GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 7, 2022

Stacey Waugh
Hope/Spectrum Health CCG
2775 East Lansing
East Lansing, MI 48823

RE: License #: AL330083930
Investigation #: 2022A0790039
Cedarwood Residential Services

Dear Ms. Waugh:

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 (517) 284-9730.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330083930
Investigation #:	2022A0790039
Complaint Receipt Date:	09/13/2022
Investigation Initiation Date:	09/16/2022
Report Due Date:	11/12/2022
Licensee Name:	Hope/Spectrum Health CCG
Licensee Address:	3375 South Division Grand Rapids, MI 49501
Licensee Telephone #:	(517) 332-1616
Administrator:	Stacey Waugh
Licensee Designee:	Stacey Waugh
Name of Facility:	Cedarwood Residential Services
Facility Address:	2711 East Lansing Drive East Lansing, MI 48823
Facility Telephone #:	(517) 332-1616
Original Issuance Date:	03/30/1999
License **Status:**	REGULAR
Effective Date:	03/13/2022
Expiration Date:	03/12/2024
Capacity:	14
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A received refills of Norco and Gabapentin on 08/29/2022. At 11:00 p.m. shift change medication counts were correct and it was verified he received three blister packs of Norco with 30 pills in each pack which matched the packing sheet. Medication counts took place again at 2:00 a.m. and 5:00 a.m. During the 5:00 a.m. count one of Resident A's blister packs with 30 Norco pills was missing.	Yes
ADDITIONAL FINDING:	Yes

III. METHODOLOGY

09/13/2022	Special Investigation Intake 2022A0790039
09/16/2022	Special Investigation Initiated – Telephone I interviewed direct care staff member direct care staff member (DCSM) Sawanda White via phone.
09/16/2022	Contact - Telephone call made to licensee designee Stacey Waugh. I left a voicemail message requesting a return call.
09/19/2022	Contact - Telephone call received from licensee designee Stacey Waugh. Ms. Waugh left a voicemail message indicating there is an ongoing internal investigation involving the missing Norco.
10/06/2022	Inspection Completed On-site
10/21/2022	Contact - Face to Face Interviewed Resident A at the facility.
10/25/2022	APS Referral called into Centralized Intake.
11/03/2022	Inspection Completed-BCAL Sub. Compliance
11/03/2022	Exit Conference with licensee designee Stacey Waugh.
11/03/2022	Corrective Action Plan Requested and Due on 11/17/2022
11/04/2022	Contact – Telephone call made to interview DCSM Lessy Toski.

11/04/2022	Contact – Telephone call made to interview DCSM Wasenka Hewage.

ALLEGATION:

Resident A received refills of Norco and Gabapentin on 08/29/2022. At 11:00 p.m. shift change medication counts were correct and it was verified he received three blister packs of Norco with 30 pills in each pack which matched the packing sheet. Medication counts took place again at 2:00 a.m. and 5:00 a.m. During the 5:00 a.m. count one of Resident A's blister packs with 30 Norco pills was missing.

INVESTIGATION:

On 09/16/2022 I interviewed direct care staff member (DCSM) Sawanda White, who functions as the residential supervisor, via phone about this allegation. Ms. White said the allegations have been reported to law enforcement and Detective Cotton from the East Lansing Police Department has been to the facility to begin his investigation.

Ms. White stated administrator and licensee designee Stacey Waugh was made aware of the allegations and is conducting an internal investigation.

Ms. White said the two involved DCSMs Wasenka Hewage and Lessy Toski are still employed, and no disciplinary action has been taken to date. Ms. White stated both DCSMs will receive a Medication Error Written Warning for incorrectly passing medications because neither followed the policy and procedures for passing and documenting medication administration. She said the Quality Team oversees this operational process and leadership is working with the Quality Team regarding follow up and next steps in the investigation. They are also waiting for further direction from Human Resources (HR) regarding what disciplinary action they feel is warranted given Ms. Hewage and Ms. Toski actions.

Ms. White said the facility has never had medication come up missing prior to this incident. She said they have searched everywhere for the medication but have not been able to locate it.

Ms. White said she spoke with pharmacy technician Adrianna, last name not known, at PharmaScript and she confirmed on 08/29/2022 that three blister packs of Norco with 30 pills in each were sent out and delivered to the facility for Resident A.

