corporate, so they know where to send the card to. Ms. Plumb gave me the phone number to the finance department to verify that the card was sent.

On 04/25/2022, an interview was conducted with Joan Schrubba in finance, regarding the above allegation. A message was left, but a response was not received at the time of the writing of this report.

On 04/25/2022, an interview was conducted with Family Member #1 regarding the above allegation. Family Member #1 said that the day after Resident A moved out of the home, they spoke with staff above getting her Bridge Card. He was told that he had to contact Corporate in order to get the card. It was hard contacting them, and they did not call him back, so they contacted the State so that they could get a replacement card. Corporate did send the Bridge Card eventually, but they already had their replacement card by then. He believes that the Bridge Card was received from Corporate within 30 days.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(16) Personal property and belongings that are left at the home after discharge shall be inventoried and stored by the licensee. The resident and designated representative shall be notified by the licensee, by registered mail, of the existence of property and belongings. Personal property and belongings that remain unclaimed, or for which arrangements have not been made, may be disposed of by the licensee after 30 days from the date that written notification is sent to the resident and the designated representative.

ANALYSIS:	Staff informed that when Resident A moved out of the home, her Bridge Card was sent to Corporate, and they informed the family. The family tried calling the Corporate Office, but did not get a return call, so they got a replacement card. The card was eventually sent and they believe that it was within 30 days of her discharge from the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
All the electrical outlets in northeast bedroom have faulty outlets that can cause sparks and the East Window can be easily pushed out.

INVESTIGATION:
On 03/04/2022, an interview was conducted with Staff, Kimberly Dancy regarding the above allegation. She informed that the plugs and the window was fixed. She showed me the receipts for the items fixed and I observed both the window and all of the outlets and they were in good working order.

On 04/25/2022, an interview was conducted with Family Member #1 regarding the above allegation. He informed that the outlets in the bedroom sometimes did not work and they would have to pull the prongs apart in order for them to fit. Sometimes the lights and the clock would flicker off and on.

On 04/25/2022, an interview was conducted with Resident A regarding the above allegation. She informed that there was something wrong with the outlets as they were loose.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Staff, Resident A and Family Member #1 informed that there were issues with the outlets and a window. These issues were resolved prior to my unannounced onsite and I reviewed receipts from the work that was completed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Resident A had to supply her own furnishings.

INVESTIGATION:
On 03/04/2022, an interview was conducted with Staff, Kimberly Dancy regarding the above allegation. Ms. Dancy informed that Resident A's room was fully furnished, but they wanted to put new furniture in her room and they allowed this to happen because it was their choice. They saw that Resident B was getting new furniture and assumed that the home purchased all new furnishings for Resident B and not for Resident A. Resident B had a stimulus check that had to be spent down, so she used her own money to purchase her new furnishings. Harbor House did not replace Resident B's furnishings.

On 04/25/2022, an interview was conducted with Family Member #1 regarding the above allegation. He informed that there was nothing in her room but a bed. He knows that licensing requirements, there needs to be a dresser, mirror, and a chair in the room. They supplied the nightstand, Lazy Boy chair and added drapes because their drapes were easy to see through. Staff said they had a dresser, but they had to get another one because the one that was in the room was falling apart.

On 04/25/2022, an interview took place with Resident A regarding the above allegation. She informed that there was no dresser or chair in her bedroom when she moved in.

APPLICABLE RULE	
R 400.14410	**Bedroom furnishings.**
	(1) The bedroom furnishings in each bedroom shall include all of the following: **(a) An adequate closet or wardrobe.** **(b) Lighting that is sufficient for reading and other resident activities.** **(c) A bureau or dresser or equivalent.** **(d) At least 1 chair.**
ANALYSIS:	Staff informed that they had furnishings but moved them out because Resident A's family wanted to put new furnishings in her bedroom. Family Member #1 and Resident A indicated that there was only a bed in the room, and they had to provide the dresser, chair, and mirror. During my unannounced visit during this investigation, as well as previous onsite, there has always been furnishings in all the bedrooms.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 04/26/2022, an Exit Conference was held with Licensee Designee, Jennifer Lockhart. She was informed of the complaint and the findings from my investigation. She informed that she will submit a corrective action plan when the report is received.

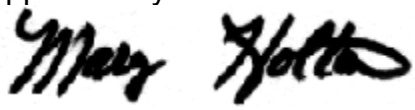
IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this small adult foster care group home, pending the receipt of an acceptable corrective action plan (capacity 1-6).

04/26/2022

Anthony Humphrey — Date
Licensing Consultant

Approved By:



04/27/2022

Mary E Holton — Date
Area Manager