GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 29, 2024

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

RE: License #: AL820395614
Investigation #: 2024A0101010
Harbor Point Dearborn Heights

Dear Ms. Frazier:

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,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820395614
Investigation #:	2024A0101010
Complaint Receipt Date:	01/17/2024
Investigation Initiation Date:	01/19/2024
Report Due Date:	03/17/2024
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
Licensee Designee:	David Paul Frazier, 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:	02/12/2024
Expiration Date:	02/11/2026
Capacity:	13
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was administered a medication that was not prescribed by a licensed physician.	Yes

III. METHODOLOGY

01/17/2024	Special Investigation Intake 2024A0101010
01/17/2024	Referral received from APS
01/19/2024	Special Investigation Initiated - Telephone No answer left message
01/24/2024	Contact - Telephone call received Home manager Crystal Delaney
02/08/2024	Inspection Completed-BCAL Full Compliance
02/13/2024	Comment – ORR referral made
02/13/2024	Contact - Telephone call made Nurse, Melanie Thomas
02/13/2024	Contact - Telephone call made Ms. Delaney
02/14/2024	Contact - Telephone call made Ms. Delaney
02/14/2024	Contact - Telephone call made Pharmascript of Michigan
02/14/2024	Contact – Documents received
02/14/2024	Contact – Telephone call made Resident A’s Clinician/caseworker, Hope Network
02/14/2024	Contact - Telephone call made “Med Passer” Daniella Jones
02/16/2024	Contact – Telephone calls made

	Direct care staff (DCS) “med passers”
02/16/2024	Exit Conference with David Paul Licensee Designee

ALLEGATION: Resident A was administered a medication that was not prescribed by a licensed physician.

INVESTIGATION: On 01/24/2024, I spoke with the home manager, Crystal Delaney. Ms. Delaney stated after an audit of Resident A’s medication log/the computerized Medication Administration Record (MAR), it was discovered that Resident A received the wrong medication for 44 days. Ms. Delaney stated that the pharmacist sent the wrong medication to the home. Ms. Delaney stated staff were unaware that it was the wrong medication because the first six letters of both medications were identical. Ms. Delaney stated the “med passer” Danielle Jones authorized the medication in the MAR system to be administered, without verifying that the pharmacy supplied label was consistent with the prescription written by Resident A’s physician.

On 02/08/2024, I conducted an onsite investigation. Present was Ms. Delaney, direct care staff (DCS)/ “med passer” Donna McLearen, Lynn Tenbrock the rights advisor for Hope Network, and the nurse Melanie Thomas for Hope Network via telephone speaker. They explained Resident A had a doctor appointment with his endocrinologist on 12/04/2023. A prescription for “Clomiphene Citrate 50 mg ½ tablet daily was sent” to the pharmacy, Pharmascript of Michigan. However, the pharmacist entered the wrong medication (Clomipramine 25 mg 1 capsule daily) into the MAR system and sent it to the home. Since the green flag was checked in the MAR system staff started administering the medication on 12/05/2023. They further stated a new policy has been implemented. Whenever a medication is delivered to the home, the staff cannot authorize approval to be administered in the MAR system without having a copy of the written prescription. They contended the home never received a copy of the prescription.

On 02/13/2024, I spoke with the nurse Melanie Thomas. Ms. Thomas stated on 01/08/2024, she was reviewing Resident A’s MAR for an upcoming medical appointment. She “asked staff why [Resident A] was taking Clomipramine, and they did not know.” Ms. Thomas called the doctor’s office and spoke with the medical assistant regarding this medication. The medical assistant informed Ms. Thomas that Clomipramine was not order through her office. Ms. Thomas called the pharmacist and was informed that the wrong medication had been delivered to the home.

Furthermore, Ms. Thomas contacted Hope Network’s physician, on 01/08/2024, regarding this medication error. Ms. Thomas was given the following instructions, since Resident A was not experiencing any side effects and the dosage was low

there was no need to taper him off this medication. The medication was discontinued on 01/08/2024.

I spoke with Resident A's caseworker, Dylan Payne on 02/14/2024. Mr. Payne stated Resident A is safe and feels comfortable at this time. Mr. Payne stated that there have been no changes in Resident A's behavior.

On 02/14/2024, I spoke with the pharmacist Opada Alzohailli. Mr. Alzohailli stated even though the wrong medication was entered into the MAR system and sent to the home on 12/04/2023, the correct prescription for Clomiphene Citrate 50 mg ½ tablet daily was faxed to the home on the same date.

On 02/14/2024, I interviewed direct care staff (DCS) Danielle Jones. Ms. Jones stated that she was the "med passer" on 12/04/2023. Ms. Jones stated when she passed medications at 4:00 p.m. and 8:00 p.m. Resident A's medication and prescription had not arrived at the home. According to Ms. Jones the medication was delivered at approximately 10:00 p.m. Ms. Jones stated that the following day she clicked the green flag in the MAR system authorizing that the new medication could be administered. Ms. Jones stated she did not have the prescription but the information in the MAR system was consistent with the pharmacy supplied label. Ms. Jones stated it is not unusual for the "med passers" to click the green flag without the prescription because the nurse Melanie Thomas had instructed the "med passers" to always click the green flag "because 9 out of 10 times the medication is coming." Ms. Jones further stated the prescription did come to the home on 12/04/2023. However, the Care Coordinator took the prescription off of the printer, scanned it into Resident A's profile, locked it in her office and left work at 5:00 p.m. Ms. Jones stated if the prescription had been available, she could had verified it with the information in the MAR system. Ms. Jones further stated that a resident profile is not part of the MAR program, and she did not know how to access the resident profile. Ms. Jones further stated the prescription was recently found in the Care Coordinator Rita Haydous' office.

On 02/14/2024, I asked Ms. Delaney to email me Resident A's prescriptions that was faxed to the home on 12/04/2023. On 12/04/2023, the home received a prescription for Resident A's Clomiphene Citrate 50mg medication and the home did not receive a prescription for Clomipramine 25mg.

On 02/16/2024, I interviewed an additional five staff who are responsible for passing medications. They all stated that they were instructed to always click the green flag when a new medication is coming to the home because "9 out of 10 times the medication is coming." The only inconsistency among the staff, was who instructed them to always click the green flag. Some said it was the nurse and others stated it was the care coordinator. One staff stated even though they were instructed to always click the green flag, in training they were taught to verify that the prescription and the pharmacy supplied label are consistent before clicking the green flag.

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 S333.1101 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:	The licensee failed to give Resident A's prescription medication Clomiphene Citrate 50mg as prescribed by his physician. On 12/04/2023, the pharmacist faxed a prescription for Clomiphene Citrate 50mg to the home, however, the wrong medication, Clomipramine 25mg, was delivered. Staff failed to compare the written prescription to the pharmacy supplied label which resulted in Resident A receiving the wrong medication for 44 days.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Edith Richardson 02/27/2024
Licensing Consultant Date

Approved By:

02/29/2024

____

Ardra Hunter Date
Area Manager