GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 8, 2022

Jennifer Brown
Hope Network Rehabilitation Serv
1490 E Beltline SE
Grand Rapids, MI 49506

RE: License #: AL410083023
Investigation #: 2023A0583010
Sojourners Transitional Living

Dear Mrs. Bos:

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 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 (616) 356-0183.

Sincerely,

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410083023
Investigation #:	2023A0583010
Complaint Receipt Date:	11/21/2022
Investigation Initiation Date:	11/22/2022
Report Due Date:	12/21/2022
Licensee Name:	Hope Network Rehabilitation Serv
Licensee Address:	1490 E Beltline SE Grand Rapids, MI 49506
Licensee Telephone #:	(616) 940-0040
Administrator:	Jennifer Brown
Licensee Designee:	Jennifer Brown
Name of Facility:	Sojourners Transitional Living
Facility Address:	1490 E Beltline Avenue SE Grand Rapids, MI 49506-4336
Facility Telephone #:	(616) 940-0040
Original Issuance Date:	02/19/1999
License Status:	REGULAR
Effective Date:	08/22/2021
Expiration Date:	08/21/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive his medications as prescribed.	Yes

III. METHODOLOGY

11/21/2022	Special Investigation Intake 2023A0583010
11/22/2022	APS Referral
11/22/2022	Special Investigation Initiated - On Site
11/22/2022	Contact - Document Sent Kent County Sheriff's Department
12/07/2022	Contact – Telephone Staff Stephanie Vickers
12/08/2022	Licensee Designee Jennifer Brown

ALLEGATION: Resident A did not receive his medications as prescribed.

INVESTIGATION: On 11/21/2022 I received the above complaint allegation via telephone from Licensee Designee Jennifer Brown. Ms. Brown reported that it was recently discovered that staff Stephanie Vickers administered Resident A's Vyvanse on 11/14/2022, 11/15/2022 and 11/16/2022 however during that period Resident A's "Vyvanse count was off" by one pill during that timeframe. Ms. Brown stated that a urinalysis was completed for Resident A on 11/16/2022 and test results were negative for amphetamine salt which is the active ingredient in Vyvanse. Ms. Brown reported Ms. Vickers has been suspended from employment since 11/16/2022. Ms. Brown stated that Resident A completed a subsequent urinalysis on 11/21/2022 which was positive for amphetamine salt. Ms. Brown stated Vyvanse remains in the human body for 72 hours and Ms. Vickers reported that she administered Resident A's Vyvanse on 11/14/2022, 11/15/2022 and 11/16/2022.

On 11/22/2022 I completed an unannounced onsite investigation at the facility and interviewed facility coordinator Lindsey McBride, staff Danielle Jones, staff Coral McFern, and Resident A.

Ms. McBride stated that on 11/15/2022 staff Danielle Jones expressed concern that staff Stephanie Vickers was inappropriately administering Resident A's prescribed

