GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 1, 2024

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

RE: License #: AL820395614
Investigation #: 2024A0992049
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

I. IDENTIFYING INFORMATION

License #:	AL820395614
Investigation #:	2024A0992049
Complaint Receipt Date:	08/21/2024
Investigation Initiation Date:	08/22/2024
Report Due Date:	10/20/2024
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:	02/12/2024
Expiration Date:	02/11/2026
Capacity:	13
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was in the community with direct care staff, Jennifer Sturgis and he was allowed to obtain drugs and used it at the home. There are concerns Resident A was not properly supervised.	Yes

III. METHODOLOGY

08/21/2024	Special Investigation Intake 2024A0992049
08/22/2024	Special Investigation Initiated - Telephone Adult Protective Services (APS), Charmaine Parks
08/22/2024	Inspection Completed On-site Licensee designee, David Paul; Assisted manager, Camilla Johnson and Resident A.
08/29/2024	Contact - Telephone call made Direct care staff, Zoe Wise-Morris.
08/29/2024	Contact - Telephone call made Direct care staff, Crystal Delaney.
09/17/2024	Exit Conference Mr. Paul

ALLEGATION: Resident A was in the community with direct care staff, Jennifer Sturgis and he was allowed to obtain drugs and used it at the home. There are concerns Resident A was not properly supervised.

INVESTIGATION: On 08/22/2024, I contacted Adult Protective Services (APS), Charmaine Parks regarding the allegation. Ms. Parks confirmed she is actively investigating the same allegation. She stated based on the information she obtained; Resident A was allowed in the community with staff supervision. She stated direct care staff, Jennifer Sturgis transported Resident A on an authorized visit and allowed him to go into a house alone that he stated was his relative's. Ms. Parks stated it is

alleged that Resident A returned to the van under the influence and brought drugs into the facility. Ms. Parks stated her investigation is pending at this time.

On 08/22/2024, I completed an unannounced onsite inspection, and conducted separate face-to-face interviews licensee designee, David Paul; Assisted manager, Camilla Johnson and Resident A. Mr. Paul confirmed the allegation. He stated the incident occurred on 07/21/2024 and he was made aware on 07/22/2024. He stated Ms. Sturgis was immediately suspended pending the investigation. Mr. Paul stated during the investigative process, Ms. Sturgis resigned. He stated program manager, Chrystal Delany and assistant manager, Camilla Johnson would have more details regarding what occurred.

I interviewed Ms. Johnson. Prior to addressing the allegation, she made me aware that all residents must have authorization for transport. She stated Resident A is authorized for transportation to church every Sunday, and it is included in his individual plan of service (IPOS). Ms. Johnson stated Ms. Sturgis normally work Sunday's, so she typically transports Resident A. She stated Ms. Sturgis was authorized to transport Resident A to church only. Ms. Johnson stated she was on shift that day and was the on-call manager that evening. She stated when Ms. Sturgis and Resident A returned, she conferenced with Ms. Sturgis, to see how the outing went and she never said anything about stopping anywhere other than church with Resident A. Ms. Johnson stated that evening she received a call from direct care staff, Zoe Wise-Morris, stating that during casual conversation with Ms. Sturgis, mentioned taking Resident A to visit a relative while on transport. Ms. Johnson stated Ms. Wise-Morris also mentioned that Resident A asked her if she would be taking him to church the following week because Ms. Sturgis was going to be off and if they could stop by his relative's house. She stated Ms. Wise-Morris explained if he has an authorization to stop by his relative's she will, but if not, he can only go to church and back. She stated Resident A stated Ms. Sturgis always takes him to visit his relative. Ms. Johnson stated she notified Ms. Delaney, and she contacted Ms. Sturgis. Ms. Johnson stated after speaking with Ms. Sturgis, she confirmed Resident A gave her the address and they stopped by the relative's house after church. Ms. Sturgis allowed Resident A to go into the house while she remained in the van. Ms. Johnson stated she is uncertain how the "relative" is related to Resident A. However, this relative is from Resident A's past and has been known to engage in bad behaviors with him. Ms. Johnson stated it is unknown if Resident A brought drugs into the facility, but it is suspected that he was under the influence. Ms. Johnson stated Ms. Sturgis submitted her letter of resignation on 07/21/2024 and is no longer with the company.

I interviewed Resident A. Resident A confirmed the allegation. He stated after church he asked Ms. Sturgis if they could stop by his aunt's house, and she did. He stated, it is really a close family friend, but he refers to her as his aunt. He stated Ms. Sturgis remained in the van while he went inside. He stated they were there for about five minutes. He stated Ms. Sturgis has taken him to his aunt's house multiple times because she lives right up the street from the church. When I asked Resident

A if he acquired drugs while visiting his aunt, he refused to answer. However, he stated he refused to take a drug test when the staff asked him to, so it is an automatic positive.

On 08/29/2024, I contact Ms. Wise-Morris and interviewed her regarding the allegation. Ms. Wise-Morris stated on the day in question, she was in the common area and Resident A was telling her about his outing. She stated Resident A told her that the church blessed Ms. Sturgis with a financial blessing for bringing him to church. She stated he went on to say after church, Ms. Sturgis took him to visit his aunt. Ms. Wise-Morris stated Resident A asked if she could take him to visit his aunt. Ms. Wise-Morris stated she explained that he needs an authorization to stop by his relative's, otherwise no unauthorized stops will be made. She stated Resident A went on to say Ms. Sturgis always allows him to visit with his aunt at her house. Ms. Wise-Morris stated Ms. Sturgis was removed from the schedule and has not returned.

On 08/29/2024, I contacted Ms. Delaney and interviewed her regarding the allegation. Ms. Delaney statements were consistent with the statements Ms. Johnson, Ms. Wise-Morris and Resident A provided to me during my interview with them on 08/22/2024 and 08/29/2024. Ms. Delaney stated when she asked Ms. Sturgis about the incident, she admitted to taking him on the reported date and on other occasions. Ms. Delaney stated Resident A is not allowed to be in the community independently. Ms. Delaney stated Ms. Sturgis has since separated from the company.

I reviewed Resident A's adult foster care assessment plan, which states "(Resident A's) safety while navigating the community has been assessed with a safety plan. While in the community (Resident A) needs supervision and staff support. While in the community (Resident A) will be accompanied by a member of staff."

On 09/17/2024, I completed an exit conference with Mr. Paul. I made him aware that based on the findings, there is sufficient evidence that Resident A was not provided with supervision as specified in his assessment plan. Ms. Sturgis transported Resident A to a house, that Resident A identified as a relative and allowed him to go into the home with out proper supervision. Mr. Paul agreed and denied having any questions. I made him aware that due to the violation, a written corrective action plan is required. Mr. Paul agreed to review the report and respond accordingly.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with licensee designee, facility staff members, Resident A and a review of pertinent documentation relevant to this investigation, there is sufficient evidence to support the allegation. It has been established that direct care worker, Jennifer Sturgis did not provide Resident A with supervision and protection as specified in his adult foster care assessment. This 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.

09/24/2024

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Denasha Walker Date
Licensing Consultant

Approved By:

10/01/2024

_____

Ardra Hunter Date
Area Manager