GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 6, 2024

Amanda Ledford
Hope Network West Michigan
PO Box 890
Grand Rapids, MI 49501-0141

RE: License #: AS410407090
Investigation #: 2024A0340024
Neo Kentwood

Dear Mrs. Ledford:

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,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410407090
Investigation #:	2024A0340024
Complaint Receipt Date:	02/26/2024
Investigation Initiation Date:	02/26/2024
Report Due Date:	04/26/2024
Licensee Name:	Hope Network West Michigan
Licensee Address:	PO Box 890 Grand Rapids, MI 49518
Licensee Telephone #:	(616) 301-8000
Administrator:	Amanda Ledford
Licensee Designee:	Amanda Ledford
Name of Facility:	Neo Kentwood
Facility Address:	4605 Eastern Ave. SE Grand Rapids, MI 49548
Facility Telephone #:	(616) 430-9454
Original Issuance Date:	03/01/2021
License Status:	REGULAR
Effective Date:	09/01/2023
Expiration Date:	08/31/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was given the wrong medication which resulted in his hospitalization.	Yes

III. METHODOLOGY

02/26/2024	Special Investigation Intake 2024A0340024
02/26/2024	APS Referral received from APS
02/26/2024	Special Investigation Initiated - Telephone Megan Pena
02/27/2024	Inspection Completed On-site
02/27/2024	Contact - Telephone call made staff Carolyn-LM
03/01/2024	Contact - Telephone call made Staff Carolyn Perry
03/01/2024	Exit Conference Acting designee Megan Pena

ALLEGATION: Resident A was given the wrong medication which resulted in his hospitalization.

INVESTIGATION: On February 26, 2024, a complaint was filed with the BCAL Online Complaints from Adult Protective Services (APS). It stated that Resident A was brought to the hospital and admitted to the ICU after being observed with decreased levels of consciousness. There was a concern that Resident A was given the wrong medication. He tested positive for Clozaril which he is not prescribed. He was experiencing acute encephalopathy and had been having agitation. He was last known to be well around 7:00 pm the prior night. It was believed that the wrong medication was given to him at evening medication pass prior to his decline in health. This complaint was filed with APS on 2/23/24, placing the medication error to be on 2/22/24.

On February 26, 2024, I contacted the licensee designee Megan Pena. She was aware of the allegation and confirmed the incident occurred on 2/22/24. According

to Ms. Pena, Resident A had a seizure and was admitted to the hospital when he was having decreased levels of consciousness. Ms. Pena has already conducted an inventory of the medication cart. She stated there is another resident who is prescribed Clozaril and that resident takes the pill in applesauce. Ms. Pena stated she does not know how a possible mix-up in the administration of these medications occurred as Neo Kentwood utilizes an EMAR (Electronic Medication Administration Record) and scanner when passing medication. Ms. Pena stated Resident A was hospitalized from 2/22/24 until 2/24/24 and returned to the home fully recovered from the medication error.

On February 27, 2024, I conducted an unannounced home inspection. I witnessed Resident A in the home. He is not cognitively able to participate in an interview. He was up and walking with his cart and did shake my hand.

I interviewed Home Manager Verneice Rogers. She stated she is a new manager. She was aware of the incident but did not work the day it occurred. I asked Ms. Rogers to show me the EMAR which she stated she was unable to do as she had not yet been trained. She provided me with the Incident Report which was completed by staff Carolyn Perry.

The IR was completed 2/23/24 by Ms. Perry. The date of the incident was 2/22/24. It stated that Ms. Perry noticed Resident A leaning over and Ms. Perry thought he was sleeping. When she leaned him back, she saw saliva coming out of his mouth. She tried to wake him, but Resident A was unresponsive. Ms. Perry and coworker Camero Adkinson tried to wake him when he seemed to have a seizure, going in and out of consciousness. Mr. Adkinson called 911 and he was taken to the hospital by EMS personnel.

I then interviewed staff Rosa Reynolds. She is a “med tech” and was able to bring up the EMAR for Resident A. I reviewed the EMAR and found no missed medication. I asked Ms. Reynolds to show me how she conducts a medication pass which she did so flawlessly. I asked Ms. Reynolds to show me the EMAR for the resident who takes Clozaril which she did. There were no missed medications for that resident. Ms. Reynolds was aware that Resident A had to go to the hospital. She believed it was for a seizure which Resident A has a history of suffering from. Ms. Reynolds did not know that Resident A had Clozaril in his system per a blood test taken at the hospital. Ms. Reynolds did not know how Resident A could have been given Clozaril since it is administered in applesauce to the other resident. The electronic scanner should also prevent Resident A from receiving an incorrect medication. The medication packs are banded together in categories, AM, noon, and PM. Only one packet group is taken for the specific resident at the appropriate time. The staff scans the packet, which is then electronically verified with the scanner. Ms. Reynolds passes only one resident’s medication at a time. Resident A does not take any medication in applesauce.

Ms. Reynolds stated that Resident A had acted fine the day of the incident. She had left the home around 7:00 pm and she understood that Resident A was taken to the hospital around 7:30 PM.

On March 1, 2024, I interviewed staff Carolyn Perry. She stated she came into work at 7:00 pm on 2/22/24. She said Resident A was sitting in a chair and everything seemed normal. She noticed he had started pinching himself on his hand and also began making noises. Ms. Perry thought maybe Resident A wanted to go to bed. She turned around and then saw Resident A had drool coming out of his mouth. Ms. Perry stated Resident A quickly became unresponsive and was shifting in and out of consciousness. Ms. Perry stated her coworker Cameron Adkinson called 911. Ms. Perry stated she thought Resident A was having a seizure. He tried to hit himself, bite himself, and couldn't stand up. She stated that an ambulance arrived and around 8:30 Resident A left in the ambulance for the hospital.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	The allegation was made that after Resident A was taken to the hospital for an apparent seizure, it was discovered that he had Clozaril in his system which he is not prescribed. Ms. Pena confirmed the status of Resident A and his bloodwork. She completed an inventory of the medications in the home. The resident who is prescribed Clozaril takes the medication in applesauce and no medications were found to have been missed. The IR was written by staff Carolyn Perry which states she observed Resident A acting lethargic and drooling then shifting in and out of consciousness. He was taken to the hospital. Ms. Reynolds was the staff who passed medications prior to Resident A going to the hospital. She showed me how she passes medications and demonstrated a med pass without error. She stated she does not know how Resident A could have been given an incorrect medication as they use scanners and documentation is electronic. While it is unknown how Resident A was given the wrong medication, he did have Clozaril in his system and upon review of his EMAR, Resident A is not prescribed Clozaril. There is a preponderance of evidence to support a rule violation.

CONCLUSION:	**VIOLATION ESTABLISHED**

On March 1, 2024, I conducted an exit conference with acting Designee Megan Pena. We discussed the lack of explanation as to how Resident A had Clozaril in his system and was somehow given this medication in the home. I requested a Corrective Action Plan which Ms. Pena agreed to and had no further questions.

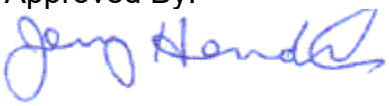
IV. RECOMMENDATION

Upon receipt of an approved Corrective Action Plan, I recommend no change to the current license status.


3/6/2024

2024Rebecca Piccard Date
Licensing Consultant

Approved By:


3/6/2024

Jerry Hendrick
Area Manager