Ms. White said she was unsure why the second and third shift DCSMs conducted medication counts at 11:00 p.m., 2:00 a.m., and again at 5:00 a.m. the morning of 08/30/2022. She stated medications are normally checked once per shift and when

they first arrive from the pharmacy. Ms. White said the medications should have been counted at 11:00 p.m.

Ms. White said DCSM Wasenka Hewage stated she counted the medications two additional times because she wanted to double check to make sure the counts were correct. Ms. White said Ms. Hewage completed all the necessary documentation and signed off on the medication counts.

Ms. White said Ms. Hewage indicated at 11:00 p.m. shift change medication counts were correct and it was verified Resident A received three blister packs of Norco with 30 pills in each pack which matched the packing sheet. Ms. White said Ms. Hewage stated medication counts took place again at 2:00 a.m. and 5:00 a.m. Ms. White said Ms. Hewage stated at 2:00 a.m. the medication counts were still correct but at 5:00 a.m. one of Resident A's blister packs with 30 Norco pills was missing. Ms. White said Ms. Hewage stated she does not remember what she did with the medication. Ms. White said Ms. Hewage stated she checked the entire medication cart, trash area, and even other medication cards as well.

Ms. White stated there are three halls at Cedarwood and they are labeled as Apartment A, B, and C. She said Resident A is in Apartment C. Ms. White said Ms. Toski was working Apartment C the night of 08/29/2022.

Ms. White said Ms. Hewage was carrying the facility keys, which includes keys to the medication cart, the night of 08/29/2022 and stated she never gave them to Ms. Toski. Ms. White said Ms. Hewage was the only DCSM with keys to the medication cart the entire shift.

Ms. White said Ms. Hewage said she set the keys down at one point and went to step away for a second to grab her note pad at the staff desk and to her knowledge no one tampered with them. Ms. White said Ms. Hewage stated she laid the keys down one other time during her shift to clean but would have noticed if somebody took them.

Ms. White said Resident A received a PRN Norco at 6:18 a.m. signed out by Ms. Hewage on his electronic *medication administration record (MAR).* Ms. White said Ms. Hewage acknowledged she did not dispense the Norco from the medication cart at 6:18 a.m., did not sign the blister pack, nor administer the Norco to Resident A but did initial for the Norco in the electronic *MAR.*

I asked Ms. White if she could email me Resident A's electronic *MAR, Resident Care Agreement*, *Assessment Plan for AFC Residents,* and *Resident Information and Identification*. I also requested the written statements from Ms. White, Ms. Hewage and Ms. Toski. I did not receive any of these documents from Ms. White.

I conducted an unannounced onsite investigation on 10/06/2022 and interviewed Sawanda White and Stacey Waugh.

I again requested Resident A's electronic *MAR, Resident Care Agreement*, *Assessment Plan for AFC Residents,* and *Resident Information and Identification*. I also requested the written statements from Ms. White, Ms. Hewage and Ms. Toski. Ms. White and Ms. Waugh provided me with the requested documentation.

I asked to interview Resident A, but he was not at the facility. Ms. Waugh stated Resident A is the only resident capable of being interviewed at the facility because the other residents have severe cognitive impairments.

Ms. Waugh said she reported the theft of the blister pack of Norco with 30 pills to the East Lansing Police Department. She said the police report number is 2236402507 and Detective Cotton conducted the investigation. Ms. Waugh said on 11/05/2022, Detective Cotton informed her he is closing the case because of a lack of evidence the medication was stolen. She stated Detective Cotton said he found no evidence indicating the blister pack of Norco was missing due to theft.

Ms. Waugh said Resident A did not fail to get any of his routine or Pro re nata (PRN) as needed medication because of the blister pack of Norco coming up missing.

Ms. Waugh said there has been no evidence garnered indicating another resident took or ingested the 30 Norco pills. She stated no resident has been harmed because of the missing medication.

Ms. Waugh said Ms. Hewage has worked at the facility for approximately seven years and has had no previous medication errors nor an incident of missing medication. She said Ms. Toski has worked at the facility for a year and a half and has had no previous medication errors nor an incident of missing medication. Ms. Waugh said Ms. Hewage and Ms. Toski have both been exemplary employees up until admitting to committing a medication error and having a blister pack of Norco with 30 pills come up missing while they were on duty the morning of 08/30/2022.

