GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 5, 2024

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

RE: License #: AL820395614
Investigation #: 2025A0992002
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 #:	2025A0992002
Complaint Receipt Date:	10/07/2024
Investigation Initiation Date:	10/08/2024
Report Due Date:	12/06/2024
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?
Direct care staff were observed in the medication room consuming alcohol while on shift. There are concerns regarding appropriate supervision of the residents.	Yes

III. METHODOLOGY

10/07/2024	Special Investigation Intake 2025A0992002
10/08/2024	Special Investigation Initiated - Telephone Office of Recipient Rights Investigator, Matthew Schneider.
10/08/2024	Contact - Document Received Pictures
10/11/2024	Inspection Completed On-site Home manager, Chrystal Delaney and Staff 6
11/18/2024	Contact - Telephone call made Staff 7
11/18/2024	Contact - Telephone call made Licensee designee, David Paul, was not available. Message left.
11/18/2024	Contact - Telephone call made Rights and Compliance Manager, Lynn TenBrock with Hope Network Behavioral Health Services, was not available. Message left.
11/19/2024	Exit Conference Mr. Paul
12/02/2024	Contact - Telephone call made Staff 1
12/03/2024	Contact - Telephone call made Staff 2
12/03/2024	Contact - Telephone call made Staff 4

12/03/2024	Contact - Telephone call made Staff 3 was not available. Message left.
12/03/2024	Contact - Telephone call made Staff 5 was not available. Message left.

ALLEGATION: Direct care staff were observed in the medication room consuming alcohol while on shift. There are concerns regarding appropriate supervision of the residents.

INVESTIGATION: On 10/08/2024, I contacted Office of Recipient Rights (ORR) Investigator, Matthew Schneider regarding the allegation. Mr. Schneider stated it was reported that there were several direct care staff drinking alcohol while on shift. He further stated he has video recordings of the staff drinking in the office and in the garage of the facility; he agreed to share the video recordings with me. He stated he also received a picture of a text conversation between Staff 1 and Staff 2, accusing Staff 1 of telling on Staff 2 for drinking on shift. Mr. Schneider stated he is actively investigating the allegation, and he will keep me updated. He stated according to Rights and Compliance Manager, Lynn TenBrock with Hope Network Behavioral Health Services, the staff involved were terminated.

On 10/08/2024, I received pictures, and videos from Mr. Schneider. In one picture, I observed two staff in the garage, one staff was pouring a drink out of what appeared to be a dark brown glass bottle; I was not able to see the label on the bottle. The other picture contained a text conversation between Staff 1 and Staff 2 accusing Staff 1 of telling on Staff 2 for drinking on shift. One message said, “Damn u (you) recorded me drinking yesterday at work and got me fired that’s some hoe shit.” One video clip contained two staff dancing in the garage. In the other video, there were two staff in a room, one had a dark colored glass bottle in front of her with a clear cup with a brown liquid and a Red Bull and the other staff was sitting in front of the computer with a Red Bull near her.

On 10/11/224, I completed an unannounced onsite inspection and interviewed home manager, Chrystal Delaney and Staff 6. Ms. Delaney confirmed the allegation. She stated based on the information she received, there were two different incidents on involving the staff drinking alcohol during second shift. Ms. Delaney stated the first incident involved Staff 2 and Staff 3 drinking alcohol in the medication room. Ms. Delaney stated that Staff 1 recorded Staff 2 and Staff 3 and notified management. She stated the second incident involved Staff 1 and Staff 5. She stated Staff 1 and Staff 5 were drinking alcohol in the garage. Ms. Delaney stated Staff 6 was also on shift but was not involved in the incident. Ms. Delaney stated apparently there were some issues amongst the staff, and they decided to tell on each other. She stated

Staff 1 recorded Staff 2 and Staff 3 and reported it to management, then Staff 2 and Staff 3 recorded Staff 1 and Staff 5 a month prior but recently notified management. Ms. Delaney stated all the staff involved were terminated. I asked about the whereabouts of the residents during the reported incidents. Ms. Delaney stated based on the information she received the residents were not exposed to the behavior; they were in their bedrooms.

I interviewed Staff 6 regarding the allegation. Staff 6 confirmed she was on shift but denied having any knowledge of the reported allegation. She stated on the day in question there were several staff onsite because it was Employee Appreciation Day and management had a “road show,” which is a parade outside. Staff 6 stated she went to her car and observed Staff 1, 2, 3, and 7 in the garage smoking what appeared to be cigarettes; she stated she did not observe them drinking alcohol. She stated she has observed staff sitting in their cars in the past but, she is not sure what they are doing while in there. Staff 6 denied there were any residents outside with Staff 1, 2, 3, and 7. Staff 6 denied having any knowledge of Staff 2 and Staff 3 drinking alcohol in the medication room.

