GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 18, 2025

Benjamin Leavell
Christian Haven Home
704 Pennoyer
Grand Haven, MI 49417

RE: License #: AH700236766
Investigation #: 2025A1021048
Christian Haven Home

Dear Benjamin Leavell:

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 authorized representative 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,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH700236766 |
| | |
| **Investigation #:** | 2025A1021048 |
| | |
| **Complaint Receipt Date:** | 04/04/2025 |
| | |
| **Investigation Initiation Date:** | 04/07/2025 |
| | |
| **Report Due Date:** | 06/04/2025 |
| | |
| **Licensee Name:** | Christian Haven Inc. |
| | |
| **Licensee Address:** | 704 Pennoyer Ave.<br>Grand Haven, MI 49417 |
| | |
| **Licensee Telephone #:** | (616) 842-0170 |
| | |
| **Administrator:** | Sue Hamm |
| | |
| **Authorized Representative:** | Benjamin Leavell |
| | |
| **Name of Facility:** | Christian Haven Home |
| | |
| **Facility Address:** | 704 Pennoyer<br>Grand Haven, MI 49417 |
| | |
| **Facility Telephone #:** | (616) 842-0170 |
| | |
| **Original Issuance Date:** | 06/01/1999 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/01/2024 |
| | |
| **Expiration Date:** | 07/31/2025 |
| | |
| **Capacity:** | 60 |
| | |
| **Program Type:** | AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A was administered incorrect medication. | No |
| Resident A's physician and family were not notified of medication error. | No |
| Residents are not provided with water. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 04/04/2025 | Special Investigation Intake<br>2025A1021048 |
| 04/07/2025 | Special Investigation Initiated - Telephone<br>interviewed complainant |
| 04/09/2025 | Inspection Completed On-site |
| 04/11/2025 | Contact-Telephone call made<br>Interviewed Heartland Home Care |
| | Exit Conference |

**ALLEGATION:**

**Resident A was administered incorrect medication.**

**INVESTIGATION:**

On 04/04/2025, the licensing department received a complaint with allegations Resident A received Resident B's morphine medication.

On 04/07/2025, I interviewed the complainant by telephone. The complainant alleged Resident A was complaining of pain and did not have a morphine prescription, but Resident B did have a morphine prescription. The complainant alleged staff person 1 (SP1) was the medication technician that administered the incorrect medication. The complainant alleged SP1 reported this error was reported to management but management did not take further action.

On 04/09/2025, I interviewed the administrator Sue Hamm at the facility. Administrator reported she was not the administrator at the time of the event and

was not aware of the situation. Administrator reported that if a medication error occurred, the facility should complete an incident report, contact the resident's family, contact the physician, and complete additional training with staff.

On 04/09/2025, I interviewed SP2 at the facility. SP2 reported she was made aware of the incorrect medication administration. SP2 reported Resident A signed on to hospice services but did not have an active prescription for morphine. SP2 reported Resident A was experiencing pain and therefore morphine was administered. SP2 reported Resident A's family was notified, the physician was notified, and the facility spoke with SP1 on correct medication administration and the five rights of medication administration.

I reviewed "*Sunset Manor Medication and Treatment Incident* Form." The narrative of the form read,

*"error occurred when Med Tech gave medication to (Resident A) when he complained of pain and she gave the med from a patient with a similar sounding name. The names of the two individuals were similar and the pain medication was new. The Med Tech gave the new med for pain when (Resident A) complained of pain. Reinforced education of confirm right patient, right medication, and importance of the med rights to prevent med errors."*

I reviewed *Sunset Employee Successes and Opportunities Form*. The narrative of the report read,

*"This ESO is in reference to the medication error of giving in error a patient a pain medication ordered for a patient with a similar sounding name. The patient whom was in pain, and whom received that medication in error, has confusion and other medical issues. However, please be careful to follow the practice of confirming the rights of medication administration-verify the right patient, the right medication, etc to prevent med errors. Thank you for reporting the error as soon as it happened so it can be addressed for patient safety."*

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1932** | **Resident medications.** |
| | **(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.** |

| | |
|---|---|
| **ANALYSIS:** | While the medication error did occur, the facility acted timely and appropriately in rectifying the situation and ensuring the facility's internal policies and procedures were followed. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Resident A's physician and family were not notified of medication error.**

**INVESTIGATION:**

The complainant alleged Resident A's family and physician were not notified of the medication error.

