GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 2, 2026

Darla Hall
H N P H Inc
852 W. Elm
Monroe, MI 48161

RE: License #: AL580007271
Investigation #: 2026A0116030
Elm House

Dear Ms. Hall:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL580007271
Investigation #:	2026A0116030
Complaint Receipt Date:	04/29/2026
Investigation Initiation Date:	04/30/2026
Report Due Date:	06/28/2026
Licensee Name:	H N P H Inc
Licensee Address:	852 W. Elm Monroe, MI 48161
Licensee Telephone #:	(734) 242-2177
Administrator:	Darla Hall
Licensee Designee:	Darla Hall
Name of Facility:	Elm House
Facility Address:	852 W Elm Monroe, MI 48161
Facility Telephone #:	(734) 242-2177
Original Issuance Date:	10/01/1980
License Status:	REGULAR
Effective Date:	04/30/2026
Expiration Date:	04/29/2028
Capacity:	16
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff, Heidi Lyons, administered the wrong medication to Resident A earlier this year requiring hospitalization.	Yes

III. METHODOLOGY

04/29/2026	Special Investigation Intake 2026A0116030
04/30/2026	Special Investigation Initiated - On Site Licensee designee, Darla Hall, Residents A-B, reviewed staff, Heidi Lyons training records.
04/30/2026	Contact - Document Received Copies of staff, Heidi Lyons, discipline, retaining, and discharge paperwork from resident A's hospital visit.
04/30/2026	Inspection Completed-BCAL Sub. Compliance
05/01/2026	Contact - Telephone call made Staff, Heidi Lyons.
05/01/2026	APS Referral Made.
06/02/2026	Exit Conference Licensee designee, Darla Hall.

ALLEGATION:

Staff, Heidi Lyons, administered the wrong medication to Resident A earlier this year requiring hospitalization.

INVESTIGATION:

On 04/30/26, I conducted an unscheduled onsite inspection and interviewed licensee designee, Darla Hall, Residents A and B and reviewed staff, Heidi Lyons, training records. Ms. Hall reported that there was a medication error on 01/07/26. Ms. Hall reported that Resident A is prescribed two different insulins. She reported that he is prescribed Novolog (on a sliding scale) only to be given when his blood

sugars are high. The other insulin is Basaglar which is administered daily. Ms. Hall reported that on 01/07/26 staff, Heidi Lyons, administered 10 units of Novolog instead of the Basaglar. Ms. Hall reported that Ms. Lyons immediately caught her error and called 911. Resident A was transported to the hospital where he was evaluated and monitored. Ms. Hall reported that Resident A stayed in the hospital for about eight hours and was released. She reported that he did not suffer any adverse effects.

Ms. Hall reported that Ms. Lyons was written up, retrained personally by her on the 6 rights of medication and required to write a plan of improvement. Additionally, Ms. Hall held an all staff meeting to address medication administration and implementation of a new process of labeling and storing PRN medications. Ms. Hall reported that Ms. Lyons has not had any additional medication errors.

Ms. Hall reported that she notified Resident A's guardian (Guardian A1) of the medication error when it occurred.

I interviewed Resident A and he reported that staff, Heidi Lyons, gave him the wrong insulin a few months back. He reported that this was the first and only time that had happened. Resident A confirmed he was taken to the hospital and released a few hours later. He reported that he felt fine, but the staff wanted him to be seen by a doctor. He confirmed that it has not happened again.

I interviewed Resident B and he reported that the staff administer all medications and to his knowledge he gets his medications as prescribed. Resident B did not recall a time when he was given the wrong medication or not provided his medication.

I reviewed staff, Heidi Lyons', training record and confirmed that she is fully trained in all required areas.

On 04/30/26, Ms. Hall emailed Ms. Lyons' written reprimand, verification of the all staff training, the new process for labeling and storing PRN medications, the incident report and Resident A's hospital discharge paperwork. I reviewed the documents and confirmed the information contained in the documents aligned with what Ms. Hall reported to me during the onsite inspection.

On 05/01/26, I interviewed staff, Heidi Lyons, and she reported that she has worked in the home for five years. Ms. Lyons reported that in January of 2026, she was in the medication room preparing to pass medications. She reported that she got distracted because there was a lot of commotion with the residents and another staff in the room. Ms. Lyons reported that she gave Resident A the wrong insulin and knew immediately after hearing the click from the insulin pin. She reported that Resident A was taken to the hospital via ambulance where he was evaluated and released the same day. Ms. Lyons reported that she was thankful that Resident A did not have any adverse effects and was okay. She reported that she was literally

sick about the medication error and admitted it took her some time to get her confidence back when it came to passing medications again. She reported that she was given a written reprimand, retrained in medication administration, wrote her own plan of improvement and asked her manager to shadow her medication passes for a couple weeks. Ms. Lyons reported she wanted to make sure she was not making any mistakes. Ms. Lyons reported that she still follows her plan of improvement and takes extra steps to ensure that she does not make errors. Ms. Lyons reported this has worked for her as she has not had any medication errors since the incident in January 2026.

On 06/02/26, I conducted the exit conference with licensee designee, Darla Hall, and informed her of the findings of the investigation and the rule cited. Ms. Hall reported an understanding.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based on the findings of the investigation, which included interviews with licensee designee, Darla Hall, Resident A, and staff, Heidi Lyons, there is a preponderance of evidence to substantiate that Resident ‘s insulin medications were not given as prescribed by his physician. Staff, Heidi Lyons, administered Resident A’s PRN Novolog on 01/07/26, instead of his daily Basaglar.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

06/02/26

Pandrea Robinson
Licensing Consultant

Date

Approved By:

06/02/26

Ardra Hunter
Area Manager

Date