



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 16, 2023

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

RE: License #: AS700365883
Investigation #: 2023A0350022
Harbor Point Intensive - North Unit

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 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) 356-0100.

Sincerely,

A handwritten signature in black ink, appearing to read 'Ian Tschirhart', with a stylized flourish at the end.

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS700365883
Investigation #:	2023A0350022
Complaint Receipt Date:	05/15/2023
Investigation Initiation Date:	05/15/2023
Report Due Date:	06/14/2023
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 Intensive - North Unit
Facility Address:	Upper Level, 16908 130th St. Nunica, MI 49448
Facility Telephone #:	(616) 414-7305
Original Issuance Date:	03/10/2015
License Status:	REGULAR
Effective Date:	09/10/2021
Expiration Date:	09/09/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff member Taneen Jackson has been calling Resident A derogatory names.	Yes
Staff member Taneen Jackson has changed the channel on the TV while a resident was watching it more than one time.	Yes

III. METHODOLOGY

05/15/2023	Special Investigation Intake 2023A0350022
05/15/2023	Special Investigation Initiated - On Site I spoke with Dedrick Fondren, Home Manager, Kaylyn Ley, DCW, and a few residents
05/15/2023	Contact - Document Sent I sent an email to David Paul, Licensee Designee
05/15/2023	Contact - Document Received I received an email from Mr. Paul
05/15/2023	Contact - Telephone call made I spoke with Taneen Jackson, DCW
05/15/2023	Contact - Document Sent I sent Mr. Paul a text message
05/15/2023	Contact - Document Received I received a text from Mr. Paul
05/15/2023	Contact - Telephone call received I spoke with Dedrick Fondren, Home Manager
05/15/2023	APS referral
05/16/2023	Exit conference – Held with David Paul, Licensee Designee

ALLEGATION: Staff member Taneen Jackson has been calling Resident A derogatory names.

INVESTIGATION: On 05/15/2023, I made an onsite inspection and spoke with Resident A and he stated that Taneen Jackson, Direct Care Worker (DCW) recently “misused” his name, but he said he didn’t remember what she called him. I asked if Ms. Jackson cussed at him and he said, “I don’t know.” Resident A hesitated in giving his answers. Resident A reported that Ms. Jackson “talks to everyone like that,” but he was not able to provide any specific examples of inappropriate comments Ms. Jackson made. He added that Ms. Jackson is bossy towards the residents.

While at this home on 05/15/2023, Dedrick Fondren, Home Manager, arrived and I spoke with him. I informed him of the allegation, and I asked to speak with other residents and a staff member who has worked with Ms. Jackson. Mr. Fondren brought Resident B to his office where he remained while I did the interviewing. Resident B told me that he heard Ms. Jackson say to Resident C, “you’re sleeping; go to your room,” and that she has said to him (Resident B) “Do not go in the kitchen,” using a harsh tone of voice. Resident B stated that Ms. Jackson treats him like a child and talks behind his back. He said he knows this because he overheard her doing that. Resident B informed me that Ms. Jackson “Yells and screams” at him and the other residents.

On 05/15/2023, I spoke with Resident C in Mr. Fondren’s office. Resident C said Ms. Jackson is “harrasive” and “belittling” especially towards Resident B. Resident C told me that Ms. Jackson speaks harshly to the residents, himself included, and that she once called him “retarded” and told him that he “would be better off in jail.”

On 05/15/2023, I spoke with Kaylyn Ley, DCW, and she said she usually works a different shift from Ms. Jackson, but they have worked together a few times. Ms. Ley informed me that Ms. Jackson “speaks harshly” to the residents and that she often “sounds mean” when speaking to them, but she has not heard Ms. Jackson swear at a resident or call any of them a derogatory name.

On 05/15/2023, I called and spoke with Taneen Jackson, DCW, and she denied calling Resident A or any other resident a derogatory name. She also denied swearing at Resident A. Ms. Jackson told me that it was Resident A who called her “the ‘N’ word,” and that she would never call a resident a derogatory name, swear at a resident or yell at a resident because “that would be disrespectful.”

On 05/15/2023, sent David Paul, Licensee Designee, an email inquiring as to whether this complaint was also made to Adult Protective Services (APS). I received his reply email later this day saying that APS was not notified about it, but he will see to it that this notification occurs.

On 05/16/2023, I called and held an exit conference with David Paul, Licensee Designee. I informed Mr. Paul that I was citing a violation of this rule and he expressed his disappointment that Hope Network sends its staff members through training so that these types of things don't happen, but sometimes they still do. Mr. Paul also stated his concern that the residents they serve were subjected to this kind of treatment. He added that this matter would be taken very seriously and dealt with quickly.

APPLICABLE RULE	
R 400.14308	Resident behavior interventions prohibitions.
	<p>(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:</p> <p>(f) Subject a resident to any of the following:</p> <p>(i) Mental or emotional cruelty.</p> <p>(ii) Verbal abuse.</p> <p>(iii) Derogatory remarks about the resident or members of his or her family.</p>
ANALYSIS:	<p>Taneen Jackson, DCW, denied calling Resident A derogatory names, cussing at any resident, or raising her voice at the residents.</p> <p>Resident A, Resident B, and Resident C as well as Kaylyn Ley, DCW, all stated that Ms. Jackson speaks harshly and often in a demeaning way to the residents. Resident C stated that Ms. Jackson called him "retarded" and told him that he "would be better off in jail." The residents reported that Ms. Jackson treats them like children and belittles them.</p> <p>My findings support that this rule had been violated.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Staff member Taneen Jackson has changed the channel on the TV while a resident was watching it more than one time.

INVESTIGATION: On 05/15/2023, I spoke with Resident B and he informed me that Ms. Jackson has changed the channel on the TV while he was watching it but he did not ask her to.

On 05/15/2023, I spoke with Resident C and he said that Ms. Jackson has changed the channel on the TV a few times while he was watching it, and when he said something about it, she made the comment; “Are you running the place?”

On 05/15/2023, I called and spoke with Taneen Jackson, DCW, and she denied changing the TV channel while a resident was watching unless the resident asked her to.

On 05/16/2023, I called and held an exit conference with David Paul, Licensee Designee. I informed Mr. Paul that I was citing violation of this rule and he expressed his disappointment that Hope Network sends its staff members through training so that these types of things don’t happen, but sometimes they still do. Mr. Paul also expressed his concern that the residents they serve were subjected to this kind of treatment. He added that this matter would be taken very seriously and dealt with quickly.

APPLICABLE RULE	
R 400.14304	Resident rights; licensee responsibilities.
	<p>(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:</p> <p style="padding-left: 40px;">(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.</p> <p>(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.</p>
ANALYSIS:	<p>Taneen Jackson, DCW, denied changing the channel while a resident was watching TV.</p> <p>Resident B and Resident C both stated that Taneen Jackson did change the channel on the TV while they were watching more than once and did so without them asking her to.</p> <p>My findings support that this rule had been violated.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

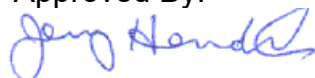


May 16, 2023

Ian Tschirhart
Licensing Consultant

Date

Approved By:



May 16, 2023

Jerry Hendrick
Area Manager

Date