Ms. Waugh said because of the medication error and missing medication, the facility is changing the way DCSMs are trained to pass medication and handle the keys. She stated DCSMs trained to pass medications must now always carry the keys to the medication carts on them. Ms. Waugh said they can choose to carry the keys three different ways. She said they can either carry them on a lanyard around their neck, on their wrist on a bungee wristband, or attached to their belt buckle. Ms. Waugh said DCSMs will not be allowed to set the keys down and will be disciplined if found to do so.

I reviewed Resident A's electronic *MAR* and other requested documents and found no discrepancies with the information provided by Ms. White and Ms. Waugh.

I reviewed Ms. White's written statement, and it reads as follows:

- "On August 30th at 9:00 a.m. I received a call from Wasenka regarding a patient's narcotic count being short 30 pills. Wasenka explained that the count was

correct was correct at the 11:00 p.m. count with the second shift staff and at 2:00 a.m. when she counted again. Wasenka stated that when she counted again at 5:30 – 6:00 a.m. the count was off by 30. Wasenka stated that she looked all over but could not find the 30-count bubble pack card anywhere."

I reviewed Ms. Hewage's written statement, and it reads as follows:

- "On Tuesday, August 30, 2022, at 5:40 a.m. I counted the narcotics in Apartment C and found that one bubble pack of 30 Hydrocodone were missing. I did narcotic count at the beginning of my shift at 11:00 p.m. (Monday August 29, 2022) with Cedric. I also counted the narcotics in all the apartments including C at 2:00 a.m. At 2:00 a.m. all the narcotics in C were present. I left Apartment C after counting the narcotics and went to the staff area to check on QuickMAR and noticed that one medication was incorrect. I went back to Apartment C at 5:30 a.m. – 5:40 a.m. to assist with patient care and medications and it was at that time when I counted the narcotics again and noticed that the bubble card was missing. Lessy was the staff in Apartment C that night and was popping [Resident A's] medications when I was down there. I do not recall if the keys were already there or if I set them down before leaving to grab a notepad/pen for report. I do know that I had the keys with me from 11:00 p.m. until 2:00 a.m. when I first counted the narcotics. I believe I took the keys with me when I left after originally counting but I cannot recall that for sure. I also do not recall if I brought them down with me at 5:30 a.m. or if they were already down there. But I was physically present in the apartment when Lessy was popping the narcotic for [Resident A]. I cannot 100% be sure that I had the keys with me between the hours of 2:00 a.m. and 5:30 a.m. due to extreme fatigue but I am certain that all the narcotics were present when I counted at 2:00 a.m." Wasenka Hewage

I reviewed Ms. Toski's written statement, and it reads as follows:

- "Hello, The morning of Tuesday August 30th, I can't remember if Wasenka gave me the keys or if the keys were sitting on the medication cart, but I was running behind because I had to leave at 6:00 a.m. I popped [Resident A's] medication, when I grabbed the bubble pack, I grabbed the first one that was already being used and popped it and initialed it, as I was getting ready to head into [Resident A's] room, Wasenka went back in to recount the narcotics and that's when we both realized the bubble pack was gone. As I stated before I was running behind and forgot to administer [Resident A's] medication, so Wasenka did it for me, but it was me who passed the medication before I left work."

I reviewed two emails sent to all HNNR Lansing Cedarwood Staff from Ms. White. The first one is dated 08/31/2022 and reads as follows:

- “Starting immediately the narcotic key for each apartment will be placed on the key ring with all the other apartment’s keys. All medication passers will be responsible to do narcotic count at the beginning and end of the shift for the apartment in which they have been assigned. If at any time another medication passer has to pass a narcotic for another medication passer a narcotic count needs to be completed immediately to verify that the count is correct. All medication passers are to always have the medication keys on them and the medication carts are to always be locked. I will be placing a hook and bracelet on the lanyard so that medication passers can choose how they would like to carry the medication keys. If you have any questions, please let me know.”

The second email is dated 09/13/2022 and reads as follows:

- “I wanted to remind all staff that when working at Cedarwood as a medication passer that you are counting narcotics with a Lead/AS or another medication passer when you arrive on your shift and when you leave your shift. Also when you receive your medication keys for the shift you are to keep the keys with you at all times, do not leave your keys on the medication cart, table or countertops. If you have any questions, please let me know.”

