GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

October 3, 2025

RE: License #: AM490392115
Investigation #: 2025A0873018 - Bay Haven Integrated Care

Dear Mrs. Frazier

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(906) 250-9318

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

I. IDENTIFYING INFORMATION

License #:	AM490392115
Investigation #:	2025A0873018
Complaint Receipt Date:	08/14/2025
Investigation Initiation Date:	08/14/2025
Report Due Date:	10/13/2025
Licensee Name:	Hope Network Behavioral Health Services
LicenseeAddress:	PO Box 890 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(616) 430-7952
Administrator:	Megan Pena
Licensee Designee:	Kathy Frazier
Name of Facility:	Bay Haven Integrated Care
Facility Address:	799 Hombach Street St. Ignace, MI 49781
Facility Telephone #:	(906) 298-8000
Original Issuance Date:	10/08/2019
License Status:	REGULAR
Effective Date:	04/08/2024
Expiration Date:	04/07/2026
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility.	Yes
Additional Findings	No

III. METHODOLOGY

08/14/2025	Special Investigation Intake 2025A0873018
08/14/2025	Special Investigation Initiated - Letter
09/02/2025	Inspection Completed On-site
09/02/2025	Contact - Face to Face Interviews with staff and Resident A
09/02/2025	Contact - Document Received Received copies of IRs and AP
09/25/2025	Contact - Document Received Email detailing a further elopement
10/03/2025	Contact - Document Received Received update email from facility.
10/03/2025	Exit Conference with licensee designee Kathy Frazier

ALLEGATION:

Resident A eloped from the facility.

INVESTIGATION:

On 8/7/25, I received an email from licensee designee Kathy Frazier. Resident A requested to go to the store for cigarettes. When an employee got ready to take her to the store Resident A was not in the facility and her whereabouts were unknown. Resident A was a consumer of Gogebic community mental health (CMH) and their office of recipient rights had been in contact with the facility to report that this behavior was not unusual for Resident A.

On 9/2/25, I interviewed program nurse Jodi Waybrandt at the facility. Resident A has eloped twice. The first time was 8/7/25 and the second time was 8/21/25. Both times police were called and a missing person report was filed. Resident A did not seem to want to live at the facility and lately had been refusing her medications.

On 9/2/25, I interviewed Resident A at the facility. When she left the facility she met with friends. She did not want to live at the facility, she wanted to go back home. She claimed her doctor that worked with her was unlicensed and evil. Despite these comments from Resident A, she claimed to feel physically safe at the facility.

On 9/25/25, I received an email from Ms. Fraizer reporting that Resident A had eloped for a third time and had been found in Wakefield, Michigan. Gogebic CMH was arranging her transportation to the hospital as she was not compliant with her medications.

On 10/8, I interviewed Ms. Frazier over the telephone. The facility was always staffed with at least 2 direct care employees. Besides this, the licensee designee, maintenance personnel, and program nurse were also at the facility during the day. After the first elopement, staff monitored Resident A more closely as required by the facility's acute risk intervention planning (ARIP) procedures. Facility employees checked on Resident A every hour with ARIP being reassessed every 24 hours. The facility had other residents with elopement tendencies but managing them had not been a problem. Since this final elopement, Resident A was seen by her sister on 10/6/25 in Bessemer, MI at hotel and at a park. Her sister did not approach her. During this conversation I requested a copy of Resident A's resident care agreement, individual plan of service, and the facility's elopement policy.

On 10/9/25, I reviewed a copy of Resident A's resident care agreement and individual place of service to ensure the resident agreed to the services provided by the facility and her community mental health. Resident A is her own guardian and had signed the agreements. I also reviewed a copy of the ARIP procedures which indicate the facility was required to provide closely monitored, specialized care in the event of a resident elopement. I also reviewed Resident A's assessment plan which indicated she was not permitted to move throughout the community independently. I also reviewed the facility's person-centered elopements policy which indicated the policy and procedures facility employees were to follow in the case of resident elopements.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be

	attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A was able to elope from the facility several times with staff nearby. Resident A came to the facility as an elopement risk.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/3/25 I explained the findings of this report to licensee designee Kathy Frazier. Resident A had gone missing in Gogebic county a fourth time after the hospital let her leave without CMH supervision. The facility issued a 30-day notice to the resident. Ms. Frazier will contact me if Resident A comes back to the facility.

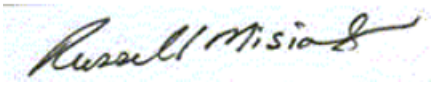
IV. RECOMMENDATION

Contingent upon receipt of a corrective action plan, I recommend no changes to the status of this license.

10/3/25

Garrett Peters Date
Licensing Consultant

Approved By:



10/13/25

Russell B. Misiak Date
Area Manager