GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 29, 2022

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

RE: License #: AL700085846
Investigation #: 2022A0467062
Harbor Point Intensive West Unit

Dear Ms. Paul:

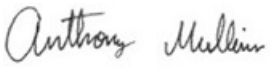
Attached is the Special Investigation Report for the above referenced facility. Due to the violation identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frames for the 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,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL700085846 |
| | |
| **Investigation #:** | 2022A0467062 |
| | |
| **Complaint Receipt Date:** | 09/27/2022 |
| | |
| **Investigation Initiation Date:** | 09/28/2022 |
| | |
| **Report Due Date:** | 11/26/2022 |
| | |
| **Licensee Name:** | Hope Network Behavioral Health Services |
| | |
| **Licensee Address:** | PO Box 890<br>3075 Orchard Vista Drive<br>Grand Rapids, MI 49518-0890 |
| | |
| **Licensee Telephone #:** | (616) 430-7952 |
| | |
| **Administrator:** | Katherine Frazier |
| | |
| **Licensee Designee:** | Katherine Frazier |
| | |
| **Name of Facility:** | Harbor Point Intensive West Unit |
| | |
| **Facility Address:** | 17160 130th Avenue<br>Nunica, MI 49448 |
| **Facility Telephone #:** | (616) 847-4460 |
| | |
| **Original Issuance Date:** | 11/15/1999 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 06/19/2022 |
| | |
| **Expiration Date:** | 06/18/2024 |
| | |
| **Capacity:** | 15 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED, AGED, MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A did not receive his Clonazepam medication at 8:00 pm on 9/21/22. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 09/27/2022 | Special Investigation Intake<br>2022A0467062 |
| 09/28/2022 | Special Investigation Initiated - On Site |
| 09/28/2022 | Contact - Telephone call made<br>Recipient Rights Investigator - Detroit Wayne Integrated Health Network (DWIHN) |
| 09/09/2022 | Exit conference completed<br>with licensee designee, David Paul. |

**ALLEGATION: Resident A did not receive his Clonazepam medication at 8:00 pm on 9/21/22.**

**INVESTIGATION:** On 9/27/22, I received a BCAL online complaint stating that Resident A did not receive his nighttime Clonazepam medication on 9/21/22.

On 9/28/22, I made an unannounced onsite investigation to the facility. Upon arrival, I spoke to licensee designee, David Paul. Mr. Paul stated that he was made aware of the medication error that reportedly occurred by staff member Alexus Cunningham regarding Resident A. Mr. Paul assisted me to the "med room" to review Resident A's "controlled drug receipt/scanner count sheet/disposal log." On 9/21/22, the controlled medication log indicated that Ms. Cunningham passed Resident A's 8:00 pm Clonazepam, leaving him with 22 pills. On the following morning, staff member Lamera Franklin audited the medication and noticed that Resident A had 23 pills of his Clonazepam as opposed to the 22 pills that Ms. Cunningham signed off on. This discrepancy led to Ms. Franklin filing an incident report. Mr. Paul provided me with a copy of Resident A's electronic MAR. The MAR was signed by Ms. Cunningham, indicating that Resident A did in fact receive the medication although he did not.

Mr. Paul and I made our way back to his office. Mr. Paul called in the program manager, Chavaun Gordon who has been involved with this incident. Ms. Gordon stated that on 9/21/22, Ms. Cunningham documented that she gave Resident A his 8:00 pm Clonazepam medication, however, this never occurred. Mr. Paul and Ms. Gordon confirmed that this error should have should have been noticed on 3rd shift and they plan to address this with staff. Mr. Paul and Ms. Gordon do not know if

Resident A is aware that he did not receive his Clonazepam medication on 9/21/22 at 8:00 pm. Ms. Gordon confirmed that Ms. Cunningham works today at 2:00 pm and she plans to address this issue with her upon her arrival. Ms. Gordon stated that Ms. Cunningham has been scheduled to retake the medication training class on October 10, 2022 from 1:00 – 4:00 pm in Holland, MI. Ms. Gordon provided me with a phone number to follow-up with Ms. Cunningham later today.

After speaking to Mr. Paul and Ms. Gordon, I spoke to Resident A regarding the allegation. Resident A stated that he has lived in the facility for 10 years and things are going "okay." Resident A added, "I just don't like my medication because it makes me shit and I want to go home. I pray to God and he can't hear me." Resident A denied that he has informed his doctor or nurse about the symptoms of his medications, but he insisted that "they won't change anything." I encouraged Resident A to be transparent with the doctors and nurses regarding his medication to address any side effects he may have. Resident A stated that he has always received his medications on time at the facility, except when he refuses to take them. Resident A had no knowledge of the 9/21/22 missed medication. It should be noted that it was difficult to understand Resident A at times as his speech appeared to be slurred. Resident A was fixated on becoming a police officer and discussing this in detail. Resident A was thanked for his time as this interview concluded.

On 9/28/22, I spoke to staff member Alexus Cunningham via phone. Ms. Cunningham acknowledged that she did in fact document that she gave Resident A his Clonazepam at 8:00 pm on 9/21/22 although she never did. Due to this error by Ms. Cunningham, she documented that Resident A had 22 pills left, when the correct number of pills was 23. Ms. Cunningham acknowledged that staff noticed the error during an audit. Ms. Cunningham confirmed that the typical process is to pass the medication first prior to documenting that it was giving. Had Ms. Cunningham followed the standard medication protocol, this incident could have been avoided.

Ms. Cunningham was adamant that this was an isolated incident. To prevent a similar situation from occurring, Ms. Cunningham stated that she will retake the medication training class as discussed with Ms. Gordon. Ms. Cunningham was thanked for her time as this interview concluded.

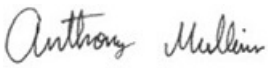
On 9/28/22, I spoke to Amanda Kevnick, Recipient Rights Officer from Detroit Wayne Integrated Health Network (DWIHN). I shared my findings with Ms. Kevnick, and she stated that she is unsure if she will be substantiating her case. Ms. Kevnick plans to follow-up with Harbor Point Intensive West Unit staff tomorrow prior to making a decision on the conclusion of her investigation.

On 09/29/22, I conducted an exit conference with licensee designee, David Paul. He was informed of the investigative findings and agreed to complete a corrective action plan within 15 days.

| APPLICABLE RULE | |
|---|---|
| **R 400.15312** | **Resident medications.** |
| | **(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.** |
| **ANALYSIS:** | Resident A did not have any knowledge of his missed medication on 9/21/22.<br><br>Mr. Paul, Ms. Gordon, and Ms. Cunningham all confirmed that Resident A did not receive his Clonazepam medication on 9/21/22 at 8:00 pm due to a medication error by Ms. Cunningham. Therefore, there is a preponderance of evidence to support the allegation. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

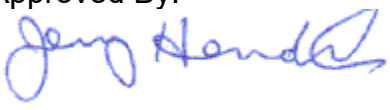
Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



09/29/2022

Anthony Mullins Date
Licensing Consultant

Approved By:



09/29/2022

Jerry Hendrick Date
Area Manager