GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 11, 2019

Thomas Zmolek
MOKA Non-Profit Services Corp
Suite 201
715 Terrace St.
Muskegon, MI 49440

RE: License #: AS700252511
Investigation #: 2019A0357002
Ferris Street Home

Dear Mr. Zmolek

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 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) 356-0101.

Sincerely,

Arlene B. Smith

Arlene B. Smith, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS700252511
Investigation #:	2019A0357002
Complaint Receipt Date:	11/13/2018
Investigation Initiation Date:	11/13/2018
Report Due Date:	01/12/2019
Licensee Name:	MOKA Non-Profit Services Corp
Licensee Address:	Suite 201 715 Terrace St. Muskegon, MI 49440
Licensee Telephone #:	(231) 830-9376
Administrator:	Thomas Zmolek
Licensee Designee:	Thomas Zmolek, Designee
Name of Facility:	Ferris Street Home
Facility Address:	17189 Ferris Street Grand Haven, MI 49417
Facility Telephone #:	(616) 850-0449
Original Issuance Date:	11/01/2002
License **Status:**	REGULAR
Effective Date:	05/20/2017
Expiration Date:	05/19/2019
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 11/08/2018 it was discovered that a staff member passed Resident B's medications to Resident A, causing Resident A to be lethargic and was transported to North Ottawa Community Hospital.	Yes

III. METHODOLOGY

11/13/2018	Special Investigation Intake 2019A0357002
11/12/2018	Contact - Telephone call received Phone Call received on 11/12/2018, from Frank Grotenhuis,the Home Manager.
11/13/2018	Contact - Telephone call made
11/13/2018	Special Investigation Initiated - Telephone To Tom Zyicks, the Regional Director.
11/13/2018	Contact - Document Sent To Briana Flower, Recipient Rights in Ottawa County.
11/13/2018	Contact - Telephone call received I received a telephone call from the Home Manager, Frank Grotenhuis.
11/16/2018	Contact - Telephone call made To Frank Grotenhuis.
11/20/2018	Inspection Completed On-site Reviewed facility paperwork and Resident files.
11/20/2018	Contact - Face to Face Brianna Flower and I conducted interviews at the AFC home. We interviewed Frank Grotenhuis, Direct Care Staff, Stephen Hentschel, and Records Assistant, Amanda Minzey. I also observed Resident A and Resident B.
11/20/2018	Contact - Document Received Received and reviewed documents: Staff Schedule, Medication Administration Records, Login Activity sheet for Medication

	administration, Med pass details, and an Incident/Accident Report dated 11/08/2018.
12/03/2018	Contact - Document Received From Briana Fowler, Director of Recipient Rights Community Mental Health of Ottawa County.
12/03/2018	Contact - Document Sent Emails sent to Briana Fowler.
12/06/2018	Contact - Face to Face Briana Fowler and I conducted an interview with Direct Care Staff, Angela Bertapelle at the AFC home.
01/09/2019	Contac -Document Received Resident A's and Resident B's, Health Care Appraisal, Treatment Plan and the Psychosocial Assessment.
01/10/2019	Contact- Telephone Call To Frank Grotenhis and Stephen Hentschel.
01/10/2019	Contact – Document Received The dates and times of Resident's Blood Pressure Results.
01/11/2019	Contact – Document Received Resident's A and B's Assessment.
01/11/2018	Contact -Telephone Call Received From Direct Care Staff, Rolanda Buford.
01/11/2019	Exit conference conducted by telephone with Thomas Zmolek, the Licensee Designee.

ALLEGATION: On 11/08/2018 it was discovered that a staff member passed Resident B's medication to Resident A, causing Resident A to be lethargic and was transported to North Ottawa Community Hospital.

