January 26, 2024

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

RE: License #:	AM440380703
Investigation #:	2024A0872016 Harbor Point-Lapeer

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 (517) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM440380703
Investigation #:	2024A0872016
Complaint Receipt Date:	12/21/2023
Investigation Initiation Date:	12/21/2023
Report Due Date:	02/19/2024
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-Lapeer
Facility Address:	5699 Genesee Road Lapeer, MI 48446
Facility Telephone #:	(810) 969-4561
Original Issuance Date:	04/08/2016
License Status:	REGULAR
Effective Date:	10/08/2022
Expiration Date:	10/07/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 12/14/23, staff failed to pass medication to Resident A but logged the medication as being passed.	Yes

III. METHODOLOGY

12/21/2023	Special Investigation Intake 2024A0872016
12/21/2023	Special Investigation Initiated - Telephone APS referral
12/21/2023	APS Referral
01/04/2024	Inspection Completed On-site Unannounced
01/04/2024	Contact - Document Received AFC documents received from the home manager, Chamari Alexander
01/26/2024	Contact – Telephone call made I interviewed staff Cathy Cherniawski
01/26/2024	Exit Conference I conducted an exit conference with the licensee designee, David Paul
01/26/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 12/14/23, staff failed to pass medication to Resident A but logged the medication as being passed.

INVESTIGATION: On 01/04/24, I conducted an unannounced onsite inspection of Harbor Point Lapeer. I interviewed Resident A and the home manager (HM), Chamari Alexander,

Resident A said that he has lived at this facility for approximately one year. He said that he takes medication three times per day and staff always administers it. I asked him if staff ever missed passing him his medications and he said no. I told him that we received a complaint that he was not administered one of his medications on 12/14/23 and he said, "I don't know anything about that."

HM Alexander said that she has been working at this facility for approximately 11 months. According to HM Alexander, on the evening of 12/14/23, Resident A received a new medication from the pharmacy. When HM Alexander got to work on 12/15/23, she noticed that the medication was in the cup, but staff apparently did not pass it to Resident A as prescribed. HM Alexander said that she notified recipient rights, and she documented the medication error. HM Alexander agreed to send me documentation related to this complaint.

On 01/26/24, I reviewed AFC documentation related to this complaint. According to Resident A's Health Care Appraisal, he is diagnosed with schizoaffective disorder, unspecified, other psychoactive substance dependence, and he has borderline intellectual abilities.

I reviewed Resident A's medication administration record (MAR) for December 2023. On 12/14/23, I noted that he was scheduled to take Risperidone, 2mg at 9pm. Staff Dorothy Harris initialed the MAR for the evening of 12/14/23 but indicated that she administered the medication at 10:18pm. I did not note any inconsistencies or discrepancies in the MAR.

I reviewed a *Medication Error Tracking & Report form* dated 12/14/23 completed by HM Chamari Alexander. According to this form, "Medication was found in the bin in the med room. The medication had seen popped and was in the cup. The bubble pack was signed, and quick mar reflected that it had been passed. The medication was identified as Risperidone. It was a new med that was delivered that the consumer was supposed to start." The form was signed by HM Alexander and staff Dorothy Harris on 12/18/23.

On 01/26/24, I interviewed staff Cathy Cherniawski, via telephone. Staff Cherniawski said that she has worked at Harbor Point Lapeer since April 2021, and she typically works 3rd shift. According to staff Cherniawski, on 12/14/23 she arrived at work and relieved 2nd shift staff, Dorothy Harris. Later that evening, Staff Cherniawski went to pass a resident a prn and found a pill in a medication cup in the med room. She said that she was able to identify and match the pill with Resident A's bubble pack of 2mg of Risperidone. She put the pill in an envelope and notified the facility nurse.

I attempted to contact staff Dorothy Harris. The phone number I have for her has been disconnected. As of 01/26/24 I have been unable to interview her.

On 01/26/24, I conducted an exit conference with the licensee designee (LD), David Paul. I discussed the results of my investigation and explained which rule violation I am substantiating. LD Paul agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	On 12/14/23, staff Cathy Cherniawski, found a pill in a medication cup in the medication room. She was able to identify and match the pill with Resident A's bubble pack of 2mg of Risperidone. I reviewed the medication log and noted that staff Dorothy Harris initialed the log, indicating that she passed Resident A's 2mg of Risperidone to him on 12/14/23 at 10:18pm. The home manager (HM) Chamari Alexander conducted an internal investigation and completed a medication tracking error form, documenting that the medication was signed for but not passed. Staff Dorothy Harris and HM Alexander signed the form on 12/18/23. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

January 26, 2024

Susan Hutchinson Licensing Consultant	Date

Approved By:

January 26, 2024

Mary E. Holton Area Manager	Date