GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 26, 2024

Amanda Ledford
Hope Network West Michigan
PO Box 890
Grand Rapids, MI 49501-0141

RE: License #: AS410407090
Investigation #: 2024A0340040
Neo Kentwood

Dear Mrs. Ledford:

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 June 5, 2024, 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 (616) 356-0183.

Sincerely,

Rebecca Piccard

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410407090
Investigation #:	2024A0340040
Complaint Receipt Date:	05/29/2024
Investigation Initiation Date:	05/29/2024
Report Due Date:	07/28/2024
Licensee Name:	Hope Network West Michigan
Licensee Address:	PO Box 890 Grand Rapids, MI 49518
Licensee Telephone #:	(616) 490-3684
Administrator:	Amanda Ledford
Licensee Designee:	Amanda Ledford
Name of Facility:	Neo Kentwood
Facility Address:	4605 Eastern Ave. SE Grand Rapids, MI 49548
Facility Telephone #:	(616) 430-9454
Original Issuance Date:	03/01/2021
License Status:	REGULAR
Effective Date:	09/01/2023
Expiration Date:	08/31/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was given the wrong medication which resulted in his hospitalization.	Yes

III. METHODOLOGY

05/29/2024	Special Investigation Intake 2024A0340040
05/29/2024	APS Referral received from APS
05/29/2024	Special Investigation Initiated - Telephone Deb Mock
06/04/2024	Inspection Completed On-site
06/04/2024	Inspection Completed-BCAL Sub. Compliance
06/04/2024	Exit Conference Amanda Ledford
06/05/2024	Corrective Action Plan Received
06/05/2024	Corrective Action Plan Approved

ALLEGATION: Resident A was given the wrong medication which resulted in his hospitalization.

INVESTIGATION: On May 29, 2024, I received a complaint from Adult Protective Services. It stated that on 5/26/24, Resident A was admitted to the hospital and was discharged the following day after being given another residents medication. This is reportedly the second time Resident A was given another resident's medication requiring hospitalization, with the previous incident occurring in February 2024.

On May 29, 2024, I received a call from Executive Director, Deb Mock. She informed me of the incident. She stated that Hope Network management was made aware of the situation after Resident A was taken to the hospital after having what appeared to be a seizure. Staff Sharon Harris reportedly acknowledged making the medication error. Resident A has returned to the home and Ms. Harris has been taken off the work schedule. I requested documentation from Ms. Mock which she sent to me.

An Incident Report (IR) was completed on 5/27/24 by acting Home Manager and Program Manager of Operations, Tmnit Mogos. It stated that Resident A was positive for Lamictal and Seroquil which he is not prescribed. Resident A is being released from the hospital and his parent/guardian is bringing him home prior to him returning to the Neo Kentwood adult foster care home.

I received a statement from Ms. Mogos which stated: *'Sharon Harris pulled me aside to let know that she was the one that made the medication error. She stated that when she was in the med room she had a residents medication in a med cup. She realized she didn't have water. She left the med room and went in the kitchen grabbed a cup of water and handed the cup of water to the resident whose meds she was passing. When the resident drank the water, she went back in the med room and hit administer on the MAR. She put the basket in the cabinet and went on to (Resident A's) medications. She then began to scan (Resident A's) meds and never realized that she never gave the other resident the cup of pills she added (Resident A's) meds to the cup thinking it was an empty cup. Therefore, (Resident A) took his meds and the other residents. She said she never realized it was her error until a day or 2 later.'*

On June 4, 2024, I conducted an unannounced home inspection. Resident A was on an outing at the time. Staff Bobby Willis was home and provided information regarding the incident. He stated third shift staff Sharon Harris had passed medications prior to leaving the home in the morning. Mr. Willis stated he did not personally observe Ms. Harris pass medications.

Mr. Willis had seen Resident A up and around that morning and stated Resident A "seemed normal" when he arrived for his shift to begin at 7 am. Mr. Willis stated Resident A ate breakfast and around 7:45 and at that time he noticed Resident A was acting and sounding "slow". Resident A then stopped responding and was "staring down". Another staff called 911 and then began making the required reporting calls. Mr. Willis stayed with Resident A and he began to "come around" prior to paramedics arriving. Mr. Willis believed the incorrect medications were "Seroquil and something else". Mr. Willis showed me the Medication Administration Record (MAR) for Resident A.

The MAR for Resident A on 5/26/24 showed Resident A was not given his PM medication on 5/26/24 or his AM medications on 5/27/24 when he was hospitalized. Mr. Willis showed me the MAR for another resident (Resident B) who is the only one prescribed Seroquil. All medications were marked as passed for Resident B.

There was a previous citation made in Special Investigation Report 2024A0340024, for this facility on March 6, 2024. This investigation resulted in a substantiated licensing rule violation that Resident A had been given medication not prescribed to him which caused him to be hospitalized. This is a repeat violation.

APPLICABLE RULE

R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	The allegation was made that Resident A was given the wrong medication which required hospitalization. Ms. Mock stated Resident A was taken to the hospital after having what seemed to be a seizure. Staff Sharon Harris acknowledged that she gave Resident A another resident's medications. Program Manager of Operations, Tmnit Mogos stated that Resident A was positive for Lamictal and Seroquil which he is not prescribed. Staff Sharon Harris reportedly acknowledged to the home manager that she made the medication error. Staff Bobby Willis reported that Resident A appeared fine at the beginning of his shift and then began "acting and sounding slow" and staring down. Staff called 911 and Resident A was taken to the hospital. Evidence was discovered through this investigation to confirm that staff gave Resident A another resident's medications. Therefore, a violation of the rule is confirmed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On June 4, 2024, I conducted an exit conference with Designee Amanda Ledford. After discussing the incident, I informed her it was a rule violation. She understood and agreed to send a Corrective Action Plan. She had no further questions.

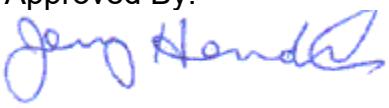
IV. RECOMMENDATION

Due to the violation established, a Corrective Action Plan was received which requested the closure of the home.

Rebecca Piccard June 26, 2024

Rebecca Piccard Date
Licensing Consultant

Approved By:



June 26, 2024

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Jerry Hendrick Date
Area Manager