INVESTIGATION: On 11/13/2018, I received a complaint from our Lansing office. This document stated that Ottawa County Department of Health and Human Services, Adult Protective Services did not open this complaint for investigation. The complaint read as follows: "(Resident A) (60) resides within Ferris Adult Foster Care Home. On 11/8/2018, it was discovered a staff member passed (Resident A) another individual's medication. (Resident A's) behavior was lethargic. Kalamazoo Long Term Pharmacy was contacted as well as poison control. 911 was called and (Resident A) was transported to North Ottawa Community Hospital. After an hour of monitoring at the hospital, (Resident A) was returned home. It is unknown which

staff member passed the medication at this time. (Resident A) may have been provided the blood pressure medication on 11/07/2018 or the morning of 11/08/2018. The pills were slightly eroded. It appears someone had the pills in their mouth and spit them out. The medications are kept locked away. (Resident A) does not have a roommate whom she could have gotten the medications from. There were two pills located in (Resident A's) bed. The blood pressure medication (Resident A) was given are passed twice a day, once in the morning and the night. The RS (referral source) interviewed staff who worked two prior days and they explained their routines, no one admitted to doing it or making a mistake…" Licensing staff and Recipient Rights staff were contacted.

On 11/20/2018, Briana Fowler, Recipient Rights Director of Community Mental Health of Ottawa County and I conducted an interview with the Home Manager, Frank Grotenhuis at the AFC home. He explained that Records Assistant, Amanda Minzey was making Resident A's bed when she found medications in the bed and she reported this to him. He stated they called their pharmacy, position control and 911.

On 11/20/2018, Mr. Grotenhuis provided a copy of the AFC Licensing Division – Incident / Accident Report, which I reviewed. The date on the report was 11/08/2018 at 7:00. The report read as follows: "I went into (Resident A's) bedroom to get her ready for the day and found (#80318) (Resident B's) Carvedilol 25 mg and Tramadol 50mg pill in (Resident A's) comforter/bed. It was partially dissolved. (Action Taken) Notified Supervisor, called pharmacy, checked blood pressure. Pharmacy advised to keep eye on her and call doctor if need be. A little while later (Resident A) vomited. I called doctor, then poison control and was advised to call 911. (Corrective Measures) Advised employees to closely monitor (Resident A) Pharmacy called, Primary doctor called, Poison Control called. Blood pressure low, 911 called and (Resident A) transferred to North Ottawa Hospital. Guardian/Parents notified. We will continue to talk with employees as we are uncertain if or when (Resident A) may have taken (80318) (Resident B's) medications." This report was signed by Amanda Minzey and Sheryl Williams, Residential Coordinator on 11/08/2018.

On 11/20/2018, we reviewed Resident B's Physician's Orders for her medications. Mr. Grotenhuis stated that she receives the medication Carvedilol tab 25 mg. "Take 1 tablet by mouth twice daily at 07:00, (7:00 AM) Daily at 20:00, 8:00 PM)." He explained that this medication was to control her high blood pressure. He stated Resident B has the prescribed medication Tramadol HCL Tab 50 mg. four (4) times per day at 07:00, 12:00, 16:00 and 20:00 and this is to help with her pain. Therefore, Resident B receives her prescribed blood pressure medication in the morning and in the evening.

We reviewed Resident A's Physician's Order for her prescribed medications. She does not have the prescribed medication, Carvedilol for high blood pressure and she has not been prescribed the medication Tramadol. He stated that he did not have evidence of the exact date when the mix-up may have occurred, but it was

discovered in the morning on11/08/2018. He interviewed six staff that had administered resident's medications and he asked each one to describe their steps they take when they passed resident's medications. He reported that each had their specific way and they had their order of who received their medications first, second, third, etc.. He also stated that each staff person denied that they had administrated Resident B's medications to Resident A. He explained that neither Resident A or Resident B would be able to be interviewed due to their disabilities. He reported that Resident A lays in her bed in the PM to watch videos, so she may receive, her medications when she was in bed. He stated; "She does not spit out her medications. The medications found in her bed were partially dissolved and these two medications were prescribed to Resident B." Resident A's bedroom is located on the main floor of the home. He reported that Resident A's blood pressure dropped significantly. He stated that Resident B receives her medications in yogurt, so she can swallow them safely. She receives a greater amount of prescribed medications than Resident A. He reported Resident B's bedroom is located on the lower level of the home and they take her medications downstairs to administer them to her. She does not come upstairs to receive her medications.

