GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 14, 2022

Kayonna Ferguson
Hope Network, S.E.
PO Box 190179
Burton, MI 48519

RE: License #: AS250395711
Investigation #: 2022A0569024
Kersey Home

Dear Ms. Ferguson:

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 (517) 284-9730.

Sincerely,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250395711
Investigation #:	2022A0569024
Complaint Receipt Date:	02/25/2022
Investigation Initiation Date:	02/25/2022
Report Due Date:	04/26/2022
Licensee Name:	Hope Network, S.E.
Licensee Address:	PO Box 190179 Burton, MI 48519
Licensee Telephone #:	(248) 505-1987
Administrator:	Kayonna Ferguson
Licensee Designee:	Kayonna Ferguson
Name of Facility:	Kersey Home
Facility Address:	7134 Blankenship Circle Davison, MI 48423
Facility Telephone #:	(810) 701-0404
Original Issuance Date:	03/04/2019
License Status:	REGULAR
Effective Date:	09/04/2021
Expiration Date:	09/03/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 1/27/22, Resident A was given another resident's medication.	Yes

III. METHODOLOGY

02/25/2022	Special Investigation Intake 2022A0569024
02/25/2022	APS Referral complaint received from APS.
02/25/2022	Special Investigation Initiated - Telephone Contact with Kelly Clark-Huey, APS worker.
03/24/2022	Contact - Document Received Report received from Pat Sheppard, recipient rights officer.
04/07/2022	Inspection Completed On-site
04/07/2022	Contact - Telephone call made Contact with Jesse Brown, staff person.
04/07/2022	Inspection Completed-BCAL Sub. Compliance
04/07/2022	Exit Conference Exit conference with Kayonna Ferguson, licensee designee.
04/07/2022	Corrective Action Plan Requested and Due on 04/30/2022

ALLEGATION:

On 1/27/22, Resident A was given another resident's medication.

INVESTIGATION:

This complaint was received from the adult protective services central intake department. The complainant reported that Jesse Brown, staff person, gave Resident A another Resident's medications on 1/27/22. The complainant reported that Resident A was placed at risk by being administered the wrong medications.

An investigation report was submitted to the department on 3/24/22 from Pat Sheppard, recipient rights officer. The report documents that Mr. Brown was interviewed on 2/22/22 by Ms. Sheppard and admitted that he did administer another resident's medications to Resident A on 1/27/22 in error. Mr. Brown stated to Ms. Sheppard that he had been looking at the wrong screen on the electronic medication administration record (MAR) while passing the residents' medications at 8:00am on 1/27/22. Mr. Brown stated that he had given Resident A another resident's medications with the same initials as Resident A, and immediately realized the error. Mr. Brown stated that he then called Resident A's physician and Melanie Love, facility manager. Mr. Brown stated that he was instructed to monitor Resident A for any signs of side effects. Mr. Brown stated that Resident A did appear drowsy but did not exhibit any additional side effects and did not have any additional negative reactions. Ms. Sheppard's report documents that she did cite a violation of Resident A's recipient rights requiring remedial action.

Mr. Brown was contacted by telephone on 4/7/22. A voice mail (VM) message was left for Mr. Brown. The VM informed Mr. Brown that the report from Ms. Sheppard had been received with his statement regarding the medication error on 1/27/22, and if he had any additional information to add to the statement, to return the phone call. Mr. Brown has not returned the VM message.

An unannounced inspection of this facility was conducted on 4/7/22. Resident A was observed to be appropriately dressed and groomed with no visible injuries. Resident A is non-verbal and could not give a statement regarding this incident. Resident A's file was reviewed. Resident A's electronic MAR documents that he was administered another resident's medications on 1/27/22 during the morning medication administration. Resident A was administered:

Potassium Chloride Micro 20 mg
Hydrochlorothiazide 25 mg
Oyster Shell Calcium 500 mg
Acetaminophen 500 mg
Tamoxifen 20 mg
Cetirizine 10 mg
Clonazepam 1 mg
Paroxetine 10 mg
Paroxetine HCL 40 mg

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	The complainant reported that Resident A was administered another resident's medication on 1/27/22, placing Resident A at risk of harm. Mr. Brown admits that he did give Resident A another resident's medications in error, and immediately contacted the facility manager and Resident A's physician to report the error. Resident A's MAR records that he was given another resident's medications on 1/27/22 in error and Ms. Sheppard cited a violation of Resident A's recipient rights requiring a remedial action be submitted. Based on the documentation reviewed and statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with Kayonna Ferguson, licensee designee, on 4/7/22. The findings in this report were reviewed.

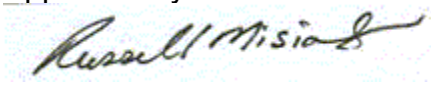
IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

4/14/22

Kent W Gieselman Date
Licensing Consultant

Approved By:



for Mary Holton 4/14/22

Russell Misiack Date
Area Manager