medication Vyvanse. Ms. McBride stated Resident A is prescribed Vyvanse 70 mg at 8:00 AM daily. Ms. McBride stated that on 11/15/2022 Ms. Jones was assigned to pass residents' medications which necessitates a "narcotic count" at the start of every shift. Ms. McBride explained Vyvanse is considered a narcotic. Ms. Jones stated to Ms. McBride that at approximately 7:00 AM, Ms. Jones counted Resident A's narcotic medications with Ms. Vickers and noticed Resident A's Vyvanse was one tablet short. Ms. Vickers informed Ms. Jones that Ms. Vickers had entered the facility at 5:00 AM, received the medication room keys from third staff, and administered Resident A's medications at 6:00 AM. Ms. Vickers stated she hadn't documented the administration of the Vyvanse into the electronic medication administration record at 6:00 AM because it would have flagged the system causing Ms. Vickers to have to add a comment regarding the early administration of the medication. Ms. Jones stated Ms. Vickers subsequently documented in Resident A's Medication Administration Record that Ms. Vickers administered Resident A's Vyvanse at 7:00 AM, which is within the acceptable one hour medication administration window. Ms. McBride stated that on 11/16/2022 staff Coral McFern reported that Ms. McFern was assigned to administer Resident A's morning medications. Ms. McFern stated she counted Resident A's Vyvanse on 11/15/2022 around 7:00 AM and observed Resident A was short one tablet of Vyvanse. Ms. McFern stated Ms. Vickers acknowledged that Ms. Vickers had administered Resident A's Vyvanse that day at 5:30 AM but did not document the administration in the electronic Medication Administration Record because she did not want to add a comment regarding the early administration. Ms. McFern stated Ms. Vickers subsequently documented the administration of the medication at 7:00 AM in the electronic Medication Administration Record. Ms. McBride stated Ms. Vickers was assigned medication passing duties on 11/14/2022 and Resident A's Medication Administration Record indicates Resident A was administered his Vyvanse at the correct time from Ms. Vickers. Ms. McBride stated Resident A completed a urinalysis on 11/16/2022 which was negative for Vyvanse. Ms. McBride stated Vyvanse is detected in urine for up to three days. Ms. McBride stated a follow-up urine screen was completed by Resident A on 11/21/2022 which was positive for Vyvanse. Ms. McBride stated Ms. Vickers was suspended from employment at the facility on 11/16/2022. Ms. McBride stated she spoke briefly with Ms. Vickers regarding the incidents and Ms. Vickers stated she didn't know why Resident A's urine screen would have been negative for Vyvanse and denied not administering the medication.

Staff Danielle Jones stated she has worked at the facility for "about a year" but was just recently trained to administer residents' medications. Ms. Jones stated that on 11/15/2022 she was assigned to pass residents' medications in the morning. Ms. Jones stated Resident A is prescribed Vyvanse to be administered daily at 8:00 AM. Ms. Jones stated she counted Resident A's Vyvanse prior to administering the medication at 8:00 AM but observed it was one tablet short. Ms. Jones stated staff Stephanie Vickers reported that she had passed Resident A's Vyvanse that day at 5:30 AM but did not document the administration because Ms. Vickers stated she didn't want to add a comment to the Medication Administration Record documenting

the early administration. Ms. Jones stated Ms. Vickers then documented the administration of Vyvanse at 8:00 AM on 11/15/2022. Ms. Jones stated she informed facility coordinator Lindsey McBride of the incident on 11/15/2022.

Staff Coral McFern stated she has worked at the facility since July 2022. Ms. McFern stated that on 11/16/2022 she was assigned to administer residents' medications. Ms. McFern stated that at approximately 7:00 AM she counted Resident A's Vyvanse with third shift staff and observed that one tablet was missing. Ms. McFern stated Ms. Vickers reported that Ms. Vickers secured the mediation room keys from third shift staff and administered Resident A's Vyvanse at approximately 5:30 AM without documenting the administration in Resident A's Medication Administration Record. Ms. McFern stated Ms. Vickers subsequently documented the administration of Resident A's Vyvanse as being administered at 8:00 AM despite Ms. Vickers acknowledgement of administering said medication at 5:30 AM.

I reviewed Resident A's Medication Administration Record which indicates Resident A is prescribed Vyvanse 70 MG CAP once daily at 8:00 AM. I reviewed that the Medication Administration Record indicates Resident A was administered Vyvanse 70 MG by staff Stephanie Vickers on 11/14/2022 8:00 AM, 11/15/2022 8:00 AM, and 11/16/2022 8:00 AM. Resident A's physical medications were consistent with the number of tablets recorded in his Medication Administration Record.

Resident A stated he resides at the facility due to a traumatic brain injury he sustained after a car accident multiple years ago. Resident A stated he is required to take multiple medications to manage the effects of his traumatic brain injury. Resident A stated he does not know the names of the medications he is prescribed and has no knowledge of not receiving his Vyvanse. Resident A stated around 11/14/2022-11/16/2022 he did feel "depressed" but currently feels at his baseline.

On 11/22/2022 I emailed the complaint allegation to Adult Protective Services Centralized Intake and Grand Rapids Police Department.

On 11/28/2022 I received an email from Sargent Josh Mollan. The email stated that the complaint allegation will not be assigned for formal law enforcement investigation.