On 04/11/2025, I interviewed Heartland Home Care nurse Leora Balm by telephone. Ms. Balm reported the facility initially contacted Resident A's physician and the physician directed the facility to contact the homecare company. Ms. Balm reported the facility contacted Heartland Home Care soon after the incident occurred. Ms. Balm reported Resident A had other medical issues and it was advised for Resident A to be transported to the emergency room. Ms. Balm reported Resident A is medically complex and is transitioning to hospice care. Ms. Balm reported it is concerning that Resident A was administered the incorrect medication; however, it is not the sole reason Resident A was transported to the emergency department.

I viewed Resident A's progress notes. The notes read,

*"03/29/2025: 10:16: Patient's wife was called, gave up date over the phone as noted in nurses note about call to home health, blood in catheter bag, no urine out in bag but in bedding, dose of morphine given at 0600 and concerns of dehydration, dry tubing/dry skin/mucous membranes; confusion and resident report of abdominal discomfort.*

*03/29/2025 10:51: Per wife of residents phone request, patient going to Trinty Hospital Muskegon for care of continued bleeding in suprapubic tubing, lack of urine output, abdominal tenderness reported by resident, confusion, restlessness, increased respiratory rate, dry skin turgor, dry mucous membranes. Heartland Home Care in agreement of plan of care when spoke with office."*

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1932** | **Resident medications.** |
| | **(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following:** |

| | |
|---|---|
| | **(c) Contact the appropriate licensed health care professional when the prescribed medication has not been administered in accordance with the label instruction, an order from a health care professional, medication log, or a service plan** |
| **ANALYSIS:** | Interviews conducted revealed Resident A's physician was immediately notified of the medication error. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Residents are not provided with water.**

**INVESTIGATION:**

The complainant alleged residents do not receive water.

Administrator reported residents receive water at shift change, with medications, and at mealtimes. Administrator reported there is also water available in the common areas.

On 04/07/2025, I interviewed Resident C at the facility. Resident C reported she receives water or a beverage many times during the day. Resident C reported no concerns with beverages not being available.

On 04/07/2025, I interviewed SP3 at the facility. SP3 reported residents receive water during shift change and at mealtimes. SP3 reported there are also beverages available in the common area. SP3 denied any concerns any residents not receiving water at the facility.

On 04/07/2025, I interviewed SP4 at the facility. SP4's statements were consistent with those made by Administrator and SP3.

Onsite, I viewed the common area and there were beverages available to the residents. I observed the lunch meal service, and each resident had a beverage available to them. I observed multiple resident rooms, and each room had a beverage in the room that was accessible to the resident.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1952** | **Meals and special diets.** |

| | |
|---|---|
| | **(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.** |
| **ANALYSIS**: | Observations made and interviews conducted revealed a lack of evidence to support this allegation. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

Review of SP1 employee training record revealed a *Medication Administration Test*. However, the test was not graded nor checked for competency.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1931** | **Employees; general provisions.** |
| | **(7) The home's administrator or its designees are responsible for evaluating employee competencies.** |
| **ANALYSIS:** | Review of SP1 employee training record revealed the facility administration or its designees did not evaluate SP1's medication administration competencies. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

Review of Resident B's MAR revealed Resident B was prescribed Carbidopa Levodopa. Review of Resident B's MAR revealed this was not initialed as administrated on 03/17/2025, 03/19/2025, and 03/28/2025. In addition, Resident B was prescribed Acetaminophen Oral Tablet, and this was not initialed as administered on 03/19/2025 at 0000.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1932** | **Resident medications.** |
| | **(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions:** |

| | |
|---|---|
| | **(b) Complete an individual medication log that contains all of the following information:**<br>**(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.** |
| **ANALYSIS:** | Review of Resident B's MAR revealed multiple instances in which the MAR was not adequately completed. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

Kimberly Horst 04/15/2025

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 04/17/2025

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section