On 11/18/224, I contacted Staff 7 and interviewed her regarding the allegation, which she confirmed. Staff 7 stated on the day in question she was looking for Staff 4 because she was training her. Staff 7 stated at the time she was relatively new to the facility, and it was her first week on the floor assisting residents. She stated Staff 4 was in the garage. Staff 7 stated when she walked into the garage, there was a car parked really close to the garage and Staff 1 and 5 had just returned from the store with a bottle of “Don Julio Tequila” (dark brown glass bottle). Staff 7 stated she observed Staff 1 and Staff 5 drinking alcohol and smoking marijuana; she stated Staff 4 was sitting in a rocking chair in the garage; she was not drinking. I asked about the whereabouts of the residents and Staff 7 stated most of the residents were in their bedrooms and a couple were in the living room. She stated the residents did not observe the staff’s behavior. Staff 7 stated Staff 1, 2, 3, and 5 were terminated.

On 11/19/2024, I contacted licensee designee, David Paul and interviewed him regarding the allegation. I made him aware that I observed videos and pictures of the staff with alcohol while on shift and interviewed a staff that confirmed the allegation. Mr. Paul confirmed he was aware of the allegation and all involved parties were terminated. I proceeded to conduct an exit conference. I made him aware that based on the findings, there is sufficient evidence to support the allegation, and a written corrective action plan is required. Mr. Paul agreed to review the report and respond accordingly.

On 12/02/2024, I contacted Staff 1 and interviewed her regarding the allegation. Staff 1 denied the allegation and stated she was not drinking alcohol on shift. She stated there were two separate incidents involving alcohol. She stated she was not drinking but witnessed both incidents. Staff 1 stated the first incident involved Staff 2 and Staff 3 drinking alcohol in the medication room. Staff 1 stated she retrieved the medications when they were delivered and went to put the medication up in the

medication room, and the door was closed but the light was on. Staff 1 stated she knocked on the door and when she opened the door Staff 2 and Staff 3 was drinking alcohol. Staff 1 stated she immediately notified management. She stated the other incident occurred in the garage and was reported by Staff 7. She stated Staff 7 sent a screenshot to management of Staff 4 pouring alcohol in Staff 2 or Staff 3's cup. Staff 1 confirmed she was in the garage but was not drinking, she stated she was making TikTok videos with Staff 5. She stated Staff 7 was drinking too but of course she did not report it. Staff 1 stated according to her termination documentation, she was terminated for violating Hope Network policies.

On 12/03/2024, I contacted Staff 2 and interviewed her regarding the allegation, which she denied. Staff 2 stated Staff 1 was drinking alcohol and smoking marijuana on shift. Staff 2 stated she was sitting in the medication room with Staff 3 finishing up paperwork while Staff 3 was counting medication. She stated Staff 1 came in the room and said she was about to go to the liquor store. Staff 2 stated Staff 1 left and when she returned, she had a bottle of liquor and a cup that she sat on the desk in the medication room. Staff 2 stated Staff 1 got on her phone and started taking pictures. She stated apparently Staff 1 sent the pictures to management and stated that we were drinking on shift. Staff 2 stated Staff 1 always drink and smoke marijuana on shift. Staff 1 stated she notified assistant manager, Camillia Johnson about Staff 1 drinking and smoking on several occasions and nothing happens. Staff 2 stated there is a lot of favoritism at that facility.

On 12/03/2024, I contacted Staff 4 and interviewed her regarding the allegation. Staff 4 stated she was in the garage smoking a cigarette. She stated Staff 1 and Staff 5 were drinking alcohol. Staff 4 stated she does not drink alcohol, she stated she is on heart medication, and she is not willing to take that risk. Staff 4 stated that there is a lot of favoritism at that facility and some things go unnoticed when it comes to certain staff. However, Staff 4 stated she was terminated, although she was not drinking. She stated she is fully aware that pictures and video were taken and sent to management, but she was not in any of the pictures. She stated that Ms. Delaney notified her that she was being terminated and had her sign the termination form. Staff 4 stated she did not thoroughly read the letter until she got home, but according to the letter she was terminated for consuming alcohol on shift. Staff 4 stated she has called management and human resources to appeal the process but no one have responded.

APPLICABLE RULE	
R 400.15201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with facility staff members, and a review of pertinent videos and pictures relevant to this investigation, there is enough evidence to substantiate the allegation that multiple staff members were drinking alcohol on shift. The staff's behavior was not suitable to assure the welfare of the residents. 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.

11/18/2024

_____

Denasha Walker Date
Licensing Consultant

Approved By:

12/5/2024

_____

Ardra Hunter Date
Area Manager