I interviewed Resident A face-to-face at the facility on 10/21/2022. Resident A said he did not even know some of his medication was missing before speaking to a detective from the East Lansing Police Department. He could not recall the detective’s name but stated the detective visited him at the facility and asked about the missing medication. Resident A said the detective asked if he knew of anyone who would take his medication. He said he told the detective he had no idea who might take any of his medication. Resident A stated he does not know when the medication came up missing but knows the missing medication was Norco which he takes as needed for pain management. He said he often experiences severe pain in his spinal cord because of a car accident. Resident A said the residential supervisor Sawanda White and facility nurse, name unknown, came to his room to talk with him about the missing medication but did not tell him when the medication came up missing. Resident A said he has not heard anything further about the missing medication.

Resident A stated he has never failed to receive his routine medication and has never been denied a PRN medication when he has asked for it. He said he has never not had a medication administered.

I called to interview DCSM Wasenka Hewage on 11/04/2022. Ms. Hewage said she was exhausted and overworked at the time of the incident and had nothing to add regarding the incidents on 08/30/2022 concerning the medication error involving Resident A’s missing blister pack with 30 Norco pills. Ms. Hewage stated she stood by the information she provided to the residential supervisor Sawanda White and in her written statement.

I called to interviewed DCSM Lessy Toski on 11/04/2022 via phone. Ms. Toski said she had nothing to add regarding the incidents on 08/30/2022 concerning the medication error involving Resident A nor the missing blister pack with 30 Norco pills and stood by the information she provided to the residential supervisor Sawanda White and in her written statement.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on information garnered during this special investigation through review of Resident A's *Resident Records, electronic MAR,* additional facility documentation, and interviews with DCSM Sawanda White, licensee designee Stacey Waugh, Resident A, DCSM Wasenka Hewage, and DCSM Lessy Toski there is sufficient evidence indicating reasonable precautions were not taken to ensure prescription medication was not used by a person other than the resident for whom the medication was prescribed. One of Resident A's blister packs with 30 Norco pills went missing the morning of 08/30/2022 and has yet to be located.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

Ms. White said Resident A received a PRN Norco at 6:18 a.m. signed out by Ms. Hewage on his electronic *medication administration record (MAR).* Ms. White said Ms. Hewage acknowledged she did not dispense the Norco from the medication cart at 6:18 a.m., did not sign the blister pack, nor administer the Norco to Resident A but did initial for the Norco in the electronic *MAR* as if she had administered the medication to Resident A.

Ms. Hewage provided the following information in her written statement: "I was physically present in the apartment when Lessy was popping the narcotic for [Resident A]."

Ms. Toski provided the following information in her written statement: “As I stated before I was running behind and forgot to administer [Resident A’s] medication, so Wasenka did it for me, but it was me who passed the medication before I left work.”

Ms. Hewage received a Written Warning for this medication error. I reviewed the Medication Error - Written Warning dated 09/30/2022 and it indicated this was Ms. Hewage’s first medication error occurring on 08/30/2022 and Poor Performance - Final Warning/Job Jeopardy was checked.

Ms. Toski received a Written Warning for this medication error. I reviewed the Medication Error - Written Warning which indicated Ms. Toski was receiving the written warning for popping, signing the bubble pack, and giving Resident A his medication but failing to sign off on the medication in the QuickMAR system. The Written Warning stated this was Ms. Toski’s first medication error occurring on 08/30/2022 and Poor Performance - Final Warning/Job Jeopardy was checked.

I conducted an exit conference with licensee designee Stacey Waugh on 11/03/2022 via phone informing her of the violations established during this special investigation and need for a Corrective Action Plan (CAP).

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4)(b) Complete an individual medication log that contains all of the following information: **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident’s refusal to accept prescribed medication or procedures.**

ANALYSIS:	Based on information garnered during this special investigation through review of Resident A's *Resident Records, electronic MAR,* additional facility documentation, and interviews with DCSM Sawanda White, licensee designee Stacey Waugh, Resident A, DCSM Wasenka Hewage, and DCSM Lessy Toski there is sufficient evidence indicating DCSM Wasenka Hewage initialed the electronic MAR - QuickMAR indicating she passed Resident A's PRN Norco at 6:18 a.m. on 08/30/2022, but DCSM Lessy Toski actually dispensed the Norco from the medication cart, signed the blister pack, and administered the Norco to Resident A not DCSM Wasenka Hewage.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

11/03/2022

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Rodney Gill Date
Licensing Consultant

Approved By:

11/07/2022

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Dawn N. Timm Date
Area Manager