On 11/20/2018, Ms. Fowler and I conducted a face-to-face an interview with Amanda Minzey, who is the Records Assistant. She said she has worked in this home for eight (8) years. She verified she worked the first shift on 11/08/2018. She stated she did not pass resident's medications, but Direct Care Staff, Angela Bertapelle passed the medications. She stated further that at 8:30 AM she observed that Resident A was in bed sleeping. She said Resident A woke up and she went to the bathroom and picked out her clothes. She stated that Resident A is "always up before I get to her in the morning." She stated that she was making her bed when she saw two pills together on the quilt top. "One was round and white and the second one was oblong and white, and they were a little bit dissolved. I picked them up and put them in my pocket and she helped Resident A to the table." She said she looked the pills up and discovered they belonged to Resident B. She informed Mr. Grotenhuis as to what she had found, and he told her to destroy the pills, which she said she did. Ms. Minzey stated, Resident A was awfully sleepy that day and she stated she had slept all night. She reported that they checked her Blood Pressure and it was low, 90/60. She called their pharmacy they told her to watch her. She reported Resident A vomited on the couch next to another resident. She then called her Primary Care Physician who told her to call 911. Resident A's blood pressure went down to 70/50 or 70/40. Ms. Minzey told us that her blood pressure normally runs high. She reported the hospital staff got an IV started and they provided fluids including water and her blood pressure was coming back-up. She said she thought Resident A arrived at the hospital between 10:30 and 11:00 AM. She pointed out that the two pills she found did not have any yogurt on them. We asked her about Ms. Bertapelle and she told us that Ms. Bertapelle does not normally pass residents' medications. Ms. Minzey stated that Resident B's blood pressure had not been entered into the computer on 11/09/2018, and the staff can't close out the computer, until the blood pressure has been entered. She asked Ms. Bertapelle if she had taken Resident B's blood pressure and if she did what was it.

She stated that Ms. Bertapelle told her the blood pressure for Resident B. She said that the recording of the blood pressure is to be entered in the computer close to 7:00 AM and when she asked for it, the time was after 8:30 AM. She reported that she entered the blood pressure numbers into the electronic medical records, even though she had not taken the blood pressure herself. She reported that Resident B "acted differently," and she was asleep in her chair which is not normal for her to do.

On 11/20 2018, Ms. Flower and I conducted a face -to-face interview with Direct Care Staff, Stephen Hentschel. He stated he has worked in the home for two (2) years. He was not working when the incident occurred. He explained that Resident B takes all of her medications in yogurt on a spoon. He said that Resident A and Resident B do not get the same medications and that Resident B has many medications, which is way more more than Resident A' medications. Five (5) to 16 pills. He explained how he administers residents' medications and in what resident order. He stated that you need extra time to administered Resident B's medications because she can be aggressive and has exhibited challenging behaviors. He denied that he had ever given the wrong medications to any resident. He reported that he reviewed the medication record on the alleged incident (11/08/2018) and he found that the medications were administrated at 7:40 AM and the required blood pressure was documented late. We asked him how long it took him to administer the prescribed medications to the six (6) residents who reside in the home. He said it can take an hour to an hour and a half and sometimes longer. He stated that he did research on the computer and he was able to produce a "Med Pass Details," (Medications, Treatments, and Vitals.) He provided this sheet which recorded the date, each resident's name, the medication for each resident by name and the times that the resident's medications were administered. On 11/08/2018, Ms. Bertapelle's charting indicated that her med pass started at 7:00 AM and the last medication administered was recorded as 7:26 AM. This would indicate that Ms. Bertapelle administered all of the prescribed medications for 6 residents along with their treatments, vital signs, and blood sugars levels. According to the printed sheets that came from the computer, Ms. Bertapelle accomplished all of these tasks in 26 minutes.

On 11/20/2018, Mr. Grotenhuis stated he administers the residents' medication two times per week and he said it can take him any where from one (1) hour to 1 ½ hour. Mr. Grotenhuis confirmed that Resident B did have a higher blood pressure after the incident, on 11/08/2018, but he reported her blood pressure did stabilize and she was fine.

