GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 31, 2023

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

RE: License #: AL820395614
Investigation #: 2023A0121031
Harbor Point Dearborn Heights

Dear Mr. Paul:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On July 6, 2023, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

K. Robinson

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820395614
Investigation #:	2023A0121031
Complaint Receipt Date:	06/05/2023
Investigation Initiation Date:	06/06/2023
Report Due Date:	08/04/2023
Licensee Name:	Hope Network Behavioral Health Services
Licensee Address:	PO Box 890 3075 Orchard Vista Drive Grand Rapids, MI 49518-0890
Licensee Telephone #:	(616) 430-7952
Administrator:	David Paul, designee
Name of Facility:	Harbor Point Dearborn Heights
Facility Address:	6500 N Inkster Road Dearborn Heights, MI 48127
Facility Telephone #:	(313) 908-4459
Original Issuance Date:	08/12/2019
License **Status:**	REGULAR
Effective Date:	02/12/2022
Expiration Date:	02/11/2024
Capacity:	13
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care worker, Shara Newell gave Resident A extra pills. Specifically, she gave him 8 pills instead of 6 that were prescribed.	Yes

III. METHODOLOGY

06/05/2023	Special Investigation Intake 2023A0121031
06/05/2023	APS Referral ORR made notification
06/05/2023	Referral - Recipient Rights ORR will not be investigation because resident is not assigned to DWIHN
06/06/2023	Special Investigation Initiated - Telephone Call to David Paul; onsite scheduled
06/15/2023	Inspection Completed On-site Interviewed David Paul, licensee designee, Shara Newell, direct care worker, Chrystal Delaney, home manager, Judy Karpinski, program director, and Nurse Melanie Thomas.
06/15/2023	Exit Conference David Paul
07/06/2023	Corrective Action Plan Received/Approved

ALLEGATION: Direct care worker, Shara gave Resident A extra pills. Specifically, she gave him 8 pills instead of 6 that were prescribed.

INVESTIGATION: On 6/15/23, I conducted an onsite inspection at the facility. Mr. Paul confirmed Resident A was given extra medication by direct care worker, Shara Newell. According to Judy Karpinski the medication was Priftin which is used to "treat latent TB." The incident happened on 6/2/23 according to the incident report. Mr. Paul explained, Shara is an experienced worker with 1 ½ year experience at the facility. In addition, Mr. Paul reported Shara is fully trained. I reviewed Shara's electronic training record; she completed the following training modules: Medication and Health Skills, Medication Administration and Monitoring, and Medication Types,

Uses and Effects. I interviewed Shara who reported Resident A was prescribed a new pill to be administered every Friday. Shara said before administering the new medication, she contacted Nurse Melanie to verify 6 pills were to be administered all at once. Shara explained, when she cut the blister pack open, she didn't realize she had released 8 pills instead of 6 as prescribed. Shara said the medication error was brought to her attention one hour later when Nurse Melanie completed the pill count.

I reviewed Resident A's June 2023 Medication Administration Record; he is prescribed Priftin TAB 150MG. The label instructions are for him to take 6 tablets by mouth once weekly for 28 days.

Nurse Melanie explained she counted the pills out of an abundance of caution since the medication was new, plus "it's an unusual quantity to be administered at once." Nurse Melanie stated once the medication error was discovered, she consulted with the treating physician. No exam was required. Per Nurse Melanie, the doctor instructed her to monitor Resident A in the upcoming days and hours. No unusual findings were reported. Resident A was also notified of the medication error; he was instructed to inform Staff if he felt ill or experienced any adverse side effects.

Home Manager, Chrystal Delaney reported Shara received a verbal reprimand and she was required to complete a medication refresher course. According to Ms. Delaney, the medication error appears to be isolated, as Shara is an otherwise, "good employee."

On 6/15/23, I completed an in-person exit conference with Mr. Paul. Mr. Paul does not dispute the department's findings. He submitted an acceptable plan of correction on 7/6/23. Shara has resumed full responsibilities of a direct care worker.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	• Resident A is prescribed Priftin 150mg; he is to take 6 tablets by mouth once a week for 28 days. • On 6/2/23, direct care worker Shara Newell acknowledged she accidentally gave Resident A 8 tablets of Priftin, instead of 6. • Nurse Melanie was available to consult with the physician and monitor Resident A; no adverse side effects were noted.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain unchanged.

7/25/23

Kara Robinson — Date
Licensing Consultant

Approved By:

7/31/23

Ardra Hunter — Date
Area Manager