GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 13, 2024

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

RE: License #: AS410416768
Investigation #: 2024A0340044
Neo Birdsong

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 #:	AS410416768
Investigation #:	2024A0340044
Complaint Receipt Date:	07/08/2024
Investigation Initiation Date:	07/08/2024
Report Due Date:	09/06/2024
Licensee Name:	Hope Network West Michigan
Licensee Address:	PO Box 890, Grand Rapids, MI 49518
Licensee Telephone #:	(616) 490-3684
Administrator:	Amanda Ledford
Licensee Designee:	Amanda Ledford
Name of Facility:	Neo Birdsong
Facility Address:	5857 Birdsong Ct. SE, Kentwood, MI 49508
Facility Telephone #:	(616) 920-8818
Original Issuance Date:	12/15/2023
License Status:	REGULAR
Effective Date:	06/15/2024
Expiration Date:	06/14/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was given a double dose of her medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/08/2024	Special Investigation Intake 2024A0340044
07/08/2024	APS Referral
07/08/2024	Special Investigation Initiated - Telephone ORR Michael Kuik
07/16/2024	Inspection Completed On-site
07/16/2024	Contact - Telephone call made Amanda Ledford
07/16/2024	Inspection Completed On-site
07/16/2024	Inspection Completed-BCAL Sub. Compliance
07/31/2024	Exit Conference Amanda Ledford
08/13/2024	Corrective Action Plan Requested

ALLEGATION: Resident A was given a double dose of her medication.

INVESTIGATION: On July 8, 2024, I received a complaint from the Office of Recipient Rights (ORR), which stated Resident A received a double dose of her medication on 6/29/24.

On July 8, 2024, I reported the allegations to Adult Protective Services.

On July 8, 2024, I spoke with Michael Kuik from ORR. He informed me that he had also just received the complaint. He had already spoken with home manager Delores Lilly. Ms. Lilly confirmed that Resident A received a double dose of her medication. It was believed that 3rd shift staff Jimmy Mwemba-Barwan had given morning medications prior to staff Jessica Phelps arriving for her 1st shift. Mr. Mwemba-Barwan did not mark in the Medication Administration Record (MAR) that

the medication was given. It is also believed that he had taken the medication from the next month which had just been delivered instead of the medication from the existing individual resident medication cupboards. When Ms. Phelps arrived, she passed the medication and then Ms. Lilly informed her that the medications had already been passed. They contacted nursing staff who instructed them not to give her medications for later that day and to monitor Resident A, which they did. There were no side effects observed.

Mr. Kuik also acquired the Incident Report (IR) for this incident and forwarded it to me which I received and reviewed on this day. The IR was completed by staff Jalen Hughes on 6/29/24. It documented contacting nursing staff and the order given not to give Resident A another round of medications due to the double dose she was given earlier.

On July 16, 2024, I conducted an unannounced on-site inspection. Resident A, who is nonverbal, was not present in the home at the time of inspection. Staff Jessica Phelps who passed the double dose of medication was present. I asked that she show me the Medication Administration Record (MAR) for Resident A. She explained that staff Jimmy Mwemba-Barwan had received the pharmacy delivery for the next month of resident medications and had put them in the storage cabinet where they belong until they are needed in the individual resident medication cabinet. The cabinets are not next to each other, and it is obvious one is for individual residents.

I asked Ms. Phelps to explain what happened. She stated that she had arrived late for her shift on the 29th. Resident A is supposed to get her medication prior to getting on the bus for school. Because she was late arriving, she hurried to get the medications passed. Her bubble packs were still there for the 29th morning medications. It was only after she passed them that Ms. Lilly informed her that Mr. Mwemba-Barwan had already passed morning medications. Ms. Phelps was confused as to how since the medication was still present. Ms. Lilly called Mr. Mwemba-Barwan and he stated he took the medications from the cupboard. That's when it was discovered he had passed medications from the packs that had just been delivered, and not the current medications for June. Ms. Phelps got the medications straightened out. She also called poison control and they just advised staff to monitor Resident A and not give evening medications.

When I reviewed the MAR and the medications, I observed that the medications for July 29th for Resident A were missing already. Ms. Phelps stated those are the ones that were passed on June 29th. The pharmacy is going to send the single dose in a separate package. The missing medication presumed to already been given to Resident A included: Lactobac, Divalproex, Risperidone, and Divalproex. In the MAR for June, Ms. Phelps initials are in the MAR for these medications for the morning of June 29th.

Ms. Phelps stated that Mr. Mwemba-Barwan has been taken off passing medications.

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 Resident A received a double dose of her prescribed medications on 6/29/24. Home Manager Ms. Lilly reports that when Ms. Phelps came to work she passed Resident A's medication before Ms. Lilly informed her that Mr. Mwemba-Barwan had already passed the medication for Resident A. Ms. Phelps stated she came into work and saw that the medication in the bubble packs for Resident A were still present, so she assumed the medication was not passed so she passed the medication. There is a preponderance of evidence to support the allegation that Resident A received a double dose of medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION: During my investigation it was discovered that staff Mr. Mwemba-Barwan did not complete the MAR after he passed medication to Resident A. This led to Ms. Phillips thinking that the medications had not been passed. Her initials are on the MAR for the morning medication pass for Resident A on 6/29/24.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **The medication.**

	The dosage. **Label instructions for use.** **Time to be administered.** **The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	During the above investigation it was discovered that Mr. Mwemba-Barwan did not complete the MAR as required after he passed medication to Resident A. There is a preponderance of evidence to support a rule violation of not completing the MAR when passing a medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

On July 31, 2024, I conducted an exit conference with Designee Amanda Ledford. We discussed the medication errors and the need for a corrective action. She stated steps are already being taken. She agreed to send a Corrective Action Plan.

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change to the current license status.

Rebecca Piccard August 13, 2024

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Rebecca Piccard Date
Licensing Consultant

Approved By:

August 13, 2024

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Jerry Hendrick Date
Area Manager