On 12/06/2018, Ms. Fowler and I conduced a face-face with Direct Care Staff, Angela Bertapellat, at the AFC home. She acknowledged that she is a staff at a licensed AFC home called Indian Trails where she works the third shift and it is considered a sleep staff which means she can sleep on the shift. She confirmed that she did work at Indiana Trails on the third shift and then she drove to Ferris Street Home to work the first shift on 11/082018. She also confirmed that she did administered the resident's medications, completed each prescribed treatment, took

vital signs and blood sugars, toileted some residents, applied creams, took blood pressures and blood sugars, and helped some to get dressed or take a shower. She reported it was a normal day and she passed medications to one resident at a time. She was aware that Ms. Minzey found pills in Resident A's bed, but she did not recall what the pills were. She stated no one refused their medications. She reported that she administered the medications to the residents whose bedroom are located on the main floor and then she went downstairs to pass medications to the residents whose bedrooms are located on the lower level. She reported that Resident B is located on the lower level and her medications are put into yogurt. She said, "I don't think I gave the meds wrong." She also stated, "There are a lot of meds here and treatments, nose sprays and taking of blood pressures and blood sugars. I know that I did Resident A last." (It should be noted that Resident A lives on the first floor and she told us that she did all the residents on the first floor before she went to the lower level.) We discussed the time frames to administrator residents' medications that the staff have one hour before the due time and one hour after the due time, which provides two hours to administrate medications. She acknowledged that she helped Resident B use the restroom. She said she did not take the blood pressures until later, so they were entered late. We asked her how long she thought it took her to administer the medications and to completed all of the treatments and she said, "45 minutes at least." We told her that Mr. Grotenhuis had worked on the computer which indicated Ms. Bertapellat, did the medication pass in 26 minutes. She said maybe Resident B was cooperative that day. She acknowledged that Ms. Minzey entered the blood pressure into the computer for her.

On 01/09/2018 I reviewed Resident A's Health Care Appraisal, Psychosocial Assessment, and her Treatment Plan. She has "a cognitive impairment resulting in the moderate range, intellectual disability." She also has a mood disorder and Severe Mental Retardation with obsessive compulsive traits/features. She has very limited verbal skills and is hearing impaired. I was not able to interview Resident A due to her disability.

On 01/09/2018, I reviewed Resident B's Health Care Appraisal, Psychosocial Assessment, and her Treatment Plan. The Health Care Appraisal include a diagnosis of Mental Retardation, depression and seizures. The following was written on the form, "does not respond verbally to questions (due to) mental retardation." She has a cognitive impairment resulting in the profound range. Her Summary Report recorded 32 medications which includes drops and topicals. "This past year, (she) struggled with an episode of severely high blood pressure." She was referred to a cardiologist for further treatment and her doctor has regular monitoring of her blood pressure and he prescribes three medications to allow her blood pressure to remain stable. She is non-verbal and communicates using vocalizations to those who are familiar with her. I was not able to conduct an interview with her due to her disability.

On 01/10/2019, Direct Care Staff, Stephen Hentschel, had checked the records for the readings of Resident B's blood pressure. Ms. Bertapellat had taken the blood

pressure on 11/08/2018. Recorded were the flowing: 8:51am 136/81. At 10:43am 90/67.

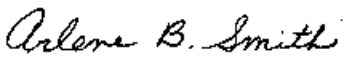
On 01/11/2018, I conducted an interview with Direct Care Staff, Rolanda Buford. She verified that she had administered the resident's medications on evening of 01/07/2018. She explained that she makes sure that the resident swallows each of their pills. She denied that she gave Resident B's pills to Resident A.

On 01/11 /2018 I conducted an exit conference by telephone with Mr. Thomas Zmolek, the licensee Designee and he agreed with my findings.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	On 11/08/2018, Amanda Minzey, found two pills, partially dissolved, in Resident A's bed and she determined that the pills were Resident B's, Carvedilol 25 mg and Tramadol 50mg. Mr. Frank Grotenhuis interviewed each staff, six in total, that had administered Resident's medications and he reported they all denied giving Resident B's pills to Resident A. Direct Care Staff, Ms. Buford, denied giving Resident B's pills to Resident A. Direct Care Staff, Angela Bertapellat was interviewed, and acknowledged she administered the residents' medications in the A.M of 11/08/2018. She stated, "I don't; think I gave the meds wrong." The total time it took her to pass medications according to the computer was 26 minutes and she estimated it took her at least 45 minutes.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

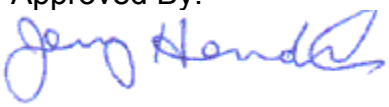
Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.



01/11/2019

Arlene B. Smith — Date
Licensing Consultant

Approved By:



01/11/2019

Jerry Hendrick — Date
Area Manager