GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 29, 2023

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

RE: License #: AL820395614
Investigation #: 2024A0992004
Harbor Point Dearborn Heights

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 (313) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

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 #:	AL820395614
Investigation #:	2024A0992004
Complaint Receipt Date:	10/18/2023
Investigation Initiation Date:	10/18/2023
Report Due Date:	12/17/2023
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 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:	02/12/2022
Expiration Date:	02/11/2024
Capacity:	13
Program Type:	DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
It was reported that on 10/7/23, Staff A heard Staff D, tell Resident A "Sit your mother fucking ass down, nobody here to see you."	Yes

III. METHODOLOGY

10/18/2023	Special Investigation Intake 2024A0992004
10/18/2023	Referral - Recipient Rights
10/18/2023	Special Investigation Initiated - Telephone Complainant, not available. Message left.
10/19/2023	Contact - Telephone call received Complainant
10/20/2023	Contact - Face to Face Chrystal Delaney, home manager and Resident A.
10/23/2023	Contact - Telephone call made Staff A, direct care staff. Not available, message left.
10/23/2023	Contact - Telephone call made David Paul, licensee designee
10/23/2023	APS Referral
10/24/2023	Contact - Telephone call made Staff A
10/24/2023	Contact - Telephone call made Staff B, direct care staff
10/24/2023	Contact - Telephone call made Staff C
10/24/2023	Contact - Telephone call made Staff D was not available, message left.
10/30/2023	Contact - Telephone call made

	Relative A, was not available. Mailbox full, unable to leave a message.
10/30/2023	Contact - Telephone call received Relative A
10/30/2023	Contact - Telephone call received Staff D
11/22/2023	Exit Conference Mr. Paul

ALLEGATION: It was reported that on 10/7/23, Staff A heard Staff D, tell Resident A "Sit your mother fucking ass down, nobody here to see you."

INVESTIGATION: On 10/19/2023, I received a return call from the Complainant. As it pertains to the allegation, the Complainant said Staff A and D were on shift when a visitor came for another resident. Resident A got up to see what was going on and Staff A overheard Staff D tell Resident A “Sit your mother fucking ass down, nobody here to see you." The Complainant stated she interviewed Resident A and he confirmed the allegation as well. The Complainant further stated that she also interviewed Staff A, B, and C; and all confirmed the allegation. The Complainant said based on the information obtained, the allegation is substantiated.

On 10/20/2023, I completed an unannounced onsite inspection; I interviewed Chrystal Delaney, home manager, and Resident A regarding the allegation. Ms. Delaney said she was previously made aware of the allegation and as a result Staff D received a disciplinary action in the form of a write-up. I requested a copy of the write-up and the incident report, which Ms. Delany agreed to provide. Ms. Delaney further stated Staff D is currently suspended for a separate issue. Ms. Delaney made me aware Relative A is Resident A’s guardian and she has been made aware of the incident as well.

According to the “Notification of Investigation/Suspension,” Staff D was suspended as of 10/18/2023 for an incident involving the Harbor Point Program. According to the letter “It was determined that Staff D violated work rule or policy, or are in violation of your employee handbook guidelines you could receive further education and/or disciplinary action, up to and including termination of employment.”

I interviewed Resident A regarding the allegation. I asked about his relationship with the staff in the home, Resident A said he gets a long with the some of the staff. He said two weeks ago, Staff D told him to “sit his mother fucking ass down, nobody here to see you." Resident A could not pronounce Staff D’s name but tried. He said Staff D was being mean. He said she had never said anything like that to him before

and that this was her first time. Resident A said Staff D has not been at work in a couple days. He said he feels safe, and everything has been going well since she has been gone. Resident A was excited, he said he is moving into a semi-independent setting in two weeks. Resident A presented as competent and credible.

On 10/23/2023, I contacted David Paul, licensee designee and interviewed him regarding the allegation. Mr. Paul confirmed he was previously made aware of the allegation. He was very cooperative and said Ms. Delaney can assist and/or provide any information required to complete the investigation. I explained the investigative process and made Mr. Paul aware that I will follow-up with him to conduct an exit conference upon completion of the investigation.

On 10/24/2023, I contacted Staff A and interviewed her regarding the allegation, which she confirmed. Staff A said Staff D is known to be disrespectful towards the staff, and managers. Staff A said Staff D's demeanor is not the most pleasant. Staff A said she is not surprised by Staff D's actions but surprised she made the comment while there was a visitor in the facility.

On 10/24/2023, I contacted Staff B and interviewed her regarding the allegation, which she confirmed. Staff B said Staff D have her days, sometimes she is pleasant but most days she is very disrespectful. Staff B said Staff D's mannerism and demeanor is very negative.

On 10/24/2023, I contacted Staff C and interviewed her regarding the allegation, which she confirmed. Staff C said Staff D is not the easiest person to get along with and she is known to be disrespectful to staff, management and the residents.

On 10/30/2023, I received a return call from Relative A, Resident A's guardian. I interviewed Relative A regarding the allegation. Relative A said she was previously made aware of the incident by a staff from the facility. Relative A said Resident A has been doing well and she denied having any concerns She said Resident A is being moved to another facility and will no longer have to deal with the staff there.

On 10/30/2023, I received a return call from Staff D; I interviewed her regarding the allegation, which she denied. Staff D said she does not use that language towards the residents. Staff D denied hearing any other staff speak to the residents in such a way. Staff D said she recall the day in question because there was a visitor for a different resident. Staff D said at the time she was in the kitchen preparing dinner and she does not believe Resident A was even in the area with the visitor. Staff D said the allegation is false.

On 11/22/2023, I completed an exit conference with Mr. Paul. I explained that based on the investigative findings, there is sufficient evidence to support the allegation. I explained that Staff A, B, C and Resident A confirmed the allegation. I further explained that based on the identified violation, a written corrective action plan is

required. Mr. Paul made me aware that Staff D no longer works for the company. He agreed to complete the corrective action plan and provide proof of termination.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(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: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**
ANALYSIS:	During this investigation, I interviewed David Paul licensee designee; Chrystal Delaney, home manager; Staff A, B, C and D; Relative A, Resident A's guardian and Resident A regarding the allegations. Staff A, B, C and Resident A confirmed the allegations. During my interview with Resident A, he was adamant and descriptive when discussing the allegations. Resident A could not pronounce Staff D's name but tried. He said Staff D was being mean. Resident A presented as competent and credible. Based on the investigative findings, there is sufficient evidence to support the allegation that derogatory remarks were made towards Resident A by Staff D. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

11/28/2023

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Denasha Walker Date
Licensing Consultant

Approved By:

11/29/2023

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Ardra Hunter Date
Area Manager