On 12/07/2022 I interviewed staff Stephanie Vickers via telephone. Ms. Vickers stated she worked at the facility on 11/14/2022, 11/15/2022, and 11/16/2022 from 5:00 AM until 3:00 PM. Ms. Vickers stated that on 11/14/2022 she was assigned to administer residents' medications. Ms. Vickers stated Resident A requested his 8:00 AM medications at approximately 6:00 AM and she provided them to Resident A at that time. Ms. Vickers acknowledged that she documented the administration of Resident A's Vyvanse in Resident A's Medication Administration Record at 8:00 AM despite the medication being administered at approximately 6:00 AM. Ms. Vickers stated that on 11/15/2022 staff Danielle Jones was assigned to administer residents'

medications. Ms. Vickers stated that on 11/15/2022 she requested the medication room keys from third shift staff and administered Resident A’s 8:00 AM medications at 6:00 AM because Resident A requested his medications early. Ms. Vickers acknowledged that she documented the actual administration of Resident A’s Vyvanse at 8:00 AM on 11/15/2022 despite the medication being administered at approximately 6:00 AM. Ms. Vickers stated that on 11/16/2022 staff Coral McFern was assigned to administer residents’ medications. Ms. Vickers stated that on 11/16/2022 she requested the medication room keys from third shift staff and administered Resident A’s 8:00 AM medications at 6:00 AM because Resident A requested his medications early. Ms. Vickers acknowledged that she documented the administration of Resident A’s Vyvanse at 8:00 AM on 11/16/2022 despite the medication being administered at approximately 6:00 AM. Ms. Vickers stated that on 11/14/2022, 11/15/2022, and 11/16/2022 she did not “watch him swallow” his medications. Ms. Vickers denied she has withheld Resident A’s Vyvanse for personal use and stated she does not know why Resident A's 11/16/2022 urine screen was negative for Vyvanse.

On 12/08/2022 I completed an Exit Conference with Licensee Designee Jennifer Brown. Ms. Brown agreed with the special investigation findings and stated she would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Resident A’s Medication Administration Record indicates Resident A is prescribed Vyvanse 70 MG CAP once daily at 8:00 AM. The Medication Administration Records indicates Resident A was administered Vyvanse 70 MG by staff Stephanie Vickers on 11/14/2022 8:00 AM, 11/15/2022 8:00 AM, and 11/16/2022 8:00 AM. Resident A completed a urinalysis on 11/16/2022 which was negative for Vyvanse. Vyvanse is detected in urine for up to three days. Resident A completed a follow-up urine screen on 11/21/2022 which was positive for Vyvanse. Staff Stephanie

	Vickers was suspended from employment at the facility on 11/16/2022. Staff Stephanie Vickers stated Resident A requested his 8:00 AM medications at approximately 6:00 AM and she provided them to Resident A at that time. Ms. Vickers acknowledged that she documented the administration of Resident A's Vyvanse in Resident A's Medication Administration Record at 8:00 AM despite the medication being administered at approximately 6:00 AM. Ms. Vickers stated that on 11/15/2022 staff Danielle Jones was assigned to administer residents' medications. Ms. Vickers stated that on 11/15/2022 she requested the medication room keys from third shift staff and administered Resident A's 8:00 AM medications at 6:00 AM because Resident A requested his medications early. Ms. Vickers acknowledged that she documented the actual administration of Resident A's Vyvanse at 8:00 AM on 11/15/2022 despite the medication being administered at approximately 6:00 AM. Ms. Vickers stated that on 11/16/2022 staff Coral McFern was assigned to administer residents' medications. Ms. Vickers stated that on 11/16/2022 she requested the medication room keys from third shift staff and administered Resident A's 8:00 AM medications at 6:00 AM because Resident A requested his medications early. Ms. Vickers acknowledged that she documented the administration of Resident A's Vyvanse at 8:00 AM on 11/16/2022 despite the medication being administered at approximately 6:00 AM. A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule. Resident A did not receive his prescribed Vyvanse as prescribed on 11/14/2022, 11/15/2022, and 11/16/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

12/08/2022

Toya Zylstra Date
Licensing Consultant

Approved By:

12/08/2022

Jerry Hendrick
Area Manager

Date