GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 19, 2022

Marlene Burgess
Hope Network, S.E.
PO Box 190179
Burton, MI 48519

RE: License #: AS820395610
Investigation #: 2022A0119005
Cambridge

Dear Ms. Burgess:

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,

Shatonla Daniel, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-3003

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820395610
Investigation #:	2022A0119005
Complaint Receipt Date:	11/19/2021
Investigation Initiation Date:	11/22/2021
Report Due Date:	01/18/2022
Licensee Name:	Hope Network, S.E.
Licensee Address:	PO Box 190179 Burton, MI 48519
Licensee Telephone #:	(248) 505-1987
Administrator:	Marlene Burgess
Licensee Designee:	Marlene Burgess
Name of Facility:	Cambridge
Facility Address:	1648 Inkster Dearborn Heights, MI 48127
Facility Telephone #:	(248) 505-1987
Original Issuance Date:	05/02/2019
License **Status:**	REGULAR
Effective Date:	11/02/2021
Expiration Date:	11/01/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff- Shelia Wade failed to report Resident A was given the wrong medication and taken to the emergency room.	Yes

III. METHODOLOGY

11/19/2021	Special Investigation Intake 2022A0119005
11/19/2021	Contact - Document Received Office of Recipient Rights
11/19/2021	APS Referral Made
11/22/2021	Special Investigation Initiated - Telephone Complainant, Left message
11/23/2021	Contact - Telephone call made Complainant, Licensee Designee/ Administrator- Marlene Burgess, and Home Manager- Layunies McCain
12/02/2021	Contact - Telephone call made Staff- Sheila Wade
12/03/2021	Inspection Completed On-site Staff- Emeralda Buley, Residents A- B
12/03/2021	Inspection Completed-BCAL Sub. Compliance
01/19/2022	Contact - Document Received Emailed incident reports and Resident A's medical documents
01/19/2022	Exit Conference Licensee Designee- Marilyn Burgess

ALLEGATIONS:

Staff- Shelia Wade failed to report Resident A was given the wrong medication and taken to the emergency room.

INVESTIGATION:

On 11/23/2021, I telephoned and interviewed Complainant, Licensee Designee- Marlene Burgess, and Home Manager- Layunies McCain regarding the above allegations. The complainant stated her staff was completing an employee performance review and it was discovered that Staff- Shelia Wade had two medications errors within the last six months and also that there were no incident reports documenting these errors.

Ms. Burgess stated there was one medication error that she was made aware of, and Resident A was transported to the local hospital to ensure he was medically checked. She stated she was informed Resident A came into the office where the medications were being passed by Staff- Shelia Wade and Resident A took Resident B's medication. Ms. Burgess stated Resident A asked to enter the office to use the telephone.

Ms. McCain stated the incident occurred in September 2021. She stated she was made aware by staff. She stated an incident report was completed and a copy of the report was requested for review.

On 12/02/2021, I telephoned and interviewed Staff- Sheila Wade regarding the above allegations. Ms. Wade stated she was administering resident medications when Resident A came into the office and snatched medications from Resident B. Ms. McCain stated Resident A ingested Resident B's medications. She stated she notified the home manager- Ms. McCain and Resident A was transported to the local hospital for a medical evaluation. Ms. Wade stated Resident A exhibits behaviors that are hard to manage at times. She stated Resident A needs a hearing aide and because of his hearing impairment, his behaviors are escalating. She stated Resident A attempted it before in May 2021 but was unsuccessful in swallowing the medications.

On 12/03/2021, I completed an onsite inspection and interviewed Staff- Emeralda Buley, Resident B regarding the above allegations. Ms. Buley stated she has no knowledge of Resident A taking the wrong medications. She stated she has never given Resident A another resident medications. Ms. Buley stated the procedure is to call one resident into the office at a time to be administered their medications by staff. Resident A was observed as he was unable to be interviewed due to his disability.

Resident B stated a while ago, Resident A took his medication from the office and swallowed them. Resident B stated this has not happened before or after this incident.

I observed the resident medication cabinets in the office. The medication cabinet is located above the desk and attached to the wall. I observed the office to be adjacent to a sitting area and a hallway.

On 01/19/2022, I received copies of incident report dated for 09/09/2021 at 7:32 a.m. and Garden City emergency room paperwork dated for 09/09/2021. The incident report stated Resident A took Resident B's medication off of the desk that was placed behind the staff. However, there was no indication or documentation that it was sent to the department.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Licensee Designee- Marlene Burgess, and Home Manager- Layunies McCain and Staff- Sheila Wade stated Resident A ingested Resident B's prescribed medications in the staff office. Resident B stated a while ago, Resident A took his medication from the office and swallowed them. I received copies of incident report dated for 09/09/2021 at 7:32 a.m. The incident report stated Resident A took Resident B's medication off of the desk that was placed behind the staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (a) The death of a resident. (b) Any accident or illness that requires hospitalization. (c) Incidents that involve any of the following: (i) Displays of serious hostility.

	(ii) Hospitalization. (iii) Attempts at self-inflicted harm or harm to others. (iv) Instances of destruction to property. (d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.
ANALYSIS:	On 01/19/2022, I received copies of incident report dated for 09/09/2021 at 7:32 a.m. and Garden City emergency room paperwork dated for 09/09/2021. However, there was no indication or documentation that it was sent to the department due to Resident A's hospitalization.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/19/2022

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Shatonla Daniel Date
Licensing Consultant

Approved By:

01/19/2022

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Ardra Hunter Date
Area Manager